Greenleaf Healthcare Limited

Livesey Lodge Care Home

Inspection report

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Tel: 01455273536

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visit was carried out on 15 May 2018 and was unannounced.

At the last comprehensive inspection in April 2017 the service was rated, 'Requires Improvement.' We found the service had made some improvements since our previous inspection in January 2017. However, further improvements were needed to ensure there was sufficient staffing to meet people's needs, risk assessments included the detail and guidance staff needed to keep people safe and meals were sufficiently varied and provided in a way in which people's needs were met.

At this inspection, we found the provider had made some improvements to meals and staffing. However, further improvements were needed to the management and administration of medicines, the safe deployment of staff and quality assurance to ensure people received consistently good care. The provider had failed to make sufficient, sustainable improvements to the quality of the service. The overall rating for this service remained 'Requires Improvement'. The service has been rated as 'Requires Improvement' for over three consecutive inspections.

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

Livesey Lodge Care Home accommodates up to 24 older people in one purpose built building. At the time of our inspection there were 18 people using the service, many of whom were living with dementia.

The service had 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.

Improvements were needed in the management and administration of medicines to ensure people received these safely. Staff demonstrated they did not consistently follow policies and procedures in managing medicines, including those related to infection control.

There were sufficient numbers of staff to meet people's needs but staff were not always deployed effectively to ensure people received the supervision they needed.

Staff demonstrated a good understanding of actions they needed to take to keep people safe. Records showed potential risks to people had been assessed, but did not always include the detail and guidance regarding the measures and interventions staff needed to take to reduce risks.

The provider had systems in place to monitor the quality of the care people received. These were not used

consistently or effectively in ensuring staff followed systems and processes and people received good care as a minimum.

There were arrangements in place for staff to make sure that action was taken and lessons learned when accidents or incidents occurred. Reviews and analysis of records was not always undertaken in a timely manner to identify trends and patterns.

People were offered a limited range of activities. Further improvements were needed to ensure people were supported to engage in meaningful activities and were provided with sufficient stimulation to meet their needs and wishes.

Staff had completed training to enable them to recognise signs and symptoms of abuse and felt confident in how to report concerns.

Staff were protected from the risk of unsuitable staff because the provider followed safe recruitment procedures.

Staff received on-going development training and supervision of their role. The registered manager reviewed and evaluated training to ensure it was effective. This supported staff to gain the skills and knowledge they needed to provide effective care.

People were provided with sufficient to eat and drink. Improvements had been made to the variety and provision of meals in the service. We found further improvements would help to enhance the 'dining experience' for people.

Care plans supported staff to provide personalised care. However, records were not always updated in a timely manner and did not demonstrate if or how people had been involved in the review of their care.

People's needs were assessed before they began to use the service. People were supported to make decisions and choices about their care. Staff understood the principles of the Mental Capacity Act 2005 (MCA), sought consent before providing care and respected people's right to decline care and support. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to access a range of health professionals to maintain their health and well-being. Staff sought advice and worked in partnership with other agencies to support people to get the healthcare and treatment they needed.

People were treated with kindness, respect and compassion and they were given emotional support when needed. Staff demonstrated they understood the importance of upholding people's right to privacy and dignity.

Staff supported people to express their views and be involved in making decisions about their care as far as possible. This included consulting with relatives and access to independent advocates if necessary.

People and relatives told us they felt comfortable in raising concerns and complaints if they needed to and had confidence in the registered manager to take action to resolve them.

People, those important to them and staff were able to share their views about the service and the quality of

care they received. These were used to review the service and bring about improvements to develop the care provided.

You can see what action we told the provider to take at the back of the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed to ensure staff consistently followed policies and procedures about managing medicines, including those related to infection control.

Staffing required further review and assessment to ensure staff were effectively deployed to keep people safe.

Risks to people had been identified and assessed. Records required further improvements to ensure they contained the information and guidance staff needed to support people safely.

People were protected from abuse and harm by staff who knew their responsibilities for supporting them to keep safe.

Is the service effective?

Good

The service was effective.

Staff received training and support to develop in their roles. Staff worked in partnership with a range of healthcare professionals to ensure people were supported to maintain their health and wellbeing.

The provider had made improvements to the provision of meals. Further improvements would enhance the 'dining experience' for people.

People's consent to care and treatment was sought in line with legislation and guidance.

Is the service caring?

Good

The service was caring.

Staff knew people's needs well and provided care in line with people's wishes and needs.

People were treated with dignity and respect and staff ensured their privacy was protected.

People were encouraged to make decisions about how their care was provided.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff knew people well, including their wishes and preferences and used this to provide personalised care. Care records were not always updated in a timely way to reflect changes in people needs.

There was a limited provision of activities for people. People were not consistently supported to engage in meaningful, stimulating activities.

The provider had a system in place to receive and monitor any complaints and people were confident to raise concerns if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had not made sufficient, sustainable improvements to provide good care as a minimum for people using the service.

Quality assurance systems were fragmented and audits were not always effective in monitoring the quality of care provided.

The provider has been rated as 'Requires Improvement' for over three consecutive inspections.

People, relatives and staff were supported to share their views about the service and these were used to bring about improvements.

Livesey Lodge Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 May 2018 and was unannounced.

The inspection was carried out by one inspector 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about what the service does well and improvements they plan to make. Our review of this information enabled us to ensure that we were aware of, and could address, any potential areas of concern.

We reviewed information we already had about the provider. Providers are required to notify us about specific events and incidents that occur in the service. We refer to these as notifications. We contacted commissioners, responsible for funding some of the people using the service, to gain their views on the care provided.

We spoke with three people and four relatives of people using the service. We also spoke with the registered manager, who was also the registered provider, the deputy manager and four staff including the activity co-ordinator. We observed care provided in communal areas, including the lunchtime meal. This helped us evaluate the quality of interactions that took place between people using the service and the staff who supported them.

We reviewed information including care planning records for three people, four staff recruitment files, training records and other records relating to the day to day management of the service and the provider's quality management systems.

Requires Improvement

Is the service safe?

Our findings

Medicines were stored safely but further improvements were needed to the recording and administration of medicines. People received their medicines from staff who had completed training in the safe administration of medicines. We observed staff supporting people to take their medicines at lunchtime. Each person had a medicine plan detailing how they liked to take their medicines and any allergies. We saw staff provided support in line with people's preferences and sought consent before administering medicines. Records were only signed once they had observed people had taken their medicines.

One person preferred to have their tablet put in the palm of their hand. We saw staff did this but the person declined their medicines and they dropped the tablet to the floor. The staff member persisted and the person dropped the tablet onto the floor on a further two occasions. Each time, the staff member picked the tablet up from the floor and attempted to re-administer it. At the third attempt, the staff member respected the person's right to decline their medicines. They told us this was the first time the person had declined their medicines. They left the tablet in a pot on top of the medicines trolley. They then visited another person in their room to administer medicines and left the medicine trolley in the corridor. Although the trolley was locked, the pot containing the tablet remained exposed on the top of the trolley. We also observed the staff member administering eye drops without wearing gloves or sanitising their hands. These observations raised concerns regarding lack of staff awareness in protecting people from the risk of infection and safe procedures during the administering of medicines.

Protocols were in place for medicines that were prescribed as and when required (PRN), for example, pain relief. Topical medicines, such as creams and lotions, were supported by a body map. This guided staff on the correct area of application. We checked a sample of medicines in stock to ensure stock records were accurate. We found paracetamol was in stock for two people dated November and December 2017. These medicines were not recorded as being in stock and were not included in people's medicine administration records. A staff member told us this was a recording error.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines. Staff demonstrated they were not consistently following policies and procedures about managing medicines, including those related to infection control.

We discussed our concerns with the registered manager who told us they would review the administration and management of medicines to ensure safe procedures were followed and records were accurate.

At our last inspection in April 2017, we found improvements were needed to ensure sufficient numbers of staff were deployed to keep people safe. Risk assessments required further detail to provide staff with the information and guidance they needed. At this inspection we found some improvements had made but further improvements were needed to ensure staff were effectively deployed and records were robust.

People and relatives provided mixed views about whether there were enough staff to keep people safe.

Comments from people included, "The staff here are very good but are overworked and not enough staff. They don't always replace staff who are off. The agency they use at night are regulars and they are excellent," and "I don't think there is enough staff but it doesn't affect me." A relative told us, "I think there is enough staff, definitely. There are always staff around." Another relative told us, "There is always two staff to help [name of person]. Even when they haven't enough staff, they work so well it isn't an issue. They manage it."

Staff told us there had been improvements in staffing since our last inspection. This included more regular, consistent staff. One staff member told us, "We have regular agency night staff which is better because there was inconsistent staff before. There is enough staff but we struggle with short notice staff absence and covering annual leave. We try extra hours and agency, but it can be difficult." Another staff member told us, "We [staff] support each other and work well together. We do need more staff to be recruited, but it is difficult to recruit."

We observed that staff were busy but responded when people required support. For example, staff responded promptly when call bells were activated. Staff were usually in or around the communal areas, although they were often engaged in tasks and had limited interaction with people during these times. This meant there were times during the day that people received limited supervision.

The registered manager told us they had reviewed staffing and were in the process of developing a dependency tool to ensure there were sufficient staff to meet people's needs. They told us from their initial review, they had found there was enough staff as people did not have to wait for care or support. They had employed long-term agency staff to cover nights as they had been unable to recruit night staff from the local area. This helped to ensure people were provided with consistent care. Staff were also providing cover for meal preparation due to the absence of both cooks. The registered manager told us this was a temporary measure until dedicated kitchen staff were in position. They told us they were in the process of recruiting more care staff.

People's care plans included risk assessments for areas such as falls, mobility and risks associated with their health conditions. In most cases we found records provided clear instructions as to how to keep people safe. For example the use of equipment such as sensor mats for people at risk of falling out of bed. However, some records were not always consistently detailed to provide the information and guidance staff needed to keep people safe. For instance, one person required a hoist to enable them to transfer. Their risk assessment detailed the procedure to be followed to protect the person during this support, but did not included what type of hoist or sling should be used. This is important information to ensure the correct hoist and sling size is used for the person. The registered manager told us they would review and update risk assessments.

People and relatives told us they felt safe using the service. Comments included, "Yes, I feel quite safe. If I want anything they [staff] look after me," "I'm safe here; it's quite secure. The staff are good to me," and "[Name of family member] is definitely safe here. [Name] had serious falls at home, but no falls here as far as I know."

Staff had attended safeguarding training to protect people from the risk of harm and abuse. Staff we spoke with knew how to recognise signs of abuse and how to report concerns. Staff were also familiar with the term whistleblowing, which is a process for staff to raise concerns about potential malpractice at work. Information about whistleblowing was available on communal notice boards to support staff and visitors to raise concerns outside of the service. Staff told us they would feel confident to raise any concerns they may have about poor care with the deputy or registered manager and they would be listened to and acted upon.

When safeguarding incidents had occurred, staff discussed these with the appropriate local authorities. This helped external agencies decide on the level of intervention required to keep people safe.

Some people using the service could demonstrate behaviours that may challenge, such as verbal or physical aggression. We saw staff were skilled at supporting people when they became distressed or anxious. For example, one person required constant supervision and distraction to reduce the risk of behaviours that challenge developing and we saw staff provided this. Another person became anxious when supported by staff to transfer from their chair. Staff were patient and did not rush the person, providing reassurance to reduce their anxiety. This resulted in the person calming and accepting the support they needed.

Information about behaviours that challenge was not always sufficiently detailed in people's care plans. For instance, one person's care plan clearly described how they expressed agitation and distress and the suggested staff intervention. This included a cup of tea, staffing sitting with the person, hand holding and an object of comfort. We saw staff intervened in a timely manner when the person became distressed and used the suggested interventions appropriately. However, another person's care plan identified their behaviour could put other people at risk. Records showed staff recorded incidents of behaviours; these were not completed consistently. Records described the person's behaviours, impact on others and potential triggers, but did not include suggested interventions and response from staff. Staff were working collaboratively with health professionals for support and guidance in managing these behaviours. The inconsistencies in records presented a potential risk that staff and health professionals may not have the accurate information they needed to ensure the person received the right support. The registered manager told us they would review and update records.

People were safeguarded against the risk of being cared for by unsuitable staff through the provider's recruitment procedures. Recruitment files we sampled contained evidence that the necessary employment checks had been completed before staff started to work at the service. These included a check with the Disclosure and Barring Service (DBS). The DBS carry out criminal record and barring checks on prospective staff who intend to work in care and support services to help employers to make safer recruitment decisions.

We observed staff followed infection control procedures when supporting people with personal care and when undertaking domestic tasks. Gloves and aprons were available and staff wore these at meal times and when supporting people. The premises and furnishings were clean and free from odours. Staff followed cleaning schedules which including a daily checklist of tasks to be completed. Records showed this had been signed as completed and checked by senior staff.

The provider had environmental risk assessments in place and there were systems which included regular fire tests and drills. People had up to date personal evacuation plans which provided information as to the level of support they required in the event of an evacuation. The premises were mostly well maintained. The registered manager told us the maintenance staff were currently restricted to light work only which had resulted in a delay in the usual maintenance service. In the meantime, they had engaged external contractors to ensure the premises were safely maintained.

The provider understood their responsibilities to review concerns in relation to health and safety and near misses. Staff recorded incidents and concerns. Records showed the registered manager had analysed and reviewed this up to December 2017, but had not undertaken any formal analysis since then. They told us they had reviewed records informally but had not completed a full analysis. Actions taken to reduce risks for people included sensor mats where people were at risk of falling during the night time. The provider had improved fencing in the rear garden to ensure the area was secure following a person leaving the service

unsupervised. There had been no further incidents since this measure had been taken. The registered manager told us they would bring incident and accidents reviews up to date to ensure any trends and patterns were identified. This would help ensure timely action was taken to make improvements where required.

Good

Is the service effective?

Our findings

People and relatives we spoke with had confidence that staff had the skills and knowledge they needed. One person told us, "The staff here are very good. I've never seen staff at a loss as to what to do." A relative told us, "They [staff] work well. [Name] wasn't well when [name] first came, but I have no concerns about [name] health now."

At our last inspection in April 2017 we rated the service as requires improvement in the effective domain. This was because we found meals were not varied and were not provided in a way in which people's needs were met. At this inspection we found improvements has been made to the meals provided; further improvements would enable people to experience a 'dining experience' rather than simply receive meals.

People and relatives were generally positive about the meals and drinks provided. Comments included, "It's [good] not too bad. They [staff] always cut my dinner up for me," "The food is very good. They [staff] ask you in the morning what you want for lunch," "You can have juice any time. They [staff] bring round tea and biscuits," and "[Name] does enjoy the food. There are two choices (of meals). Some have an omelette instead. [Name] was like a skeleton when they came in. [Name] has put on a stone (in weight)."

We observed the lunchtime meal and the support people received to have sufficient to eat and drink. Meals were served to people in accordance with their preferences and choices. Staff checked people's choices before serving to ensure they were still happy with them. We saw one person asked for cheese with their mashed potato and this was provided. Where people required support to eat, a member of staff sat with them and supported them to choose what they wanted to eat first. The atmosphere was quiet and calm and people were supported to eat at their own pace. Staff offered verbal and physical encouragement where people became distracted or needed prompts to have enough to eat. A choice of juice was offered during the meal.

We found further improvements would help to ensure people had a positive dining experience. For example, people were not consulted about portion sizes; all the portions were of a large size which could be off putting for some people. People did not have access to condiments without staff support. Some staff consulted with people as to whether they wanted condiments, whilst other staff poured sauces over meals without consulting with people. One person lived with sight loss and we saw staff placed the meal in front of the person without advising them what was on the plate or the position of the food. They used their fingers to explore the food, pushing some of the food over the edge of the plate.

The registered manager told us they had used people's feedback to improve the meals provided. Improvements included more variety in meals provided, more alternatives and fresh food wherever possible. They told us they ensured they kept people's personal food preferences in stock so they always had something available that they really liked. Four people who we spoke with following the meal told us they had enjoyed the food provided.

Staff told us they had completed training that gave them the knowledge and skills they needed in their role.

One staff member told us, "There is always training available here. We do on-line training and in-house." Another staff member told us, "[Name of registered manager] puts in place enough training and it's regularly updated. We are supported to develop. I am studying for my NVQ 2 at the moment." Records showed staff had completed a range of training to enable them to understand and meet people's needs. This included dementia awareness, mental capacity and equality and diversity. Staff who were new to the service completed an initial induction and worked alongside experienced staff before supporting people.

Staff spoke about a positive culture where advice and guidance was readily available. Staff told us they received good support from the deputy manager and regular supervisions. This provided them with the opportunity to review their competency and working practices and identify any training and development needs.

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 are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

People told us they were supported to make decisions and were free to choose how they wanted to spend their time. Comments included, "I have never been restrained from doing anything ever," and "I can have what I want." A relative told us, "[Name] is able to make decisions. They [staff] come and ask [name] things." Records showed people's mental capacity to understand, consent and make decisions about their care and treatment had been assessed. For example, one person had been assessed as being able to make day-to-day choices and decisions about their care but required family support to make more complex decisions. Staff demonstrated they sought consent before providing care and respected people's choices where they had capacity to make decisions about their care. For instance, one person preferred to spend time alone in their room. We saw staff respected this and providing care in accordance with the person's wishes.

Some people were subject to DoLS authorisations, for example, because they were unable to consent to care or choice of home. Care plans included appropriate paperwork. The registered manager kept all authorisations under review and submitted requests to review applications before expiry dates. This helped to ensure that any restrictions on a person's liberty were being lawfully applied.

People's care plans showed staff worked in partnership with other agencies to ensure people's health and wellbeing was maintained. Staff supported people to access routine appointments, such as dentist and chiropodist, in addition to specialist appointments. One person told us, "The doctor comes regularly. I see the chiropodist." Another person told us, "The doctor comes if needed. The chiropodist came last week. It's every ten weeks. I've had one eye test here." A relative told us how staff monitored their family member's health care and were quick to refer to health professionals if they had concerns, for example if they suspected a possible infection. The relative told us staff had kept them informed of their actions and the outcome which demonstrated staff were effective in meeting people's needs. Staff spoke about referrals to dementia in-reach team and Speech and Language Therapists (SALT) where they needed extra support or advice to meet people's changing needs. Care plans had been updated to reflect advice from health professionals in line with best practice.

The provider was committed to improving the premises for people. Improvements made included the re-decoration and replacement furnishings in the main communal lounge. The registered manager discussed further improvements that had been planned and for which they were waiting for external contractors. The premises were spacious, clean and bright. We found further improvements would ensure people's needs were fully supported by the environment. For example, communal corridors had been painted different colours to support people to orientate around the building. However, although there were some signs on people doors, signage around communal areas was poor. There was a lack of appropriate directional signage to support people to move around independently. Staff told us a person using the service regularly removed items from walls. Fixed signage would address this concern. There were little interactive items in communal areas to interest people who liked to walk around. For instance, tactile wall art or rummage drawers; which can help to provide a sense of purpose. The registered manager told us they would review this as part of the up-grade works.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. Comments about staff included, "They [staff] are very caring. I have never been mistreated at all," "Staff are very caring, I can do what I like," "They [staff] are always respectful to me. It's quite dignified," "They [staff] talk to me very well. 'It's fine' they say, 'we are here to help you'," and "They [staff] treat [name] very respectfully. They are careful how they treat [name]; quite dignified I think."

Staff understood the best communication methods for people and were knowledgeable about the people they supported. They were quick to respond if people became distressed or anxious. For example, one person was anxious about walking from the lounge to the dining room. A staff member was quick to observe this and asked the person. "Would you like to come with me and link my arm?" The person responded by smiling and saying, "Oh yes please." They looked happy and began to communicate on the way with the staff member.

Staff demonstrated a person-centred approach when providing care and support. They were knowledgeable about people's needs, preferences and interests. For instance, they were able to discuss past and current interests and key events, such as work and marriage. Staff talked with people and we saw shared humour. This encouraged a relaxed and informal atmosphere for people. Staff told us they felt they had enough time to be caring and provide the care and support people needed.

Staff supported people to maintain their dignity, for example, by ensuring their clothing was clean and appropriate. Staff were discreet when providing personal care and respectful of people. We saw staff knocked on doors before entering and addressed people by their preferred term of address.

People and their relatives were involved in the planning of their care as much as they were able to. People were treated as individuals and supported to make decisions and choices about the way they wanted things to be done. For example, what they wanted to wear and which room and chair they wanted to be in. People's care plans recognised and promoted people's equality and diversity, including religious and cultural beliefs and wishes. For example, for one person, it was important for them to have support to go for regular walks outside of the service. We saw staff provided this support and the person returned looking happy and relaxed.

Staff encouraged people to do as much as possible for themselves. For example, during mealtimes, staff used verbal and physical prompts to support people to eat independently before they considered providing full support. People were encouraged to move around the building independently if they were able to.

If people were unable to make decisions for themselves and had no relatives or representatives to support them, the registered manager had provided information on advocacy services in communal areas. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Visitors were welcomed. All the people and relatives told us they were able to visit at any time, could stay as long as they wanted to and were always made to feel welcome. A relative of a person who used to use the service was visiting at the time of our inspection. They told us their family member had received such good care from the service that they liked to visit staff from time to time to keep in touch. We saw staff were attentive to the visitor and gave them a warm welcome.

People's care records and personal information were kept securely and the provider had a confidentiality policy. Documents were kept in cabinets and offices and only accessed by relevant staff members.

Requires Improvement

Is the service responsive?

Our findings

People mainly received care from a consistent team of staff who knew people well and were familiar with their needs. This helped to ensure people received care in line with their wishes and preferences.

Some people we spoke with were able to recall their care plan. One relative told us, "The paperwork is kept up to date. They [staff] discuss [name] care with me on a need basis." The assessment and care planning process considered people's values, beliefs, hobbies and interests along with their goals and wishes for the future. People and, where appropriate, their relatives were involved in developing their care plans, which were detailed and personalised. They included a summary of the person's life history, significant events and who and what was important to them. For example, one person's care plan described the number of pillows they liked to sleep on and which side of the bed they wanted a glass of water to be placed at night. Care plans included how people liked their personal care to be provided and what they liked to have around them, such as favourite toiletries. This helped staff to provide personalised care.

Records showed care plans were regularly reviewed. People and relatives we spoke with could not recall being involved in reviews of the care provided. We found some care plans had not been updated in a timely manner to reflect people's current needs. For example, one person had been assessed by health professionals as being at risk of choking. They had provided guidance that the person should have soft diet, with alternative loaded and empty spoons to encourage the mouth to be cleared. We saw staff supported the person to eat sausages at lunchtime. When we questioned this with staff, they told us the person had improved and the guidance was no longer followed. The care plan had not been updated to reflect this. The deputy manager told us they would update the care plan.

People and relatives provided mixed views on activities available in the service. Comments included, "I do word search and watch television. I like sport. There are activities in the lounge; I don't do them," "They [staff] do some activities in the lounge; ball and skittles. They don't do any sing songs. They do take me out in the wheelchair to the village," "They do knitting and painting. It's usually in the afternoon because they are so busy in the morning," " I come every afternoon. I don't see any activities," and "I like the exercising here. I go in the garden sometimes."

We spoke with the staff member responsible for co-ordinating activities, who was also the domestic staff. They told us, "My priority is on the cleaning. I aim to do the cleaning by 1.00pm. Activities are between 2.00 and 2.30pm. They have had an activity today, music and movement, I heard it. I've been doing activities for two years. I target two-three residents at a time. I rarely do one-to-one's. I'd like to."

We saw the activity for the day displayed on the notice board was music with instruments in the morning and games, dominoes, cards, skittles and board games in the afternoon. During the morning, we saw people provided with music instruments, such as maracas. Some people seemed at a loss as to know what to do with the instruments and staff struggled to support people to engage with the session. A small number of people participated and enjoyed the music being played. This activity lasted around 20 minutes. Apart from this activity, we saw staff providing stimulation to a small number of individual people. For example, one

person was supported to engage with a 'rummage box'. This was a box containing personal items to trigger memories and provide stimulation and comfort. The box contained photographs of family members, a book of particular interests and small items to handle. The person responded positively to this and spent time looking at and discussing items with staff. Another person was provided with a book about the recent Royal wedding and this triggered conversations and memories with staff. These were examples of staff following best practice in providing meaningful engagement for people living with dementia. However, many other people were only stimulated when staff provided care and support.

We discussed the lack of meaningful engagement and stimulation with the registered manager. They told us they would review the provision of activities to ensure staff had the skills, knowledge and resources they needed to engage people in meaningful activities.

The provider had a complaints policy and procedure in place which was displayed in communal areas for people and visitors. People and relatives told us they were aware they could raise concerns but felt they had not had make any complaints to date. Records showed complaints received since our last inspection had been acknowledged and investigated. Where investigations had concluded, complainants had been provided with a response and outcome. The registered manager welcomed complaints and used these to improve the service. For example, improvements in the provision of care.

People were supported at the end of their life to have a comfortable and pain-free death. People we spoke with confirmed staff had asked for their wishes and preferences regarding end of life care and these had been included in people's care plans. These included resuscitation wishes and specific requests, such as people to be present and any cultural or religious preferences.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality of care but these were not used effectively to bring about improvements in the service. For example, regular audits were carried out on medicines and records. However, audits had not identified the concerns we found in terms of how staff administered medicines and inconsistencies in stock records. Audits and checks had not been consistently undertaken in other areas, such as care records or the environment. The areas of concern we found, such as care records, staff deployment and activities, had not been identified as requiring improvement. The registered manager told us quality assurance had lapsed within the service due to exceptional circumstances but they continued to monitor the service informally. They told us they were in the process of developing an action plan to ensure improvements were identified and made to the quality of the service.

The service has been rated as requires improvement over three consecutive comprehensive inspections. This failure to demonstrate sustainable improvements to achieve a Good rating is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives shared mixed views on the leadership and management of the service. One person told us, "I don't think the owner has any interest. [Name of deputy manager] has been here for years. The service is mediocre and could be done better. There is a lot that needs doing." Another person told us, "[Name] is the manager. Never seen much of them, never speaks to me. It could be better managed." A third person told us, "I get on fine with [registered manager]. They are on top of things. They worry a lot. I think they are alright, they are very transparent here." A relative told us, "I think they are very approachable [registered manager]. I feel very welcome here and never faulted any of the staff." A second relative told us, "I think it's run very well. It pleases me because I know [name] is being looked after."

The service had a registered manager in post who was also the registered provider. They were supported by a deputy manager who oversaw the day-to-day management of the service. Staff spoke positively about the support and guidance they received from the deputy manager. They told us both the registered and deputy managers were approachable. Comments included, "We can share views with [registered manager] anytime but she is not here a lot. [Name of deputy manager] is the manager day-to-day. She has a lot to do but we can go to her for advice and guidance," and "[Registered manager] makes sure we have what we need, for example training. She lives quite far away but if there are any problems she comes around as soon as she can. [Name of deputy manager] does a lot. She manages on a day-to-day and is very supportive."

Staff were supported to share their views and contribute to decision making through regular staff meetings. We viewed minutes of staff meetings held in February 2018. Records showed meetings were used to share information with staff in addition to developing staff. For instance, discussions around the recent reduced food safety rating and identifying remedial actions required. Best practice was also discussed, such as maintaining confidentiality. Staff told us they enjoyed working as a team, felt there was good communication and respected each other's diversity. Some staff told us they felt morale was low because they didn't always feel valued by the registered manager. The registered manager felt this was because of recent staff changes which they were working on resolving as a priority.

People and their relatives were encouraged to provide feedback on their experience of the service. Relative and resident meetings were held periodically and provided people with opportunities to make suggestions and for information to be shared. Surveys were sent out annually to people and relatives to enable them to comment on the quality of the service. The results of these were collected and made available on communal notice boards for everyone to see, in addition to being discussed in meetings. The registered manager used this feedback to bring about improvements. For example, comments in surveys sent out in January 2018 had resulted in improvements to the provision and variety of meals in the service.

The Care Quality Commission had not always been notified of events and incidents that had occurred. For example, incidents of behaviours that challenged. The registered manager had notified the local authority of an incident that had occurred in April 2018 but had not submitted a notification to CQC under separate reporting procedures. They told us this had been an oversight and they would ensure notifications were made in line with their legal responsibilities. The provider had ensured they displayed their current ratings at the registered location.

The provider worked in partnership with other agencies in an open and transparent way. Working in partnership with other agencies who commissioned services, local authority safeguarding and community health teams ensured that people received a joined-up approach to their care and support. Commissioners, responsible for funding some of the people using the service, told us they had no significant concerns about 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 Staff demonstrated they were not consistently following policies and procedures about managing medicines, including those related to infection control.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance to monitor the quality of the care provided and ensure people received good care as a minimum.

The enforcement action we took:

warning notice