Eleanor Palmer Trust

Eleanor Palmer Trust Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection of this service, on 1 July 2017, we found three breaches of legal requirements. These were in respect of safe care and treatment, person-centred care, and good governance. The service was placed in 'Special Measures' and we undertook further enforcement action because of the potential impact on people using the service. The provider sent us an action plan in respect of the three breaches. We undertook this inspection to check that the action plan had addressed the breaches. This was also a comprehensive inspection, to make sure the service was providing care that is safe, caring, effective, responsive to people's needs and well-led.

Eleanor Palmer Trust Home, also known as 'Cantelowes House', is a care home that is registered to provide accommodation and personal care for up to 33 people and specialises in dementia care. The home is run by The Eleanor Palmer Trust, a voluntary organisation. There were 20 people using the service at the time of this inspection. This was because, following our December 2016 inspection, the provider had made a decision to temporarily stop admissions into the service until care delivery concerns were addressed.

The service had a registered manager, a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found significant improvements in people's care and service quality at this inspection. This matched the overall feedback we received from people and their relatives, most of whom praised the capability and approach of staff and the effectiveness of the management team.

Risks to people were appropriately managed so as to keep them safe. This included for pressure care management, unexplained bruising, and for falls. People were supported to move around safely.

Everyone was supported to gain health professional input when needed. The service paid good attention to people's health, nutrition and hydration needs. People were supported to have regular baths and showers. People's medicines were properly managed so that they received them safely and as prescribed.

Feedback and our observations showed people were treated in a kind, friendly and respectful manner. Attention was paid to supporting people with their appearance. Choice and independence was promoted.

There were enough suitable staff to keep people safe and meet their individual needs. Whilst there was some reliance on staff from a specific care agency, many of these staff had worked at the service for a while. Staff at the service knew people's individual needs and preferences, and treated them well.

The service had worked hard at setting up extensive care plans that encompassed a range of individualised needs and preferences and guided staff on providing responsive care. Feedback and our observations

showed people received individualised care.

Staff reported an open and empowering culture, good teamwork, and an approachable management team. There were improved standards of record-keeping, which helped document people's care and helped communicate key information to incoming staff. There were also audits of care quality and risk management, to help ensure good quality care was being delivered.

However, the service required improvement in a few areas. There was an inconsistent approach to documenting health and safety checks and ensuring actions took place as a result of a professional fire safety risk assessment.

Duty of Candour requirements had not been formalised and documented in respect of two incidents of people being admitted to hospital with injuries. Whilst there was no suggestion these injuries were avoidable, this did not demonstrate an open culture of learning from incidents so as to minimise the risk of reoccurrence.

The service was almost working within the principles of the Mental Capacity Act 2005 (MCA), but capacity assessments of people's ability to consent to specific care decisions were not consistently following these principles. This put people with greater needs at risk of being subject to care practices without appropriate consent.

Staff supervision processes were not yet embedded as an ongoing practice, to help ensure staff provided effective care. However, staff were suitably trained for their care roles.

This comprehensive inspection identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of Duty of Candour processes. You can see what action we told the provider to take at the back of the full version of the report.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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. There was an inconsistent approach to documenting health and safety checks and ensuring actions took place as a result of a professional fire safety risk assessment.

Individual risks to people were appropriately managed so as to keep them safe, both on an individual and service-wide basis. The provider had systems to prevent abuse from occurring and to take action if abuse was suspected.

There were enough suitable staff to keep people safe and meet their individual needs.

People's medicines were properly managed so that they received them safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective. The principles of the Mental Capacity Act 2005 (MCA) were not fully adhered to, which put people with greater needs at risk of being subject to care practices without appropriate consent.

Staff supervision processes were not yet embedded as an ongoing practice, to help ensure staff provided effective care. However, staff were suitably trained for their care roles.

Everyone was supported to gain health professional input when needed. The service paid good attention to people's health, nutrition and hydration needs.

Is the service caring?

Good

The service was caring. People were treated in a kind, friendly and respectful manner. Attention was paid to supporting people with their appearance. Choice and independence was promoted. Everyone had a life history document in place, which helped staff understand and respond to people as individuals.

Is the service responsive?

Good

The service was responsive. People had extensive care plans that encompassed a range of individualised needs and preferences and guided staff on providing responsive care. Feedback and our observations showed people received individualised care.

The service had systems listening to and addressing people's concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Duty of Candour requirements had not been formalised and documented in respect of two incidents of people being admitted to hospital with injuries. Whilst there was no suggestion these injuries were avoidable, this did not demonstrate a culture of learning from incidents so as to minimise the risk of reoccurrence.

Staff reported an open and empowering culture, good teamwork, improved care practices, and an approachable management team.

There were improved standards of record-keeping, which helped document people's care and help outgoing staff to communicate key information to incoming staff.

There were also audits of care quality and risk management, to help ensure good quality care was being delivered.

Eleanor Palmer Trust Home

Detailed findings

Background to this inspection

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

This was an unannounced comprehensive inspection. The purpose was to check the provider now met the legal requirements relating to all previous breaches, as identified at the last focussed inspection of 1 July 2017, and those outstanding from the last comprehensive inspection of 29 November and 13 December 2016.

The inspection team consisted of two adult social care inspectors, a pharmacist inspector, and an Expert by Experience who is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked for any notifications made to us by the provider, any safeguarding alerts raised about people using the service, and the information we held on our database about the service and provider such as the action plan submitted in response to breaches identified at the last inspection.

There were 20 people using the service at the time of our inspection. During the inspection, we spoke with ten people, two people's relatives, six care staff, three other staff members working in the service, and the registered manager. We also received feedback from a health and social care professional.

During our visit, we looked at selected areas of the premises including some people's rooms and we observed the care and support people received in communal areas. We looked at care records of five people using the service, everyone's medicine administration records, the personnel files of five staff, and some management records such as for health and safety, fire safety, accidents and incidents, and staff support.

Following our visit, we met with the provider's CEO and three members of the provider's board of trustees, to check on long-term governance arrangements for the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, our findings included cases of unexplained bruising and injuries which the manager told us they were not aware of. Referrals were made to the local authority's safeguarding team as a result. Two other safety risks to different people, in respect of choking and bed-rails, had not been documented on incident forms and so had not been formally reviewed to minimise risks. One person received unsafe care and treatment in respect of skin care and pressure ulcers. Medicines were not safely managed on a consistent basis. This included one person not receiving their medicines as prescribed. This meant the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We undertook further enforcement action against the provider for the regulatory breaches, because of the potential impact on people using the service.

At this inspection, we found the provider had addressed the above concerns. Records and feedback gave reasonable explanations for any visible injuries anyone had. This included two people with scabs on their foreheads. For example, there was an accident record, a 24-hour injury observation form, and records of phone discussions and a GP visit for one of these people. A staff member explained how the injury occurred and what actions had been taken to minimise the risk of reoccurrence. Another staff member could explain the ongoing treatment of the other person, and there were extensive records about this in the person's care file.

We checked three people's care records for the previous two weeks and did not find any records of bruising or injury that had not been reported as an incident. The registered manager told us of investigating the previously raised safeguarding matters to ensure no reoccurrence of the unexplained injuries.

The registered manager had reviewed and documented any actions taken to address accident and incident records. A monthly summary provided an oversight of these occurrences, by which to further monitor safety risks. These explained likely causes of unexplained injuries, such as through linking to a record on a behaviour chart or through an ill-fitting wheelchair. Other records and a staff member confirmed wheelchair services had visited the person and hence a new wheelchair was imminent.

There were individual risk assessments in people's care files to help demonstrate regular review of specific risks they were subject to. For example, one person's vulnerability to sustaining bruising and skin tears due to taking a specific medicine had been risk assessed. There was a care plan to guide staff on how to minimise these risks. In addition, everyone's risk assessments for some generic matters such as the risk of falling and for adequate nutrition were kept under review.

Where one person had previously experienced a safety risk in relation to a bed-rail, this had now been addressed. Staff we spoke with knew about the specific risk, and the person's care plan clearly guided staff on addressing the risk. In general, there was a specific risk assessment in place for anyone using a bed-rail, to ensure it was an appropriate safety response. Where safety concerns were identified, alternative arrangements were put in place including lowered beds, crash mats and equipment that alerted staff to when the person got up. Records showed people were attended to if the equipment alerted staff.

Staff and the registered manager told us no-one had had a pressure ulcer since our last inspection visit. Oversight records confirmed this. We saw staff pay attention to ensuring people had pressure-relieving equipment where needed. For example, when someone was supported to transfer from their wheelchair into an armchair, their pressure cushion was also transferred. Repositioning charts were being used to ensure people at higher risk of skin breakdown were having position changes on a regular basis throughout the day and night. Charts also helped demonstrate people regularly had creams applied where needed to help prevent dry skin. There were records of district nurse visits where any skin integrity concerns arose. The service reviewed people's pressure ulcer risks on a monthly basis, to help monitor risks and take action where needed.

We saw staff support people to move around safely. This included where equipment such as hoists were used. People's consent to transfers was gained, they were talked with throughout the process, and were regularly asked if they were ok. No-one showed signs of undue anxiety. The correct slings were used according to guidance in people's care plans. The registered manager informed us there were now individualised slings in place. Staff were also careful to make sure people were not struck by the equipment or surrounding objects when supporting them.

We found some progress had been made to address recommendations from fire safety risk assessments. In particular, the back gate was now locked and a 'break glass key box' had been installed next to the gate. In addition, fire drills for staff were now occurring. The registered manager said they would work to include people using the service in routine fire drills where possible.

However, there remained some fire safety recommendations. There was no list of trained fire marshals and staff were not specifically trained in the use of fire extinguishers. These concerns had been identified in the latest fire safety risk assessment undertaken in July 2017 as well as the previous one, and were documented in the current management action plan. The registered manager and the maintenance worker explained priorities from the risk assessment were being addressed, and informed us of plans to address remaining points.

We identified ways in which checks on the safety of the premises were not consistently robust. There was no overarching health and safety audit available to demonstrate sufficient management of safety risks.

Checks on bed-rails took place daily and were clearly documented. However, weekly checks on window restrictors in all of the rooms were not recorded. We identified no concerns when we checked some rooms, and we were informed a log of those checks would be implemented; however, there had been no audit trail of these checks until our intervention.

Routine water temperature checks were undertaken on a three-weekly rotation in communal areas and rooms that were not in use. The temperatures were recorded as being within an appropriate range. However, there were no records to show safe water temperatures within rooms used by people, which did not ensure sufficient safety.

All rooms had call-bells near the bed and in the bathroom. People had fobs on them that linked to this system, so they could attract staff attention. However, there was an occasion during our visit when staff could not identify where an activation had come from. When everyone had been checked, the call was reset. Records showed the system was due a professional service. We were not confident this would have been planned for without our intervention.

Overall, the approach to health and safety was inconsistent. The registered manager was aware of this and

confirmed additional training had been sourced to enable the service to manage health and safety more systematically.

Appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw supplies were available to enable people to have their medicines when they needed them. There were improved procedures for checking stock quantities and deliveries to ensure no-one's medicines ran out.

Appropriate arrangements were in place for recording the administration of medicines. Medicines Administration Records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records, and any reasons for not giving people their medicines were explained. The service undertook weekly and monthly checks to ensure the administration of medicine was being recorded correctly. A running stock balance was kept for all medicines and what we checked was correct.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual when-required protocols (administration guidance to inform staff about when these medicines should and should not be given) were in place. This meant there was information to enable staff to make decisions as to when to give these medicines, to ensure people were given their medicines when they needed them and in way that was both safe and consistent.

Medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately. Records showed they were kept at the correct temperature and so would be fit for use. The room temperature in the clinical room was recorded daily and these records showed the temperature was in the correct range.

There were enough staff working at the service to keep people safe and meet their needs. People's comments included, "I think there's enough staff" and "Staff are always here doing something." Rosters and feedback showed us five care staff and a team leader worked during the morning and early afternoon, reducing by one care staff during the rest of the day. Three care staff worked across the night. Other staff worked in support roles, such as cooks, cleaners and a maintenance worker. Records showed staffing levels were occasionally exceeded. The registered manager and staff explained this was to enable specific tasks such as receiving the monthly supply of medicines into the service safely.

A number of staff were employed from one specific agency to work at the service. Records and feedback showed many of them had worked at the service for a number of months. New staff members worked a supernumerary shift, to help them understand how the service operated and what people's needs were. There was mainly positive feedback about improved capability of staff, which showed these staffing arrangements were working. A relative praised those agency staff who continued to work at the service. Whilst unhappy that some agency staff were not so interactive, they recognised those staff were not kept on. Another relative said, "I am aware there were problems, but they've really improved; there is a good core of staff now."

Records showed pre-employment checks were carried out before staff started work. These included two written references, proof of identity, employment history consideration and a criminal records check. This showed there was a system in place to ensure staff were suitable to work with people at the service.

People were at ease in the presence of staff and said they felt safe. Staff told us they had received training to

safeguard people from abuse, which records confirmed. Staff were able to describe what constituted abuse and understood the reporting procedures. Staff were aware of how to escalate concerns outside of the service if needed, for example to CQC, the local authority or police. The provider had an appropriate safeguarding policy in place. The registered manager additionally knew of the updated London Multi-Agency Safeguarding Policy and Procedures, and told us of plans to summarise key information into one folder for use by staff in the absence of a manager at the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, our findings included monitoring systems not working where people were experiencing constipation, as contact with community healthcare professionals was not occurring in a timely manner when needed. This contributed to the provider being in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We undertook further enforcement action against the provider for the regulatory breaches, because of the potential impact on people using the service.

At this inspection, we found the provider had addressed the above concern. The constipation monitoring chart used by senior staff to monitor any concerns had been revised to only include people at risk of constipation. The guidance remained for gaining GP advice after four days. Records showed this was being followed where needed, and so people were supported to gain appropriate health professional support in due course. We also noted this additional support was not needed for most people, indicating the service was providing good healthcare and dietary support.

Everyone was supported to gain health professional input when needed. One person said, "Everything is brought in for us, opticians and doctors. We don't have to go out for anything." Another person told us of having a hospital appointment later in the week. They were happy a particular staff member would be attending with them, and that the service's company car would be used to give them a lift there.

There were clear records in people's files of health professional visits and advice. Records showed referrals being made for specialist input such as in response to someone's weight loss. The behaviour of one person in the days leading up to the inspection had resulted in a urine sample being sent for analysis on the morning of our visit, in case further healthcare professional input was needed. Weekly manager reports also showed health professional advice being sought and acquired, for example, in respect of chest infections, dry skin and swollen legs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service to be almost working within the principles of the MCA. Records showed all care staff had been trained on these principles. They could inform us of appropriate care practices. One person told us staff asked permission to provide care: "If going to wash me they would say, 'Do you mind if I do this?'" We saw staff informally requesting consent to provide care, such as for hoisting people and supporting them to

eat and drink. Staff recognised and respected refusals, but tried again in due course where care considerations were a priority.

The registered manager showed us applications had been made for DoLS renewals for those people deprived of their liberty by using the service. They showed good oversight of these processes, and told us no-one had been subject to authorisation conditions. We found no records in people's care files to indicate otherwise. People's DoLS status was identified as part of their care plan, along with guidance on their support needs in respect of choice and control. One person needed little support in that respect, telling us they had been out for lunch, which staff confirmed. Another person was at known risk of absconding, but staff knew specific triggers that might put them at risk, and they were subject to a DoLS. This showed the range of individualised responses the service provided to people in respect of leaving the service.

Where people had a formal Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) document under MCA, this was easily available at the front of their care file. However, where anyone was registered as the person's Lasting Power of Attorney (LPOA), those people's files were not always clear on whether this was the case or not. In some circumstances, such as for consenting to care planning at the service, the LPOA must be consulted, so it was important to establish this status for people using the service.

People's care files showed there was assessment of everyone's capacity to make informed decisions about aspects of their care. However, the documented process showed the four-stage assessment occurred before the various decisions were considered, which did not make sense as people can have different capabilities in respect of different decisions. Where best interest decisions were needed when someone lacked capacity for a specific decision, there was no record of how the decision was made except for evidence of family involvement. The capacity assessments also failed to include the significant restriction of bed-rails that some people were using, or where a few people were receiving medicines covertly. Therefore, the capacity assessments were not yet following all the principles of the MCA. The registered manager sent us a plan to address these matters shortly after the inspection visit.

People and their relatives told us staff had the knowledge and skills to provide effective care. People's comments included, "The staff look after us well", "The staff are excellent" and "They're marvellous; they work so hard." Staff told us and records showed they were trained in a range of subjects that enabled them to meet the needs of people living at the service. These included topics such as moving and handling, health and safety, dementia, falls prevention, diversity, and end of life care. The registered manager was aware that a few staff needed refresher training in certain topics and this was being addressed.

The service had not yet embedded staff supervision processes as an ongoing practice, to help ensure staff provided effective care. However, progress was being made. Approximately half the staff received group supervision during May 2017; and most staff received group supervision in July 2017. A few individual sessions had also occurred. One staff member said, "There is not much supervision as such but we sit as a group and talk about people and their care plans. This helps us to get to know people and plan their care." The registered manager confirmed a more structured approach to supervisions and annual appraisals would be implemented, and included this in the action plan sent to us shortly after the inspection visit.

Most people told us of good food and drink being provided. One person said, "The food is very good; I'm putting on weight!" Another person said, "They know exactly what I want." A relative described the meals as "brilliant." Another relative told us of their family member's declining appetite but added, "They always offer her food. She really enjoyed the food when she could eat."

There was a calm and supportive atmosphere at lunch, with a classical music station being played on the

radio. Dining room tables were well laid with condiments, sauces and cloth serviettes. People did not have to wait long for their meals, and everyone received a meal. The main course was served on the plate but vegetables were in a dish, one per table, and served by staff where needed. Staff chatted with people across lunch, and supported people to eat where needed. Where one person needed blended food, it was served in component parts to enable them to still taste the different aspects of the meal.

The service monitored some people's food intake through specific charts. These recorded what the person ate, when, and how much. This helped ensure their dietary intake was adequate. People's care files showed their weight was kept under review. Some people had gained weight in line with care plans.

Most people told us they could get drinks at any time. Staff paid good attention to people's hydration needs, providing regular drinks. They encouraged and supported people to drink. A staff member told us, "We are very particular about fluids, even if we go into the garden for a short while we must offer people a drink." Records showed staff had received training on nutrition and hydration. Records of some people's fluid intake were kept, to ensure they had enough to drink. These records were up-to-date at the time of our visit.

Good

Is the service caring?

Our findings

People and their relatives told us of many ways in which the service was caring. People described the staff as "kind", "friendly", "helpful" and "polite." Another person said, "I've nothing but praise (for the staff), they need the patience of a saint." Relatives' comments included, "Most staff here at the moment are quite nice" and "Mum is really well cared for."

People told us of staff being respectful towards them. One person told us of memory difficulties resulting in them asking staff lots of questions, which staff always answered. A relative said, "They treat her with respect." Staff greeted people warmly when arriving for breakfast. We saw people's call-bells being responded to diligently, and one person told us, "They do answer them."

We saw staff being kind, patient and caring. Questions about care and support were put to people in a gentle manner and were repeated where needed. People were given time to finish meals, and were patiently helped where needed. Staff brought one person's watch to them at breakfast, telling them they'd found it "under the bed." Staff laughed with people and provided appropriate physical contact. Where one person was leaning sideways in their wheelchair, a staff member brought them a cushion to help them sit more upright and be more comfortable. People's care records showed evidence of a caring approach, for example, that bedding which had slipped off them was put back on them during night checks. A non-care staff member confirmed this caring approach, telling us, "Staff interact now with love, and talk to people more."

Attention was paid to supporting people with their appearance. Everyone was clean and well-dressed, and we heard staff complementing people on their appearance such as for new clothing. One person told us of regular hairdresser visits to the service. Some people had been supported with lipstick and nail varnish. Where someone knocked a drink over themselves, staff promptly and kindly supported them to get changed.

Staff promoted people's independence. For example, staff spent time encouraging a person to spread their own marmalade at breakfast. Another person was given time to finish their meal by themselves as they did not want staff support. Tables were set up with many condiments and gravy for people to manage themselves. Some people had phones in their rooms. One person showed us their key to their room. People's frames and sticks were within easy reach so as to enable them to get around by themselves. One person told us they changed their bedding themselves, but staff helped them where needed.

People were offered choices where appropriate. We saw this occurring at mealtimes, one person being asked how toasted someone wanted their toast. The day's menu was handwritten on the board in the dining room, together with a poster with pictures of a wider range of food. People said there was choice at mealtimes, for example, "They ask you what you'd like." The registered manager confirmed people were asked about meal choices mid-morning, but they could change their mind when meals were presented.

Everyone had a life history document in place. Often written by relatives, these gave details of the person's

upbringing, family, employment, personality, and how they spent their spare time. This helped staff to have an insight into what people might be referring to or experiencing, especially those with dementia, and so enabled staff respond to the person in a more informed way.

Good

Is the service responsive?

Our findings

At our last inspection, our findings included people not being supported to have baths or showers regularly. One person's hearing aid was not working properly but staff had not identified this. Therefore people's care needs and preferences were not always being met. This meant the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We undertook further enforcement action against the provider for the regulatory breaches, because of the potential impact on people using the service.

At this inspection, we found the provider had addressed the above concerns. There was now an oversight chart used by staff to ensure everyone had a bath or a shower at least once a week. The chart matched records within people's care files and those kept in people rooms to check that a range of personal and individualised care had been provided each day. People also confirmed they were supported to have baths or showers regularly, for example, "pretty frequently" according to one person. Another person said, "I have a bath every week, that's enough. I could have more but I like to wash myself."

The charts in people's rooms had been revised to include whether the person's glasses or hearing aid had been provided and were cleaned or working properly. During our visit, people had these items where appropriate. This included glasses for one person arising from a recent optician visit, which had not yet been added to their care plan summary document, but which care staff told us they knew about through handovers and the person's room chart. This helped show individualised care.

People told us of responsive staff. One person said, "They always help you." Another person explained, "Sometimes I forget where I am in the morning and I call staff. They ask me 'What's up?' and they help me." A third person told us, "If you want something they listen to you." We saw staff attending to people when requested, and where appropriate. For example, when one person coughed, a staff member came over and asked them "Are you alright?"

The service had worked hard at setting up extensive care plans that encompassed a range of individualised needs and preferences and guided staff on providing responsive care. The registered manager and staff had informed us the process had involved using the knowledge that staff had on how people liked to be cared for, along with the input of people and their relatives. The plans were also based on comprehensive baseline reassessments of each person's needs across a range of functions, for example, health matters, communication abilities, personal hygiene abilities, skin condition, and eating and drinking needs. These assessments were occasionally reviewed, but there were monthly reassessments of how dependent each person was, by which to check whether their needs had significantly increased or not.

People told us of receiving care that met their preferences. One person said "I read the paper. Staff get it for me and I get it every morning." We saw staff offer people newspapers during breakfast. Another person told us, "I get up at 6:30 to have breakfast because I don't eat supper." However, we saw many people coming for breakfast later, and it was clear breakfast could be provided at any time. One person was provided a flask of tea so that they could have a warm drink whenever they wanted. Another person was very enthusiastic

about the Sunday services that took place.

Staff demonstrated good knowledge of people's individual preferences. For example, one person's care plan stated they liked a particular biscuit. When we asked a newer staff member which person particularly liked those biscuits, they knew who we were asking about.

Many people spoke positively of the activity provision in the service. One person said, "There's a good library here." Another person told us, "I join in with whatever is going on as I want to keep my brain with it." They spoke of enjoying quizzes, art sessions and gardening, adding, "We sit around outside and chat." A third person pointed to the activities coordinator and said, "That lady is very good." A relative agreed, adding they were "good at trying to get them to join in." We saw around half the people taking part in a gentle exercise session in the morning, with a few care staff helping people to join in. After mid-morning drinks, a quiz took place with some people really enjoying shouting out the answers. The activities coordinator sometimes explained a little more about the context of the question, and had illustrations to show help people join in. The registered manager informed us activity sessions took place twice daily across the week, but further provision was being planned for weekends and to better involve more dependant people.

People were encouraged to make comments about issues that were important to them. Minutes from a meeting with people and their relatives in June 2017 showed people were comfortable to express their opinions and make comments even when these were negative. A relative told us of a suggestion from that process being implemented. There was a more recent meeting although minutes of that were not yet available.

The registered manager told us there had been no formal complaints about the service this year. Where concerns about care were raised, these were addressed promptly. For example, one person's family was unhappy with the frequency of bathing support. Records showed the frequency had increased in line with the request.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, our findings included that some incident forms had not been reviewed and signed off by the manager. Risks relating to these matters had not therefore been properly assessed and addressed, and were not accurately reflected in weekly manager reports to the provider. There was some ineffective staff communication through staff handover sheets which did not support people to receive safe care and treatment. Records relating to people's care and treatment were also not consistently completed. This meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We undertook further enforcement action against the provider for the regulatory breaches, because of the potential impact on people using the service.

At this inspection, we found our concerns had been addressed. The registered manager was now signing off incident forms promptly, and recording actions taken to reduce the risk of reoccurrence. Incidents were reviewed monthly to identify trends. Accidents and incidents were correctly reported on the manager's weekly report to the provider, along with updates on other significant health matters affecting individuals plus staff training and resources. This all helped ensure the provider had an accurate account of key matters at the service.

Handover sheets, used to communicate key information about the service and each person using it, were now being properly and consistently completed. This helped ensure effective communication between outgoing and incoming staff. For example, information about the last three accident reports had been recorded in handover sheets, so that incoming staff could continue monitoring for any safety and welfare concerns. The staff communication book was also being used to ensure prompt healthcare advice was sought and to advise of successful input from healthcare professionals or where medicines had been acquired.

People's care delivery records were now being completed throughout the day and night, and with greater detail than at previous inspections. For example, people's reaction to visitors was now sometimes being documented, and there was evidence of involvement in activities. Where people's care plans required behaviour charts to be filled out, these were now occurring each day, which helped emphasise positive behaviours. Where someone was found on the floor of their room at night, this was recorded in that record, on an incident form, and within the staff handover records. This helped ensure a good audit trail of the concern, to help with minimising the risk of reoccurrence.

We had been notified of two unintended or unexpected incidents involving people using the service in the last four months. In both cases, people were treated in hospital, one for a fracture and the other for necessary treatment to avoid permanent or prolonged damage. At our visit, we asked to see any Duty of Candour letters sent to the person involved or where applicable their relevant representative. These letters are required to summarise the results of the provider's enquiry into the incidents. The process is not an admission of liability, but the investigation is to determine the extent to which the incident was avoidable and to help ensure that learning took place if needed. The registered manager told us there were no such letters or investigations. This was contrary to legislative requirements, and did not demonstrate an open

culture of learning from incidents so as to minimise the risk of reoccurrence. However, the registered manager also told us of updating people's care plans to help prevent reoccurrence of the accident.

At the time of our visit, the registered manager confirmed there was no policy in place for Duty of Candour that guided senior staff on actions needed as a result of specific safety incidents that resulted in injury or death of people using the service.

The evidence above demonstrates a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other than the above breach, we found the service to be operating in an open and transparent manner. The rating from our last inspection report was conspicuously displayed in the service. The registered manager had notified us of any significant events occurring at the service. Records were made available to us on request, and staff were free to talk with us throughout the visit. The registered manager demonstrated understanding of the progress the service had made and the work outstanding. They took notes of any areas we suggested for improvement, and sent us an action plan to improve on those points shortly after our visit, including a new Duty of Candour policy.

People and their relatives praised the service. One person told us, "If anyone has to go into a place I'd say here." Another told us of living in another care service but it was "not a patch on this one." A number of staff, including those working at the service a long time, told us of improved care practices under the new registered manager. One staff member said, "A lot of staff have left or gone sick but it's actually getting better." Staff felt there was more team work, and that everyone was working together to help meet people's needs. For example, one staff member said, "Staff check with each other that everything is done."

The registered manager had been in post since February 2017. Staff told us they liked working at the service and felt well supported by the registered manager and each other. One staff member told us the registered manager is "approachable and easy to speak to." Another staff member confirmed this, adding the registered manager "is particular about how people are cared for and the paperwork. He checks everything and tells us if it has not been done right." A third staff member told us the registered manager "encourages us to speak up." Staff also told us the registered manager assisted with care when needed.

The service used some auditing processes to help ensure good quality care and minimise risks to service delivery. There were audits of people's care plans and care files, to ensure they were up-to-date and contained all relevant information. Senior staff continued to undertake a range of weekly audits, for example, of how anyone with an infection was being treated, of anyone with wounds or ulcers, and of appropriate environmental temperatures.

The registered manager undertook an unannounced night visit earlier in the month, to check on appropriate night care practices. The records identified no concerns, and showed how additional good practice at night was discussed, for example, for enabling people to have a good night's sleep, encouraging fluid intake amongst those awake, and how to complete new care charts. A night staff member confirmed the visit occurred and was helpful.

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 20 HSCA RA Regulations 2014 Duty of candour The registered persons failed to provide a written notification to the relevant person in respect of notifiable safety incidents occurring, and failed to keep a copy of all such correspondence. Regulation 20(4)(5)(6)