Butts Croft Limited

Butts Croft House

Inspection report

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Tel: 01676540334

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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

This inspection took place on 18 and 20 September 2018. The first day of our visit was unannounced.

Butts Croft House provides care and accommodation for up to 35 people. Whilst the majority of people who live at the home are older people living with dementia, the service also offers care and support to young people living with dementia. The home provides eight temporary beds for people who have come from hospital for further care or assessment before going back to their own home. At the time of our visit there were 26 people living in the home.

People in care homes receive accommodation and 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.

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

At our previous inspection in November 2017, we found a breach in the governance of the home and the legal requirements and regulations associated with the Health and Social Care Act 2008 were not being met. We found breaches of the regulations related to managing risks to people's safe care and treatment, the need for consent, safeguarding service users from abuse and improper treatment, requirement to have a registered manager and display performance ratings and notification of incidents. We gave the home a rating of inadequate in well-led and served the provider with a Warning Notice. The overall rating of the home was 'Requires Improvement'.

At this inspection we looked to see if the provider and registered manager had responded to make the required improvements in the standard of care to meet the regulations. Whilst we found that sufficient improvements had been made to meet the terms of the Warning Notice and the service was no longer in breach of the regulations, we found improvements were still required in how managers assured themselves they were providing a safe service, that ensured people's health and welfare needs were fully met.

Since our last inspection visit the manager had become registered with CQC and the provider had provided them with more support to improve the quality of the service. A management consultant had been appointed who had introduced systems and processes to monitor the quality of the service, but these needed to become embedded in every day practice to be consistently effective.

People felt safe living at Butts Croft House because there were enough staff to meet their care and support needs. Staff were recruited safely because the provider had checked they were of good character. However, improvements were needed to ensure any gaps in employment history were explored within the interview

process. Staff received training and support to provide them with the skills and qualities to provide effective care. Some refresher training was overdue, but the provider had plans to address this.

Staff understood their responsibility to record and report any concerns they had about people's health or wellbeing. Safeguarding concerns had been referred to the local authority as required. Processes had been introduced for managing accidents and incidents that occurred within the home. Accidents and incidents were analysed as part of the provider's monthly quality checks to identify any trends or patterns and as further scrutiny to ensure appropriate actions had been taken.

People were supported to eat a balanced diet and encouraged to eat and drink enough to maintain their wellbeing. People were able to access support from external healthcare professionals to maintain and promote their health. Overall, people received their medicines as prescribed, but staff did not always follow good practice to demonstrate medicines management was consistently safe.

The registered manager had improved their understanding of the principles of the Mental Capacity Act 2005 (MCA) and how to put these into practice. Capacity assessments were completed and where required Deprivation of Liberties authorisations to keep people safe were in place.

People were positive about their experience of living at Butts Croft House and told us staff were kind and caring. Staff were tolerant and patient with people and respected their individuality. People were provided the opportunity to engage in some social activities, but this was dependant on staff having time to spend with them. The registered manager was recruiting an activities co-ordinator to improve people's social opportunities.

The provider had improved the governance of the home, and a system of checks and audits had been introduced to identify issues and drive improvement. This included the quality of care plans as they sometimes lacked sufficient detail to ensure staff had the information they needed to deliver person centred care.

The provider had a better understanding of their legal responsibilities under the legislation and informed us of important events that occurred within the service and displayed their ratings from our previous inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements had been made to ensure people lived in a safe environment. Risks to people's health and safety had been identified, but the level of detail in risk management plans was inconsistent. Overall, people received their medicines as prescribed, but staff did not always follow good practice to demonstrate medicines management was consistently safe. The provider had improved their processes to manage accidents and incidents and safeguard people from potential or actual abuse.

Is the service effective?

Good

The service was effective.

Staff ensured people received the care and support necessary to manage any healthcare needs. People had enough to eat and drink during the day and were provided with a choice of meals that met their dietary needs. Staff received training that supported them in providing effective care. The registered manager had improved their understanding of the Mental Capacity Act 2005 and where people were deprived of their liberties, an appropriate referral had been made to the authorising authority.

Is the service caring?

Good

The service was caring.

Staff were kindly and compassionate in their approach and had developed good relationships with people. People made positive comments about the caring nature of staff and enjoyed being with them. Staff were tolerant and patient with people and respected their individuality.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans lacked sufficient detail to ensure staff had the information they needed to consistently deliver person centred

care. There were systems in place to ensure staff were aware of people's changing needs. Social activities were provided but were dependant on staff having time to spend with people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems and processes had been introduced to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. However, the improvements needed to become embedded in every day practice to be consistently effective. Managers had a better understanding of their management responsibilities and staff felt supported in their roles.

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

This comprehensive inspection visit was carried out on 18 September 2018 and 20 September 2018. The first day of our inspection visit was unannounced and carried out by one inspector, an assistant inspector and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had similar care needs. We told the registered manager one inspector would return on the 20 September 2018 to look at the provider's quality assurance systems.

The provider had not completed a Provider Information Collection (PIC) before this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The provider had not received our request for a PIC, but we gave the registered manager the opportunity to tell us about the service and their plans for the future, during our inspection visit.

Prior to the inspection visit we reviewed the information we held about the service. This included 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 reviewed the 'share your experience' information we had received. This is information that people who use the service/ relatives/members of the public or social care professionals want to tell us about. These can be concerns or compliments. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority. Information received was considered as part of our inspection planning.

During our inspection visit we spoke with 10 people and two relatives about the quality of care provided at Butts Croft House. We spoke with the registered manager, deputy manager and the provider's interim management consultant about their management of the service. We spoke with three care staff and three non-care staff about what it was like to work at the home.

We observed how care and support were delivered in the communal areas and reviewed three people's care plans to see how their care and treatment was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records and the provider's quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found breaches of the regulations and rated this key question as 'Requires Improvement'. This was because risks to people's health and wellbeing had not always been mitigated and action had not been taken following accidents and incidents to keep people safe. During this inspection visit we found improvements had been made, although further improvements were still required.

At our last inspection we found a breach of the regulations because risks related to the premises had not been recognised and mitigated to ensure people lived in a safe environment. For example, at our last visit we found windows and doors to restricted areas were not secure and some alarms and call bells were not working properly. At this inspection we found improvements had been made.

A patio door leading onto a large first floor balcony was secure and doors leading into the boiler room and to the lift machinery were locked. However, we found a 'shed' in the garden where cleaning chemicals were stored was open and accessible to people and a door to a disused sluice was not locked. The registered manager took immediate action and put the coded lock on the door to the sluice and on the second day of our inspection, the shed had been secured.

There was a call bell system in bedrooms which people could use if they required support or assistance. Some people were unable to use a call bell and the provider used sensor mats by the side of people's beds so staff were alerted if people at risk of falls tried to get out of bed unsupported. We checked a selection of call bells and sensor mats to ensure they were working effectively. We only identified one sensor mat that was not fully effective and the registered manager arranged for this to be replaced immediately. The registered manager told us staff completed checks of safety equipment as part of their daily responsibilities, and the new maintenance person completed formal checks on a weekly basis.

At our last visit we found a fire exit in one person's bedroom which led onto a steep and narrow external fire exit stairwell was not working properly and could be opened with the slightest touch. At this inspection we found the fire exit was secure and working effectively. The provider had introduced a system to ensure fire safety checks, including extinguishers, fire exits and automatic door closures were regularly completed to identify any issues that could compromise people's safety.

Other risks to the environment were mitigated because the provider used external contractors to check the safety of essential services such as gas and electricity.

At our last inspection there was a breach of the regulations because potential safeguarding incidents had not always been managed and reported in accordance with the provider's legal responsibilities. At this inspection we found the registered manager had a better understanding of their safeguarding responsibilities. They told us they would report, "Anything I thought put a resident at risk." They explained this included any unexplained marks or bruising to people and any accidents or incidents where poor practice by staff had caused injury. The registered manager also understood their responsibility to notify us of any safeguarding referrals they had made to the local authority so we could be assured that risks to

people were being appropriately managed.

We did identify one minor incident that had occurred between people who lived at the home. The registered manager believed they had discussed this with the safeguarding team, but the conversation had not been recorded. They assured us they would record such conversations on the incident form to demonstrate they had considered their safeguarding responsibilities.

Staff understood the importance of reporting any concerns they had about people's safety or wellbeing. One staff member explained how they had dealt with a safeguarding concern successfully in the past by recording the person's injuries in detail, completing an incident report and passing on their concerns to the managers and the person's family. Another member of staff told us they would report any abuse to their managers and if they did not take appropriate action, "We can ring the local authority safeguarding." This member of staff also told us they would report poor practice by other staff, such as not using the proper equipment to transfer people. They explained, "People have been assessed and it is in their care plan for a reason."

At our last inspection we found a breach of the regulations because incidents that affected the health, safety and welfare of people had not always been investigated to prevent further reoccurrence and ensure improvements were made. Following that inspection, the provider's interim management consultant had introduced a new procedure for managing accidents and incidents that occurred within the home. Staff completed an accident/incident form which was reviewed by the managers to ensure any immediate action had been taken to keep the person safe, and whether any further action was needed to prevent it happening again. Accidents and incidents were analysed as part of the provider's monthly quality checks to identify any trends or patterns and as further scrutiny to ensure appropriate actions had been taken.

Individual risks to people had been identified and management plans were in place to reduce the risks of harm or injury. For example, risks associated with skin damage, malnutrition, falls, and moving and handling. However, we found some risk assessments would benefit from more detail. For example, one person was at high risk of skin damage and experienced some pain. Their care plan stated staff needed to change the person's position every two hours using a slide sheet which staff knew. However, there was no guidance in the care plan on how to minimise the risk of skin tears or prevent pain when moving the person. One staff member told us they put gauze in the person's hands to prevent soreness and blisters. The registered manager confirmed that this had been advised by the district nurse, but acknowledged it had not been incorporated into the person's care plan. They assured us the risk assessments and care plans would be reviewed as a priority.

We looked at how medicines were managed in the home to make sure people received their medicines when needed and as prescribed. Staff completed medicines administration records (MARs) when they had given people their medicines. MARs we looked at indicated that most people had received their medicines as prescribed. However, we identified one person who was prescribed a cream that was to be applied to their skin twice a day. We found this medicine was regularly only being applied once a day.

Staff did not always follow good practice to demonstrate medicines management was consistently safe. For example, handwritten amendments to MARs were not signed by the member of staff making them or countersigned by a second member of staff to confirm their accuracy. Where a medicine was transcribed onto the MAR, staff were not always adding the administration instructions. For example, one person was prescribed eye drops, but the handwritten MAR did not state which eye they were to be put in. We also found that staff were not routinely carrying the balance of stock medicines onto the MAR charts so it was difficult to know how many medicines people had in stock or identify any discrepancies.

Overall, medicines were stored and kept safely and in accordance with manufacturer's instructions to ensure they remained effective. Medicines that required extra checks because of the potential for abuse, were managed safely and in accordance with the legislation. However, we found that one person's cream that should have been stored in a refrigerator when opened was being stored in their bedroom.

Where people were prescribed medicines on an as required basis for pain or anxiety, there were guidelines in place to inform staff when these should be given. Some people received their pain relief medicines through a patch applied directly to their skin. Staff maintained a record of where the patch had been applied to ensure the application sites were rotated to reduce the risks of skin irritation.

Following the first day of our visit, the management consultant carried out a full medicines audit in the home with the deputy manager. Any issues identified had immediately been addressed and further safe medicines management training had been arranged for staff. The deputy manager told us they now had a better understanding of their responsibilities to ensure medicines were managed safely in the home. They explained that previously they had carried out 'stock checks' but now planned to complete a full medicines management audit on a monthly basis.

We found risks of infection were not always mitigated. Clinical waste should be put into yellow clinical waste bags and then a lidded clinical waste bin for collection. We found the service had run out of yellow bags and clinical waste was being put in plastic black bags. The clinical waste bins were full and around 12 bags containing clinical waste were on the floor around the bin. When we informed the registered manager, they took immediate action. They contacted the contractor responsible for collecting clinical waste who confirmed they had missed a collection. Arrangements were made for a further collection and the waste had been cleared on the second day of our visit. The registered manager told us a memo was being sent to all staff to remind them of their responsibility to report any issues that could risk the spread of infection.

Personal protective equipment such as plastic gloves and aprons were available for staff which they used when carrying out personal care tasks, serving food and cleaning. We saw the home was mostly clean and tidy although there was sometimes a malodour in some areas of the home. A member of domestic staff knew what cleaning products and equipment were needed for different tasks and areas of the home. However, the laundry was disorganised with dirty laundry on the floor. Staff explained this was due to a broken washing machine which was waiting to be repaired.

People told us they felt safe living at Butts Croft because staff were around to help them. One person told us, "I feel safe to mobilise because the staff will always walk with me due to my failing eyesight." Another said, "I can mobilise on my own but I like a carer with me in the garden."

Staff told us they thought there were enough staff to support people safely. They told us that if people wanted a shower in the morning, they had time to support them with that. The management consultant explained that staffing levels were flexible and were reviewed if a need was identified, for example in response to any changes in people's mental health.

However, there was a strong reliance on agency staff to cover staff vacancies on some shifts. Rotas showed the registered manager tried to use the same agency staff, but one staff member told us, "It is hard working with agency staff because they don't know the residents as well as we do." The registered manager told us there was an ongoing recruitment drive and they and the deputy manager worked shifts to cover unexpected staff absence. Staff confirmed this happened.

In November 2017 the provider was not able to demonstrate they consistently followed safe recruitment

procedures to ensure staff were suitable for their roles. At this inspection we found improvements had been made. We looked at the recruitment files for two new members of staff. Checks had been made with the Disclosure and Barring Service (DBS) and references had been sought. However, there was a gap in one person's employment history and there were no records to evidence this had been followed up during the interview process. The deputy manager assured us this would be addressed and the information recorded.

At our last inspection we found that although the provider had a system of recording people's personal evacuation plans (PEEP) in the event of an emergency, they had not been kept up to date. At this inspection we found PEEPs were regularly reviewed to ensure they accurately reflected the needs of every person living in the home. A copy of the PEEPs was kept centrally so they were immediately available for the emergency services should the home need to be evacuated.

Good

Is the service effective?

Our findings

At our last inspection visit we found there was a breach of Regulation 11 because the management team did not have a good enough understanding of the Mental Capacity Act 2005 to ensure compliance with the legislation. This key question was rated as 'Requires Improvement'. At this inspection we found managers had a better understanding and the effectiveness of the service is now rated as 'Good'.

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 are called the Deprivation of Liberty Safeguards.

Where a need had been identified, records demonstrated that people's capacity to participate in the development of their care and risk management plans had been assessed. Where people were assessed as not having capacity to consent to their care, we saw capacity based care plans for the activities of daily living such as nutrition and personal care had been developed in the person's best interests. The registered manager explained that when there were restrictions in people's care, they completed a capacity assessment in respect of that particular decision. For example, staff kept one person's cigarettes for them. The person's capacity to manage their own cigarettes had been assessed and there had been a 'best interests' meeting to agree the plans for staff to support this person to manage their daily cigarette consumption.

When necessary for people's safety, applications had been made to the local authority to deprive people of their liberty. At our last inspection visit, the provider was unable to confirm which of the people living at the home had DoLS applications submitted, approved and authorised. At this inspection the provider had recorded the status of the DoLS applications so the management team could ensure any conditions were adhered to and DoLS could be reapplied for in good time before they expired.

Some people had chosen to appoint a Power of Attorney to make decisions on their behalf. At our last inspection we found the provider was not able to confirm whether people's Power of Attorney related to health and welfare or finances. At this inspection we found the registered manager had requested sight of the documents to assure themselves the Power of Attorney had the legal right to make decisions on the person's behalf and what it related to. However, we found one document that had not been registered with the court. The registered manager assured us they would request a copy of the legal registered document as a priority.

Staff worked within the principles of the MCA and understood the importance of giving people choices and gaining people's consent before, for example, supporting them with personal care.

Staff received an induction when they first started working in the home and completed refresher training to keep their skills up to date. The induction included the completion of mandatory training and a period working alongside more experienced staff. The provider maintained a staff training matrix which ensured staff completed essential training on an ongoing basis to ensure they had the knowledge and skills to care for people safely and appropriately. The consultant manager acknowledged that some refresher training was overdue, but confirmed that training was being booked and said, "Training month on month has been improving."

At our last inspection we found staff were not always appropriately supervised or given regular feedback about their performance. At this inspection staff confirmed they had opportunities to meet with managers to discuss their performance and developmental needs.

People were supported to maintain a balanced diet and encouraged to eat and drink enough to maintain their health. A member of catering staff told us they were planning the new winter menu and had spoken with people who lived in the home about what meals they would like on it. They told us they were including options such as a mild curry and hot pot in response to people's comments. This member of catering staff was knowledgeable about people's specialised diets and provided for specific needs such as a softened diet. They ensured where people had soft diets, these were presented in an attractive way to encourage people to eat. They went on to say, "When they weigh the residents, if they have lost weight, the staff will tell me straightaway." They described how they added extra calories to those people's meals to minimise the risks of further weight loss.

Overall, people who lived at the home told us the food provided was home cooked, good quality and that there was plenty of food and drinks available. Comments included: "The food is good, there's usually a choice between meat or fish" and, "The food is lovely and fresh." A member of care staff told us, "I ask service users what they want, I do ask everybody what they'd like for breakfast, lunch and tea….they always get plenty of snacks, biscuits, crisps and cakes." A relative confirmed, "They always seem to be offering food and snacks."

We observed people's lunchtime experience and the support they were offered by staff. Meals were good sized portions and the food smelt appetising. People were asked if they wanted any more food before their plates were cleared away. Where people were not eating their food, they were offered an alternative. A member of staff told us, "Whatever they want they have. There are no rules here with regards to the food. At 8.00pm some people will ask for a chip butty, nothing is refused."

We also observed one person in bed being assisted with their meal. The person was given time to eat, they had their back raised and a cloth placed on them to protect their clothing. However, the agency member of staff did not speak to the person which would have made it a more sociable experience.

People's care needs were assessed by the registered manager before they moved to Butts Croft to make sure staff were able to provide appropriate care and support. Following assessment, a plan of care and support was developed so staff understood the care the person required.

People were able to access support from external healthcare professionals to maintain and promote their health. Where needed, staff supported people with routine healthcare appointments. People's records contained information on communication with professionals such as GPs, district nurses and dieticians. A nurse practitioner qualified to prescribe medicines visited the service every Wednesday, and at other times if a need was identified. We saw that referrals to other healthcare professionals had been made where an issue was raised. For example, one person's mental health had deteriorated and they had been referred to

the mental health team.

Communal areas of the home were pleasant and well-decorated and there was a large accessible garden people could explore if they wished to. On the ground floor we found the environment was supportive of people living with dementia. People's doors were painted in different colours and there were memory boxes outside so people could locate their room more easily. However, on the first floor, bedroom doors were the same colour and there were limited aids to help people identify where they were. The registered manager told us they planned to introduce coloured bedroom doors to the first floor and were exploring ways of making the corridors more interesting and stimulating for people as they moved around the home.

Good

Is the service caring?

Our findings

At our last inspection we rated 'caring' as Requires Improvement. People were happy living at Butts Croft House because they felt staff cared for them, but the provider had not demonstrated the same caring values by ensuring managers and staff had consistent and timely support. At this inspection we found the provider had taken action to ensure staff were supported by managers who had been given the opportunity to develop within their role and understand their responsibilities. The rating is now Good.

People made positive comments to us about the staff who provided care and support for them. One person told us, "All the carers are lovely, it's not just a job to them." Another said, "The staff are so kind and considerate."
We saw that permanent staff who knew people well chatted with them as they went about their caring tasks. There were light hearted and friendly conversations which people clearly enjoyed. One person told us, "I can always have a laugh and a joke with the staff."

Staff reflected in their conversations that they were fond of people and wanted to develop caring relationships with them. One staff member told us that to be caring, "You have to have compassion and understanding of different people and their different backgrounds. It makes you understand the person better and the care they want to receive." Another told us that an important aspect of caring was to give people time and explained, "We are there for them. If they want to chat, I will sit and talk to them." One person told us what this approach meant to them and explained, "The carers were a great comfort to me when [name] passed away."

Staff were kindly and compassionate in their approach. One person took comfort from holding two 'baby dolls', but this meant they could not hold their drink. A staff member offered to hold one of the 'babies' so the person could drink, but the person declined. The staff member waited a while and then asked another member of staff who had a good relationship with the person if they could assist. This staff member asked if they could cuddle a 'baby' and the person happily passed one of the 'babies' to them saying, "Be careful, I want the baby back." The staff member reassured the person by speaking to them about their 'baby' and showed the person how they were carefully looking after it for them so they could take time to have their drink.

Staff were tolerant and patient with people. When staff asked one person if they could support them with personal care, the person was verbally challenging in their response. Staff responded calmly and reassuringly and the person then happily accepted their offers of support. When this person was later helped to the dining room they smiled at the staff member supporting them and said, "I'm happy because you are here." The staff member responded positively to the person by putting their arm round them and giving them a hug. Another person told us, "They are lovely carers, I consider them as my best friends. They are very patient with the awkward ones."

Care staff appreciated that some people could feel anxious when receiving personal care. They told us how they alleviated people's anxiety by promoting their privacy and dignity and encouraging them to do as much

for themselves as possible. One member of staff explained how this minimised people's anxieties whilst promoting their continuing independence. They told us, "Those who can, we encourage to do as much for themselves as possible. If they stop doing something, they might not want to do it again. It is giving them that self-respect."

Nobody living at the service had any specific cultural or diverse needs that care staff supported. Staff, however, told us they respected people's individuality and beliefs. One staff member told us if someone had any specific cultural or religious beliefs they were not familiar with, they would research it to increase their awareness. They explained, "It's looking at things from their point of view. I would research because I would want to have a better understanding so I could talk to them about it."

During our visit we saw relatives arrived and enjoyed being with their family members in the communal lounges. One relative told us, "You are always made to feel welcome."

Staff understood the importance of maintaining confidentiality. We saw that when staff had finished working on people's records and care plans, they made sure they were locked away in a cabinet so they were safe and secure.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found staff were not consistently responsive in meeting people's individual needs and rated the service as 'Requires Improvement'. At this inspection we found improvements had been made, but further improvements were still required. The rating remains as 'Requires Improvement'.

We looked at two people's care plans and found inconsistency in the level of detail recorded within them. One person's care plan gave very detailed information, for example about how they liked to be supported with personal care and their preferred routines at night. The other person's care plan said they were 'easily tired', suffered pain and could be resistant during personal care. There was no plan to help staff identify if the person's behaviour was caused by pain or tiredness or how they could divert the person's behaviours if they became resistive. We spoke to the deputy manager about this who told us staff distracted the person by telling them they were going to church. However, the person was not supported to attend church by staff. We explained why this may cause feelings of disappointment for the person and suggested a way of talking about things which interested the person to distract and influence their behaviour without misleading them. This person was cared for in bed, but there was no care plan for night staff to follow. This meant it was unclear whether night staff were instructed to change the person's position, provide personal care or offer food and fluids through the night.

We discussed the inconsistency in care plans with the provider's management consultant. They explained that the provider had recently introduced a new care planning system and people's care records were gradually being transferred over to the new system. They told us they had already identified that some care plans lacked sufficient detail to ensure staff had the information they needed to deliver person centred care. They told us, "Some details have been lost in the transfer so I am going through the care plans to ensure they contain all the relevant information." The management consultant told us they had arranged further training for staff in the new care planning documentation to ensure consistency in the quality of information recorded within them.

There was information in people's care plans about any support they required to understand information. The registered manager told us that where people needed information to be provided in an alternative format, such as large print, this would be sourced for them on an individual basis.

Staff told us they could respond to people's changing needs because they had a handover of information about each person in between shifts. One member of staff told us, "We have a handover sheet which includes personal care, food and fluids, observations, broken equipment, medication, red areas [sore skin], changing bedding and appointments go in the diary."

People were supported at the end of their lives. The registered manager explained care staff worked alongside other organisations, such as district nurses, to provide end of life care to people which was responsive to their needs and ensured they were pain free. Some people had information in their care plans about their preferences for their end of life care. The registered manager told us they planned to discuss advance care planning with people during their initial assessment and as part of their care reviews.

Some people had 'Respect' forms in place which captured their views regarding resuscitation in the event of a cardiac arrest or death. A 'butterfly' was placed on each person's bedroom door who had a 'do not resuscitate' decision in place. This meant staff could see at a glance what action they needed to take to ensure people's wishes for resuscitation were respected.

There was no member of staff specifically employed to deliver activities, but rather it was the responsibility of all staff to engage with people as part of their working day. We saw one member of staff sitting at a table with two people. The member of staff was drawing pictures on a chalkboard for the people to guess what they were. One person was deliberately sabotaging it and guessing incorrectly. This was generating fun and laughter and inspiring lots of conversation between the member of staff and the two people engaging in the activity.

However, because of demands on staff time, staff told us they did not always have the opportunity to engage in activities with people as they wished to. One member of staff told us, "It would be nice if we got more time to spend with them doing things. We do, do things with them, I would just like to do more with them." This was confirmed by people who commented, "There's nothing to do in here" and, "I get involved if there's anything going on – playing cards or dancing." One person was cared for in bed and their records showed they liked 'listening to music' which staff needed to provide. However, on the day of our inspection the person had no music on in their bedroom. The registered manager had already identified this as an area that required improvement and was recruiting someone to the role of activities co-ordinator.

People told us they would not hesitate to raise any concerns about the care they received. Comments included: "If I had a problem, I'd go to the manager", "I've had no need to make a complaint so far" and, "If I had a problem I'd ask the nurse [care assistant] and if that was no good I'd ask the manager." Records showed complaints were managed appropriately and analysed to identify any trends or patterns.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2017 we found the provider had not ensured there was a person with the skills and experience to manage the service. The service was not well-led and the provider did not have effective systems in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. The provider had also failed to comply with their responsibilities under our registration regulations. We judged this was a breach of the regulations and rated the leadership of the service as 'Inadequate'. We served the provider with a warning notice in respect of Regulation 17.

At this inspection we found sufficient improvements had been made to meet the terms of the warning notice. Systems and processes had been introduced by the provider and registered manager to monitor the quality of the service. However, the service continues to be rated 'Requires Improvement', because although some action had been taken, the improvements needed to become embedded in every day practice to be consistently effective. We will schedule a follow up inspection to check that the improvements have been consistently sustained throughout the home.

Following our inspection in November 2017, the provider recognised they needed external support to improve the quality of the service. They had appointed an interim 'management consultant' to provide them with guidance and advice. The management consultant understood the requirements of meeting the regulations within the Health and Social Care Act 2004. The appointment of the management consultant had increased management capacity, which had allowed more time to plan and implement improvements.

At our last inspection we found the manager and newly appointed deputy manager did not have the knowledge or understanding required of their role. Since that inspection, action had been taken to provide the managers with the skills to lead and manage staff effectively and be more competent in their managerial roles. The manager had successfully applied to become registered with us (CQC) and was now the registered manager for the home. The registered manager told us they now felt more confident in their management skills and told us, "At the beginning the responsibility was quite overwhelming. I feel a lot better now because I can see things changing, slow but sure."

In November 2017 there were no effective systems to monitor safety checks had taken place. Equipment was not maintained and risks within the environment had not been managed. At this inspection we found action had been taken. The provider had recently appointed a maintenance person who had taken over responsibility for such checks, including fire and water safety. Records showed checks were being completed in accordance with the provider's audit schedule. Environmental risks we had identified at our last inspection had been addressed and action taken. For example, the provider had commissioned an external contractor to complete a fire risk assessment of the premises in January 2018, and all but one of the actions from that assessment had been completed. The management consultant assured us this last action would be met within the next few months.

Previously we found the management of accidents and incidents was ineffective which put people at risk. At this visit we found improvements had been made to accident/incident management systems. Accidents and

incidents were audited monthly to ensure appropriate action had been taken and to identify any trends or patterns. However, the management consultant told us further improvement was required in the amount of detail within the accident and incident reports and this was to be addressed with staff.

Regular audits had been implemented by the management consultant on behalf of the provider covering a wide range of areas including medicines, care plans and risk management. Whilst some audits had highlighted the areas we found with regard to medicines management and care plans, action had not always been taken in a timely way to address them. The management consultant explained this was because the registered manager and deputy manager had to cover some shifts because of staff shortages. They acknowledged that whilst this ensured people received consistency of care from staff who knew them well, this impacted on the time the managers had for the managerial aspects of their role. The management consultant told us they were going to discuss their hours with the provider so they could provide more managerial support until staff had been recruited and the vacancies filled.

As part of their quality checks the registered manager told us they, or the deputy manager, walked around the home every day at different times of the day. However, we found the spot checks had not identified issues such as a lack of clinical waste bags or a missed clinical waste collection.

In November 2017 the provider had not maintained sufficient oversight of the service. At this inspection the management consultant told us they had completed a quality review of the service on behalf of the provider in July 2018. Actions had been identified within the review to improve the service and assure the provider as to the quality of care provided.

At our last inspection we found records to support the effective management of the home were not in good order and could sometimes not be located. For example, there was no central record of staff training, safe recruitment procedures had not been consistently applied and there was no 'tracker' to identify who had an authorised DoLS in place. Since that inspection, the provider had appointed a part-time administrator to ensure records supporting the management of the service were available and kept up to date. The management consultant told us this would free the registered manager to concentrate on the management of the home rather than the administrative aspects of the service.

At our last inspection we found the provider had not sought people's views as to the quality of the service and to involve them in the development of the service. At this inspection we found that people had been invited to provide feedback through a quality questionnaire. We found the main areas of concern identified was about people not feeling involved in making decisions about their care or encouraged to share their views. The registered manager told us they had tried to involve people's families about what was happening in the home and had arranged relatives' meetings, but these had not been attended. The management consultant explained this was being addressed through the new care planning process which would involve people in developing their care plan and, where appropriate, relatives would be invited so their views of the care provided could also be considered.

Staff spoke positively about the support provided by the registered manager and felt confident to raise issues or concerns with the managers. One staff member told us, "I've got no complaints I love it here. If you've got a problem she'll do her hardest for you" Another staff member said, "They are trying, they are doing their best and they do listen. I think we are getting there. It is a lot better since you last came here." This staff member particularly spoke of the relationship the registered manager had with people who lived in the home and said, "[Registered manager] as soon as she comes in, she will go round and chat to every resident who is up. Through the course of the day she will have spoken to every resident."

Staff told us the registered manager and deputy manager worked well together which motivated the staff team to improve the quality of care people received. Staff told us they all worked well as a team and that communication had improved. One member of staff said, "They both have all the support of the staff and they are always there if I need to talk about something, but I think there are still areas we could improve." One person confirmed, "[Names of managers] have good standards."

Staff received supervision to discuss their practice and personal development and managers worked alongside them regularly to make sure they worked to the provider's procedures. Management meetings and staff meetings were held to keep staff up to date with any changes and discuss any improvements required within the home.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a notification. At our last inspection the provider was in breach of the regulations because they had not submitted all the notifications in accordance with their legal responsibility. At this inspection the provider had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

At our last inspection the provider in breach of the regulations because they were not displaying the ratings from their last inspection visit as required by the regulations. At this visit the ratings were displayed in the entrance to the home.