Avante Care and Support Limited

Bridge Haven

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

The inspection was carried out on 26 and 27 April 2017 and was unannounced. Bridge Haven is a large single storey accessible service located in a residential area of the village of Bridge on the outskirts of Canterbury and close to public transport links. There are parking restrictions in the surrounding area but the service has a large car park.

The service provides accommodation and personal care for up to 53 older people with dementia; there were 37 people in residence at the time of the inspection. The accommodation is provided on one level and this is divided into two units 'Primrose' and 'Bluebell'. One unit accommodates 29 people and one unit accommodates 24 peoples. Separate dining and lounge areas are provided in each unit but these are visible from each unit and people can move freely between these areas.

At our previous inspection of this service in September 2016 we issued an enforcement notice for Regulation 17 in respect of quality monitoring and quality audits; these were shown to be ineffective in identifying and addressing recurrent and new breaches of regulation. We required the service to be compliant with the enforcement notice by the end of December 2016. We also issued requirement notices in respect of regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 16 Receiving and acting on complaints and Regulation 18 Staffing. We asked the provider to send us an action plan of what improvements they intended to make to address these shortfalls. An action plan was sent to us when requested. Since the last inspection we received information of concern about staffing levels and some care practice issues at the service

Since the previous inspection the service had seen a change in its management team. A new manager and deputy manager were now in post. The new manager had applied to register with the Care Quality Commission and their application was in progress. A registered manager is a person who is 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.

This inspection highlighted that overall progress towards meeting the regulations had improved but further improvements were needed. The provider had taken all reasonable steps to address the staffing issues, however, there was a need for staffing to stabilise and improvements to be embedded and sustained over a longer period of time. We have made a recommendation about this.

People and their relatives were involved in the development and review of care and support plans including end of life wishes, this informed and guided staff about people's needs and preferences. Relatives felt confident raising concerns and complaints were appropriately managed. People were able to make decisions and choices for themselves about how they spent their time, but there was no mechanism for recording their level of participation. People's behaviour was monitored using an appropriate tool. However staff needed guidance on how to monitor this effectively to help inform the support they provided to people.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent on a daily basis. However, improvements were needed in how staff recorded people capacity to make decisions. We have made a recommendation about this.

During inspection the atmosphere in the service was calm and the majority of people were in positive moods; those who were not were appropriately supported by staff. People lived in a well maintained clean environment where equipment for their use and safety was serviced and checked regularly. Care and domestic staff said they felt happier with the new management team and morale was improving. Relatives spoke positively about the care being delivered, the attitudes of staff and confidence in the new management team. They voiced concerns about the level of staff turnover, staff shortages and the use of agency and the impact this had on continuity of care for people, but felt things overall were improving.

Health professionals were positive about the general wellbeing of people. However, they felt the partnership working could be improved.

Recruitment checks of staff had been strengthened and improved to ensure new employees were suitable to work with vulnerable people. Staff showed they knew how to keep people safe from harm and abuse and risks were appropriately assessed. Staff received appropriate induction and training for their role and their performance, development and training was assessed through regular supervision and annual appraisal. Staff said they felt better supported and listened to by the new management team.

Staff treated people well and spoke kindly to them treating them with respect, ensuring their dignity was maintained. People were encouraged to retain as much independence as they were able to. New people into the service were assessed before admission to ensure their needs could be met. People were able to bring personal possessions to make their rooms more homelike and help them settle in. They were supported to maintain links with the important people in their lives. Visiting times were flexible and visitors were made welcome.

Relatives were provided with opportunities to express their views through family forum meetings.

We found a 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 consistently safe.

Staffing shortages remained a challenge to the service to ensure continuity of care and keep people safe. Medicines were not always managed safely to prevent harm.

The premises were in good order, important servicing was undertaken, and infection control improvements made. Risks were assessed to reduce the occurrence of harm. Accidents and incidents were reported and acted upon.

Staff recruitment procedures ensured important checks were made of their suitability. Staff understood how to recognise and respond to abuse to keep
people safe.

Is the service effective?

Good

The service was effective.

Systems were in place to ensure staff received appropriate induction, training to their role, supervision and appraisal of their performance.

Staff were working to the principles of the Mental capacity Act (MCA) 2005, and peoples consent was always sought for everyday decisions. People with behaviours that challenged required appropriate strategies to be developed.

People's nutritional needs were understood and they could choose from a varied menu. Healthcare needs were monitored and appropriate referrals made.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respect. Their privacy and dignity was respected and they were supported to personalise their own space with personal possessions to help them settle.

People were consulted about their care and end of life wishes and were provided with opportunities to comment about the service.

People were supported to retain important relationships and their relatives and visitors were made welcome.

Is the service responsive?

Good

The service was responsive

New people were assessed to ensure their needs could be met. Care plans guided staff in supporting people in accordance with their preferences and needs.

A programme of structured activities was in place that people could participate in if they chose to.

Complaints were recorded and acted upon and relatives felt confident of raising concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Good communication and networking had not been established with medical professionals. Quality monitoring had improved, however, required further development.

Communication with relatives and staff was good. Staff felt supported and found the new management team approachable. Staff had opportunities to meet together and to express their views.

The service notified the Care Quality Commission appropriately of events that affected the service.

Bridge Haven

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 checked 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 comprehensive inspection took place on 26 & 27 April 2017 and was unannounced. It was carried out by two inspectors on day one and one inspector on day two.

Prior to the inspection we looked at the previous inspection report and notifications about important events that had taken place at the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned a PIR within the set time scale. We also contacted six health and two care professionals for feedback.

Most people were not able to tell to us about their experience of living at the service although we spoke with many of them during the course of the inspection; six people were able to provide brief comments. We observed peoples interactions with their environment, each other and with staff. using an observation tool called the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight care staff about the care needs of people and the operation of the home. We looked at eight care plans; four in depth. This enabled us to see how people's care was planned and delivered. We also observed a handover from morning to afternoon staff. We spoke with five relatives during the inspection in addition to domestic, kitchen and administrative staff and the deputy manager.

During the inspection we viewed a number of records including five staff recruitment records, the staff training programme, staff rota, supervision and appraisal records, medicine records, environment and health and safety records, risk assessments, staff team minutes, menus, compliments and complaints logs and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "Oh yes I feel very safe here because there are always people around you know, so if I need anything I know I can just ask one of them [staff]" and, "They [staff] make sure I don't trip." A relative told us, "Our mum is safe here, we have peace of mind because we know she is well looked after 24/7." Although relatives spoke positively several expressed concern at what they saw as a lot of staff turnover and occasional shortages in staffing.

Concerns were raised with us that some people were not receiving their medicines. An external pharmacy audit had identified areas for improvement and the service was working through these. We checked the processes for receipt, storage, administration, recording and disposal of medicines including those that required safer storage. In general medicines were being managed appropriately but there were areas for improvement. For example medicines were not routinely dated upon opening. This meant that when gaps in administration occurred, particularly for 'as required' bottled medicines and creams, staff were unable to tell if medicines had been given or not. There were gaps in recording administration of some medicines including a prescribed steroid cream to be administered three times a day. However, this was administered at inconsistent frequencies so the person's skin condition was not treated consistently.

A medicine error had occurred because the checks made on prescriptions returned from the GP had not been effective in identifying a duplicate prescription. The person therefore received twice the dosage of medicines they were prescribed for, placing them at risk of harm. The monthly medicine audits were not completed effectively to ensure medicines were managed and administered to people safely.

There was a failure to ensure that medicines were managed safely and this is a breach of Regulation 12 (1) (2) (g) of the Health & Social care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

Our previous inspection highlighted that staffing and recruitment to vacant posts remained an on going issue for the service. Prior to this inspection concerns were raised with us that staffing levels were not always maintained during the day and at night. Also that agency staff were sometimes not booked to fill gaps in shift. There were concerns that some agency staff had no experience of supporting people with dementia needs. At the inspection we spent time talking with staff who confirmed that on occasion's shifts could be short but this was usually due to unexpected staff sickness. A review of agency bookings showed that a number of the gaps had been covered by agency staff but this was not always made clear on rotas. Staff said that occasionally they did have support from agency staff without the necessary knowledge of dementia or familiarity with Bridge Haven; this could be a frustration and unhelpful for them. Overall they thought most of the agency staff used were familiar with the service and experienced in dementia care.

Some gaps in shifts were covered from within the existing staff team including members of the domestic staff team; some of whom have dual domestic and care contracts. These staff provided care and support for breakfasts or some personal care tasks when required to do so by the team leader on duty. Staff rotas detailing care shifts were unclear when these staff provided cover for care hours. We discussed this with the deputy manager. We were informed that on one day in particular the service was short of staff. We checked

the nurse call system for that day and found that whilst 80% of the nurse calls made during that period were responded to within three minutes, approximately 16% were not. We found that 9% of calls were not responded to in less than ten minutes and people could have come to harm whilst awaiting a response. The overlap between the previous management team and the new management team made it difficult to assess whether there remains concerns with staffing levels within the home.

The provider was taking action to cover gaps in the shifts by reducing the numbers of staff on leave at the same time, using existing staff and agency staff familiar with the service and implementing a programme of recruitment to vacant posts. The unsettled staffing, lack of clarity within staff rotas coupled with anecdotal evidence from staff whistle-blowers and some relatives does not give us confidence that the measures implemented have had sufficient time to embed and make an impact. The provider had taken reasonable steps to address staffing shortfalls however further improvements could be made.

We recommend that the provider ensures sufficient staff are on duty at all times to meet people's needs

At our previous inspection we had found that some risks were not always appropriately assessed or managed. Individual risk assessments were in place for people who were at risk of trips and falls, choking, malnutrition, loss of weight, skin damage, or harm resulting from behaviours that challenge. Control measures to minimise risks were clear and appropriate. For example, plans of care for nutrition and hydration were in place for three people whose weight had reduced. Three hourly checks were carried out at night for a person whose sleep pattern was irregular and another person was provided with specific reassurance from staff when they experienced anxiety. Our observations and checks of relevant documentation confirmed that staff followed this in practice.

At the previous inspection the laundry area was without appropriate hand wash facilities for staff to fully meet infection control standards. The provider told us that they had installed a hand wash sink and we checked this was in place. The laundry was clean and there was appropriate separation of dirty, soiled and clean clothing. Staff used protective aprons and gloves appropriately. Cleaning rotas were in place and there were enough domestic staff to ensure the environment was maintained to a good standard of cleanliness.

Environmental and health and safety checks were carried out regularly to ensure the environment was safe and that equipment was fit for use. This included visual checks, maintenance of equipment and services, fire drills for staff and personal evacuation plans for people to ensure they were supported appropriately at a time of evacuation. Maintenance and repairs were recorded and completed in a timely manner. We noted however, that one of the hoist baths in one of the units had been out of service for some time. This did not impact on the people in that unit but was seen as inconvenient. We spoke with the duty manager about this.

Accidents and incidents were recorded by staff. An analysis of these was undertaken by senior staff to ensure that appropriate action had been taken and to look for emerging patterns or trends. Where necessary control measures were implemented to try to reduce recurrence, for example falls monitoring - a service user experiencing two falls would be referred to the falls clinic.

A business continuity plan was in place so that staff understood the actions they should take if an event that stopped the operation of the service occurred. Staff were provided with emergency numbers and out of hours support by the manager and deputy manager.

Staff understood the procedures to follow for reporting any concerns. Staff were able to identify different

types of abuse and were clear about their responsibility to report suspected abuse. Their training in the safeguarding of adults was up to date and had access to the service's safeguarding and whistle blowing policies. They told us they would feel confident that any reported concerns would be addressed appropriately by the management. A member of staff told us, "Our residents are very vulnerable; it is our job to protect them."

Thorough recruitment procedures were followed to check that staff was of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and work in the United Kingdom prior to starting work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. Gaps in employment history were explored and recorded. Staff were subject to a three to six month probation period. Disciplinary procedures were followed and action was taken appropriately by the regional manager Therefore people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Good

Is the service effective?

Our findings

Relatives told us that staff gave their loved ones the care they needed. They told us, "The staff obviously know what they are doing, they appear well trained and patient; they certainly understand [X] well and know how to approach her when she gets agitated" and, " We know the new manager, the team leader, and who the key worker is, we can communicate well with either of them." Health professionals said that they were satisfied that people's general care and support was managed appropriately.

At our last inspection we identified that measures to reduce the risk associated with people's health conditions such as diabetes, epilepsy, heart pacemakers and hernias were not adequately covered in people's records. People were not assured that staff would recognise signs of deterioration and take appropriate action and alert the relevant medical professionals if necessary. We also issued a requirement notice in regards to the absence of Mental Capacity assessments.

At this inspection we found improvements had been made. Criteria had been development for referral to relevant healthcare professionals. Support plans for conditions such as diabetes had also been developed. People's wellbeing was promoted by regular visits from healthcare professionals and plans were being developed for a visiting medical officer (VMO) to check and review people's medicines on a regular basis.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. 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 Deprivation of Liberty Safeguards (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 and were satisfied they were.

Training had taken place for the staff at the service in the principles of the MCA and DoLS. This enabled the staff to accurately describe the principles of the MCA. Some assessments of people's mental capacity had also been carried out. These covered areas such as their ability to participate in the care planning process, understand and sign their care plans; and for a person who declined taking their medicines. However, three consent forms, in five people's files had been signed by people who lived with dementia. These were not supported by an assessment of their cognitive ability. When people were offered routine vaccination against influenza, their mental capacity had not been assessed to check whether they were able to consent before the decision had been taken by relatives. The deputy manager and the Admiral nurse (these are specialist dementia nurses who give clinical and practical advice) employed by the service were aware of this. They had identified a need for a review of all people's care files to update the mental capacity assessments. This was in progress at the time of the inspection.

We recommend the provider seeks guidance and support from a reputable source regarding appropriate implementation and recording of people's capacity to make specific decisions affecting their lives.

Staff sought consent from people before they helped them move around, before they helped them with personal care and with eating their meals. We observed staff respecting people's refusals, for example to eat or participate in an activity. Staff used a different approach a short while later; to check whether consent could be obtained.

Staff received essential training to enable them to carry out their roles effectively. New staff received an induction, shadowed experienced staff and underwent competency checks before they were allowed to work on their own. When a satisfactory level of competency had not been attained, staff received regular updates and received additional support through supervision. Essential training was provided for care staff that included moving and handling, fire awareness, basic first aid, health and safety, safeguarding, mental capacity and 'dementia and relationships'. Ninety three of staff were up to date with their mandatory training. Additional training that was relevant to people who lived in the home was offered and delivered to staff. This included for example 'care of the dying', care planning and the principles of the Eden alternative (a philosophy aiming to combat loneliness, helplessness, and boredom experienced by older people in residential settings). There was an effective system to record and monitor staff training and highlight when refresher courses were due. The staff we spoke with were positive about the range of training courses that were available to them. One member of staff said, "We get good support with training here".

Staff were supported in their roles. They received quarterly one to one supervision sessions and were scheduled for an annual appraisal of their performance. Staff told us they were able to obtain informal supervision and support at any time. One member of staff told us, "This is time for me, where I can talk frankly about any problems I have within the job." The deputy manager checked staff knowledge acquired at their training during supervision, and asked staff to revisit the home's policies when necessary, setting objectives that were followed up until completion. Staff were encouraged to study and gain qualifications. Forty Nine percent of care staff had gained a diploma at level 2 and above during employment, and 8% were currently studying towards their qualifications.

Menus were presented in a pictorial form to ensure people could recognise the options that were presented to them. The kitchen staff were aware of people's dietary requirements, of any allergies, their likes and dislikes, and were promptly updated when there were any changes. Kitchen staff attended training to inform them about how to support people's different dietary requirements. Care staff provided unhurried and appropriate assistance with meals when needed, along with encouragement and prompting.

People were weighed monthly or weekly when fluctuations of their weight were noted. On admission a special dietary needs form was completed, that was shared with the cook. This included details of people's fortification needs and preferences, allergies and sensitivities. A food action plan took into account individual requirements, such as a vegetarian diet; refusals to be weighed; and relevant communication needs. Food and fluid intake was recorded when necessary for people identified as at risk which was monitored daily. People were referred to the GP, a dietician or a speech and language therapist (SALT) when necessary. Any recommendations were followed in practice, such as providing them with soft or pureed diets, thickened fluids, or helping them sit in a particular position when eating. Community nurses were called when a specialised mattress was needed to preserve a person's skin. Occupational therapist referrals were made to assess a person's need for equipment; and to a GP and community psychiatric nurse for behaviours that challenge. Chiropody, optician and dental services visited the home every six weeks or as required to provide treatment and assess people's needs. Emergency services had been called appropriately when people had become unwell or needed treatment at the hospital.

Good

Is the service caring?

Our findings

People told us that staff were "kind" and, "very nice people". "They (staff) are very good," Relatives told us, "The staff deserve a medal for their patience, they don't get annoyed, they seem to understand dementia because they are gentle and they keep smiling." Another said "He doesn't understand but he is fine, I visit several times every week and he always looks presentable." A third said "We are very happy with the home; we know his key worker and we talk with him when we come in."

Staff addressed people respectfully and with kindness throughout our inspection. They addressed people by their preferred names. People were encouraged, praised and appropriately conversed with during mealtimes and activities; appropriate banter was part of conversations. We saw a number of examples of kind and positive interactions between people and staff. When two people started to dance, staff paid attention to their mood, complimented them and briefly danced with them. Staff ensured people were comfortable and offered explanations ahead of any interventions, such as explaining where they were going, and which food was being offered at each mouthful. Staff showed kindness and were gentle in their responses, they understood and respected how people liked to be spoken to and engaged with. Sometimes staff were seen to touch people affectionately as they passed by them touching a shoulder or acknowledging the person, people actively sought staff out to stroke a hand or kiss a cheek and were seen to enjoy this contact.

Staff spent time with people and gave them one to one attention. Staff promoted people's independence and ensured walking aids were provided when necessary. People were encouraged to do as much for themselves as they were able to. A member of staff told us, "It is important to keep their skills going and if they can do things like wash part of their body we encourage them to do that." People's wishes were respected, such as having a late breakfast, stay in night clothes or remaining in bed.

People's relatives or their legal representatives were involved in care planning and decision making when necessary. They were informed of any changes of needs and were consulted when care plans were updated following a routine review or a review prompted by an event such as a fall, an incident, or a period of hospitalisation.

There was a key workers scheme in place. A key worker is a named member of staff with responsibilities for making sure that a person has what they need. The relatives we spoke with were aware of the key worker allocated to their loved one. They told us they were able to approach the key worker to obtain or provide information if the management team was not available.

Outside every bedroom there was a memory box. The person and their relatives were involved in filling this with items important to the person that they mostly recognised from their past. This helped the person to recognise that this was their bedroom; it also helped staff and others to see the person with all their rich life and history and not just someone with dementia. There was clear signage around the service that helped people recognise toilet and bathroom areas if they were able to manage their own continence. For those that needed support their continence needs were met quickly and in a discreet manner, as staff helped

people use the toilet facilities, closing doors while helping them with any personal care. People were well groomed and clothing had been chosen with care to help them maintain the appearance they would have wanted.

Peoples bedrooms had been personalised with photographs and possessions that were important to them, these helped settle them into their new life in the service. Some people spent a lot of time in their rooms and had books or family albums that they liked to look through on their own or with staff and visitors.

People were supported to maintain links with the important people in their lives, relatives and visitors were made welcome and could sit and have a meal with their relative if they wanted. "Gordon's cabin" a small tea room in the garden was a popular location for people to go in good weather with relatives. There was also a small room decorated as a pub "The Haven snug" this had a bar and small pub tables; some people liked to sit in here with their relatives to eat their meals. In good weather people had access to the garden area with seating. Some people went out with relatives for the day or a few hours when they visited. Staff reminded people of important dates in their lives including their relative's birthdays or anniversaries. The kitchen staff knew the dates of everyone's birthday or special anniversaries and produced birthdays cakes and tea for people to celebrate.

When people had expressed their end of life wishes regarding resuscitation or had made any advance care planning, this was appropriately recorded. Avante end of life care policy focused on the important areas that people needed support with at this time of their life. Staff received training in end of life care and the deputy manager told us of their plans to work in collaboration with a local hospice specialist palliative care team. Anticipatory medicines were kept for a person who approached the end of their life which showed arrangements for their pain management was appropriately planned.

Good

Is the service responsive?

Our findings

A relative told us, "Our mum cannot retain information and is constantly asking the same things, and the staff know how to get around this and reassure her; they understand what she means." Another relative said "I have had no cause to complain but I feel confident I would be able to."

At our last inspection we issued a requirement notice in regards to how complaints were handled and recorded. At this inspection we found improvements had been made. The complaints log showed that four complaints had been received since November 2016 all of which had been responded to and resolved. There had been no recent relative survey to ask whether they felt their concerns were being dealt with appropriately. However, relatives spoken with felt listened to and confident of raising concerns with the management team or team leaders. The complaints procedure was displayed which explained what action people or their relatives could take should they wish to raise any concerns with staff or management team.

Staff told us several people were on respite care at the service (this is temporary care provided as relief for their usual carer). Before admission to the service a pre-admission assessment was conducted by the manager, deputy manager or a team leader. Information to inform the assessment was gathered from a number of sources. Other professionals were contacted about the person to inform the decision as to whether their needs could be safely met by the service. Other sources of information included the person, their relatives or who may know the person well. People also had the opportunity to visit before moving in. However, because of the confusion and distress this could cause to some people, relatives usually undertook to visit on their behalf. Pre admission assessments viewed were completed well and provided a range of information for the manager and deputy to discuss with the assessor before a decision to admit to the home was made.

There was good communication between staff. Information about each person's care was handed over between team leaders at every shift change. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. The deputy manager also held a morning meeting with team leaders to oversee an effective sharing of information relevant to people's care and needs. Follow up action was taken from one staff shift to another. Shift leaders cascaded relevant information to staff members where necessary to ensure continuity of care.

People received personalised care. Their care plans addressed their social, cultural, spiritual, communication, medical and wellbeing needs. Care plans were person-centred and detailed, including their likes, dislikes and preferences about food, past and present interests, routine and communication. They included vital information about their life history and past occupation, and people or places that were important to them. People's individual needs were outlined in specific care plans. For example a plan of care for night-time instructed staff that a person did not like them to enter their bedroom. Another plan detailed that a person was upset about continence matters and how to reassure them.

Staff we spoke with were aware of people's care plans and these informed their practice. They

demonstrated a good knowledge of people's individual needs and could describe several people's likes, dislikes and how to meet their needs.

There were individual 'Antecedent-Behavior-Consequence' (ABC) chart in place for people whose behaviours may challenge. These are direct observation tools that can be used to collect information about triggers and events that were occurring within a person's environment. However, these were not being used effectively or as intended. Staff recorded every incident of behaviour rather than being focused on one type of behaviour, which helped to establish the triggers and a strategy for supporting this behaviour. As a consequence the strategies developed lacked detail and did not address the behaviour being exhibited. They only enabled staff to remove the person from the situation and space to calm down.

We recommend the provider seeks further guidance and support from a reputable source to establish how positive behaviour support can be developed within the service.

An activity plan was established for week days, this provided activities like hairdressing, 'walks in the sunshine', bingo, shopping trip, arts and crafts, music for health. Weekends were family time when people's relatives and friends visited. At the inspection we observed several activities over the two days including 'music for health' session where people were encouraged to have a small musical instrument to play and join in with others. We noted ten people present at this activity eight of whom were active participants. Staff encouraged people to join in but respected the decision of those who chose not to. During the afternoon a pianist played whilst a staff member sang softly with one resident because she could remember the words to the war-time song. Another staff member was helping another person with a puzzle as a distraction because the person was agitated. On the second day of inspection a group of approximately eight people were playing bingo with staff support whilst others sat and watched. Active participation in activities from the wider resident group was limited but a number of people observed the activities. It was unclear if this was passive or active observation and the benefit they derived from it. There was no mechanism in place for recording the levels of individual participation at any level or attendance amongst people. We discussed this with the deputy manager as an area for improvement.

Requires Improvement

Is the service well-led?

Our findings

Staff described the manager and deputy manager as, "approachable" and told us they felt able to voice any suggestions with the confidence that they would be valued and listened to. They told us that the management team operated an open door policy and they could go in the office at any time to discuss any concerns they may have. One member of staff told us of their respect and confidence in their team leader, saying, "[X] always makes time to listen and gives good advice." Another said "it's getting there, some staff are not happy with changes but things are getting better, I feel supported and confident in the new management". Relatives also told us they had confidence in the management team, saying, "The new manager and the deputy manager seem very good, if they stay it will be a relief to get some stability and know we can build a good rapport with them."

At the previous inspection we took enforcement action and issued a warning notice. There was lack of oversight of the service and progress had not been made, implemented and sustained with some continued and new breaches. At this inspection we found improvements had been made but further developments were needed in areas we have identified. For example the medicines audit completed by the manager was not effective in identifying the areas of concern we found at this inspection. Health and safety and infection control, were not added to the wider action plan in place for the service despite this being monitored by senior staff. This would ensure progress was being made. Quality monitoring is an area for further improvement.

We recommend that the provider ensures in house quality audits are carried out effectively to provide assurance that all aspects of care and operational support are adequately monitored.

The service had been without a registered team for some time. A new manager was in post and there was a clear management structure with manager, deputy manager and team leaders for care staff to report issues to. The new manager was applying for registration with the Care Quality Commission. Staff felt morale had improved and spoke positively about the support from the management team. They preferred the clear boundaries given to staff by the new manager and deputy and understood this did not suit everyone. The atmosphere within the service on the days of our inspection was relaxed, open and inclusive. Staff were seen to work in accordance to people's routines and support needs. Staff spoke positively about good communication which they felt had improved. They said they had more regular staff meetings at which they felt able to raise issues, they felt better informed and involved.

A health professional we spoke with was disappointed with the lack of communication and networking from the new management team about how they referred people to their service. Another medical professional said they found the service lacked co-ordination in the way it used their resource and did not make the best use of health professional's time. For example community nurses were present in the service every day between specific times. Whilst onsite community nurses said they were not routinely approached to look at other people who may have skin tears or other issues which they could deal with. These people were then referred separately to the community nurse service when some could have been seen by the visiting nurse that day. Another health professional told us that the service management team should have identify those

people who required reassessment for their dietary needs rather than refer everyone which had been resource intensive for their services.

Policies and procedures were updated centrally and sent out to respective services. These were then brought to the attention of staff who were required to read and sign they had done so. We checked a number of memos sent out to staff. These required that staff read the information and then sign they had done so. Only a few staff names were recorded as having read some of the important memos. It was unclear who was monitoring this to ensure information was being cascaded and whether this was the most appropriate way to do so This is an area for further improvement.

In the absence of the manager we met with the deputy manager who had been in post for three and a half weeks at the time of our inspection. They were visible in the service, knew people and staff by names and was knowledgeable about people's individual needs.

The deputy manager chaired a daily meeting with the team leaders and admin staff to be updated about current issues operationally and in regard to people's needs. New systems were being implemented to ensure aspects of the service were monitored on a daily basis. This was to try and overcome previous deficiencies in quality monitoring that allowed shortfalls to occur without being identified. Each team leader was provided with a daily tasks list to be completed on each shift. They allocated work to care staff which helped team leaders to keep track of tasks that must be completed each day. Staff said they liked the more structured approach from the management team.

Relatives were given opportunities to express their views at relative forums which were held regularly. A relative said people felt able to say what they liked at those meetings and felt they were useful. Surveys of relatives were conducted annually and were sent out by the provider, feedback was analysed and provided to the manager to identify any areas for improvement and an action plan was usually developed from this.

Staff referred to people appropriately in their records and reflected a positive attitude to the people they supported. Records were stored confidentially, archived and disposed of when necessary as per legal requirements.

The service management team ensured that the Care Quality Commission was notified appropriately of notifiable events that occurred in the service.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that medicines were managed safely to protect people from harm. This is a breach of Regulation 12 (1) (2)(g)