QH (Rosewood) Limited

Estherene House

Inspection report

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Date of inspection visit:
26 September 2016
29 September 2016

Date of publication:
28 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Estherene House provides accommodation and personal care for up to 36 older people who may also be living with dementia. There were 35 people in the service when we inspected on 26 and 29 September 2016. This was an unannounced inspection.

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

There was a positive, open and inclusive culture in the service. The providers had acquired the service in October 2015 and were committed in their approach to drive forward improvement to ensure all people's care and support needs were being met. They were working with the staff team to help them to understand and share the culture, vision and values of the service in its main objective to provide high quality care and continued positive life experiences to those who used it.

However, there were times of the day when more staff were needed to ensure all people's needs were being met in an appropriate and timely manner. Risks to people injuring themselves or others were not always appropriately assessed and managed.

Staff had a good knowledge and understanding of each person, about their life and what mattered to them. People were mostly complimentary about the way staff interacted with them. Independence, privacy and dignity was promoted and respected by most staff but there was still work to be done to ensure these were core values in the service upheld by all staff.

Care plans reflected the care and support that each person required and preferred to meet their assessed needs and promote their health and wellbeing. Further work was needed to ensure care plans were consistent and demonstrated individual's differing care needs in terms of interests, social activities, types and stages of dementia.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. They were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

People presented as relaxed and at ease in their surroundings and told us that they felt safe. Staff knew how to minimise risks and provide people with safe care. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. People knew how to raise concerns and were confident that any concerns would be listened and responded to.

People were provided with their medicines in a safe manner but there were times when these had not been

provided at the times prescribed. People were prompted, encouraged and reassured as they took their medicines and given the time they needed.

The management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some work was needed to ensure all staff understood the importance of gaining people's consent to the support they were providing.

The service had a quality assurance system in place which was used to identify shortfalls and to drive continuous improvement. The provider was working through a comprehensive improvement plan which was regularly updated as changes were being made within the service and as other areas requiring improvement were identified. The directors and management team were open and responsive to concerns we raised and immediately began work on making changes as a result.

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 were times of the day when more staff were needed to meet people's needs.

Risks to people injuring themselves or others were not always appropriately assessed.

Procedures were in place to safeguard people from the potential risk of abuse.

People were provided with their medicines in a safe manner but there were times when these had not been provided at the times prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training in key areas but training had not been completely effective in providing staff with the knowledge and understanding they needed in relation to the specific needs of people living with dementia

Additional work was needed to ensure staff understood the importance of giving people the opportunity to be able to make decisions for themselves.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's independence, privacy and dignity was promoted and respected by most staff but there was still work to be done to

ensure these were core values in the service upheld by all staff.

People were mostly complimentary about the way staff interacted with them.

Staff took account of people's individual needs and preferences. However, there were times when people felt rushed by staff.

People were involved in making decisions about their care and their families were appropriately involved.

Is the service responsive?

Good

The service was responsive.

Care plans reflected the care and support that each person required and preferred to meet their assessed needs and promote their health and wellbeing. These were in the process of being reviewed and updated to ensure consistency.

Staff were aware of the importance of physical and mental stimulation, social contact and companionship and supported people to access a range of activities.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

The service provided a positive, open culture. People were asked for their views about the service and their comments were listened to and acted upon.

The service had a robust quality assurance system and identified shortfalls were addressed promptly. As a result the quality of the service was continually improving. This helped to ensure that people received a high quality service.

Estherene House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 26 and 29 September 2016 and was carried out by two inspectors, one of which was a pharmacy inspector, a specialist advisor who had knowledge and experience in dementia care, 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.
Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with seven people who used the service, five relatives and received feedback from a health care professional who visited the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered manager, six members of staff and two directors representing the provider. To help us assess how people's care and support needs were being met we reviewed three people's care records and other information, for example their risk assessments and medicine administration records. We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People felt that there were times of the day when more staff were needed. One person when asked if there were enough staff said, "At times yes. At others no". Another person said, "Not at times, no", and a third person said, "No" there were not enough staff. We asked a visitor whether staff responded quickly to their relatives call for assistance and they said, "Mostly, except when they're [staff] short". Another relative said, "Sometimes it feels a bit understaffed. It's got better recently." However one person told us, "Yes. They answer my bell quite quickly".

The management used a dependency tool to calculate the numbers of staff needed to meet people's needs and the number of staff on duty during the night had increased from three to four as a result of this. We observed that during the day there were enough staff to meet people's needs, including during the busy lunchtime period. A member of staff told us, "Staffing has improved. In terms of numbers. It's a massive improvement." However, changes had been made to the rotas which meant that there were only four staff on duty from 7pm in the evening. The same member of staff commented, "I'm not a supporter of two plus two [two care staff and two senior care staff] after seven." They explained that this was because there were at least seven people who needed the assistance of two members of staff to help them with their nightly routine and into bed. People had noticed that there seemed to be less staff in the evening and at night. One person commented, "There is less of them [staff]…sometimes there is quite a wait to go to the toilet". A relative when asked if there were enough staff to meet their relatives needs said, "Not at night, no."

We had received feedback prior to the inspection that there were people living at the service who on occasion behaved in a way which challenged staff and caused distress to other people. It had been established that these people needed to be closely monitored to prevent them or others coming to harm. However, we found that this monitoring was not taking place as it should have been and on some days the records indicated that there had been no monitoring at all. The service was divided into two units and spread over three floors. If two members of staff were engaged in assisting another person and the senior carer was administering medication this left only one staff member free to provide assistance to everyone else. This meant that monitoring of a person's whereabouts would be difficult and there was the risk of them or others coming to harm.

People told us that sometimes their medicines were delayed during the late shift. One person told us that their medicines were, "Not on time sometimes. It's been 1am sometimes. They [staff] have woken me up before now". Another person said "I've been forgotten at night. I go to bed about 9:30pm to 10pm with no tablets. I've told them not to wake me up; it's not good is it?" A third person commented, "My medication is often late at night. They [staff] have to do the other side [the dementia unit] before they come to me". This demonstrated that the lack of staff available during the late shift was impacting on their ability to administer medicines in a timely manner as they had been prescribed. This put people at risk of their health conditions not being effectively managed and their health deteriorating as a result of this.

The lack of staff deployed at certain times of the day, particularly during the evening, meant that people were not always receiving the care and support they needed in a safe, effective and timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. For example, the risk of falls, developing pressure sores, malnutrition and risks associated with their physical and mental health conditions. These had been regularly reviewed and updated which demonstrated that staff were provided with the information and guidance they needed to keep people safe in relation to their care needs. However, risks specific to each individual according to their daily activities and additional support they may need, had not been appropriately assessed. For example, there was no specific risk assessment for one person who smoked to guide staff as to how they could ensure the person and others were kept safe whilst engaging in this activity. A risk assessment in another person's care records identified that there was risk due to them walking freely around the home, ascending and descending the stairs, picking items [belonging to other people] up and carrying them around with them. Risk assessments showed that staff may be at risk if they tried to remove these items from the person or that other service users may be at risk. However, the risks to the person themselves, of falling on the stairs for example, had not been identified or appropriate control measures put in place to prevent the risk of the person coming to harm.

There were seven people whose bedrooms were on the first floor of the service, There was no passenger lift so these people either needed to use the stairs or stair lift to be able to access the communal areas of the service or to go out. The records of these people did not contain adequate assessments to show how the risks associated with them ascending and descending the stairs were to be managed or how they were to be supported with this. The moving and handling plan of one person stated 'not applicable' in the section relating to use of stairs. However, this person did independently use the stairs when they felt well enough to do so. Another person's care plan showed that they independently used the stair lift. However the manager told us that they used the stairs not the stair lift. Their moving and handling plan stated 'independent' in relation to use of the stairs. There was no risk assessment or additional detail to show how they should be supported. We discussed our concerns relating to this with the directors and management team. They acknowledged that the current documentation was not adequate in ensuring people were kept safe from harm and by the second day of our inspection this had been amended.

There were comprehensive risk assessments relating to all areas of the services operation and environment which had been carried out by an independent company. We were concerned that the information contained in these was generic and not specific to the service or the people who lived there. For example, the assessments in relation to the stair lift, floors, stairs and passageways had identified general hazards but did not take into account the design and layout of the service, identify risks specific to the needs of the people living in the service, for example, risks associated with living with dementia which may mean people have varying levels of awareness in their environment and what may cause them harm. The assessments did not offer guidance to show how appropriate and specific control measures could be implemented to protect people from the risk of harm. We were also concerned that these assessments were only due to be reviewed every three years which meant that emerging risks may not be identified.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People presented as relaxed and at ease in their surroundings and with the staff. A person told us, "yes, I suppose I do" when asked if they felt safe. Another person said, "Oh yes. I have to make the best of it, don't I?" A relative commented, "Safe and well treated, oh yes."

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received training in safeguarding adults from abuse. Staff understood the provider's policies and procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. A member of staff told us, "I'd go straight to [Registered manager]. [They] are very approachable." Staff also had an understanding of whistleblowing and told us that they would have no hesitation in reporting bad practice. A staff member commented, "We've all got a phone number we've been given for whistleblowing."

People were protected by robust procedures for the recruitment of care workers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire and there was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

Our pharmacist inspector looked at how information in medication administration records for people living in the service supported the safe handling of their medicines. Staff authorised to handle and give people their medicines had received training and had been assessed as competent. We observed part of the lunchtime medicine round and saw staff following safe procedures when giving people their medicines.

Medicines were being stored safely. Records showed that people were receiving their medicines as prescribed. There were frequent internal audits in place to enable staff to monitor and account for medicines. Errors that had been identified were reported to the manager and actions taken. There were a small number of medicines that had not been received at the home on time and so had not been given to people as scheduled, however, the registered manager had been taking action to resolve this.

When people were prescribed medicines on a 'when required' basis, there was written information available to show staff how and when to administer these medicines. However, more detail was required for medicines prescribed in this way that were used to treat people when they became distressed to ensure they were used appropriately and consistently.

For people with limited mental capacity to make decisions about their own care or treatment there were records of decisions to administer their medicines given to them crushed in food or drink (covertly). The records showed staff had consulted with people's GPs about this, however there were no records showing how assessments of people's mental capacity had been conducted. We discussed this with the manager and work was started on this immediately.

Requires Improvement

Is the service effective?

Our findings

Staff were provided with a range of training to assist them to meet people's needs and preferences. However, training in dementia care was delivered via e-learning and our observations told us that this had not been completely effective in providing staff with the knowledge and understanding they needed in relation to the specific needs of people living with dementia. For example, we saw that communication with people could be improved by ensuring better eye contact, slowing down, taking time to be sure that people understood and being less task focussed. We discussed this with a director and the registered manager who told us of their plans to engage all staff in additional dementia training.

The director told us how they had initially "focussed on safety" by ensuring all mandatory training was up to date. This included moving and handling, infection control and legionella training. They were now working on supporting staff to increase their knowledge in other areas. For example, training had been delivered relating to communication and dignity. Staff were also receiving training in specific health conditions relevant to the needs of the people they were supporting, for example a member of staff commented, "We've had someone in to do diabetic training because we've got quite a few with diabetes." This demonstrated that the provider was working to provide a support system for staff that developed their knowledge and skills, and which motivated them to provide a quality service.

Staff told us that when they started working in the service they had received induction training. One member of staff commented that this had been, "welcoming, friendly and positive." However, records showed that staff were not receiving regular one to one supervision and these meetings were mostly only taking place in response to concerns. The management team explained how initially there had been a need to concentrate on supervisions taking place where poor performance had been identified but they were now working on putting a regular supervision programme in place. It was recognised that staff supervisions were important so that staff were supported in their role and given the opportunity to talk through any issues, seek advice and receive feedback about their work practice.

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 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us that relevant applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. They

told us about examples of this and the actions that they had taken to make sure that people's choices were listened to and respected. They understood when applications should be made and the requirements relating to MCA and DoLS.

We observed that staff mostly sought people's consent and acted in accordance with their wishes. For example, asking them what they would like to eat or where they would like to go within the service. However, at lunch time staff did not seek permission from every person in the room before helping them with clothes protectors. This demonstrated that additional work was needed to ensure staff understood the importance of giving people the opportunity to be able to make decisions for themselves.

Care plans identified people's capacity to make decisions. For example, there were three people who required the use of bed rails. Their records showed that this had been discussed with them and their capacity in relation to this decision had been assessed to ensure that the use of bed rails was not restrictive or depriving them of their liberty. Where people did not have the capacity to consent to care and treatment, people's representatives, health and social care professionals and staff had been involved in making decisions in the best interests of the person and this was recorded in their care plans. A relative told us how they had been involved in a decision relating to a potential surgical procedure for a person. Another person's care plan showed details of a best interests meeting to discuss whether the service was able to meet their care and support needs. This had involved a relative of the person, independent advocate, deputy manager, senior care assistant, social worker and community mental health nurse.

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Records showed that guidance and support had been sought from relevant professionals to ensure that all people's dietary needs were being met. People's weights were regularly monitored to ensure that people were not at risk of malnutrition. Staff told us how it had been identified the previous week that a person was losing weight so they were asking the GP to refer them to a dietician. This demonstrated that systems were in place to recognise when people needed additional specialist support in order to help them maintain a healthy weight.

The kitchen held a central record of people's specialist dietary needs such as any allergies or diabetic diets. However, further work was needed on this so that staff were alerted to intolerances, likes, dislikes, preferred portion sizes or special diets needed relating to other healthcare conditions such as those which may mean people may have difficulty swallowing. We observed that not all staff were up to date regarding peoples dietary needs. For example, at lunch time a separate custard had been made for one person using soya milk. A member of staff was about to serve this person with the normal custard but was fortunately prevented from doing so by another staff member. This showed that this person's dietary needs had not been appropriately communicated.

People were involved in deciding what they would like to eat and drink. A relative told us, "I think the menu and choice seems okay. The cook comes around to get people's [residents] orders for lunch each day". Show plates of food were produced by the kitchen staff to help people to understand what it was they were choosing. The care records for one person read, "[Person] needs [their] milk served in a separate jug and gravy served in a separate jug". The records explained that this was so the person was able to decide for themselves how much milk or gravy they added to their drinks or meals.

We received mixed feedback about the food on offer. People felt that the quality of the meals was not consistent and depended on which staff were on duty. One person said, When [member of staff] is on the food's fine but the food is often cold on the other days". Another person commented "The food just isn't as nice."

Lunch for many was a pleasant experience. Staff worked efficiently together in order to serve the meals and when they had finished serving some sat together with people and ate their own lunch alongside them. We observed a member of staff supporting a person by guiding them with their spoonful's of food. They were patient, kind and offered appropriate encouragement. Another resident began to choke and staff responded swiftly, calmly and provided appropriate reassurance and support.

However, some people were assisted with their lunch by staff who were standing over them, despite the fact that there was plenty of room and chairs for them to sit. One person who frequently called out for help was largely ignored by all staff. We discussed our observations with a member of staff who told us that the person was not being ignored but was being encouraged to do things for themselves. We felt that this showed a lack of empathy and understanding towards this person who was living with dementia and would have benefited from a more supportive approach from the staff.

People mostly had access to health care services and received on-going health care support where required. A person told us, "They've [staff] organised a [physiotherapist] visit quite soon to see if my mobility can be improved". A visiting healthcare professional told us how staff were proactive at requesting additional support and commented, "Like this morning they called me directly so I could get here quicker. They call when needed." People's records showed details of appointments and contact with other professionals involved in their care and treatment. However, we had received information of concern prior to our inspection relating to the escalation of challenging behaviours shown by one person. Their care records did not demonstrate that there had been any recent contact with the persons GP or mental health team to discuss their general well-being and current state of mind. We discussed this with the registered manager who told us that this had been considered but acknowledged that a referral to the relevant professionals should have been made sooner. The registered manager confirmed shortly after our inspection, that this contact had now been made in order to seek the appropriate support.

Requires Improvement

Is the service caring?

Our findings

The atmosphere within the service was relaxed and welcoming. One person told us "The staff are very caring and very good". A visitor commented, "I always feel welcome when I come." People mostly felt that staff were kind and compassionate. One person when asked said, "Yes they are. If I'm awake in the night they bring me a cup of tea". People felt some staff showed more kindness and patience than others. When asked whether staff were patient one person said, "Some are. Some rush about". Another person told us, "They're [staff] mostly okay. They just get on with things".

People gave us mixed feedback about the care and support they received. One person said, "On the whole" staff treated them well, but went on to say, "I wish some [staff] would have some empathy". Another person said, "Oh yes" staff cared for them, "very well. They're all nice". A third person said, "They [staff] do very well with my personal care. Some folks might complain but I'm not." All of the visitors we spoke to felt that their relatives care and support needs were being met. One told us, "They are catering for her individual needs. They are very friendly, the staff. They work so hard." Another relative had provided feedback in the services compliments folder, "I would like to say how happy we are with the care and attention given to [person] at Estherene House. The staff are always extremely helpful and considerate towards [person] and indeed ourselves when we visit."

Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. A relative commented, "They know [person] well." A person told us, "The staff know I like my own space. That's why when the lounge was done up they [relative's name] suggested I could sit in this corner and they agreed. I like to be out of my room in the day, but don't like mixing. I've made this area my own and I'm as comfortable as I can be here".

Records showed that some people had been involved with discussing their care and support needs. One person said, "Yes both [relative] and I are" involved in updating their care plan. Another person told us, "My [relative] sees to all that but I know what's going on". Other people were unsure whether they were involved in discussions relating to their care. One person said, "They [staff] seem to just get on with it". People were not aware of meetings taking place which would give them opportunity to give their views. One person commented, "We don't have meetings. The staff have meetings". However, the registered manager had recently started a new initiative, "Feedback Friday", where they were putting aside time each Friday to meet with people to gather their views and establish whether there were any issues they would like to raise. Feedback included, "[Person] was upset about part of [their] meal and this was exchanged for something of their choosing". And, [Person] has had parts of the bible read to [them] which [they] thoroughly enjoyed." Relatives were free to speak with the registered manager at any time when they were available but protected time was also being allocated each Thursday. A relative said, "There is an open invitation to meet with the manager and I'll probably do that". This showed that the management of the service were exploring ways in which they could give people and their families the opportunity to express their opinions.

People felt that they were mostly encouraged by staff to make decisions about their care, support and daily routines. A person told us, "If I'm not feeling too good they leave me in my pyjamas all day if that's what I

want". Another person said, "I chose this place to sit during the day, it's sort of private and yet I'm out of my room which is good". This demonstrated that staff were usually guided by the wishes of the people they were supporting and encouraged people to have independence and control. However, some people commented that there were times they felt rushed because the staff were busy. One person said, "It depends how busy they [staff] are". This demonstrated that although staff aimed to promote a person centred ethos of care which valued each person as an individual, they were not always able to give people their full attention for the length of time people needed.

We received mixed views on how staff respected people's privacy and dignity. One person told us, "Do you know sometimes when they [staff] come in here to make the beds they whisper to one another – it's so rude." We observed a person sitting in the dining room drop their cup of coffee. A member of staff loudly told a colleague in front of everyone else who was in the room. This demonstrated a lack of awareness of how this person may be feeling and did not promote their dignity. However, we also received positive comments such as, "They [staff] close the door and the curtains when they're helping me with the commode or to have a wash". A relative told us, "When [relative] has a bath they always lock the door. They're [staff] very good". Minutes of a recent staff meeting showed that the subject of dignity had been discussed. "[Registered manager] reminded staff that a resident's dignity should be respected at all times…Any requests for the toilet should be kept private between the resident and carer." This demonstrated that although some staff recognised the importance of people's privacy and dignity there was still work to be done to ensure these were core values in the service upheld by all staff.

We recommend that the provider extends their training programme to incorporate further guidance for staff with regard to respecting people's privacy and promoting their dignity.

Good

Is the service responsive?

Our findings

People and their families told us they received personalised care which was responsive to their needs and their views were listened to and acted on. A person expressed how they were happy with the support they received and commented, "They [staff] really look after me".

Staff were knowledgeable about people and communicated with each other to pass on any changes in people's individual needs. Staff were encouraged to read people's care records to familiarise themselves with people's current needs. A senior member of staff commented, "I'll say to them [staff] can you sit and read their care plan." This helped staff to have a good understanding regarding the specific needs of people.

Work had been taking place over the last few months to improve people's care plans. The management team told us how their first step had been to get the records to a, "Working standard." A member of staff said, "The care plans were in a real mess now they have absolutely improved…They've only just now come into place. Now we can build on it." A relative told us, "I know the importance of a care plan, the previous documentation was horrific as my loved one's care was so badly written up. I complained but no action was taken, however the new owners said they would be establishing a new care planning system, I can actually say how easy it is to understand and that they actually are reviewed as I have been invited to talk through [relative's] care."

Each day there were two 'King or Queen's' for the day where that person received special attention and their care records were reviewed. This helped to ensure that everyone's care records were reviewed at least once a month. The new care plans were person centred and reflected the care and support that each person required and preferred to meet their assessed needs. Particular attention was paid to people's wishes and preferences such as, "[Person] likes pink, likes to be warm," and details about how people liked to receive their personal care. Each section was clearly laid out in a way which was easy for people and staff to understand. Details were included relating to people's specific health conditions. For example, the care records of a person with diabetes gave details about this condition to inform staff and ensure they were aware of the specific support needs of the individual so they could monitor and review any changes.

We found that some care records were not always consistent. For example, three separate eating and drinking care plan documents were identified throughout one persons' records each containing different information. This could have been confusing for staff and mean that people were at risk of not receiving care and support appropriate to their current needs. The management team had identified that now the care records had been put into their new format there was a need to thoroughly review each one to ensure consistency. The deputy manager had already begun work on this.

There was little information relating to the emotional and psychological needs of people. Further work was needed to demonstrate how the service responds to individual's differing care needs in terms of interests, social activities, types and stages of dementia. This would further strengthen the care records to show how people's whole well-being was being considered and provide additional guidance to staff to ensure a holistic approach to people's care.

The service employed two activities co-ordinators and there was an activities board displayed in the service which showed people what planned activities had been arranged for that week. We observed that the advertised manicures and painting activities took place and people were enjoying these experiences. The activities co-ordinator went with one person to their bedroom to carry out a manicure which was in line with the guidance in their care records that they preferred this to be done in private. The registered manager told us that links had been formed with another service so that activities co-ordinators could share ideas and learn from each other. The registered manager told us, "We are trying to get away from bingo, bingo, bingo." A relative commented, "They [staff] are very good. Really making lots of effort to stimulate [person] more." Additional work was being done to build on the activities offered and new clubs were being planned to cater for a wider range of people's interests. These included, club house [games], creating, investigation and research, housework, exercise, community café, pamper day and gardening. This demonstrated that staff were aware of the importance of physical and mental stimulation, social contact and companionship and focussed on what was most important for individuals.

There was a complaints procedure in place which explained how people could raise a complaint. Records of complaints showed that they had been responded to appropriately and in a timely manner. For example, records of one complaint showed that a number of actions had taken place as a result including a written response from the registered manager, contact with the persons GP and a safeguarding referral made to the local authority. This showed that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right.

Good

Is the service well-led?

Our findings

There was a positive, open and inclusive culture in the service. A relative commented, "I'd describe this place as homely and that's important". The providers had acquired the service in October 2015 and were committed in their approach to drive forward improvement to ensure all people's care and support needs were being met. They were working with the staff team to help them to understand and share the culture, vision and values of the service in its main objective to provide high quality care and continued positive life experiences to those who used it.

The directors acknowledged that there had been a need to work closely with staff to improve practice. For example, they told us as the result of an external audit in one area of the services operations, a member of staff was now working through an improvement plan and being regularly monitored. The staff file for this person confirmed this to be the case. Staff meetings had addressed areas of concern with the staff team and updated staff on any changes to people's care and support needs. Additional work was in progress to ensure that all staff would be regularly supervised and encouraged to share their views so that they would feel valued and motivated to drive continual improvement within the team.

People gave positive comments about the management and new providers of the service. A relative had commented in the compliments folder that the service was, "Better under new ownership. The care is very good. Staff have increased." Another relative told us, "Matters I thought were going to be made worse when I heard a new company was taking over. To my surprise, the home has gone from strength to strength. I met the owners early this year on an evening they had arranged. I heard that they would increase staffing, bring new staff, training, and improve the environment, which it badly needed… To my relief and many other families I'm sure, they have actually delivered on what they said they would do for the home."

A senior member of staff told us how they were encouraged to report any issues of concern and commented, "I have had problems where I've had to go to [registered manager]. You feel things are being dealt with." [Director] gave me [their] mobile number and said any problems to call [them]…you do see things happen." Staff also showed that they were aware of their duty of care to the people they supported. One staff member told us how they would feel should they need to report a colleague for poor practice, "We are colleagues not friends first. We are here for the resident well-being". This demonstrated that staff were confident that they could raise any issues of concern and that these would be dealt with appropriately.

Staff felt that they were being supported in their role and their opinions were valued. One member of staff told us, "I've found we are now starting to see some real improvements. You have the support you need." They added, "We wanted some DVDs, karaoke ones and musical instruments. I asked [registered manager]. [They] asked [regional manager] and a couple of days later they appeared in the post. If there is a need they will meet it."

The registered manager understood their roles and responsibilities in ensuring that the service provided care that met the regulatory standards. A relative told us, "Since the new manager is here. [Registered manager] is on site all of the time". The regional manager told us how they had been working closely with

the registered manager to offer support to help them to make the improvements which had been needed. The registered manager confirmed, "If I've got a problem or need advice I can go to them [regional manager and directors] We are gradually going through everything."

The provider had put together a comprehensive improvement plan which was regularly updated as changes were being made within the service and as other areas requiring improvement were identified. This was a working document which the directors and management team frequently consulted and actions were taken as a result of it. For example, it had been identified that people's care records were not being reviewed and updated as regularly as they should have been. The 'King and Queen' for the day initiative was put into place as a result of this. When progress was reviewed it was identified that, although practice in this area was getting better, there was still room for further improvement. This continued to be monitored and addressed with staff accordingly until the directors and management team were confident that this change had been embedded and staff were doing what had been asked of them.

To supplement the improvement plan, quality assurance systems were in place to identify shortfalls and to drive continuous improvement. The manager completed a weekly assessing and monitoring plan which included monitoring of all areas of the homes operations. This was sent to the regional manager for review and comment each week before being sent to the directors. The directors demonstrated an awareness of issues which were arising within the service generally as well as specific issues relating to individuals.

Concerns had been previously raised by the local authority relating to the management of infection control within the service. Monthly infection control audits were now being carried out and actions taken as a result of this. For example, the audit had identified that there was an odour in one bedroom. On investigation it was discovered that the cause of the odour was rotten floor boards and these had been replaced. Although these audits were comprehensive in all other areas of the service's operation they did not include monitoring of the toilet and bathroom areas. This meant that they had failed to identify and monitor an issue with the flooring in one toilet and bathroom area. The type of flooring present was of a type which was inappropriate for this area and was not easily cleaned. A strong odour was present and we discussed this with a director and registered manager. They were aware of this issue and had future plans to redevelop the area in which the bathroom was situated. We told them that the potential for spread of infection needed to be carefully considered and steps taken to remedy the situation as soon as possible. They agreed that the infection control audit should include monitoring of toilet and bathroom areas and indicated that this would be added to the audit.

People and their relatives were asked for feedback through surveys, One person confirmed, "I completed a form". The result of a relative's survey which had taken place in December 2015, shortly after the providers had taken ownership of the service, showed that 27% of respondents felt that the way their relative was treated by care staff was poor and 55% felt it was adequate. By contrast, a survey carried out in September 2016 showed that nobody responding felt that the way care staff treated their relatives was poor or adequate, 47% said it was good and 37% very good. None of the 15 questions asked in the initial survey had prompted a 'very good' response and very few 'good'. However in the latest survey all of the questions asked had prompted a high percentage of people to respond as 'good' or 'very good'. This showed that people were empowered to voice their opinions and could be confident that they would be listened to and appropriate actions would be taken to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people injuring themselves or others were not always appropriately managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always deployed appropriately to meet all of people's needs.