Gilead Care Services Ltd

Gilead House

Inspection report

Quality Street
Merstham
Redhill
Surrey
RH1 3BB

Tel: 01737648300
Website: www.gileadcare.org.uk

Date of inspection visit:
29 May 2018

Date of publication:
05 July 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Gilead House 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. Gilead House is registered to provide accommodation and personal care for up to 22 people. There were three people living at the service at the time of our inspection.

This inspection site visit took place on 29 May 2018 and was unannounced.

There was no registered manager in post on the day of the inspection however a new manager had started at the service who had submitted their application to register. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the last inspection on 27 November 2017, we asked the provider to take action to make improvements. This related to the safety of people, the processes around the recruitment of staff, how people were being safeguarded against the risk of abuse, staff training, the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the involvement of people in their care, how people were received interaction from staff, activities and care planning for people, the leadership at the service, the quality assurance and how complaints were being responded to. We found at this inspection that there had been improvements although we have recommended further improvements around the care planning for people and there has been a continued breach around the lack of notifications being sent to the CQC.

Notifications were not always being sent to the CQC which is a requirement of the providers registration.

Improvements were required in relation to the lack of guidance in care plans that related to people's clinical diagnosis and end of life care. We have made a recommendation around this. Other aspects of care planning were detailed and provided appropriate guidance for staff. People's individual needs were being met and staff understood what care needed to be provided.

There were appropriate levels of care staff to support people when they needed it. The management of medicines was safe by staff that had the appropriate training. There were appropriate plans in place to ensure that risks to people were managed. Staff understood what to do to minimise risks in relation to people including the management of infection control. Personal emergency evacuation plans were in place and staff understood what they needed to do to support people. Where people had accidents and incidents actions were taken to reduce the risk of them reoccurring.

People told us that they felt safe with staff. Relatives felt that their family members were safe in the service. Staff had a good knowledge of what they needed to do if they suspected abuse.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate assessments had been completed where people's capacity was in doubt and applications to the Local Authority were submitted if people were being restricted in their best interests.

People enjoyed the meals at the service and had sufficient choices. People's health care needs were monitored including weight loss and any changes in their health. People had access to appropriate health care professionals where needed.

Relatives told us that staff were kind and caring and treated people in a respectful and dignified way. This was confirmed through our observations. People and relatives were involved in their care planning. Relatives and friends were welcomed at the service to visit people.

People had activities that they could be involved in and were taken on trips outside of the service. Staff communicated changes to each other about any changes in people's care. Complaints were investigated, recorded and responded to appropriately.

Relatives and staff felt that there had been improvements at the service. We could see that the staff team worked well together and that staff enjoyed working there.

There were effective systems in place to assess the quality of care and to make improvements. This included audits, meetings and surveys where feedback was sought. Improvements were made as a result of this.

We could not improve the rating for safe and effective from inadequate to good because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

Recruitment practices was safe as relevant checks had been completed before staff commenced work.

There were sufficient care staff to meet the needs of people.

Appropriate plans were in place to assess and manage risks to people. In an emergency staff understood what they needed to do.

People were protected against the risk of abuse and neglect. Staff understood what they needed to do to protect people.

Medicines were stored, administered and disposed of safely. Accidents and incidents were acted upon and measures were in place to reduce the risks. Appropriate infection control was being followed by staff.

Is the service effective?

Requires Improvement

The service was effective.

Staff had received training and supervision specific to their role. However, we did raise that dementia awareness training should be provided.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of people's health.

Staff understood and knew how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was in line with appropriate guidelines.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

The environment suited the needs of people that lived in the service.

Is the service caring?

Good

The service was caring.

Staff treated people with compassion, kindness, dignity and respect.

People's privacy was respected and promoted. Staff were happy, cheerful and caring towards people. People were involved in their care planning.

People's relatives and friends were able to visit when they wished. People were supported with their independence

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives were not involved in detailed discussions about end of life care. There were some aspects of care planning that required more detailed guidance.

Complaints were investigated and responded to in a timely way.

Other information regarding people's treatment, care and support was reviewed regularly and shared with staff. There was sufficient guidance for staff in relation to people's care.

People had access to activities and people were protected from social isolation.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

Appropriate notifications were not always sent to the CQC which had also been identified at the previous inspection in November 2017.

There were sufficient systems in place to regularly assess and monitor the quality of the service the service provided.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

Staff had regular discussion and told us that they were able to approach the providers when they needed to.	

Gilead 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 inspection site visit took place on 29 May 2018 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is because we were following up on breaches from the previous inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with the manager, one person, one visitor, and two members of staff. There were people that were unable to verbally communicate with us; instead we observed care from the staff at the service. We looked at a sample of three care records of people who used the service, medicine administration records and training, supervision and three recruitment records for staff. After the inspection we spoke with three relatives.

Requires Improvement

Is the service safe?

Our findings

At the previous inspections in May, July and November 2017 we found that care and treatment was not being provided in a safe way, medicines were not being managed safely, accidents and incidents were not always recorded and analysed and people were put at risk because appropriate infection control was not being followed by staff. At this inspection we found that this had improved.

We could not improve the rating for safe from inadequate to good because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Relatives told us that they felt their family members were safe at the service. One told us their family member mobilised with a frame and said, "She zooms around the place on that." Another told us, "She's (their family member) very safe…everything is very secure. There's never any worry." A third told us, "X feels very safe at the home."

Assessments were undertaken to identify risks to people. One relative told us, "She's (their family member) very good on her feet. When she has a shower, they stay in the room and they keep an eye on her when she's getting dressed." Another told us, "He (their family member) has a walking frame so he can get about safely. He knows the home so he moves about freely."

Risks were assessed in relation to people's falls, mobility, skin integrity, mental health needs, nutrition and choking. The care plans identified the potential risks to people and gave instructions and guidelines to staff in order to manage those risks. The staff we spoke to said they had read the care plans and understood the risks and the action they must take to minimise the risk of harm. One person had fallen in January 2018 and as a result their risk assessment had been updated to show the need for staff to help the person when moving around. We saw staff helped the person from their chair and made sure they walked beside the person. Where appropriate food and fluid charts were in place to ensure that staff were aware of what people had drunk and eaten.

Accidents and incidents had been recorded and reviewed. There had been one incident which had been investigated and a staff member had been disciplined. Where people had fallen steps had been taken to reduce the risks. For example, to reduce the risks for one person we observed staff stayed with the person when they walked and made sure their foot wear was correct and there were no trip hazards. This was consistent with the directions in the assessment. A member of staff said that there had been no further falls for the last six months.

Staff were aware that each person had a personal evacuation plan (PEEP) in place in the event there was an emergency. PEEPs were available in reception so that they could be easily accessed and a copy was kept in their care plans. There was a business continuity policy with detailed information about what needed to happen in the event of an emergency such as a loss of electricity or where people would be evacuated to in the event of an emergency.

People were supported to take their medicines as prescribed. One relative told us, "They make sure that she (their family member) takes all of her medication." The storage room for medicines had been improved since the last inspection with a new floor cover and decoration. The medicines were stored securely. The room temperature was checked daily to ensure medicines remained fit for use. The manager carried out medicines administration and did this correctly according to best practice. When the manager approached people, they explained what their medicines were for and made sure they had water and swallowed their medicines. They signed correctly to say the person had taken the medicines. There were no gaps in the medicines administration records which meant people received their medicines as prescribed. One person required patches for pain relief. The staff maintained a body map to show the sites of application. This is important so that side effects are reduced. The relative told us, "He (the family member) receives his meds on time and every day. He has a patch that he needs every day, which he gets." When medicines were prescribed 'as required' there were protocols in place to guide staff about how often they could be given and for what reasons. The manager had assessed the competency of other staff to safely manage medicines and the results had been recorded.

People were protected against the spread of infection within the service. One relative said the service was clean and hygienic when they visited, including their family members room. They said, "It's always nice and clean and tidy." Another told us, "The home is very clean. There are hand gels everywhere." The environment was clean and smelt pleasant. Bathrooms were clean and tidy; sluice rooms were locked and the laundry room was tidy and organised. Handwashing prompts were seen around the service and staff were observed washing their hands. One member of staff said that they had a cleaning schedule they followed and the manager checked the standard of cleanliness. Although they said they were yet to complete infection control training they could describe how they cleaned to prevent the spread of infections, this included using different equipment for different areas and using personal protective equipment. Staff were wearing gloves and aprons when cleaning or providing care.

At the previous inspections in November 2017 we found that recruitment practices were not robust and there were gaps around the background checks for staff. At this inspection we found that this had improved.

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for three staff members. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people in this type of care setting. There were also copies of other relevant documentation including full employment histories, professional and character references.

At the previous inspection in November 2017 we found that people were not always protected against the risk of abuse. At this inspection we found that there were still concerns although processes had improved. The provider had not always ensured that the Local Authority had been notified of safeguarding concerns. There had been an allegation of abuse in relation to a person that lived at the service. Although the provider dealt with the concerns they had not made the Local Authority aware that staff had been dismissed as a result of the findings by them. We contacted the Local Authority regarding these concerns. The provider had made the Local Authority aware of other safeguarding concerns.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. There was guidance and policies available to remind staff of the correct procedures and who to contact if they suspected abuse. One member of staff said, "I have been trained and I would report to the manager or tell the local authority". They went on to describe different types of abuse and what signs to look

for that may indicate someone was being abused such as unexplained bruising or changes to behaviour.

On the day of the inspection people were supported by appropriate levels of care staff. When people needed support staff were able to assist quickly. One visiting friend said, "When I visit there are always enough staff to help X". One relative told us there were enough staff to meet people's needs as there were only three people residing at the service at the time of our inspection. They said, "I don't think they need any more [than two]." Another told us, "There are only three residents there at the moment. There are plenty of staff." A third said, "There is always staff there." The manager told us that as well as themselves every weekday there was a senior carer who supervised, two carers and a cook. At night there was one waking night staff and one sleep in. In addition, there was a maintenance person and administration staff. The staff duty rota confirmed that this level of staff was available at all times.

Requires Improvement

Is the service effective?

Our findings

At the previous inspections in May and November 2017 we identified that staff did not always have the skills and knowledge to provide effective care. We found that this had improved on this inspection.

We could not improve the rating for effective from inadequate to good because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Staff were sufficiently qualified, skilled and experienced to meet people's needs. One relative said, "The staff are trained well." Another told us, "Staff are competent. They make sure he (their family member) is ok and they know what to do in an emergency." Staff had been supervised between two and three times between February and May. Staff said, "Yes, the manager supervises us and senior staff also tell us if we are doing something wrong." Supervisions allow staff to talk about their role and the manager can set the expected standard of work. The manager had started to carry out, out of hours visits, so they could assess how night staff and weekend staff were caring for people and keeping them safe.

Staff had received appropriate training in relation to their role. Staff had been trained in medicines administration, first aid, health and safety, food hygiene and fire. These have all been done in the last four months, along with other training courses including effective communication. The staff could describe how they used their training in practice. The staff in the kitchen said they knew to keep food separate to prevent cross infection and they dated all open food to ensure it remained fit for use. The open food in the fridge contained date stickers. Care staff told us how the training had helped them to communicate more effectively with people. Staff were bending down to speak to people, making sure they listened carefully and responded appropriately. We however raised with the manager that as people that lived in the service were living with dementia that training should be provided to all staff in relation to this. They told us that they would ensure that this took place.

On the previous inspections in May and November 2017 we had identified a breach the requirements of the Mental Capacity Act (MCA) There were a lack of decision specific capacity assessments for people and consent for people was not always being sought. On this inspection this had improved.

The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the Local Authority as being required to protect the person from harm. There were mental capacity assessments in place for people accompanied by evidence of best interests meetings. For example, in relation to every day care and the locked front door.

Staff asked people for their consent before starting any care. The manager could explain which people had the mental capacity to make their own decisions. People had signed to say they agreed to staff helping them to take their prescribed medicines. One relative said, "She's (their family member) got capacity to make

decisions. Recently they reviewed the DNAR and she was adamant that she does not want to be resuscitated."

One relative told us their family member liked the food and enjoyed whatever was on the menu. Another told us, "There is a choice of menu and if she (their family member) doesn't fancy what is on the menu they will make her something else." A third said, "They (staff) don't force him (their family member) to eat. In the evening they will have a pizza or sausage rolls or something light. For breakfast he will have toast and marmalade which he likes. He eats what he wants to eat."

The staff knew people's dietary needs and preferences. One person required a low-fat diet and this was recorded in their care plan and in the kitchen. The staff were fully aware of this and provided suitable foods. People had been assessed if they were at risk of malnutrition or dehydration. People had been weighed and body fat measured (BMI) regularly to monitor any changes and so advice could be sought. A relative told us, "Since leaving hospital he (their family member) has gained weight which is good." One person was referred to the speech and language therapist because of difficulties and the advice was being followed. They advised a normal diet but for staff to support them to eat slowly and take breaks between mouthfuls. Staff supported the person in line with this guidance at lunch time.

We observed lunch being prepared in the morning and people were being offered a choice of two main meals. There was guidance in the kitchen in relation to people's dietary needs. One person required a soft meal and there was information displayed on how the person's meal should be given and the support needed for the person when they ate. People were offered drinks throughout the day. Meals were freshly prepared each day and people had a choice of eating in their rooms or at the dining table.

The staff knew people's health and medical diagnosis. These were recorded in detail in the care plans. People had been referred to medical professionals and appointments and outcomes had been recorded. GP's had seen people regularly and people had been supported to attend hospital appointments. The manager had introduced checks for staff to follow. These included the basic care people required such as checking their glasses were cleaned, hearing aid battery checks and teeth or dentures cleaned daily. People were wearing clean glasses and staff told us how they made sure people had help, if needed, to clean their teeth or dentures. One relative said, "He (their family member) needed an eye test which the home arranged and now he has glasses to read. Staff make sure they are clean and accessible to him." Another relative told us, "She (their family member) is waiting for an OT [occupational therapist] assessment for extra aids in her room. She sees a chiropodist, opticians and the GP." Another relative said, "Doctor visits the home on Mondays. They always make sure he (their family member) is ok. If there were any problems, I know they would contact the doctor."

The environment allowed for people (that were able) to walk around independently. People's bedrooms were spacious and there were signs to indicate different rooms to help people negotiate their way around. One visitor said, "It's very nice, I like X's room, they have some of their belongings and nice photos." A relative told us, "He (their family member) knows his room, there used to be a photograph of him near his door. He knows his way around the home. He can walk down the corridors without bumping into things."

Good

Is the service caring?

Our findings

At the previous inspections in May and November 2017 we found that there was not sufficient interaction from staff for those people that were being cared for in their rooms or those sat in the lounge. We also found that people did not always have choices around their care delivery. We found that this had improved on this inspection.

Relatives told us that they thought staff were caring. One told us, "I'm quite happy about it. The ones [staff] I have met have been pretty good." We observed examples of kind and caring interactions between people and staff. Staff spent time engaging with people. One relative said, "The staff involve themselves with the people, which I think is important." Another relative said, "The staff are very caring. They treat them (people) like relatives." A visitor told us, "X always looks well cared for." A third relative said, "The care is sufficient, it is suitable for X. He looks well and he is well looked after."

People were treated with dignity and respect. When personal care was delivered this was done behind closed doors. One relative said, "Staff always knock on the door before they go in." Another told us, "They make sure he (their family member) is comfortable and gets what he needs." A third told us, "They always make sure that the door is closed; he (their family member) is covered when they wash him. Normally the male member of staff will wash him."

We looked at care plans to ascertain how staff involved people and their families with their care as much as possible. One relative said, "She (their family member) chooses what she wants to wear." Another told us, "They asked us questions about what he (their family member) liked and disliked, medical history and stuff before he moved in. Any further questions, they would either ask him or my daughter." Care plans detailed people's backgrounds and the things that were important to people. They detailed people's family histories and the work people used to do. A third relative said, "Staff are very good with him, they talk to him, they make sure he has his coffee and his occasional Guinness, which he likes."

People were able to personalise their room with their own furniture and personal items so that the rooms felt more homely. One relative said, "He (their family member) can personalise his room. They are full of sculptures; he used to sculpt, so he has them all around him. He also has photographs of people in his room. The room is suitable for him and he has his things around him."

Relatives and friends were welcomed at the service to visit people. One visitor said, "The staff are always friendly and kind when I visit and I am always offered tea or coffee." One relative told us they could visit whenever they wanted and was made welcome.

People were supported be independent as much as possible. The care plans included what people could do for themselves. One person was busy laying the table before lunch and staff knew they enjoyed doing this. During lunch people were supported as much as they needed but also encouraged to do what they could for themselves. One relative said, "They encourage her to be as independent as possible. She helps to lay the table. She used to run a guest house, so she thinks that she is in charge." Another told us, "Staff make sure

he is ok. He will do things for himself."

Staff treated people with kindness and respect. On most occasions we saw staff sitting chatting with people. There were occasions when a member of staff was sitting away from people and not engaging but later in the day they joined people and initiated conversation about a jigsaw someone was doing. A relative told us, "I would like to see staff talk to the residents more, they don't seem to relate to them sometimes." They talk to them when they need to help them or give them something, they don't always have a general chat with people." We raised with the manager that staff could be more proactive with creating conversations with people. The manager told us that they would raise this with the staff. One visitor said, "She (the person) seems happy, it is her home now".

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in May and November 2017 we found that people did not receive person centred care. Care plans lacked guidance and there were not sufficient activities for people. We found that this had improved on this inspection. However, there were improvements required in relation to care plans around people's clinical diagnosis and end of life care.

There were care records which outlined individual's care and support. We identified however that there was guidance missing around people's mental health and dementia needs. We raised this with the manager who stated that they would update the care plans to reflect these needs. Despite this there were individual care plans in place where other needs had been identified. For example, care plans had been developed in relation to skin integrity, communication and sensory needs. There was information about the person's preferred routines, for example in relation to washing, bathing, getting up and going to bed, dressing and undressing. One person had stated a preference for only female staff to help them with personal care. This was recorded in their care plan and communicated to staff at handover between shifts. Only female staff had helped them. Another person's care plan had detail around how they needed to be supported with their oral hygiene.

There were not sufficient arrangements in place to ensure that people that were cared for at the end of their life had been involved in their care planning. Although people were asked about end of life care this was limited to whether they wanted to be resuscitated and where they wanted to be nearing the end of their life. We spoke to the manager about this who told us that they would spend time consulting with people and their relatives about end of life care.

We recommend that the provider ensures that detailed care planning is in place around all of the needs of people including mental health, clinical needs and end of life care.

Staff on the day were knowledgeable about people's care needs. Staff could describe people's individual routines and preferred activities. For example, one person liked to go to their room for a rest several times a day and staff knew when they preferred help to do so. They also knew the person enjoyed reading the paper and colouring. They provided colouring books in the morning and talked to the person about the news. One person enjoyed going to the shops so they were regularly offered to go with a senior staff member. During lunch staff offered people choices but if they did not respond staff knew them well enough to know what they would prefer. One person told us they really liked jacket potatoes and they had this for lunch.

Daily records were also completed to record each person's daily activities, personal care given, what went well and any action taken. The staff had up to date information relating to people's care needs. Relatives were always updated if their family members needs changed. One told us they always asked staff for an update on their mother's health and that staff always provided it.

Since the last inspection there had been improvements in the activities on offer for people. Comments from relatives on the activities included, "They do cooking with them. She (their family member) loves the arts

and crafts. She made pom-poms at Christmas and she painted a money –box for her new great-grandchild", "They paint nails with them (people) and play games every day" and, "We make sure we print off big pictures which he (their family member) colours in. He loves that. He has his own radio and loves listening to classical music, so we make sure his radio is tuned to classical stations." People also had the opportunity to go out on trips. One relative said, "They took her (their family member) to [shop name] on her birthday to choose her birthday cake. They take her for walks. They sit in the garden at this time of year. They took her carol singing." Another told us, "I know X goes out sometimes, I have seen photos of trips."

Staff ensured that people were involved in seasonal events and special occasions. One relative told us, "They always have parties for birthdays and there was a party for the royal wedding." Another relative said, "There are things going on if she (their family member) wants to participate."

At the previous inspection in May and November 2017 we found that the provider had not followed the requirement that related to how complaints should be dealt with and responded to. We found that there had been improvements around this.

We noted the complaints procedure was available for people and visitors in reception. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. There had been one complaint since the last inspection in November 2017. The provider had considered the concern and responded to the complainant according to their own procedure and copied in the local authority. One relative told us, "I have never had to make a complaint. If we did my daughter would make it." Another told us, "If I thought there was a problem. I would tell them."

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in November 2017 we identified that notifications were not always being sent to the Care Quality Commission (CQC). Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. After the inspection in November 2017 we were made aware by relatives of a safeguarding incident at the service. The provider had not sent in a notification in relation to this. Since us making the provider aware of the incident that was raised to us by relatives they have provided information relating to this. However, it was only after the most recent inspection that the manager has now sent in the appropriate notification. We have been informed of other events that have taken place.

As notifications were not always being sent in to the CQC this is a continued breach of regulation 18 of the (Registration) Regulations 2009.

At the previous inspections we identified that there was a lack of robust quality assurance processes in place and a lack of leadership. The provider sent us an action plan to advise how improvements were going to be made. Since the last inspection in November 2017 the provider had recruited a new manager. We found on this inspection that the manager had made improvements in relation to the monitoring of care and oversight of the service.

During the inspection we found that the manager responded well to any areas of improvement they needed to make. We raised with them the need for more detailed care planning for people and to ensure that safeguarding allegations were referred to the appropriate authorities as soon as practicable. The manager confirmed that this would be implemented straight away.

Relatives told us that they had seen improvements in the service. One told us they were happy with everything and could not think of anything they could do better for their family member. Another told us, "He's (the provider) got a new manager now, [name of manager]. He (the manager) seemed interested, which is the most important thing." A third told us, "The manager is new. He's really experienced."

Regular checks had started to be carried out. These included monitoring the care plans, environment, the medicines, cleaning and fire safety. Water temperatures were checked and the system had been flushed to avoid a build-up of legionella bacteria. As a result of these checks the maintenance staff were carrying out routine jobs such as replacing bulbs and checking fire alarms. There were actions plans in place for each audit with deadlines for actions to be addressed.

Staff said they were supported by the manager and could discuss any concerns or seek advice. The manager said the provider spent time in the home and visited at least two or three times a week and was also available for telephone advice. We contacted the provider to ask questions during the inspection and they were available to answer those.

The staff understood they were trying to offer care to people in a way they preferred and needed and

according to their wishes. One staff said, "We try to do what people want and always ask them what they would like." A relative told us, "There is a positive culture among staff."

People and visitors had an opportunity to give feedback by using the suggestion boxes in the hallway and the dining area. One relative told us, "I know that they have asked my daughter for her opinion. My (family member) will tell us if he wasn't happy and my daughter would do something about it." Surveys were sent to people and relatives to gain their view of the service. There were positive responses to these surveys which included, "I am satisfied that my mother is given adequate treatment", "Since the new manager things have been exemplary. I can see changes and improvements" and, "X is very happy and well cared for."

There was evidence that the provider was working with external organisations in relation to the care provision. For example, the provider had regular contact with the GP, speech and language therapy team, dieticians and other community care teams.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to ensure that notifications were sent to the CQC