

The Orders Of St. John Care Trust

OSJCT Whitefriars

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?	Good 
Is the service responsive?	Requires Improvement 
Is the service well-led?	Good 

Summary of findings

Overall summary

This was an unannounced inspection carried out on 31 May 2018.

At the previous inspection in May 2017, we identified some improvements were required in two key areas we inspected; 'Safe' and 'Well-led'. This resulted in the service having an overall rating of 'Requires Improvement'. One breach of regulation was found, this was with regard to the Care Quality Commission (Registration) Regulations 2009, the registered provider had not notified us of information they were required to inform us about. The registered provider sent us information on how they intended to improve the rating to at least 'good'. At this inspection we found some improvements had been made however some improvements were still required.

OSJCT Whitefriars is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

OSJCT Whitefriars can accommodate up to 57 older people and people living with dementia. On the day of our inspection, 45 people were living at the service. The accommodation is a purpose built, single storey property. It is divided into five self-contained units or 'households' each of which has its own communal facilities and bedrooms. The households are called Fern, Poppy, Lavender and Primrose in each of which nine people can live. The other household is called Jasmine where 20 people can live. All of the households are intended to accommodate people who live with dementia, with Primrose and Jasmine being reserved for people who need the most support.

The service had a registered manager at the time of our inspection who had been in post since March 2018. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had safeguarding policies and procedures and staff were aware of their responsibility to protect people from avoidable harm and abuse. However, a concern was identified in how the management team had responded to a recent allegation of abuse. Risks associated with people's needs had been assessed. Whilst staff were aware of people's needs, recorded information to instruct and guide staff of how to manage risks, lacked detail or was out of date. Risks associated with the environment and premises had been assessed and were monitored regularly.

Safe staff recruitment checks were completed before staff commenced employment. The registered provider used a dependency tool to assess people's needs and staffing levels required. However, the deployment of staff required reviewing to ensure this was effective in meeting people's needs.

Some shortfalls were identified in the management of some medicines and with some of the infection control measures in place.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service were not always followed. Where people lacked mental capacity to consent to their care and support, assessments to ensure decisions were made in their best interest had not always been consistently or fully completed. Where people had a Deprivation of Liberty Safeguards (DoLS) authorisation, staff were aware of this and the person was cared for effectively.

People's nutritional needs had been assessed, but information to guide and instruct staff either lacked detail or was out of date. People received a choice of meals and drinks and support to eat and drink where required.

The registered provider had policies and procedures that were based on current legislation and best practice guidance. Staff received an induction, ongoing training and support.

People were supported to access health care services and staff worked with external healthcare professionals in the management of their health care needs.

Staff were aware of people's needs, routines and what was important to them. Staff were kind, caring, and they supported people ensuring their privacy, dignity and respect was met. Independence was encouraged and supported. Information about independent advocacy services was available.

Staff had information to support them to understand people's needs, preferences and diverse needs. However, this information lacked detail in places or was out of date. People received opportunities to participate in meaningful activities. The provider's complaint policy and procedure had been made available to people who used the service, relatives and visitors. People and their relatives received opportunities to review the care and support provided. Consideration to people's advance decisions in relation to their future care needs had been made.

The registered provider had met the Accessible Information Standard because they had considered and assessed people's communication and sensory needs.

The service had a new and experienced management team and people, relatives and staff were positive about their leadership and improvements made. Systems and processes were in place to monitor and improve the quality and safety of the service. An action plan was in place to drive forward continued improvements. People who used the service and their relatives received opportunities to share their experience about the service.

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.

Processes were in place to take action when allegations of safeguarding were made. One allegation of safeguarding had not been responded to as expected.

Information to inform staff of how to manage risks associated with people's needs, lacked detail or were not up to date.

Staff deployment needed reviewing. Safe staff recruitment checks were in place.

Some shortfalls were identified in the management of some medicines and with some infection control procedures.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

The Mental Capacity Act 2005 had not always been fully adhered to.

Information about people's nutritional needs had not always been kept up to date. People had a choice of meals.

People's care was provided in line with best practice and current legislation. Staff received an induction, ongoing training and support.

People received support with any associated healthcare need and staff worked with healthcare professionals to support people appropriately.

The design and layout of the building met people's needs.

Is the service caring?

Good ●

The service was caring.

People were cared for by staff who showed kindness and compassion in the way they supported them. Staff were

knowledgeable about people's individual needs.

People had information about independent advocacy services to represent their views if needed.

People's privacy and dignity were respected by staff and independence was promoted.

Is the service responsive?

The service was not consistently responsive.

Information to instruct and guide staff about people's needs lacked detail or was out of date. Important information such as people's life history lacked detail or was not available.

People were involved in reviewing their care and support needs.

A complaints procedure was available that informed people of their rights to make a complaint.

People's advanced decisions about their future care needs had been considered and recorded. Plans were in place to complete end of life care plans.

Requires Improvement ●

Is the service well-led?

The service had a new and experienced management team. People, relatives and staff were positive of their leadership, and improvements they had made since being in post.

People received opportunities to share their experience about the service.

There were processes in place for checking and auditing safety and quality. The management team had a commitment to continually drive forward further improvements and an action plan was in place to achieve this.

The registration and regulatory requirements were understood and met by the registered manager.

□

Good ●

OSJCT Whitefriars

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 was a comprehensive inspection that took place on 31 May 2018 and was unannounced. The inspection team consisted of two inspectors and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return to plan the inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law. We also sought feedback from the local authority commissioning team. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority or by a health clinical commissioning group. We also checked what information Healthwatch Lincolnshire had received on the service. Healthwatch Lincolnshire is an independent organisation that represents people using health and social care services.

On the day of the inspection, we spoke with seven people who used the service and four visiting relative's for their views. We observed care and support in communal areas of the service and used 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.

During the inspection, we spoke with the registered manager, deputy manager, the area operations manager, the cook, an activity coordinator, a senior care worker, four care workers and the laundry person. We looked at all or parts of the care records of eight people, along with other records relevant to the running of the service. This included how people were supported with their medicines, quality assurance audits, training information for staff and recruitment and deployment of staff, meeting minutes, policies,

procedures, and arrangements for managing complaints. We also spoke with a visiting GP.

Is the service safe?

Our findings

The provider had systems and processes in place to guide staff of how to safeguard people against the risk of abuse, avoidable harm and discrimination and staff followed these. People told us they felt safe living at the service and relatives told us they were confident their family member was cared for safely. A person said, "Yes, I feel safe living here, there is no animosity." A relative said, "Yes I feel my family member is safe living here and I know they (staff) don't just let people wander in here. At least visitors don't have codes to let themselves in. It's a safety precaution."

Staff told us they had completed safeguarding training and were aware of the signs and indicators of potential abuse and discrimination. A staff member said, "Any concerns are recorded and reported, the manager then takes action."

Whilst we were aware the registered manager had taken action when safeguarding concerns had been reported, we were concerned of how one allegation of a safeguarding concern had recently been dealt with. This had not been reported to the local authority safeguarding team or CQC. After discussion with the registered manager, they reported the safeguarding concern as required and this was completed on the day of the inspection. Additional action was also taken after our discussion with the registered manager to ensure there was no risk to any person.

Risks associated with people's health and safety needs had been assessed and plans had been developed to instruct and guide staff of how to manage any known risks. Risks assessed included pressure ulcers, nutrition and falls. However, there was limited information in two people's care records of actions taken by staff to reduce these risks. For example, these people had falls, which resulted in a broken hip for one person. Their care plans did not show these plans had been reviewed as a result of the falls. Additionally, there was nothing recorded to show if further interventions had been implemented to reduce further reoccurrence. A staff member told us of another person who had experienced a fall and the action taken in response to this. This showed that consideration had been given to factors influencing falls. In this example it was identified there was a problem with the person's footwear and after this had been addressed, the person had not had any further falls.

The management team told us they were aware there were some inconsistencies in documentation, but were confident appropriate action had been taken to reduce risks and that this was a recording issue. From reviewing the analysis of accidents, incidents including falls, there was no reoccurring themes that highlighted any person was at significant risk. We therefore concluded, documentation had not always been completed to fully reflect action taken to mitigate risks.

Some concerns were identified about how staff responded to requests for assistance. A person told us they had to sometimes wait for assistance. This person said, "My only down thing to say really is that it takes them (staff) a long time to come to me when I press the buzzer. I sometimes am wet, like now, and it's uncomfortable." We were present when the person used their buzzer to request assistance and it took eight minutes for a staff member to respond. Another person said, "They (staff) do come whenever I press my

buzzer, but I try not to use it too much as they are busy and that you know."

Staff overall said they felt when the planned number of staff were on duty, they had enough staff to meet people's needs. They said they had "run short" a few times and there had been staff vacancies, but new staff were being recruited. A member of staff told us night shifts had been short staffed, but there was now an agreement to have an extra member of staff on night duty. The management team agreed this was correct and told us how staffing levels had increased in recent months. This was supported by a visiting GP who confirmed staffing had improved, "In the last month or two." The provider used a dependency tool to assess what staffing levels were required. We concluded there were sufficient staff provided, but the deployment of staff required reviewing to ensure staffing was used effectively.

Some shortfalls were identified in the management of people's prescribed medicines. The temperature of the room used to store medicines was above the recommended limit. The management team told us they were aware of this and showed us correspondence that confirmed a new air conditioning unit had been ordered. Some liquid medicines, topical ointments and creams were not labelled with the date of opening. This is important because once opened they have an expiry date. People's medicines administration records (MARs) showed of two instances when oral medicines were not signed as being given. There were also occasional gaps in the administration record for some eye ointments and drops. When people were prescribed topical creams, their cream charts stated the creams should be applied as directed. However, there was no information that provided this information. We noted an external pharmacy audit record dated July 2017, had identified the same issue. The management team told us they had followed this up but was experiencing difficulties resolving the issue.

People told us they received their medicines safely. One person said, "I have my tablets given to me when I require them and I've never had a problem with them."

Processes were in place for the regular ordering and supply of people's medicines. Where people had specific needs with regard to the administration of their prescribed medicines, this was recorded and followed by staff. Staff confirmed they had received training and competency checks on medicines management and records confirmed this.

The environment was visibly clean and hygienic. During the inspection, we observed the housekeepers cleaning people's bedrooms and the communal areas. We reviewed the cleaning schedules and saw they were consistently completed and they provided evidence that daily and weekly cleaning duties were systematically undertaken.

Care staff were aware of the action to be taken when people had infections to reduce the risk of cross contamination. There were sufficient supplies of personal protective clothing and equipment for staff to use. We identified the bags used to store soiled and infected linen were not water soluble. Best practice guidance recommends bags are water soluble as this is the best way of reducing risks associated with cross contamination. The management team told us they would change their procedures of how they managed laundry, to ensure it followed best practice guidance.

Staff had received training in the prevention and control of infections, including food hygiene. An environmental health inspection of the kitchens in 2017 gave the service a level five rating (highest awarded).

Some people living with dementia or mental health needs experienced periods of anxiety that could affect their mood and behaviour. The management team told us people's behavioural needs were low level. We

saw an example of a person's care plan that instructed staff of the signs for low mood and the action required to support the person during this time. A staff member told us how they supported people with any behaviour and said, "We must respect people's rights, if it is not critical we leave it (support provided) and we try later or someone else will go back."

People were supported safely when being assisted with their mobility needs. We saw staff supported people using a hoist to transfer them into different seating positions. Staff were seen to follow best practice guidance, ensuring the person was safe at all times. People looked relaxed and reassured in their demeanour throughout these transfers, and the staff members appeared confident in their manoeuvres.

People were living in a safe, well maintained environment and there were systems in place to minimise risks. This included risks associated with fire and legionella, and control measures were in place to reduce risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were risk assessments in place in relation to the risks people faced if they needed to evacuate the building in an emergency. Staff had access to the provider's business continuity plan that advised of the action required should there be an event that affected the safe running of the service.

People were supported by staff who had been through the required recruitment checks as to their suitability to provide safe care and support. These included references and criminal record checks. Recruitment files showed the necessary recruitment checks had been carried out. Staff also confirmed they commenced employment after checks had been completed.

The provider had systems and processes in place to record, review and monitor any accidents and incidents. Senior management also had oversight and reviewed this information for lessons learnt.

Is the service effective?

Our findings

The Mental Capacity Act 2005 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.

We checked whether the provider was working within the principles of the MCA. We identified some shortfalls with how the principles of the MCA had been followed. For example, a person's care records stated they were living with dementia and information indicated they could consent to their medications but would decline at times. However, this was inconsistent with the information provided in other parts of their care plan. For example, information indicated it was unlikely the person would be able to understand the information relating to their medicines and therefore was unlikely to be able to give informed consent. Another person's care records showed a family member had made a decision about an aspect of their care needs, but they did not have legal authority to do this. There had been no recorded assessment or best interest decision completed, to show how this decision had been made. The care records for a further three people contained a mental capacity assessment for them living at the service and for their care and treatment. The best interest decision stated care would be provided in their best interests. However, the individual decisions and other options which were considered, were not recorded.

The management team told us they were aware that improvements were required in how the MCA was used, when people lacked mental capacity to consent to their care and support. The management team told us they were reviewing people's care records and this included reviewing people's capacity to consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications to the local authority when concerns had been identified about people's freedom and liberty. Where authorisations had been granted to restrict people this was known and understood by staff. At the time of our inspection, no person had conditions attached to their authorisation.

We saw examples where people had signed documents in their care records as a method to demonstrate they had consented to their care and support. We saw some care records for people who had a decision not to attempt resuscitation order (DNACPR) in place and found these to have been completed appropriately. Some people had lasting power of attorney (LPA) that gave another person legal authority to make decisions on their behalf.

People had their needs assessed in relation to their nutritional needs. Care records contained nutrition assessments and care plans to advise staff of their support needs. However, the information in them was not always up to date. For example, one person's care plan stated their food and fluid intake was to be recorded, but staff said the person ate well and did not require a food and fluid chart. Action taken when a

person was identified to lose weight was inconsistent. For example, a person's care records stated due to their weight loss they required their weights to be taken weekly. However, their records showed this had been monthly. Where a person had been identified as requiring their fluid intake recorded, the target of fluid required was far too low and the recordings of intake did not always show this target was met. For example, a person's target fluid intake was recorded as being 500 / 750mls. We discussed this with the management team who agreed this calculation was incorrect. We did see some evidence that when a person lost weight they had been reviewed by their GP and nutritional supplements were provided. We concluded that people's information was not kept up to date to reflect their current needs.

People had a choice of meals. A person said, "The food here is okay, there's always plenty of it. It could be more interesting sometimes though." The head cook told us they had recently reviewed the menu and had made some alterations based on feedback received from people. The cook told us the menu was due to be implemented imminently.

Some people could recall being offered a choice of meals and we saw the cook asked people in the morning what their choice was from the two options available. We also saw how staff showed people the choice of meals at lunchtime. This visual choice was supportive and enabled people to make a full informed choice and was good practice in care of people with short term memory needs. People were encouraged to eat independently and were prompted where necessary. Where people needed full assistance, staff assisted and provided support in an unhurried way.

However, we saw an example where a person could have received a better lunchtime experience. For example, we saw a person at 12.45pm ask staff if they could have a sandwich instead of the cooked meal. After two repeated requests, they were served their meal at 1.35pm. Staff had served the person a pint of beer in the meantime and the cook was seen to apologise. We were advised later that a member of the kitchen staff had to leave, to assist at another service within the organisation. This therefore had impacted on all people receiving a positive mealtime experience.

People's care was provided inline with best practice and current legislation. Staff used nationally recognised tools to assess risks of pressure ulcers and nutritional risk. Assessment of people's needs, included the protected characteristics under the Equality Act and these were considered in people's care plans. For example, people's needs in relation to any disability were identified. This helped to ensure people did not experience any discrimination. Staff had access to policies and procedures, which referenced national guidance. Leaflets were available for people about dementia and there was a booklet for staff on dementia care, providing practical advice about the symptoms people living with dementia might experience and how staff could best support them.

People were supported by staff that had received an induction and ongoing training and support. People who used the service and visiting relatives were confident staff were knowledgeable about their needs and that they were supported by staff who were competent.

Staff were positive about the support they received. Staff told us about their induction that was structured and supported them to understand their role and responsibilities. A staff member said, "I completed an induction, started my care certificate and shadowed staff who have been really supportive, there's some wonderful staff." The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life. Staff also told us they were reminded when their mandatory training was due and if they felt they needed additional training they were able to ask for it and it would be sourced.

Staff had received training in areas identified by the provider as required. We reviewed the staff training plan and discussed with the registered manager some gaps in refresher training. The registered manager was already aware of this and told us the plans in place to address this. Staff told us they received opportunities to meet with their line manager to discuss their work, training and development needs. The registered manager told us they had identified some shortfalls in the frequency staff had received these meetings. They showed us their supervision and appraisal plan and this confirmed meetings with staff had taken place and included ongoing support. The registered manager told us how they checked staff competency by asking staff to complete competency questionnaires on different topics.

People could be assured important information was shared where required, with external organisations such as the ambulance service. Transfer forms were used to share information to support other clinicians in the ongoing care of a person.

People's health needs were assessed and they received support to access health services to monitor their health needs. People were confident they received support with their healthcare needs. Staff worked with external health care professionals in meeting people's needs and people's care records confirmed this. For example, people had received support from the GP, community nurses, occupational therapists, dentist and optician. We saw a community nurse was contacted quickly when a person's skin showed evidence of redness and the possible development of a pressure ulcer. Staff followed the instructions of the community nurse to prevent further pressure damage.

We spoke with a visiting GP who attended the service regularly. The GP was positive that people's healthcare needs were managed well and staff followed any recommendations made.

The premises adaptation, design and decoration met people's individual needs, the internal and external environment considered people's needs associated with their disability and or healthcare needs. For example, corridors were spacious to meet people's mobility needs. Signage supported people to orientate around the building. Communal rooms had good lighting and the garden was easily accessible and was a safe and pleasant environment.

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. People we spoke with including relatives, felt the staff were kind, courteous and polite. A person said, "They (staff) are good to me and I love them all." A relative said, "I think the care staff here are unique, they are kind and gentle with the residents and treat them all with great respect. I observe a lot and can say wholeheartedly that everyone is always very professional and they really do care about their residents in every respect." Another relative said, "My relative has only recently come here but I cannot emphasise enough, how kind and caring they have all been to them. The girls (staff) have been so very attentive. I know my relative is happy and well cared for so far so good as they say."

Staff were knowledgeable about people they cared for and showed an understanding of what was important to people such as their routines and preferences. One staff member said, "We respect each person is different and treat them so." Staff told us whilst they were busy they had time to spend with people and knew this was important to them. We saw staff spend time with people and chatted to people as they went about their work.

We saw how staff were attentive, sensitive and caring towards people. For example, we saw how a staff member supported a person with their meal, they sat alongside the person and encouraged them to eat and assisted when they struggled. The staff member chatted to the person in a nice manner describing the food on their plate. Some people were seen to be restless at lunchtime and constantly left the table and walked around. Staff were seen to be patient and kind, encouraging people to sit and eat and offering alternative meal choices to tempt people to eat. We saw the staff's approach had a positive impact. For example, a person who was constantly walking around responded well to a staff member, they sat in the lounge together and the person responded positively and ate their meal.

We saw people were relaxed within the company of staff and light-hearted jovial exchanges were had. Staff showed an interest in people asking how they were, complimenting them on their appearance after visiting the hairdresser who was present. We saw how staff were responsive to people's comfort needs. For example, a person said they felt cold, a staff member responded and closed a nearby window and offered to get the person an item of clothing, which they did immediately when this offer was accepted.

People and visiting relatives told us they were involved in discussions and decisions about how they received their care. A relative said, "They (staff) all listen and we work together, the care plan has been devised accordingly with family involvement. [Family member] has complex needs and all these are managed very professionally by the staff." Another relative said, "We have been heavily involved in the care plan. It's a lovely place and we are so happy [family member] are doing so well and settling in. They are improving already, we can see it each time we visit. The staff have been so co-operative and caring it's amazing."

People's care records showed evidence that people were involved in the review of their care and were encouraged to give their views on the care provided.

People had access to information about independent advocacy services. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. At the time of our inspection, no person was receiving advocacy support.

Staff were attentive and sensitive towards people and respected their privacy and dignity and independence was encouraged. People who used the service and visiting relatives, were positive that they were treated with dignity and respect. A person told us they preferred to remain in their room and said that staff respected their choice. We saw this person was enjoying a glass of sherry. This person said, "I have a sherry every day before lunch it's nice that they bring me one."

A newly appointed member of staff said, "Attention to privacy and dignity here is really good." They went on to say, "I have never winced, thinking that someone could have approached a situation better. I have learnt a lot about the way you approach people living with dementia." Another staff member said, "It's really important we encourage people to be as independent as possible, whatever they can do for themselves we promote."

People's personal information was stored securely and staff were aware of the importance of confidentiality. The registered provider had a policy and procedure that complied with the General Data Protection Regulation.

People's friends and relatives were able to visit them whenever they wanted to. Staff confirmed this and told us people's relatives and friends were able to visit them without any unnecessary restriction.

Is the service responsive?

Our findings

People had an assessment of their needs, preferences and routines including discussions, about what was important to them before moving to the service. This ensured the management team could consider if any additional staff training or resources were required, prior to the person transferring to the service. A relative told us how they and their family member, had been involved in the assessment and ongoing reviews of the care provided. This relative said, "They (staff) keep me well informed and ring me if needed. I know about their [family member]'s care plans and have been involved in them and reviews."

People's care records contained an information record that advised staff what was important to them, things that other people admired about them and how best to support them. In addition, another document entitled, "All about me," recorded important information about a person's life history. This is particularly helpful in the care of people living with dementia. However, the majority of people's care records we reviewed found this document was not completed. The management team told us they were aware of this and had plans to address this as part of their action of reviewing people's care records and care plans.

People had a range of care plans that instructed staff of how to support them. However, the amount of detail including specific individual information was variable and not always up to date. For example, a person's tissue viability care plan did not state that a pressure relieving mattress and cushion was used to reduce the risk of a pressure ulcer occurring. Staff had recently taken the decision to reduce the frequency in which the person was assisted to change their position. A member of staff was able to explain the rationale for the decision, but the frequency had not been changed in the person's care plan or the reason for the decision record. There was also nothing to show that an external healthcare professional had been consulted and involved.

Another person's eating and drinking care plan stated their intake should be recorded on food and fluid charts, but this was not being undertaken. A person had a care plan for their emotional well-being which stated they became very confused and agitated at specific times during care interventions. However, there were no clear directions for staff as to the action to take other than to reassure the person. When we spoke with a member of staff, they were able to describe the specific factors, which distressed the person and how they were able to calm them and gain their cooperation. None of this information was in their care plan. We concluded the impact on people was reduced because staff knew their needs and the management team had plans in place to get people's records and care plans up to date.

Consideration had also been given of people's diverse needs, including their religious, spiritual, sensory and communication needs. The registered manager said the service had a commitment in treating all people equally and without prejudice and discrimination. Where required, people were supported to participate in religious services provided at the service. At the time of the inspection, no person had any specific communication needs. However, the management team told us if a person required information presented in a different way such large print, braille or audio this would be provided. This meant the provider had considered the requirements of the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or

sensory loss.

People received opportunities to participate in social activities and to pursue their interests and hobbies. One person said, "I enjoy the garden and often go out there at 6 o'clock in the morning as I get up early. I am head gardener. We have lots of bedding plants and things and the lady (staff) helps me do things together." We observed this person earlier in the day picking flowers in the garden, with the activities coordinator. A relative said, "I do see things happening when I visit, they (staff) have all sorts of things going on and try to get the residents involved in as much as they can."

The provider employed specific activity coordinators that arranged activities each day for people. People told us about the activities that were available and we saw records and photographs and an activity planner, to confirm what people had participated in and what was available. Activities included Mayday Morris dancing, bowling in the sunshine, armchair exercises and arts and crafts. The activity coordinator explained the activity for the week was a beach theme. We saw people participating in painting a beach theme, this included making headwear handkerchief hats. The activities coordinator also led a session on beach ball catch. Many of the people were seen from their smiles and participation, to enjoy catching the ball and throwing to each other. Ice creams were served to people as part of the themed beach week.

The activities coordinator told us for people that preferred to remain in their rooms, they provided one to one time with them. This included chatting, reading the paper and doing manicures. Records were kept of people's engagement, this helped to monitor if any person was at risk of self isolation. The activity coordinator was positive about their work and gave examples of how they provided a responsive service that was dependent on people's needs and choices. They said, "It's a rewarding job because like today, one of the residents has done some painting today, they used to enjoy this before they came here. Also, a person has actually been involved, and enjoyed, catching the beach ball and has never engaged in that before."

People had access to the provider's complaint procedure and people who used the service including visiting relatives, told us they had no concerns about raising a complaint if they were required to do so.

Staff were aware of the complaints procedure and told us they would be informed via staff meetings or handovers, if there were any changes as a result of any concerns or complaints made. Three complaints had been received within the previous three months. We saw there had been a formal written response from the service within a month of the complaint. We saw evidence the complaints were investigated and changes implemented as a result.

Advance care plans that recorded people's future decisions about their care were being developed. We did not see any care plans for people who were at the end of their life because no person at the time of our inspection was at this stage in their life. However, we saw attempts had been made to establish people's wishes for when they reached that stage in their lives and in some cases some basic information was recorded. The management team told us as part of their plan to review people's care records, end of life wishes would be discussed in more detail with people and planned for.

Is the service well-led?

Our findings

At our last inspection in July 2017, the registered provider was found to be in breach of one regulation. This was in relation to the Care Quality Commission (Registration) Regulations 2009 because CQC had not been notified when an authorisation to deprive a person of their liberty had been granted. At this inspection, we found improvements had been made. When authorisations had been granted, we had received a notification from the registered provider to notify us this

People who used the service and visiting relatives were positive about the current leadership of the service. A relative said, "Yes I think it's well led considering all the turmoil it's been through here, there's been a number of managers all gone now, a high turnover of staff, so its unsettling for people. However, throughout all of that there is a core group of staff that have kept it all going strong." People told us they knew who the registered manager was and that they were very approachable, visible around the service and supportive.

A visiting GP said the new registered manager was organised and that record keeping had improved. The GP said the recent turnover of registered managers had created issues in respect of continuity of care but this had now improved.

The registered provider had a clear vision and set of values for the service that was based on people receiving care and treatment that was person centred, responsive and transparent. Staff were seen to work to the provider's set of values; they had a calm and caring approach towards people in their care. Staff worked well together, they were organised and understood their role and responsibility.

As part of the registered provider's internal quality assurance checks, annual satisfaction surveys were sent to people who used the service, relatives and friends. In addition, people could share their views directly with the registered manager or by using a suggestion box located within the service. Resident and relative meetings were also arranged every two months. People told us they felt able to express their view and share their experience about the service. This meant people and their relatives received a variety of opportunities, in how they could contribute to how the service continued to develop.

Since our last inspection, a new management team for the service had been appointed and had been in post a few months. This consisted of a new registered manager, deputy manager and area operations manager. All were present during our inspection and were found to be open, transparent and knowledgeable. They were all very experienced managers and had worked hard at driving forward improvements.

Staff were positive about the registered manager who they said was available and came into the units to oversee the care. One member of staff who worked in the units for people living with advanced dementia said, "In the past we didn't see the manager and were left to our own devices, but the new manager does come down here." They said they felt, "Very much involved." Additional staff comments about the registered manager included, "She's a very good manager and her heart is in the right place." A member of staff said there was always someone to go to if they had a concern or question. They told us a senior care worker and

the deputy manager were supportive and that they could also go to the registered manager if necessary. A new member of staff said the rest of the staff had been very supportive and the team worked well together.

Staff told us they felt supported and valued by the management team and staff meetings were used as an opportunity to discuss any areas that required improvement. A staff meeting the previous day to our inspection, had been held to discuss the staff rosters. Staff told us they had the opportunity to give their views.

The registered provider had systems and processes in place to monitor, review and manage the service and an action plan had been developed to drive forward improvements. Audits and checks were completed, daily, weekly, monthly, and covered areas such as health and safety, the management of medicines and care records. Night spot checks were also completed unannounced to review and monitor care

The shortfalls we had identified during this inspection had already been identified by the current management team and action was being taken to make improvements. A priority for the service was reviewing people's care records including care plans and risk assessments, to ensure these were reflective of people's current needs. This work had already commenced. Staff told us improvements had also made in staff training, support and staff recruitment. The deputy manager said, "Staffing levels are much better, we've fully recruited staff now and are waiting for their checks to clear. We're looking at the staff skill mix, made a start of reviewing care plans and staff morale has greatly improved."

The registered manager told us how they service linked in with the local community and that this was an area they were developing to support people to feel more involved. People were supported to access local community attractions such as a local garden centre. Local nursery children had visited and links with the local community college was being formed with a plan to engage with students completing their Duke of Edinburgh Award.

The registered provider had policies and procedures in place that were in line with legislation and best practice guidance. The registered manager attended local and national forums and received CQC alerts. They also worked with external health and social care professionals, such as Admiral nurses (these are specialist dementia care nurses who give expert support), to keep their knowledge and awareness up to date. The registered manager attended bimonthly managers meetings where information, learning and best practice guidance were discussed and shared. The registered manager completed weekly reports to share with senior managers about events such as safeguarding, accidents and incidents and the area operations manager visited weekly. This meant senior managers had clear oversight of the service and there was accountability within the management team. The ratings for the last inspection were on display in the service and available on the provider's website.