Sir Josiah Mason's Care Charity

Alexandra House

Inspection report

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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

We carried out this inspection on 9 August 2017 and it was unannounced.

Alexandra House provides care for up to 36 older people in Solihull. At the time of our inspection there were 27 people living at the home. Some people lived with dementia.

We last inspected this service October 2016 and gave an overall rating of 'Requires Improvement'. We found the service required improvement in how it kept people safe, was responsive to their needs and how it was led. We also found a breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to governance and how the service managed.

The provider sent us an action plan outlining the improvements they intended to make. At this inspection we found some improvements had been made and the service was no longer in breach of the regulations. However we found some improvements were still required.
The date of this inspection was brought forward because we had received concerns about the management of people's medicines, updating of risk assessments and the amount of activities available to people.

There was no 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.

The previous registered manager left the provider's employment shortly after our inspection and the service had been supported by an interim manager with support from another of the provider's Registered Manager's and the Sheltered Housing and Care Services manager. The provider had made robust attempts to recruit a new manager and one had been appointed in April 2017. They officially joined the service in June 2017 following a delay in part of their application process. This person had begun their application to register with us.

People received medicines from staff who were trained; however some medicines were not always administered correctly and record keeping was not always accurate. For medicine taken 'as required' (PRN), guidelines were not available to tell staff when people needed this.

Risks to people's safety had been identified by staff and ways to manage and reduce these risks were mostly in place to ensure a consistent and effective approach was taken. Staff were knowledgeable about people's risks and how to support them safely.

Care records contained information for staff to help them provide personalised care, however updated information, that staff needed, was not always clearly recorded. The provider was actively addressing this at the time of our visit.

Most people told us there were enough staff to provide the support they needed and the provider assessed staffing levels daily to ensure there were sufficient staff available for people. We saw sufficient staff were available to support people and keep them safe.

Checks were carried out prior to staff starting work to ensure their suitability to work with people who used the service. New staff received an induction into the organisation, and completed relevant training to support them in meeting people's health and care needs.

Staff had a good understanding of what constituted abuse and knew what actions to take if they had any concerns. People and relatives told us staff were caring and had the right skills and experience to provide the care required. People were supported with dignity and respect and people spent their time how they wanted to. Staff encouraged people to be independent.

Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making. People told us they had enough to eat and drink. They enjoyed the meals provided and special dietary needs were catered for. People were assisted to manage their health needs. Referrals to other health professionals were made when this was required.

Some people told us they had enough to do to keep them occupied, however there continued to be limited activities arranged for people. The provider was actively addressing this. People were given the opportunity to feed back their views about the service they received through surveys and meetings for people and relatives were held.

Most people knew how to complain if they wished to and the complaints procedure was on display in the home. The provider was aware of their responsibilities in relation to managing complaints received about the service.

The provider had improved systems, and audits, in place to review the quality and safety of the service provided and to drive forward improvements. Staff told us they found the constant changes in the management unsettling. However, they were positive about the new manager and people and their relations felt the service was mostly well led.

There were formal opportunities for staff to feedback any issues or concerns at team meetings, one to one meetings and staff surveys. Checks of the environment were undertaken and staff knew the correct procedures to take in an emergency.

We had received the required notifications to enable us to monitor the service. The provider was able to tell us which notification we were required to receive such as safeguarding referrals and of serious injuries.

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 always safe.

People received support from staff who understood the risks related to their care. People received their medicines from trained staff. However, medicines were not always administered or recorded correctly. Staff had a good understanding of what constituted abuse and knew what to do if they had any concerns. There was a thorough staff recruitment process and enough experienced staff available to provide the support people required during the daytime.

Is the service effective?

Good

The service was effective.

Staff were trained to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and how to support people with decision making. People were supported with their nutritional needs and specific diets were catered for. Staff referred people to other professionals if additional support was required to support their health or social care needs. Staff were supported with supervision (one to one meetings) with the manager.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate. Relatives told us staff were caring and respected people's dignity and privacy. People were encouraged by staff to be as independent as possible and were given choices about how they spent their time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received a service tailored to their personal preferences. Care records were being reviewed and contained information

about people's likes, dislikes and routines; however some information had not been updated. People enjoyed some activities; but there were limited activities for people, however the provider was addressing this. People knew how to complain if they wished to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had not had a registered manager in post since our last inspection and had been supported by interim managers. Staff found this unsettling; however a new manager had recently been recruited. People, relatives and staff told us the new manager was approachable. Systems were in place to review the quality and safety of the service provided and to drive forward improvements. There were opportunities for staff to discuss issues or concerns at meetings. People were given opportunities to feedback their views of the service provided by completing surveys and attending meetings.

Alexandra 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.

The inspection took place on 9 August 2017 and was unannounced. The inspection was conducted by two inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of care service.

Before our visit we reviewed information we had received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We looked at information received from relatives and visitors.

We spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They had visited the service in June 2017 following information of concern we had received from a member of the public. This related to concerns about the management of people's medicines, updating of risk assessments and the amount of activities available to people. Their findings were similar to ours.

Some people who lived at the home were not able to share their experiences of the care and support provided as they were lived with dementia. We spent time observing the interactions between them and the staff who provided their care in the communal areas.

During our visit we spoke with nine people and five relatives. We also spoke with nine staff (including five care staff, one team leaders, two deputy team leaders and the cook). We also spoke with the new manager, the 'Sheltered Housing and Care Services' manager and a visiting healthcare professional.

We reviewed five people's care records to see how their care and support was planned and delivered. We checked two staff files to see whether staff had been recruited safely and were trained to effectively deliver

the care and support people required. We looked at other records related to people's care and how the service operated, including safety records and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in October 2016 we found medicines were not consistently managed well. At this inspection we found some improvements had been made however, we found further improvements were required.

Prior to our inspection visit we had received information of concern which stated that some people were not correctly supported to take their medicines and some medicine records were not correctly updated.

We looked at seven medicine administration charts (MAR) and found some medicines were not given as prescribed. We also found some records were incorrect and some medicine stock levels had not been maintained.

For example, one person required pain medicine, their MAR chart indicated they did not require this anymore and their course was 'completed.' However the course was not incomplete, instead, the service had not ordered enough stock and as a consequence the person did not receive their medicine for three and a half days. This meant the person's health and well-being was at risk as they may have been in pain. Two other records we looked at showed staff did not correctly record the stock levels of some medicines, this is important so staff can monitor when medicines require ordering and all medicines in the service can be accounted for.

Another person's records indicated they had not received their medicines in the morning and at lunchtime, during our inspection visit. We asked staff about this and they confirmed the person had received their medicines but staff had not signed the MAR chart to confirm they had been given.

Some people received 'as required' medication '(PRN). We could not see medicine plans advising staff when to give the medicine, or how effective it was in reducing the person's symptoms. The new manager told us this would be addressed immediately and the team leader would ensure plans were put in place for people who required them.

At our last inspection visit in October 2016 we found there was inconsistency in how people received prescribed creams and we found similar issues at this inspection. For example, two people required a prescribed heel balm to be applied once a day. Records showed they were receiving this twice a day because staff had misread the directions on the box.

We discussed this with the new manager who told us, "I think there are still issues with how we manage creams." They went on to say they were introducing a new system of records in people's rooms which would contain specific MAR charts for prescribed creams and charts to indicate to staff which part of the body these needed to be applied to.

Since our last inspection the provider had introduced a new medication administration system and each

person had individual pots, issued from the pharmacy, that contained the correct dose of medicine at specific times. The new manager told us this had been implemented to reduce the risk of people receiving their medicines incorrectly. The errors we found related to individual packets of medicines and not from the new administration system.

We observed staff administering medicines and saw the medicine trolley was not locked and left unattended whilst the member of staff went to give people their medicines. This is unsafe practice, as medicines could be removed from the trolley by a person without staff being aware. This could place people at risk of harm if they were to take a medicine not prescribed for them. We also saw some good practice when staff sought people's consent to administer medicines, and explained to them what their medicine was for. Staff encouraged people to take their medicine and took time to support them safely.

We discussed this with the team leader who informed us there was a problem with the lock. During our visit, they contacted the supplier and arranged for a new trolley to be delivered. To ensure people's safety they told us another member of staff would stand by the trolley, whilst the first member of staff was administering medicines to people.

Team leaders were responsible for auditing medicines. It was acknowledged their audits had not identified some of the issues we found. The new manager told us they would be addressing this directly with the team leaders and in addition they would be overseeing the audits of medicines on a monthly basis. Following our inspection visit the manager informed us a team leader meeting had been held to address the issues we found and the audit process had been made more robust. In addition regular checks of medicine stocks were being carried out by the manager every other day.

Most people told us they received their medicines on time. Comments made were, "I get my medication regularly and they never forget." However one person told us they required medicine to manage their diabetes and on occasions there was a delay in them receiving it if staff were busy. They also told us staff did not always watch them take their medicines and they had nearly been given some incorrect eye drops. The person told us, "Fortunately I have enough 'awareness' to know. Some don't."

Staff received training to administer medicines and we asked the new manager if their competency was checked. They told us they conducted random 'spot checks' (observed practice) on staff but these had not been formally recorded. Moving forward they told us they would now be documented. We spoke with the previous interim manager who told us they had carried out formal competency checks on staff but the documentation had been archived and we were not able to view them. Staff however confirmed these checks took place.

Staff understood the potential risks associated with each person's care and told us how they supported people safely. Care records we looked at showed risk assessments in place for continence, mobility, pain, and skin damage. Some of the risk assessments had not been updated in the main part of the person's care plan; however we saw they had been in a summary of the latest care plan review. The team leader we spoke with told us they were in the process of fully updating the care plans to include the review information. This meant staff would be able to see the updated risk assessments, and information on how to reduce risks to people.

We saw staff put into practice their knowledge about people's risks. For example, one person's records indicated they were at a high risk of falling and needed to be supported by two staff to use a walking frame. We saw staff assist the person and when they became tired a member of staff provided a wheelchair to help them to the dining area. The person also had sensor mats in their room to alert staff if they were getting out

of bed and would be moving around, and there were soft mats next to their bed in case they fell out of the bed. A referral to the specialist 'falls team' had been made so they could assess the person and provide further advice on how to reduce their risk of falling.

We asked people if they felt safe. Comments made were, "The staff support me when I am walking, and this makes me feel safe." And, "I have a shower every other day and I am assisted by staff, this makes me feel safe."

We had a mixed response from people and staff about whether there were sufficient numbers of staff to keep people safe. Overall people told us they felt there were enough staff to support them safely. Most told us staff responded promptly when they pressed their call bell; however one person told us during the night time they sometimes had to wait for staff to respond in a timely manner. We discussed this with the new manager who told us they were in the process of reviewing staff numbers at night time to ensure there were sufficient numbers to meet people's needs.

The staff team consisted of three teams that included a team leader, a deputy team leader and three care staff. Staff told us they felt there were enough staff to keep people safe. However some told us the team leaders and deputy team leaders did not always assist with personal care and this placed pressure on the remaining staff to support people with their needs. We observed the staff were very busy during the morning of our inspection visit.

Staff numbers were also reduced in the afternoon period from five care staff down to four. We asked the new manager why and they advised this was because the evening period was quieter. However, some staff told us this could be a busy period and on occasions, when a person pressed their call bell there could be a delay in responding because staff were providing personal care to another person.

The new manager told us they were aware of the staff concerns and were holding a meeting to discuss the deployment of the deputy team leaders to ensure there were sufficient numbers of staff available for people's needs. They told us they felt there were sufficient numbers of staff to support people safely, but the deployment of staff could be improved to ensure people received support in a timely manner.

The new manager told us staffing levels were regularly reviewed to meet people's needs, they commented, "We assess the situation each day and adjust staffing according to people's needs." To assist with busy periods there were additional 'floating' staff members who were deployed to assist with personal care and to provide extra support to release staff for training sessions.

Staff understood the importance of keeping people safe and their responsibilities to report any concerns. Staff had received training in safeguarding people, and were able to tell us what actions they would take if they had concerns people were not safe. Staff were aware of what 'whistleblowing' meant (raising concerns about other staff at the home) and how to report concerns. A notice in the foyer also advised people and visitors who to contact if they suspected abuse.

Staff were aware of the procedures to take in an emergency such as an evacuation. Personal emergency evacuation plans documented how each individual should be supported by staff to evacuate safely during an emergency. A business continuity plan documented how people could be supported safely in the event of any issues such as flooding or disruption to services occurred.

Accidents and incidents records had been analysed to identify any trends or themes which might prevent these from reoccurring. A monthly falls audit had been completed.

The provider's recruitment procedures minimised the risk to people's safety. Prior to staff starting work at the service, the provider checked their suitability to work with people who lived there. Background checks were obtained and references were sought. The disclosure barring service completes background checks to ensure as far as possible, that staff are of suitable character to work with people. We checked two staff files and saw these had been completed.

We checked whether the premises were safe and well maintained. Two maintenance staff were employed but were not available to speak with on the day of our visit. Instead, the provider sent us information to show safety checks of the environment were completed such as gas safety, electrical and call bell checks. Equipment had been serviced regularly to ensure it remained safe to use.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received and most staff had the skills and knowledge to meet their needs. One relative we spoke with told us how impressed they were at the staffs' knowledge in managing their relation's medical condition. They described staff as being, "On the button; they recognise when something is wrong and act straight away." They went on to say they knew staff had received training in supporting people with diabetes and this reassured them their relation was safe as staff were trained to recognise problems.

Staff told us they felt they had received the necessary training needed to carry out their roles, and some had completed additional health and social care diplomas to enhance their knowledge and skills. Two staff told us they had undertaken further training in supporting people living with dementia.

Training had been completed in areas such as moving people safely, first aid and health and safety. A schedule was kept by the provider to enable them to monitor training completed by staff and when this was next due. New staff completed the Care Certificate. The Care Certificate sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment. A visiting healthcare professional told us, "The staff are good, I hear them explaining what they are doing, for example when they are moving and handling someone."

Staff received supervision (one to one meetings) with a member of the management team to discuss training needs and any concerns they might have. The new manager told, "Staff can also request a supervision meeting at any time with me, my door is always open."

Staff kept up to date with changes in people's conditions through shift 'handover' meetings held twice each day as the staff shift changed. Information was shared by staff about people's health or well-being, so people could be supported consistently. We saw the handover meeting and found staff were knowledgeable about the support people required and their 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 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. 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 (DoLS) were being met. We found four of the people who lived at the home were having their liberty restricted. Decisions had been correctly taken to submit applications to a 'Supervisory Body'. At the time of our visit the applications had been submitted or authorised.

Staff had an understanding about the principles of mental capacity and had received training in this area. Most people at the home could make some day to day decisions. Staff said they had received MCA training and from our discussions with them, we were assured they knew the importance of people giving consent. A relative told us, "They treat [person] as an individual…she is still independent and hates her independence being taken away. The staff have a way of supporting her which leaves her still feeling in control of her life and believing she is still calling the shots."

Most people, and staff, told us staff checked people gave consent before any care task was undertaken, and we saw this happen during our visit. For example, we saw a staff member ask a person if they could help them to the dining room table for lunch. However a person told us that staff had helped them tidy their wardrobe but said, "It would have been nice if they asked me first."

People's nutritional needs were met with support from staff. We spoke with the cook who told us there was a four week rolling menu. They told us they attended resident and relative meetings and this gave them the opportunity to hear people's suggestions about what they would like to see included in the menu. The menu contained a vegetarian and diabetic option each day. They also informed us that care staff regularly told them about people's specific dietary needs.

Lunch time was a positive experience for people. We spent some time speaking with people and heard them chatting to each other whilst having their lunch. One person commented, "Mealtimes are enjoyable; a group of us go into the conservatory to eat." People were served their meals in a timely way. During the afternoon people were provided with a hot drink and a snack, this also included a sugar free option for people who had diabetes.

People were supported to manage their health conditions and had access to health professionals when required. One person told us, "The doctor would come and see you if needed, the chiropodist and optician also visits." A relative we spoke with commended staff for prompt action in speaking with the doctor if their relation was unwell, they told us, "They are great and contact the doctor if there are any issues."

We saw in people's records where they had been referred to a dietician for support and advice around the management of their weight. Where appropriate the advice of other healthcare professionals was sought, for example the local 'falls team' and opticians. Staff followed recommendations and advice given by healthcare professionals.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. Comments made were, "The staff help me with my personal care; they treat me with respect and they speak to me when delivering care." And, "The staff are all very nice and answer any questions I have."

Staff told us they thought people received good care, and they would be happy for one of their family members to live at the home.

Staff supported people with kindness, and showed respect and encouraged people. During our visit we saw positive relationships had been formed between staff and people and heard good natured banter between them which people clearly enjoyed. One relative told us, "Staff attitudes are excellent, they are always caring for others and not just [person]."

We heard staff were reassuring to people, for example, one person had expressed concern about another person's well-being. Staff responded immediately and went to investigate and returned to reassure the person that all was well. One member of staff explained how in the morning, they used the 'dimmer' light switch to gradually increase the light in the room. This meant the person did not have a harsh light for their eyes when they first woke up.

Staff supported people with privacy and dignity. A visiting healthcare professional told us, "When I come to see people, staff will take them to their rooms so they have privacy."

People confirmed staff were respectful and maintained their privacy and dignity. One person told us, "The staff respect me; they treat me with respect and help maintain my privacy." One relative told us their family member always appeared clean and well-presented and how important that was for the person. They commented, "I am really happy, [person] is looked after well." We saw people had clean clothes, their hair had been brushed and their bedding appeared fresh.

People made choices about how they spent their day. Some people enjoyed spending time with others in the communal areas of the home, whilst other people preferred to remain in their rooms. During the day we heard staff asking people what they would like to do and supported people to move about to different areas of the home.

People and relatives told us they were happy with the care they received and staff knew the people they supported well. One person told us, "They treat me with respect by asking me questions about myself and talk to me in general." A relative we spoke to told us, "Absolutely they know him well and what he likes and doesn't like."

People told us they were encouraged to be independent where possible and how important it was for them they were given the opportunity to maintain their own independence. One person commented, "The staff treat us with respect and support us to be independent." We heard one member of staff ask a person if they

would like help to cut up their food for them at lunchtime. The person said they would like to try themselves and the staff member respected their wishes. They waited until the person appeared to be having difficulty and then provided support when the person asked for assistance.

People's rooms were individualised and contained their own personal items. People were encouraged to make these comfortable to suit their needs and preferences.

People were encouraged to keep in touch with their families and friends and there were no restrictions on visiting times. One relative told us they were always made to feel welcome at the home whenever they visited. They went on to tell us they liked Alexandra House because it had a 'nice family atmosphere', and care workers 'always chatted and gave tea and cake'. They got to know other people and their relatives and that helped make the home feel more 'relaxed and homely, rather than institutional'.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection visit in October 2016 we found improvements were required. This was because care records contained information about people's likes, dislikes and routines; however other information was missing or conflicting. People enjoyed some activities; however there were limited activities for people living with dementia. At this inspection, we found improvements had been made but there continued to be scope for further improvement.

Prior to our inspection visit we had received information of concern from a person, stating there were still insufficient activities and some people were isolated in their rooms.

At this inspection we still received mixed views from people when we asked if they were involved in any activities. One person told us, "Staff don't support me with my hobbies and interests; I just get on with it." However another person told us, "There are a variety of activities available but I choose not to take part in much. My daughter takes me out or around the grounds." One relative told us they 'could not fault the care' their family member received, but felt there could be more activities for people to be involved in.

The Sheltered Housing and Care Services Manager acknowledged that improvements were still required to improve the range of activities on offer for people who lived at the home but this was being addressed. Minutes from a recent residents' meeting, and the last resident survey, confirmed the provider was looking to improve this. It was agreed that more activities were required and suggestions about what people would like to see included were put forward.

The manager told us they were working to make improvements in the level of activities on offer and staff had been asking people about their preferences for activities. They agreed that individualised, one to one activities, for people living with dementia were needed. One person we spoke with told us, "They came around the other day questioning likes and dislikes." The manager went on to tell us, "We are also researching 'dementia' friendly decorations and want to make the home more personalised with smaller areas for people to sit with their families." New furniture was being purchased and new bedding and curtains had been provided for some rooms.

On the day of our visit we saw people were involved in chair exercises to music and staff were also playing a card game with people called 'higher and lower'. The manager told us a three week activities plan was being introduced, based on suggestions put forward by people and a group of staff had been identified who would be responsible for carrying out the activities. The provider had also purchased additional activity resources, such as games, for people to enjoy.

Before moving to Alexandra House, people's needs were assessed to check that their care and support needs could be met safely. Pre - admission assessments were completed and information obtained about people's life histories, likes and dislikes from people and their families. People were involved in writing their care plan with their relatives. Care records contained information about routines and preferences. We saw information about what was important to people and significant life events.

At our last inspection visit in October 2016 we found care records were mostly 'person centred' and contained information which enabled staff to get to know people better. However, some care records did not detail the level of support people required or how staff were to provide this support. At this inspection visit we found improvements had been made, however the manager acknowledged that information in the care plans still needed to be streamlined to make them easier to read. They told us, "We have done a lot of work to bring the care plans up to date." They went on to say they were planning to introduce further training for the staff on how to complete care plans.

Staff worked in teams and were allocated specific people to support so people had consistent staff they knew well. 'Keyworkers' were assigned to people and these staff ensured people were supported with individual needs. A staff photo board was displayed in the main foyer of the home so people and visitors knew who staff were.

The manager explained the keyworker' was responsible for getting to know and understand people and to establish their likes, dislikes and to build a relationship. They planned to ensure all staff were aware of the responsibilities and expectations of the role and the importance of knowing as much as possible about the person they were supporting. This information would be shared with other members of the team and team leaders, who would update the care plans.

The care plans we looked at had been reviewed regularly, however some information identified on the review, such as changes in people's health needs and support had not been transferred from a short summary report into the main part of the care plan. For example, one person had required a hospital visit for treatment for a wound. This was recorded in one section of the care plan but was not explored in detail in the main body of the care plan for staff to easily find. This meant staff may not have been aware of the changes in the person's needs. We discussed this with the team leader who told us they would complete this immediately. However, staff we spoke with were knowledgeable about the person and the support they required.

Care plans contained information about how people liked to receive their care and support. For example, one person's records informed staff they wished to remain independent with their personal care and they preferred to have a female care worker to support them. Another person's plan informed staff they were 'quiet and shy' and their preference was to spend time in their room. Some people told us they were involved in reviews and updates with their care plans. One told us, "I was involved in planning my care and I signed it myself." Another commented, "I have seen my care plan and it is good enough to meet my needs."

The manager told us they had plans place to audit care plans every three months and the team leaders were responsible for auditing them monthly. The Sheltered Housing and Care Services Manager also conducted random checks of care plans each month. They told us, "I look at three care plans each month, I think standards have improved…we have spent time looking at them, previously there may have been too much detail and information."

Care review meetings were held annually or more frequently if required. One relative we spoke with commented, "I have been a part of planning mum's care, I can't remember reviews though." However all relatives told us they were notified of any changes with their family members' care or condition. Comments made were. "They keep me regularly updated about [person's] care." And, "I feel listened to and I am well informed of mum's condition and they reassure me."

A copy of the provider's feedback policy for complaints, compliments and concerns was displayed in the main foyer area. Formal complaints were responded to appropriately and investigated by the person in

charge. The manager told us no themes, of complaints or concerns, had been identified.
People and their relatives told us they usually spoke with staff in the first instance if they had any problems, one person told us, "I would feel comfortable raising concerns or making a complaint but I never had to."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection visit in October 2016 we rated the service as 'requires improvement and found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems were not always being operated effectively to assess, monitor and improve the quality and safety of the service.
At this inspection visit we found some improvements had been made and the provider was no longer in breach of the regulations. However we found improvements were still required and the service continued to require improvements in how it was led.

The service did not have a registered manager. The previous registered manager left the service in November 2016, shortly after our last inspection visit in October 2016, and the service had been supported by an interim manager with support from another of the provider's Registered Manager's and the Sheltered Housing and Care Services manager. The provider had made robust attempts to recruit a new manager and one had been appointed in April 2017. They joined the service in June 2017 following a delay in receipt of their DBS check. This person had begun their application to register with us.

Staff we spoke to were positive about the new manager, however, all told us they had felt unsettled with managerial changes. One told us they thought the new manager was good but went on to say they were 'sceptical' because there had been changes in the last year. The provider reassured us that staff did not need to feel sceptical and they would continue to receive support from all levels of management at the service. The Sheltered Housing and Care Services Manager, acknowledged staff had experienced considerable changes but were confident things would now improve. They told us, "We are moving forward now and we have a good manager in place."

We saw there had been improvements in how the provider monitored and assessed the quality of the service. Accidents and incidents were also analysed to identify themes and trends to reduce the risk of reoccurrence.

The provider conducted regular audits of the service, for example, on care plans, falls, and equipment to support people such as bed rails. However we found medication audits had not identified some of the issues we had found. Following our inspection visit the manager informed us they had addressed the issues we found with the team and deputy team leaders and regular 'spot checks' of stock levels were now being undertaken by the manager to ensure people had sufficient medicines in stock. In addition they told us audits forms were being reviewed and amended to ensure the audit process was more robust.

People and relatives told us they were happy at the home. Comments made were, "I think that the new manager is going to be marvellous, she is approachable". And, "I know who the new manager is and she is approachable." One relative told us the changes in managers had not affected the care and support their family member received. They commented, "I feel it's well-run, there is nothing wrong here."

A visiting healthcare professional told us, "Families and people tell me they are happy here. I have never had

any concerns with this service and the way it is managed."
Staff told us they were happy working at the home and enjoyed their job. Staff had formal team meetings and one to one supervision meetings. These provided opportunities for staff to raise any concerns or issues they had with their manager and the provider.

An annual staff survey was carried out by the provider to provide staff with the opportunity to share their views on the service. We saw the most recent one carried out in January 2017 where 75% of respondents indicated they felt that as a whole, the Trust was 'very or extremely' well led. Where areas of concern had been expressed by staff, the provider had noted these and identified ways to make improvements. For example ensuring regular supervisions and team meetings were planned so staff could express any views or concerns.

People at the home had an opportunity to feed back their views on the service provided and resident and relatives meetings were held. Questionnaires had been sent out in October 2016 to obtain feedback about the service and 18 responses had been received. Ninety four percent were overall happy with the service they received. Seventeen percent of people indicated they would like to see more activities on offer. One person told us, "The best thing is that we have a say in what we do here."
The provider told us they encouraged whistleblowing (anonymous reporting of concerns) and feedback from staff, residents and other professionals working with the service.

Further developments were being planned at the home to improve the environment for people. A structural building survey had been recently carried out and the provider was awaiting the results in order to plan major refurbishment of the home.

A recent audit had been completed by the clinical commissioning group in June 2017. This was carried out in response to information of concern we had received. They had identified similar issues to us, for example the lack of individual activities, however feedback from people about the home and the staff was positive.

The provider understood their responsibilities and the requirements of their registration. They were able to tell us what notifications they were required to send us, such as changes in management, safeguarding and serious injuries. The provider displayed out last inspection rating in the foyer.
The provider worked in partnerships with the local authority, and other care providers, to share information and best practice, in order to improve people's experiences and outcomes.