Crossways Residential Home Limited

Crossways Residential Home

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 took place on 04 and 05 April 2017 and was unannounced. At the last inspection completed on 06 and 07 December 2016 we identified multiple breaches in regulation. The provider was in breach of the regulations around providing person-centred care, dignity and respect, obtaining consent and following the Mental Capacity Act 2005, safe care and treatment, safeguarding people, meeting people's nutritional needs, staffing levels and training, safe recruitment practices and good management of the service. The provider was also not submitting all required statutory notifications to CQC. A statutory notification is required when significant events arise such as serious injury or allegations of abuse. As a result of these findings we rated the service as 'Inadequate' and it remained in special measures. The provider submitted an action plan telling us how they would make improvements. This service first entered special measures following the completion of an inspection in August 2016.

Crossways Residential Home provides accommodation and personal care for up to 23 people. At the time of the inspection there were 17 people living at the service, most of whom were living with dementia. The registered manager had left the service in January 2017. There was a new manager in post who was in the process of becoming registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People were not always protected by a staff team who understood how to manage risks to them effectively. People were sometimes moved in way that increased the risk of injury to them. People were however protected by a staff team who understood how to recognise and report any signs of potential abuse or mistreatment of people.

People were supported by sufficient numbers of care staff. However, staff were not effectively deployed in order to ensure they were available to meet people's needs. People were supported by care staff who had been recruited safely. People mostly received their medicines as prescribed. However, some improvements were needed with the administration of topical creams. Steps to make these improvements were already in place at the time of the inspection.

Staff did seek people's consent and were using the Mental Capacity Act 2005, however this practice was not yet consistently being used across the service. People were supported to meet their nutritional needs, however further support was required to assist people during mealtimes. People were supported by a staff team who had recently undergone additional training. However work was still required to ensure the staff team's skills and knowledge enabled them to support people effectively in all areas of their care. People were supported to access healthcare professionals in order to maintain their day to day health needs.

People were mostly supported in a dignified way, however further support at mealtimes was required. Most care staff were kind and caring in their approach however this was not consistent across the staff team.

Some interactions with people were not kind and caring. People were offered choices however staff did not always understand how to communicate these choices effectively. People were supported to maintain independence in some aspects of their care although this was not consistent.

People's needs were not consistently met as some care staff did not understand specific support needs. Care plans did not always contain clear guidance to staff around how to support people effectively. People were involved in some activities and trips out.

People, relatives and staff were positive about the changes made within the service. Everyone felt more involved in the service and felt their views would now be listened to and heard. Complaints were being recorded and investigated appropriately.

We found new audit and quality assurance systems had been introduced into the service. However, we found this systems were still not adequately identifying the areas of improvement required within the service.

We found the provider was not meeting the regulations around the effective management of the service. 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.

People were not always protected by a staff team who understood how to manage risks to them effectively. People were sometimes moved in way that increased the risk of injury to them. People were supported by sufficient numbers of care staff. Staff were however, not always available to people when needed.

People were protected by a staff team who understood how to recognise and report any signs of potential abuse or mistreatment of people. People were supported by care staff who had been recruited safely.

People received their medicines as prescribed. Improvements were required in the monitoring of the administration of topical creams.

Is the service effective?

Requires Improvement

The service was not always effective

People's consent was sought although staff practice was not yet consistent. Staff did not always have the skills and knowledge to support people safely and effectively in all areas of their care.

People were supported to meet their basic nutritional needs during mealtimes. People were supported to access healthcare professionals in order to maintain their day to day health needs.

Is the service caring?

Requires Improvement

The service was not always caring

Care staff were not consistent in their approach with some interactions with people not being kind and caring. People were supported to maintain independence in some aspects of their care although this was also not consistent.

People were offered choices however staff did not always understand how to communicate these choices effectively.

People were supported in a dignified way although further support was needed at mealtimes.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's needs were not consistently met as some care staff did not understand specific support needs. Care plans did not always contain clear guidance to staff around how to support people effectively.

People were involved in some activities and trips out.

Complaints were being recorded and investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not well-led.

People, relatives and staff were positive about the changes made within the service. People felt more involved in the service and felt their views would now be listened to and heard.

Quality assurance and audit systems were not adequately identifying areas of improvement required and risks to people living at the service.

Crossways Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 04 and 05 April 2017 and was unannounced. The inspection team consisted of two inspectors. As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with three people who lived at the service and one relative. Most people living at the service were living with dementia and were not able to speak with us about their views around the care they received. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We spoke with the provider, the manager, the deputy manager and 12 members of staff; including the cook, assistant cook, domestic staff and care staff. We spoke with two visiting healthcare professionals. We reviewed records relating to people's medicines, six people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance.

Requires Improvement

Is the service safe?

Our findings

At the last inspection completed in December 2016 we rated the provider as 'inadequate' for the key question of 'is the service safe?'. We identified they were not meeting the regulations regarding the provision of safe care, safe staffing levels, safe recruitment practices and safeguarding people from abuse. The provider submitted an action plan telling us how they would make improvements. At this inspection we found the provider had met these regulations although further improvement was required.

During the inspections completed in August and December 2016 we found people were not being protected by the effective management of risks. We found people were being supported to move in a way that increased the risk of injury to them, staff were not effectively managing risks around behaviours that could challenge and risk assessments did not provide staff with the knowledge to safely minimise risks to people. We found improvements had been made around the management of risk connected to behaviours that could challenge although the provider was still not effectively protecting people from the risk of injury and harm.

People continued to be moved in a way that increased the risk of injury to them. We saw the provider had completed training with staff around how to move people safely, however, this training was not always being implemented safely. We saw two examples of people being hoisted in an unsafe way. During both examples we saw people were not seated safely and slings were too large for the people being supported. Staff were seen to be questioning the safety of the transfers. We heard staff saying, "It doesn't look right" and "This isn't the right sling". However they did not stop to ensure people's safety. Staff we spoke with told us they did not have clear guidance around which sling to use. One staff member told us, "There used to be list of who uses [which sling], but I don't know where that is anymore". We looked at people's care plans and risk assessments and found they did not contain information about which sling should be used or how they should be hoisted to keep them safe. We also saw someone being transferred in a wheelchair without being safely seated and their feet overhanging the supportive foot rests. Two staff members told us that this practice was regularly used by staff as the person had difficulty in bending their legs. We looked at the care plan and risk assessment for this person and found there was no information to advise staff how to keep this person safe while supporting them in their wheelchair. Their risk assessment outlined there were no issues with this person using their foot plates which did not reflect what we saw or what staff told us. We spoke with the manager and deputy manager about this concern and they were not aware staff were supporting the person in this way. The provider had not ensured staff consistently implemented the training they had received to supportpeople to move and transfer in a safe way.

We found that some areas of risk were being managed effectively. For example, risks associated with pressure ulcers were understood by staff and steps were taken to regularly move and turn people to reduce the risk of skin breakdown. However, we found other risks were still not being managed safely. For example, we identified two people that required an optical prescription but had refused to wear their glasses, one of these people also had two further conditions that affected their vision. Both of these individuals had experienced recent falls. The management and staff team had not considered the potential risks to these people. We found risk assessments were not present to provide guidance to staff around how to protect

these individuals from potential injury when they chose not to wear their glasses. We found accidents and incidents were now being recorded. However, we saw that risk assessments were not updated following accidents to provide guidance to staff about how to reduce the risk of the reoccurrence of accidents and further injury or harm to people.

We saw improvements had been made around the management of behaviours that challenged. The number of incidents arising in the service had reduced and staff knowledge around people's needs had improved. We found that improvement was still required to ensure the provider was effectively and consistently managing risks to people. At our last inspection we identified one person had assaulted other people living at the service. While a risk assessment around this person's behaviour had been introduced it did not adequately outline the risk to other people living in the service. Staff were not always able to describe how they used techniques the management team had advised were now implemented in order to protect others from the risk of harm. We also spoke with staff about another person who had been found in their room with an item of clothing around their neck. Staff members knew that regular checks should be completed if this person was in their room and we saw these were completed. However, both staff we spoke with told us they did not have a full understanding of the initial incident and the risks to the person. This meant checks may not always be effective in ensuring this person was kept safe. Effective communication with these staff to ensure they fully understood risk and how to protect people had not taken place. The provider was not ensuring clear guidance was in place and staff understood how to effectively manage key risks to people.

During the inspections completed in August and December 2016, we found there were insufficient numbers of staff available to support people. At this inspection we found the provider had increased staff levels during the day and there were sufficient numbers of staff available. We did however see at this inspection that the way that staff were deployed during the evenings meant that some people had to wait for support.

Most people were not able to share their views about the staffing levels in the service. One person did tell us they often had to wait for staff to support them. They told us, "Two minutes can go into hours, I know they're busy". Care staff told us they felt there were now sufficient numbers of staff available during the day. We saw that while the skills and communication of care staff sometimes impacted on the efficiency of the support provided, there were sufficient numbers of staff available to provide support during these times. However, during the evening we saw there were three members of staff working. One of these staff members was in the kitchen preparing an evening meal for people and one staff member was administering medicines. This meant there was one member of staff remaining to support 17 people. We saw this staff member struggling to provide effective support during this time. We also saw the one available staff member being required to provide one to one support to a person with behaviour that could challenge, meaning other people requiring support were left to cope alone. Staff told us they struggled with only one member of care staff supporting people at this time. We saw care staff had raised this concern during a staff meeting in December 2016 although no action had been taken by the management team. We found a staffing tool was in place to assist the provider in determining the numbers of staff that were required but didn't look at how staff were deployed. We spoke with the management team and provider regarding our observations. While the provider had not recognised this issue prior to the inspection, they have advised us they have taken steps since the inspection to change the timing of the medicines administration to ensure staff were deployed so that two staff members are available at all times.

During the inspection completed in December 2016 we found improvements were required in the management of people's medicines. At this inspection we found improvements had been made. We found medicines were being stored securely and the temperatures of storage areas were regularly monitored to ensure medicines remained effective. Where people needed 'as required' medicines, guidance was now in

place to outline to staff when and how this medicine should be given. Staff were now taking steps to support people in alternative ways prior to the administration of their 'as required' medicines which is in line with best practice guidelines. This had resulted in the reduction of the use of some of these medicines such as antipsychotic medicines, which we had found previously being administered at their maximum doses. We saw that most medicine was in stock, administered when needed and accurate medicines administration records (MAR) were held and updated. We did however find that the administration of creams was not always accurately recorded and one person had not had a supply of their cream for two days prior to the inspection. The deputy manager showed us a new system that had been introduced just prior to the inspection to address these concerns.

During the inspection completed in December 2016 we found staff and management were not recognising the serious nature of incidents that arose in the service. Safeguarding concerns were not being reported to the local safeguarding authority to be investigated. As a result steps were not put in place to ensure people were being protected from the risk of harm such as abuse and mistreatment. At this inspection we found improvements had been made. A relative told us, "I used to worry that [my relative] was here, but now I'm ok about it". Staff were able to describe signs of abuse and how they would report these concerns. We also found there had been examples of where staff had recognised and reported concerns. Measures had therefore been taken to protect people from further harm. We found concerns were now reported to the local safeguarding authority where appropriate. Staff also understood how to whistle blow if this was required and told us they felt confident to do so. Whistleblowing is when concerns about people are reported directly to outside organisations such as the local safeguarding authority or CQC. One staff member told us, "If I see poor practice I report it to the manger or deputy. I'd also write a report about what I'd seen. If [management] here didn't do something I'd report to the local authority or CQC." The management team were now keeping a record of all safeguarding concerns and any investigations completed. People were now more appropriately protected from the risk of ongoing abuse or mistreatment.

At the last inspection we found the provider was not ensuring people were sufficiently protected due to unsafe recruitment practices being used. At this inspection, we found improvements had been made to recruitment processes. We saw that pre-employment checks had been completed including identity, reference and Disclosure and Barring Service (DBS) checks. DBS checks allow the provider to review a staff member's potential criminal history to ensure they are appropriate for employment. We saw steps had been taken to contact some referees to ensure their identity and authenticity was checked and verified. Staff members were subject to appropriate pre-employment checks before they began working with people.

Requires Improvement

Is the service effective?

Our findings

At the last inspection completed in December 2016 we rated the provider as 'inadequate' for the key question of 'is the service effective?'. We identified they were not meeting the regulations regarding the training and skills of staff, the effective use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and meeting people's nutritional needs. The provider submitted an action plan telling us how they would make improvements. At this inspection we found the provider had met these regulations, although further improvements were still needed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the inspections completed in August and December 2016, we found staff and management had an inadequate knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). At this inspection we found where people had capacity to make decisions or provide consent, this was sought by staff members. One person told us care staff always sought their consent before providing care and support. Care staff we spoke with told us they sought consent and could give examples of how they did this. One member of staff said, "Because of capacity their needs are changing every day so we always ask them what they want". As most people were not able to share their views we completed observations of the support they received. We observed examples where care staff asked people before providing support but this was not always consistent where people did not have capacity. Where people did not have capacity to provide consent we did not always see care staff acting in their best interests. For example when making decisions about their day to day care and activities.

We found the knowledge of staff and management around the MCA had greatly improved. Staff had developed a basic knowledge of the MCA and how they should make decisions in people's best interests where they lacked capacity. One staff member told us, "I recently had MCA training, I learned new things. It's about making decisions in people's best interests". Another staff member told us they had changed the way they supported people due to the recent training they had received. They told us they gave people more time to enable them to make choices and do more for themselves. They explained they understood people could make unwise decisions and choices where people had capacity to understand these choices. We saw the management team had begun to record best interests decisions made on behalf of people where they had been unable to make a decision about or provide consent to specific decisions. We also saw that some further work was required to ensure that all decisions were made in line with the MCA. The management team had tried to consider potential decisions before the need to make them had arisen. For example, a decision had been recorded that one person should always receive medical treatment and support even if

refused. The MCA requires that decisions are considered at the time they are required and a person's capacity at that specific time should be considered. While improvements had been made and some decisions were now being made in line with the MCA, this was not always consistent and some people's rights were not being upheld.

Where people were being deprived of their liberty by care staff in order to protect their health and well-being, we saw the appropriate applications for authorisation had been submitted to the local authority.

During our last inspection we found the skills and training of staff were inadequate. Care staff and management had insufficient knowledge in areas such as dementia care, managing behaviour that can challenge, the Mental Capacity Act 2005 (MCA) and safeguarding people from abuse. At this inspection we found there had been improvements. Staff had completed additional training in areas such as moving and handling people, dementia and MCA. Staff told us they felt training and support had improved. They told us they were also now receiving regular supervision meetings with a manager. One staff member told us, "If we feel we need more training we can just ask. I'm being trained better and I can train new staff better." They also told us, "I've had more training in the last six months that I had in the last two years". Another staff member told us, "I had supervision with [the provider] and I told [them] I needed more training. [They're] organising this". A third staff member said, "We're having a lot more training in the areas we need". The provider had introduced a staff induction programme. They had also appointed a 'Staff Mentor' from the care staff team whose role was to induct new staff members and provide additional support to existing staff where required. The provider had taken steps to make improvements to the skills and training of staff members.

We found while staff skills overall had been improved, there were still some areas in which insufficient or ineffective training had resulted in people being put at risk of harm. For example, we saw all staff members had completed training in moving and handling people, however, they were not able to support people to move in a safe way. The management team had failed to ensure training was effective and embedded in staff practice. As a result we observed people being put at risk of injury while they were supported. We found the number of staff who had completed dementia training had increased, although over a third of the staff team still required this training. Staff did not always have the knowledge and skills to effectively communicate with people or to understand their behaviour. The management team had begun to complete spot checks and observations on staff care practice. This process had begun to identify and address areas of improvement required in staff skills and care practice. However, it had not yet been successful in fully addressing areas of improvement required. Staff skills had improved, however, improvements were still required to ensure staff were able to support people in a consistently effective and safe way.

During the inspection we completed in December 2016 we found people were not having their nutritional needs met. We found people were losing weight, they had insufficient food intake and adaptive cutlery had not always been made available when needed. The provider was not able to confirm people were receiving their nutritional supplements as prescribed and food intake records were not being accurately completed or monitored. During this inspection we found improvements had been made and there were no longer people at high risk of malnutrition. People who could share their views told us they had enjoyed their breakfast on the day of the inspection. People's weights were now stable, food intake was being accurately recorded and people were being more closely monitored to ensure they were not at risk. Where people were prescribed nutritional supplements these were provided and a record was kept of their administration. We also saw people were offered drinks regularly throughout the inspection. We saw a choice of food was available for people to select from and staff provided people with these options. We received positive feedback from a visiting healthcare professional regarding the staff team's progress in meeting people's nutritional needs. We also found that the cook and staff team understood where people had allergies or special diets, for

example where a soft diet was required. We did however still see that people continued to receive insufficient support during mealtimes. For example, we saw people still struggled to eat without staff support or appropriate adaptive equipment. People were no longer at risk of malnutrition, however, there were further improvements required to ensure people's needs were appropriately met.

People were not able to share their experiences of the service assisting them with their day to day health needs and helping them to access healthcare professionals when needed. We saw from records that there was regular intervention with healthcare professionals such as GPs, the chiropodist, Speech and Language Therapists (SALT), dieticians, the falls prevention team and community psychiatric nurses. We saw two visiting healthcare professionals reviewing the needs of people living at the service during our inspection. Improvements had been made in this area since our last inspection and the service was being more proactive in involving external professionals where required to help maintain people's health.

Requires Improvement

Is the service caring?

Our findings

At the last inspection completed in December 2016 we rated the provider as 'inadequate' for the key question of 'is the service caring?'. We identified they were not meeting the regulation around providing dignified care to people. The provider submitted an action plan telling us how they would make improvements. At this inspection we found the provider was no longer in breach of this regulation although further improvements were still required.

During the last inspection we saw people's dignity compromised. We found there was insufficient support available to people and staff were not recognising when care was being provided in an undignified way. We saw people left shouting out in distress for extended periods of time. At this inspection we found improvements had been made. While most people were not able to share their views around the care they received, one person was able to tell us staff upheld their dignity. They gave us an example of when staff supported them to go to the bathroom. They described how staff left them in private and returned when the person called them. Staff we spoke with were able to describe how they took steps to protect people's privacy and dignity. One staff member described how they ensured personal care was completed in private and how they encouraged people to do as much for themselves as they could. We saw that people's dignity was mostly protected during the inspection. However, insufficient support during mealtimes meant some people continued to be left struggling to eat which compromised their dignity. Care plans did address ways to protect people's dignity, however, people continued to be referred to in an undignified way. For example, one care plan stated, "[Person's name] does not need to eat on [their] own at mealtimes as [they] eat in an acceptable way". We spoke with the manager about this concern and they recognised this was not a dignified or respectful way to refer to people.

One person was able to tell us they liked the care staff. They said, "I have no complaints about the staff. They're all very nice and helpful". While we saw some very positive and caring interactions between care staff and people, this was not consistent across the service. We saw one person woken up by care staff and forcibly sat up without consent in order for the staff member to give this person a drink. We saw another person woken up and care staff began to feed them without consent. This person had their hand in front of their mouth and appeared confused. Care staff moved their hand to put the spoon in their mouth. These interactions were not kind and caring and this had not been recognised by care staff. We saw further examples of support provided at mealtimes not being caring. For example; people receiving meals from staff without caring interaction and support being provided. We did however see an improvement in the overall interactions by the staff team. We saw care staff being more proactive in spending time with people who demonstrated signs of distress. We saw the environment within the home was calmer and more relaxed than at the last inspection and people seemed more at ease. Staff told us they had also noticed a change in the environment. One staff member told us, "It's a happier place to come. The residents seem more settled". Another said, "The environment is so much better. It has really improved. It seems really calm. The residents are interacting more". We saw most care staff were well intentioned wanted to do the right thing by people living at the service. For example, we found care staff had volunteered to come to take people out in their own time to improve the quality of people's lives.

We saw staff trying to give people choices throughout the inspection. Staff told us they recognised the importance of providing choices. They told us they felt people should be able to choose what they ate, what they wore and what time they went to bed and recognised that people's needs and preferences were different. One staff member said, "Everybody's needs are different". Another staff member said, "It's their home at the end of the day. Nobody tells me what time I go to bed in my home so I'm not going to tell them". While we saw people being offered choices, consideration was not always given to people's communication needs, in particular due to their dementia. For example, when offering lunch choices we observed one person becoming distressed. We asked the staff member providing the choices if they had any picture cards. Once pictures were used the person was able to recognise a picture they liked and became more relaxed. We saw several examples of where people were given choices from a list and looked confused, struggling to answer. We saw further improvements were needed around the understanding of communication with people living with dementia. For example, one care plan outlined someone to 'communicate well' yet this did not match our observations and information provided to us by the staff team. We also found staff were moving people following falls if they told them they were ok, without considering that people with dementia may not recognise or be able to communicate any pain they may be in.

One person was able to share some examples of how staff involved them in jobs around the home. They told us this gave them purpose and helped them to remain independent. Staff told us they tried to help people retain independence by encouraging people to do as much as they could for themselves. For example, encouraging people to wash themselves where they were able to do so. We did see examples of staff encouraging people to be independent, however, we also saw examples of where staff did not always promote independence. For example, we found staff sometimes fed people rather than ensuring they had appropriate equipment to be able to feed themselves. We identified one person required an adaptive spoon to enable them to feed themselves independently. This spoon was not always made available to them resulting in the person trying to use their hands or being unable to eat without support. People's independence was not always fully promoted.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection completed in December 2016 we rated the provider as 'inadequate' for the key question of 'is the service responsive?'. We identified they were not meeting the regulation around providing person-centred care to people. The provider submitted an action plan telling us how they would make improvements. At this inspection we found the provider had met this regulation although further improvement was still needed.

During the inspections completed in August and December 2016 we found staff were not always aware of specific care needs. Care being delivered by staff and care plans did not always reflect people's needs. At this inspection we found improvements had been made although some care staff remained unaware of how to provide certain specific support to people.

Most people were not able to share their views about the care they received or their care plans. One person was able to tell us they had seen their care plan and had beeninvolved in developing this. We found care staff often did not have a clear understanding of how to meet some people's specific needs. For example, care staff had a poor understanding of how to use initiatives that managers had put in place such as doll therapy. The provider had given assurances that staff understood how to effectively use doll therapy in order to manage people's anxiety and behaviours that can challenge. During the evening of the first day of the inspection we observed a person who we were told regularly used doll therapy becoming increasingly agitated. We saw one staff member trying to support this person. We asked this staff member when they were required to introduce the doll therapy and they told us they were unsure as they had not been present when this was used. Another staff member we spoke to was also unable to describe how they effectively used doll therapy to support people. They told us, "We just offer a doll". We found further examples where care staff did not have the required knowledge; for example which sling to use when hoisting people or how to support people effectively during mealtimes. We looked at people's care plans to see if clear guidelines had been provided to care staff. We saw that despite care plans having been updated since the last inspection they did not always include clear instructions for staff to enable them to provide effective support in these areas. We found care plans did not outline how to use doll therapy to support people. We also found there was insufficient or inadequate information around specific needs such as adaptive cutlery or how to support people to move. We saw one person's care plan contained conflicting information about where this person ate their lunch. We saw this confusion reflected in the care provided by staff. We saw four care staff discussing where they felt the person should be eating lunch as they were not certain what the requirement was in order to meet the person's needs.

We saw poor communication between the staff team often led to people's needs not being met effectively. For example, we saw one person being asked to move to the dining area multiple times by four different staff members. We also saw one person asking a staff member for support to move to the dining room, guided back to their original seat by a second member of staff. People's needs were not always understood by staff members. Clear care plans and communication systems were also not in place to ensure staff were able to meet people's needs effectively in a person-centred way.

We saw reviews were being completed of people's care plans although these reviews were not always effective. For example; we saw one keyworker review completed stated that the person was now able to feed themselves. This did not reflect what we saw or the information given to us by the management and staff team about the support this person needed. We did see the provider was taking some positive steps to develop staff knowledge to help them meet people's needs. For example the newly appointed 'dementia lead' told us they were currently trying to work with GP's to identify the type of dementia each person had. They told us this would enable them to develop guidance for staff about how to better support each individual in order to meet their needs more effectively. While improvements were being made the provider had still not yet ensured people's needs were reviewed effectively and fully understood.

People were seen to be taking part in activities such as organised games during the inspection. We saw a member of care staff had taken on some additional hours to work as an activities coordinator. They had begun to speak to people about outings and activities that they would like to take part in and were creating a schedule of activities and events. Care staff told us they were given more freedom by the new management team to complete activities. One staff member told us, "[The new manager] lets us organise activities". We were told by staff they had taken people out to the pub for a carvery in the week prior to the inspection. They also told us people had enjoyed a visit from some ponies. We saw a compliment from a relative saying they had seen people happily singing to music during a visit. We did see that outside of these organised activities people were left sitting with minimal staff interaction or stimulation for long periods of time. We did see the TV on during the inspection and saw one person engaged in the daytime quizzes. However, we saw other people were not consulted about what they may want to watch or how else they may wish to spend their time. The provider had made improvements although some further improvements were still required.

A relative told us they felt able to share concerns if required. They told us, "If I wasn't happy I'd just say something, say what I think. I've got no concerns at the moment though; if I did I'd happily say". We saw people were being encouraged to share concerns and were getting involved in residents and relatives meetings. We saw one person had raised concerns through meetings and these had been recorded as complaints and addressed appropriately. We saw a record of complaints was now kept along with a recording of actions taken by the management team to resolve any issues.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection completed in December 2016 we rated the provider as 'inadequate' for the key question of 'is the service well-led?'. We identified they were not meeting the regulations around effectively managing the service and submitting legal notifications to CQC. The provider submitted an action plan telling us how they would make improvements. At this inspection we found the provider remained in breach of the regulation around effectively managing the service. They had met the regulation around submitting legal notifications to CQC.

During the last inspection we found the provider's quality assurance systems were inadequate. They had failed to recognise and identify the failings within the service. Since the last inspection the registered manager had left the service and a new manager was in post. The provider had also engaged the services of an external care consultancy to assist with making the required improvements in the service. We found that improvements had been made although further improvements were still required.

The provider had introduced a new audit and quality assurance system. This system included checks on infection control, medicines, care plans, laundry, first aid and accidents. We saw the management team were now developing action plans as a result of their findings from these audits and other sources of information, such as staff and residents meetings. We could see progress against the actions was reviewed and recorded. We did however find the audit and quality assurance system was still not effective in consistently identifying all of the shortfalls we found in the service during our inspection. We saw an audit had been completed of one person's care plan. This audit had not identified the gaps in the delivery of care to this person or missing information in the care plan; for example the lack of adaptive cutlery. We found the care plan contained conflicting information around how the person mobilised. There was a series of statements which outlined a range of support required from them being independent to requiring support from staff. A second care plan did not include the person's diagnosis of depression, nor did it provide guidance to staff around how to provide support when they demonstrated regular distressed behaviour. The audit system developed had failed to identify these discrepancies and therefore corrective action had not been taken to ensure the person's needs were met and their care records were accurate.

The provider had also not developed effective systems to ensure people's risk assessments were a clear and accurate record of their needs. For example, during our December 2016 inspection we identified that one person had assaulted multiple people. Their care plan and risk assessment did not reflect these events and the potential risk that remained to people. We did however note the incidents of behaviour had significantly reduced, however, the risk assessment did not clearly reflect this person's behaviour and the potential risk. Where risk assessments were in place we found they did not always reflect the individual needs of people. For example, we found risk assessments were often similar to other people's and many contained the names of other people living at the service. Two people had the same risk assessment in place for the use of a crash mat in their bedroom. The risk assessments did not adequately outline how to protect these people from harm such as injury. The staff and management team when asked, were not able to describe the risks they had considered for each person to ensure they were safe.

Effective systems to ensure risks to people were reviewed and action taken to minimise the likelihood of the reoccurrence of injury from accidents were not in place. We saw an audit of accidents was in place, however, this was a summary of the incidents that had taken place. There was no analysis completed to identify any reoccurring trends or the root cause of incidents. As a result no measures were being put in place to reduce the ongoing risk to people and care plans and risk assessments were not being revised to assist with the mitigation of risks. We saw where actions had been identified on accident records there was no system to ensure these actions were completed. For example, one person's accident record outlined they should use a plastic mug to reduce ongoing risk. During the inspection we saw this person using a normal mug and therefore the actions outlined were not an accurate reflection of the current support being provided. The provider had not ensured steps were taken in line with recommendations made to protect people from further harm.

The provider had not yet developed effective systems to ensure staff skills were appropriate and training provided was implemented safely by staff. We saw multiple examples of staff supporting people to move in a way that increased the risk of injury to them. We found staff had received training in moving and handling although observations of staff practice had not been effective in ensuring skills learned were sufficiently understood and implemented. We saw staff observations had identified some areas of improvement which had been addressed by management. However, this was not consistent. Where some areas of improvement had been identified by managers systems were not in place to ensure improvements were made. For example, we saw that managers had identified adaptive cutlery was not always available and flash cards were not being used. However, no action was taken to make improvements in these areas. These were areas that we highlighted as requiring improvement during our inspection.

We found further examples of where the provider had not yet developed systems to ensure records were accurately maintained and a clear and accurate record was being kept around people's care or actions taken. For example; the provider had created a 'You said, We did' board within the service which was a positive step to outline improvements being made. However, one action point outlined a stand aid had been purchased and delivered in February to assist with moving people safely. We were told by the management team during the inspection that this stand aid remained unavailable for use when supporting people. Healthcare professionals we spoke with told us they were pleased with the progress made with people's care although records were not always clear and easy to understand. We also found while the management team had begun to record best interests decisions in line with the MCA they had not always clearly recorded the individuals who had been involved in the decision. They had also often used other people's documents and changed the names which meant recorded decisions were not always unique and specific to the individual concerned. The provider had made improvements to recruitment practices although they had not ensured that a record of all required documentation was held. The provider gave assurances that a DBS check had been assessed and viewed for one staff member before they started work at the service. However, a record of this check had not been made. The provider did seek to obtain a further copy of this document shortly following the inspection to ensure they could record the check. The provider had made improvements to records within the service, however improvements were still required to ensure records were a clear and accurate reflection of support provided, people's needs and action taken.

We found the provider was working to involve the staff team in improvements and had appointed lead roles for staff members. This was still being developed at the time of the inspection. There were also team leaders responsible for each shift. The provider still needed to make improvements to ensure the role of the team leader was effective in ensuring risks were minimised and care delivery was effective. We found communication systems between staff during shifts were ineffective and resulting in some confusion with different staff members working at crossed purposes with people. We also found not all care staff were aware of who was responsible for leading the shifts and therefore who they should be seeking guidance

from. The provider needed to do further work to ensure roles and responsibilities were clearly established to ensure care provision was effective and efficient.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

People who were able to share their views recognised improvements were being made. One person told us, "I think it's a lot better". They told us they felt they could share their views with management and they would be listened to and heard. A relative told us, "Things have improved a lot here in the last six months, staff seem happier and that has to make a difference to my [relative]". People were being more involved in the development of the service. We saw people and relatives were being involved in meetings where the provider had given an update on the position of the service, including the recent CQC inspections and improvements required. We also saw people's views were being sought and the management team were beginning to take steps to make changes in the service to meet people's requests. For example, organising trips out, ordering different food and snacks and whether or not people wanted music playing during mealtimes. A relative told us, "We had a relatives meeting recently which was good, we haven't had one of those before". They also told us, "Things are much better it's never going to be perfect, but if it's heading in the right direction then I feel that's good". People and relatives could recognise the improvements being made and felt more involved in the service.

Staff also told us they felt more involved in the service. They were positive about the management team and told us they could see the improvements being made. One staff member told us, "Everything seems more professional now, I would have no problem talking to [the new manager] and telling them what I felt. I feel like we can make the changes we need to." Another staff member told us, "We can approach management more". They said, "Communication is a lot better between managers and staff. We're not in the dark now". A third staff member said, "[The new manager] and [the deputy manager] are a good partnership; I feel [the deputy] is supported by [the manager]. They also said, "We have staff meetings each month now, which is better; I feel we are being listened to now. I'd asked for a long time for an additional yellow bin downstairs, as it's better for infection control, we now have one". Staff were committed and motivated in their roles. They felt involved and listened to by the management team.

While we did see there were still improvements to be made, we saw the culture and environment within the service had improved. We saw staff still lacked the knowledge and skills to always recognise poor care practice, however, they were more willing to challenge the practice of other care staff. The provider and management team were supportive of this change in culture. Care staff told us the provider was more involved now and more visible in the service. Staff told us they felt care staff were working more effectively together as a team and the sickness levels of staff had reduced. One staff member speaking of the culture and environment told us, "It seems happier and much calmer". The provider acknowledged there remained significant improvements to be made within the service. However, they demonstrated a commitment to address the areas of improvements required and to develop a consistently good service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured effective systems were in place to monitor the quality and safety of the service being provided to people. Improvements required were not always identified therefore action was not always taken where needed.

The enforcement action we took:

We issued a warning notice to the provider which required them to be compliant with this regulation by a specified date.