ONH (Herts) Limited

# The Orchard Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

This inspection was carried out on 20 March 2018 and was unannounced. At their last inspection on 8 August 2017, they were found to not be meeting the standards we inspected. As a result we issued a warning notice in regards to the management of the home. In addition we placed the service in special measures. At this inspection we found that although they had made some improvements and were meeting the standards, there were some areas that required improvement and further development.

The Orchards Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 63 people in one adapted building over three floors. At the time of the inspection there were 36 people living there. This was because parts of the home were going through refurbishment.

The service had a manager who was not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run. The manager had submitted an application to register and this was in progress.

There were systems in place to monitor the quality of the home. However, they had not identified all of the areas that required improvement that we found on inspection. The service was making good progress in regards to an action plan in place to ensure a good quality service was provided and sustained. People and staff were positive about the running of the home which included the new manager and staff were proud about what they had achieved.

Most people were supported in a safe way. However, some people did not always receive appropriate pressure care.

There were sufficient staff to meet people's needs, however, feedback was mixed. We found that staff were recruited safely. Staff knew how to recognise and report any risks to people's safety and medicines were managed safely.

People were supported by staff who had received updates to their training and people were supported in accordance with the principles of the Mental Capacity Act 2005. People were supported by staff with respect and kindness and confidentiality was promoted in most cases. However further development was needed to ensure people's dignity was always promoted.

People gave mixed views about the food, however, most were positive. We sampled the food and food that it was tasty and looked appetising.

People had regular access to health and social care professionals. The design of the building on the two refurbished units was well throughout and made for a pleasant environment. The second floor was still waiting to be refurbished.

People were involved in the planning of their care and most people received care in a person centred way.

People told us that they enjoyed the activities provided, however, these needed further development to ensure they reflected and met people's individual hobbies and interests. Some feedback was that activities did not meet everyone's needs.

People's feedback was sought to help make changes in the service and there was a complaint's process which people and their relatives knew how to use.

## 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.

Most people were supported in a safe way. However, some people did not always receive appropriate pressure care.

Medicines were managed safely.

There were sufficient staff to meet people's needs, however, feedback was mixed.

Staff knew how to recognise and report any risks to people's safety. However, feedback from two people some staff were not as gentle as others.

Staff were recruited safely.

### Is the service effective?

**Good**

The service was effective.

People were supported by staff who had received updates to their training.

People were supported in accordance with the principles of the Mental Capacity Act 2005.

People gave mixed views about the food, however, most were positive.

People had regular access to health and social care professionals.

The design of the building on the two refurbished units was well throughout and made for a pleasant environment.

### Is the service caring?

**Good**

The service was caring.

People were supported by staff with respect and kindness.

Further development was needed to ensure people's dignity was always promoted.

People were involved in the planning of their care.

Confidentiality was promoted in most cases.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Most people received care in a person centred way. However, some areas needed to be developed further.

People enjoyed the activities provided, however, these needed further development to ensure they reflected and met people's individual hobbies and interests.

There was a complaint's process which people and their relatives knew how to use.

People's feedback was sought to help make changes in the service.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

There were systems in place to monitor the quality of the home. However, they had not identified all of the areas that required improvement that we found on inspection.

The service was making good progress in regards to an action plan in place to ensure a good quality service was provided and sustained.

People and staff were positive about the running of the home which included the new manager and staff were proud about what they had achieved.

# The Orchard Nursing Home

**Detailed findings**

## Background to this inspection

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

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We reviewed the action plan submitted to us following our last inspection setting out how they will make the required improvements.

The inspection was unannounced and carried out by two inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with and received feedback from eight people who used the service, six relatives, six staff members, the deputy manager and the manager, the regional manager, the operations manager and two additional supporting members of the management team. We received information from service commissioners and health and social care professionals. We viewed information relating to seven people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

# Is the service safe?

## Our findings

When we inspected the service on 8 August 2017 we found that they were not meeting the standards in relation to promoting people's safety and welfare. At this inspection we found that there were improvements made in these areas however, some issues remained. This was mainly in relation to management of pressure care.

Staff were knowledgeable about risks associated with people`s daily living. They were able to tell us names of people who were at risk of falls, at risk of developing pressure ulcers and at risk of malnutrition. We also observed that staff asked for a speech and language therapist assessment for people who were having difficulties swallowing their meals. We found that risk assessments were completed appropriately to offer guidance to staff how to mitigate the risks. However, we did note that one person who was on oxygen had a sparse risk assessment for the management of their oxygen. We also noted that their cylinder stored in the medicines room was not secured so that it could not fall over. We raised this with the deputy manager who immediately addressed this. We discussed oxygen management with the management team who told us they would review their medicines audit to ensure the safe handling of oxygen and ensure the manufacturer's guidance was available to staff to help ensure they had the appropriate knowledge.

People were supported by staff who knew how to keep people safe and were confident that the registered manager would respond to any concerns of abuse. Staff knew how to recognise and report abuse. There was information about safeguarding people from abuse displayed around the home to help raise awareness and we found that unexplained bruises or other incidents had been reported and investigated in most cases. We noted that one bruise had not been investigated or reported. However, two people told us that some staff were rough. One person told us that the management team were aware of this. They said, "There is one person who is a bit rough, but it seems a bit better now." Another person said, "90% of staff were very good with the hoist but some were more gentle than others, they haven't all got the technique. I have never felt unsafe. I like to go to bed at 11.00pm, some night staff are rough when they handle you, they rush me, you feel like a piece of meat." We discussed this with the management team who told they had been made aware of concerns. We asked that this was investigated as a matter of urgency and information was shared with us regarding the outcome which ensured people were safe.

People who were at risk of developing pressure ulcers had appropriate risk management plans in place to support staff in understanding how to mitigate these risks. For example people had appropriate pressure mattresses in place and staff regularly checked if these were set at the right setting. Every person who required a pressure mattress had their weight recorded and the setting on the mattress adjusted appropriately. On one unit staff regularly repositioned people who were not able to change their position in bed. We found that this was effective in preventing people developing pressure ulcers and in healing those for people who moved into the home already with a pressure ulcer. However, on the second unit, regular repositioning was not always happening at night and one person was not sitting on their required pressure reliving cushion when in their wheelchair until we raised it with staff.

We noted that people who had been assessed as requiring bedrails on their beds to prevent them falling had

protective covers over the rails to reduce the risk of entrapment.

Staff were seen to be working safely. For example, we observed two staff members using a mechanical hoist to assist a person to transfer from an armchair to a wheelchair. The staff members reassured and talked with the person all the way through the procedure. However, some moving and handling care plans in relation to the use of a hoist required consistent information in relation to the size of sling to be used detailing which of the loops of the sling to attach to a hoist.

Care plans included strategies for staff to employ in the event that people demonstrated behaviours that may challenge others. For example, to reassure the person, to move away and leave the person for a few minutes if they started to show they were becoming anxious or resistant to support or for a different staff member to offer the person support. On the day of this inspection a community psychiatric nurse visited the home at the request of staff to discuss how a person's behaviours could be better managed. This was because the person was fiercely resistant to staff supporting them to eat and this was having a negative impact on their overall health and staff were concerned for the person's wellbeing. This showed that staff took the appropriate action to help keep people safe.

Accidents and incidents were noted and recorded. For example, staff had reported that they had noticed a 'large bruise' on the inside of a person's arm whilst they were providing personal care. This had been recorded on an accident form however, there was no information available to show what had been done in response to this matter. We discussed this with the home manager who had not been made aware. Accidents and incidents were recorded on an internal system while the new provider's systems were being implemented in the home. This helped them to identify themes and trends. This system also checked that all remedial actions had been taken.

Most people told us that there were enough staff to meet their needs. Two people told us that they felt there were not enough staff at times. One person said, "There are enough staff for my needs, it's nice here, what more do you want?" Another person said, "Generally it's OK, I have a call bell, sometimes you ring and ring and have to wait for someone to come. I slipped out of bed during the night once, they were there very quickly." A third person told us, "At times they could do with more staff but they usually respond to call bells quickly. I think sometimes they can't get night staff and day staff have to stay on." Another person told us, "Continuity and quality of carers needs to be addressed. There are days when you have a very good team such as today, and others when the balance is not the best. Days when there are enough staff are pretty infrequent." During the day we found that people's needs were met promptly.

Staff told us that there were enough staff available to meet people's needs. One staff member said, "There are definitely enough staff, we rarely use agency staff now." Another staff member said, "There are enough staff now and there are more staff coming. More activity staff, more cleaners too, we seldom use agency now." Staff told us that permanently recruited staff numbers had been increased reducing the needs for agency staff cover which they believed had a positive impact on the standard of care delivered. We reviewed the rotas and found that shifts were staff had called in sick or were on annual leave were covered by staff employed by the home and only a few occasions with the use of an agency staff member.

Throughout the course of the day we noted that there was a calm atmosphere in all units in the home and that people received their care and support when they needed it and wanted it. Call bells were answered in a timely manner and staff went about their duties in a calm and organised way.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable to support people who may be vulnerable. All pre-employment checks were completed to help ensure staff

were fit for the role. This included written references, proof of identity and qualifications and criminal record checks.

Systems were in place to help ensure effective infection control. During the inspection we saw that the environment was clean and fresh and staff followed infection control guidelines. This included hand washing and the use of gloves and aprons. Staff had received training and we noted staff worked in accordance with guidance. For example, with the use of gloves, aprons and hand washing. We also looked at hygiene practices in the kitchen and standards of cleanliness and found these were at a good standard.

Lessons learned were shared by the senior management team to unit managers at daily meetings and with the staff team at team meetings. We also found that these were shared, including outcomes from previous inspections, through the supervision and recruitment process. One staff member said, "I feel like we are now all singing the same song, with the same goals."

When we last inspected the service we found that fire procedures needed further development and staff needed to update their knowledge. At this inspection we found that people's personal evacuation plans had been updated to include a realistic evacuation plan. We discussed with the management team how these could be further developed to include the time it would take to evacuate people and an area of the home to get people to safety. Fire training had been provided for the staff team and the staff members we spoke with were clear about what they would do in the event of a fire. One staff member said, "A few of us have experienced evacuation by use of a sledge so that we know what it feels like." Fire drills took place monthly and fire alarms were tested weekly.

When we last inspected the home we found that medicines were not always managed safely. At this inspection we found that processes had been put into place to help ensure that safe management of medicines. Medicines were administered in accordance with the prescriber's instructions. We observed staff working safely in the administration of medicines and there was a checklist for each medicine round prompting staff to monitor the records, storage and for any issues. We saw that there was a staff signature list and protocols for medicines on an as needed basis. One person told us, "They ask you if you have any pain, if you have they give you pain relief." We found that quantities of stock tallied with records of medicines received into the home and administered. Care plans included clear guidance about the support people needed with their medicines. For example, one care plan stated, "Staff to give [person's] medicine when they are in a sitting position and with a teaspoon."

Good

# Is the service effective?

## Our findings

People told us that they felt staff were trained and skilled for their roles. One person said, "Very occasionally I feel a member of staff doesn't know what they are doing but they seem to be doing training every day." A relative told us, "The staff are well trained and deal with my wife's specific needs with care and consideration."

Staff received training to support them to be able to care for people safely. A staff member told us, "Training has improved, there are far more opportunities available to us now. I asked for some training about dysphagia and we had it yesterday." Another staff member told us, "I have had loads of training, it is constant. I recently had training about dysphagia, dementia and constipation. It is made quite clear to us that we have to attend the training provided." Records showed that the overall training for the staff establishment was at 89% which was an improvement from previous inspections.

Staff told us that in addition to the core subject matter, champions had been identified in areas such as nutrition, dementia, infection control, dignity, diabetes and engagement. Additional training was being provided for these areas for example one staff member told us that they had recently attended training in their role as nutrition champion. They said they had found the training very informative and that they planned to deliver small sessions with care staff to cascade the learning through the staff team. Another staff member told us that they had been appointed as a dementia champion and had been provided with training about positive interventions via a local care provider's association.

The management team and staff confirmed that there was a programme of staff supervision in place, all staff we spoke with said they received support as and when needed and were fully confident to approach the management team for additional support at any time. One staff member said, "I feel more supported now. For example, they have said they will help me towards my nursing training."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. All staff had completed relevant training and understood their role in protecting people's rights in accordance with this legislation. Where people did not have capacity to make decisions about their care and treatment we noted that best interest decisions had been made involving people's relative where appropriate and staff members. For example, a best interest decision had been made about covert administration of medicines for a person who lacked the understanding of why they needed to be taking prescribed medicines. Other examples included best

interest decisions around personal hygiene and use of bed rails.

We saw that staff explained to people what was happening and obtained their consent before they provided day to day care and support. For example, we heard one staff member say, "[Person], I am just going to take your feet off the (wheelchair) footrest is that OK?" Staff members were knowledgeable about capacity, best interest decisions and how to obtain consent from people with limited or restricted communication skills. We noted that 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that most people had been involved with making the decisions and, where appropriate, their family members as well. However, we noted that one person's DNACPR was completed by the GP and discussed with the homes care staff. We raised this with the management team to review as the person was noted to have capacity to make decisions and had a relative with the legal authorisation to make decisions on their behalf.

Most people told us that they enjoyed the food. One person said, "The food is fine and I get plenty to drink." Another person told us, "We get a choice of meals, we choose the day before. We get regular drinks during the day." However one person stated, "The food has gone right down, they are moving to a cheap type of food. Over the last 2 months it has gone down. The menu often does not relate to what we get. I enjoyed my lunch today, it was much better." A relative told us, "The food is generally very good and I must say my [relative] eats very well and seems to enjoy it." There was some feedback about the menu not always reflecting what was served and one person told us that they had requested a specific item of food to meet their dietary requirements but this had not yet been provided. The chef told us that as part of the resident of the day audit, people got to choose what they wanted on the menu.

A staff member told us, "The food is much better now, there is more variety and it is presented nicely. People seem to enjoy it, there are plenty of empty plates." We tasted a sample of the meals on offer and found the food to be tasty, well presented and hot. We observed the lunchtime meal served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. People were asked for their meal preferences the day before to give the chef a rough idea and then people were asked again at point of service to help make sure they had a choice they were happy with. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were nicely laid with cloths and condiments were on the tables to support people to be independent. We saw interactions which were kind, patient and sensitive. People were offered a choice of drinks, some people had thickened drinks and were assisted to drink by staff. Staff were vigilant and made sure everybody drank at least two glasses including those who had thickened drinks and needed assistance.

One person had been given biscuits as they were hungry and the lunch had not yet arrived. The soup was cauliflower rather than tomato as shown on the menu and a staff member told each person about the change and asked them if they liked it, one person said, "Mmm I like it." Staff were very kind and coaxed people to eat a little more, and there were a lot of gentle touches and smiles.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people`s needs. One person had lost weight steadily over a few months, this had been identified and staff tried to tempt the person to eat. For example, on the day of this inspection we heard staff contacting the kitchen to request a bacon sandwich for the person.
Some people were at risk of choking and we noted that care plans detailed this along with guidance for staff to help keep people safe. External professionals were also involved including a dietician and speech and

language therapists (SALT).

Care records indicated that people's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary. We noted that appropriate referrals were made to health and social care specialists as needed and there were regular visits to the home from dieticians, opticians and chiropodists. One person said, "I've seen the chiropodist and they can get you a dentist, I wasn't very happy with the optician so I see my own optician, the podiatrist comes in most weeks." We spoke with a healthcare professional who attended the home on the day of this inspection. They told us that the staff team at The Orchard Nursing Home were, "Responsive to instruction."

The environment throughout the home was clean, fresh, warm and welcoming. The home was in the process of being refurbished at this time to good effect. People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions and pictures. Progress had been made towards developing the environment on the dementia unit to make it more homely and dementia friendly. Thought had been put into enabling people with dementia to locate their bedrooms, each bedroom had a memory box on the wall with photos or other favourite things, it also gave the name of the person's keyworker. All doors had knockers giving the appearance of individual flats. Various tactile items were accessible in the corridors, handbags, jewellery and baskets. There was clear signage on toilet doors. However one relative told us, "I am disappointed that whilst the lower floors have been redecorated, this does not seem to be happening on the top floor, where carpets are tired, stained and worn, a shelf is hanging off the wall in the room, and the bed table is broken so that my mother cannot reach her food when in bed." A member of the management team told us that the second floor was next to be refurbished and they were currently working on the logistics so to avoid disruption for people

Good

# Is the service caring?

## Our findings

Staff had developed positive and caring relationships with people they clearly knew well. People were relaxed and comfortable to approach and talk with care staff, domestic staff and management alike. We observed staff interact with people in a warm and caring manner listening to what they had to say and taking action where appropriate. One person told us, "I am quite content, the staff are nice, it's a nice place to live, the days are pleasant and acceptable." Another person said, "90% of staff are very good and there are one or two good cleaners." A third person said, "The carers are fantastic." A fourth person told us, "Some nurses are more pleasant than others, night staff are very good."

A staff member said, "The carers here are amazing, we all really care. We have enough staff now to give people the time they need for example, a long soak in the bath or chat with people."

Staff respected people's dignity and made sure that they supported people in the way they wished whilst encouraging them to remain as independent as possible. During our inspection we noted that staff were calm, gentle, courteous and kind towards people they supported. We saw staff promoting people's dignity and privacy by knocking on people's doors and waiting before entering people's rooms. We also observed staff support someone to transfer to a chair and they spoke gently to the person, telling them exactly what was happening. The person appeared very relaxed throughout the move and they were aware of their dignity at all times carefully straightening the person's clothes. However, we did note some instances where this needed to be improved. For example, one person had their trousers rolled up and prepped to have cream applied in a communal area. The person wasn't asked and they sat there for around 10 minutes waiting for it to be applied when the nurse was free. In addition, a person's care plan had a photo of their bottom to monitor skin integrity. However, this should have been concealed so that not everyone who viewed the care plan had access to this photo.

Staff supported people to maintain their appearance. One person's care plan stated that they were prone to facial hair and wanted staff support to make sure that their appearance was maintained in the manner they had always done for themselves. We met the person and noted that they did not have any facial hair.

There was evidence to suggest people influenced and participated in their care delivery. Some people signed their care plans to agree for their records to be shared with other professionals, and there were records to indicate people and their relatives where appropriate were invited to review their care plans. We saw that some people`s relatives signed care plans and also had meetings with staff to discuss the content of the care plans.

People were encouraged to maintain relationships with family, friends and partners. Visitors were encouraged and invited to events and staff knew about who was important to people. We noted from the visitor's books that there was a regular flow of visitors into the home.

People's records were stored in cupboards in locked offices in order to promote confidentiality for people who used the service. However, we did not at times that the doors to these offices were propped open

making records accessible to people who were authorised access.

There was a regular church service at the home and people could choose to attend. In addition there were planned visits to various places of worship that people could participate in.

Requires Improvement

# Is the service responsive?

## Our findings

When we inspected the service on 8 August 2017 we found that people did not always receive person centred care, care plans did not always include the required information and activities did not meet people's needs. At this inspection, although we found some improvements in relation to person centred care, detail in care plans and the provision of activities, some areas still needed further development.

People told us that were happy that the staff knew what care they needed. They told us care was mostly provided in a way they liked. A relative said, "I can confirm that I am very satisfied with my [relative's] care at The Orchard." However, one person said, "Sometimes I have to wait three days for a wet shave. I could do it myself, I just need a little tuition but they don't like me doing it." The person's care plan stated that they used an electric razor and the regional manager told us that they were able to have a wet shave whenever they wished. However, this may need to be factored into the care plan so that staff are clear the person may want a change of shave at times. Another relative said, "Still the care is somewhat sporadic. There seems to be so much time taken up completing notes and tick box exercises as opposed to delivering care." Ensuring care was provided consistently was an area that the manager had identified as an area needing further development. We discussed with the manager the culture of staff that had been there for some time and they told us it needed lots of work as staff had not been led sufficiently allowing bad habits. However, they were confident, and it was evident from speaking with staff, that there had been a shift in the attitude and approach of staff with a few members needed more support to embrace the changes.

People and their relatives had been involved in developing people's care plans. People's care plans were reviewed regularly to help ensure they continued to meet people's needs. We saw that people's relatives were invited to attend monthly review meetings where appropriate. However, care staff told us that the nurses undertook people's monthly care plan reviews but did not involve care staff. This was an area that needed further development.

People's care plans were sufficiently detailed to be able to guide staff to provide their individual care needs. For example, care plans included specific guidance about the support people needed in areas such as eating and drinking, pressure area care, personal hygiene and engagement.

Care plans showed that people had been asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes or if they had declined to talk about this matter when they moved in to the home.

Staff were knowledgeable about people's preferred routines, likes and dislikes, backgrounds and personal circumstances and used this to good effect in providing them with personalised care and support that met their individual needs. For example, a staff said about one person, "[Name] needs her knitting, her handbag and her tissues within reach."

People's changing needs were responded to appropriately in most cases and actions were taken to improve outcomes for people. For example, when people had lost their appetite for food and their weight reduced

staff involved the kitchen staff to provide tempting snacks and relevant health professionals for advice and guidance. This demonstrated that people's needs were responded to and actions were completed to improve outcomes for people. However, we did note that one person had sore and sticky eyes and this had not been recorded on the handover records. After we raised it the nursing staff told us that they were aware but it wasn't written down. Following this a GP was contacted for eye drops. Ensuring all information was recorded was an area that required improvement.

People were provided with an improved range of activities. For example, children from a local school visited the home to sing for people, a bible reading session took place weekly on a Sunday, board games and bingo and armchair exercises to help improve people's postural stability. On the morning of the inspection people were making Easter baskets to give to the school children when they visited that afternoon. People had the opportunity to take part in monthly outings to places of interest such as museums, gardens centres and activity farms. We also noted that age appropriate music playing in communal areas. One person told us they liked to spend time in their bedroom and was busily colouring the paper baskets for the children. They said "They are trying to provide more activities. I don't like the loud music, they have it on at lunchtime. They have the television on as well, the television is on all the time." A relative told us, "I do think the new manager is having an impact and I am glad to see, for example, the appointment of an additional activities coordinator, however, I wait to see whether this person will identify activities that are suitable for my [relative], who is on the dementia floor, but could play a good game of cards, for example. I do not think that regular care is as person-centred as it could be in respect of activities; when well, my [relative] frequently complains that [they are] bored, but I find [them], as I did this afternoon, sitting doing nothing in [their] room."

There had been recruitment of additional activity organisers to ensure that activities could be provided seven days a week. We saw that they was a weekly plan and one to one sessions and room visits were planned daily. However we noted in engagement books that there was not an entry every day for some people, some of which had gaps of three days in entries. We spoke with people about hobbies and interests. These had not all been included in the activities plan. One person said, "I can't do any of my previous hobbies as they were outdoor activities." Another person told us, "I'd like to watch Flamenco dancing." We spoke with a member of the activities team about enhancing and developing the plan to included individual interests. For example, boules for a person who had previously planned for a club.

Complaints were responded to appropriately and in a timely manner. People and their relatives, in most cases, felt they could raise concerns with the management team. However, one relative was worried there would be repercussions if they made a complaint so said they would speak to a member of care staff. We noted that historically the relationship between some members of management and some relatives had been ineffective and broken down and left some relatives reluctant to speak up. Feedback about the current manager was positive and they hoped in time concerns would be alleviated.

There was survey sent to people, relatives, staff and stakeholders. They were able to complete this anonymously on an electronic device. We saw that feedback on the service linked to actions on the action plan. For example, improvements to activities.

A resident's forum had been introduced with one person taking the lead as a resident ambassador. We spoke with them and they told us, ""I get their opinions and speak up and give a general opinion." The meeting was attended by people who lived at the service, the activities organisers and the home's manager. The first meeting discussed menus and changes needed to the food, activities and staffing. The manager had added the required actions to the meeting notes to enable them to review progress at the next meeting.

Requires Improvement

# Is the service well-led?

## Our findings

When we inspected the service on 8 August 2017 we found that there were areas of the quality assurance systems that required improvement and there had been a prolonged period of the service being in breach of regulation. In response to this we issued a warning notice stating how the provider must improve and gave them a date that this must be achieved. We also put the service into special measures. The service had previously had positive conditions imposed stating that they must ensure a person was responsible to give guidance and ensure staff were working safely and that they must review and implement sustainable governance systems. At this inspection, we found that the service was now meeting the standards but some areas needed further development to ensure they continued to improve and improvements were sustainable. However we noted that the management structure was working well with a new addition of head of care due to start to develop the staff team further in regards to care delivery.

There were a range of checks undertaken routinely to help ensure that the service was safe. These included such areas as water temperature checks, safety checks on bedrails, inspection of the call bell system, and fire checks. We noted that where issues had been identified through this system of audits they were passed on to the relevant person to address. This showed us that the manager and provider were committed to providing a safe service.

There was an audit system in place. Many audits were completed by the deputy manager and we noted some were completely by members of the supporting management team. We noted that these had picked up issues within the home and actions were signed as completed and we saw that they had been completed. For example, staff showing people living with dementia plates of food to choose from and to ensure people knew who their key worker was.

Satisfaction surveys were distributed annually to people who used the service, their friends and relatives and relevant external professionals. Once the completed surveys were received the provider collated the information and produced a report of the findings which was shared with the manager along with suggested actions.

Actions arising from the audits, regional manager visits, meetings, surveys and checks were added to an action plan. This action plan included actions from previous inspection visits from the CQC and the local authority who commissioned beds at the service. We reviewed the plan and saw that it showed steady progress and actions being completed. We found that the completed actions corresponded with our findings on inspection.

However, as part of our inspection we found that some information was not being identified or shared. For example, an unexplained bruise had not been shared with the manager and gaps in repositioning charts had not been found. We were also concerned that management were aware of allegations of staff being rough but we had not been notified and limited remedial action had been taken. There were still areas of staff culture that needed to be developed. For example, nurses and care staff not working fluently and some concerns about staff always ensuring people's dignity. Therefore, well led remained an area of requires

improvement until all improved practice is embedded and sustained.

People, staff and the relatives were all positive about the manager at the home. One person said, "The management team is much more settled now." The manager was in the process of registering with the CQC but had been in post since November 2017. A relative told us, "On balance, steps are clearly being taken to make improvements, but it may be too early to tell if these are having a sustained impact." Another relative said, "With regard to new manager I would say that she has definitely had a positive impact, indicative by the improvements to team management; activities; housekeeping and communication."

One person told us, "I like her, she does relate to people, she knows who they are and speaks to them. She has a dog, some people don't like him going into their bedrooms and he walks into the kitchen which is not very hygienic, but without her dog she wouldn't be here and she's certainly the best manager we've had for a long time." Another person said, "I'm not really impressed with the management of the home, hopefully with the new manager it will improve." A third person told us, "I have seen the manager a couple of times and I know the deputy. Now we have someone properly in charge, it will take things in the right direction"

The manager demonstrated an in-depth knowledge of the staff they employed and people who used the service. They were familiar with people's needs, personal circumstances, goals and family relationships. We saw them interact with people who used the service, relatives and staff in a positive, warm and professional manner.

Staff told us that the management team was approachable and that they could talk to them at any time. They said that the management was always open to suggestions from the staff team and that they listened to everybody and always provided them with opportunities for improvement. One staff member said, "The manager is lovely, she is hands on, she has done a lot here, she came to us with so many ideas." Another staff member said, "It's fantastic, [Manager] is fantastic, staff morale has gone up, the residents appear much happier, there is more structure now." A further staff member said, "The new manager is amazing. She is here for the residents but approachable for us too."

The manager had introduced a daily meeting with heads of departments to discuss any issues arising in the home. For example, the meeting for the day of the inspection noted that one boiler was not working, a tumble dryer was out of order together with information about some people's health status. Staff told us that there were regular staff meetings held to enable them to discuss any issues arising in the home.

Staff told us that there had been improvements with how the home functioned in recent times. One staff member said, "We have done so much, it's all about team work, I am so confident that you will see a great change." Another staff member said, "Communication has improved, we work as a team. The management is 100% better, more approachable and they listen to us." An example given was that the manager had facilitated a training session about dysphagia. (Difficulty or discomfort in swallowing) One staff member had asked if insulated plates would help to keep people's food warm if they ate their food very slowly. The manager had undertaken to look into securing the plates. Another staff member said, "It's so much better, a great atmosphere, everyone gets along."

There had been work with external agencies to help improve the quality of the service and drive further improvement. This included working with the local hospice, a national care homes association for activities and the local authority for developing the action plan and additional training. The introduction of champions in key areas was to help ensure all staff were kept informed about best practice and new ideas in these areas. For example, dementia care, nutrition and falls.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in most cases in a timely way which meant we could check that appropriate action had been taken.