Morven Healthcare Limited

Morven House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this inspection on the 2 and 7 February 2017, the first day was unannounced.

Morven House is registered to provide residential care for up to 40 older people who are living with dementia. Some people use the service for respite care breaks. Accommodation is arranged over three floors and there is passenger lift access. There were 22 people using the service at the time of our inspection.

At our comprehensive inspection in February 2015, we found the provider was not meeting a number of regulations. We therefore asked the provider to take action in relation to staff training and support, providing safe care for people at risk of pressure ulcers, person centred care and good governance. Following the inspection, the provider sent us an action plan which set out the action they were taking to meet the regulations. At our next inspection in November 2015 we found improvements although we identified a continued breach in relation to good governance and a new breach in respect of medicines management. We also asked the provider to review people's mental capacity assessments as they did not fully meet the principles of the Mental Capacity Act. We took enforcement action and issued a warning notice for the continued breach. When we checked for compliance with this notice on 12 July 2016, the provider had taken the required action.

The aim of this inspection was to carry out a comprehensive review of the service and to follow-up on the requirement action made in relation to the management of medicines. At this inspection we found the provider had followed their action plan and improvements had been made.

The manager in post at the time of our previous inspection left employment shortly afterwards and a new manager was appointed in November 2016. The new manager had begun the process of applying for registration. 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.

Improved arrangements were in place for the recording, safe keeping and administration of medicines. New audit systems had been introduced and regular checks were being carried out. People received their medicines as prescribed and when needed.

At this inspection we found improvements in care planning. Care plans were up to date and reflected people's needs. Individual health, care and support needs were assessed and reviewed in a timely manner. Referrals were made to other professionals as necessary to help keep people safe and well.

People felt safe and the staff took action to assess and minimise risks to people's health and well-being. Staff knew how to recognise and report any concerns they had about people's care and welfare and how to

protect them from abuse. The service responded appropriately to allegations or suspicions of abuse.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. Conditions on authorisations to deprive a person of their liberty were being met.

Appropriate recruitment checks were followed to make sure staff were suitable to work at the home. Staff received an induction and essential training at the beginning of their employment. This was followed by ongoing refresher training to update and develop their knowledge and skills.

At the time of our inspection there were enough staff to meet people's needs and keep them safe. Management were aware that staffing levels would need review should the number of people using the service increase. There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. Staff maintained people's privacy and dignity at all times and treated individuals with respect and courtesy.

More activities were provided for people that met their needs and choices. The home had employed an activity coordinator who supported people to take part in activities either individually or in groups.

Morven House had undergone refurbishment and redecoration and further home improvements were taking place at the time of this inspection. We found that areas within the home could be decorated and equipped more suitably for people living with dementia. We have made a recommendation about improving the environment to provide more engagement and stimulation.

People and their relatives were comfortable to raise any issues and felt they were listened to. The provider had a complaints procedure to support this.

Management had oversight of how the home was performing and was aware of its strengths and weaknesses. Arrangements to assess and monitor the quality of the service had been strengthened and included feedback from people, their relatives and staff. The new manager knew what was required to develop the service and was working to an action plan. This showed us there was an upward trend towards improvement in the service.

The provider worked in partnership with other agencies and professionals to support care provision and service development. Management had been working with the local authority safeguarding team and commissioners to improve standards. This helped ensure that lessons were learnt and similar incidents were less likely to happen again.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

We found that action had been taken to improve the safety of the service. Previous shortfalls around medicines management had been addressed. Medicines were managed safely and people received their medicines as prescribed.

People staying at the service felt safe and able to raise any concerns. Staff had completed training and understood how to protect the people they supported from abuse and harm.

Risks to people's safety were identified and planned for. Steps were taken to minimise these and keep people safe.

People were supported by sufficient numbers of staff and the provider followed the correct recruitment process.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The environment did not fully meet the needs of people who used the service living with dementia. Management recognised the need to address this.

The provider acted in accordance with the Mental Capacity Act 2005 Code of Practice to help protect people's rights.

Staff were provided with training that gave them the skills to care for people effectively. The manager was taking action to improve arrangements for staff support and supervision.

People were supported to eat and drink well although they were not involved in day-to-day decisions about their meals as much as they could be. People were protected from the risk of poor nutrition and hydration.

People received the support and care they needed to maintain their health and wellbeing. They had access to appropriate health, social and medical support when it was required.

Is the service caring?

Good

The service was caring. People felt well cared for and were

involved in making decisions about their care. Their relatives were consulted where appropriate.

Staff respected and promoted people's privacy, dignity and independence.

People were supported to maintain relationships with those who were important to them. Relatives spoke positively about the care their family members received.

Is the service responsive?

Good

The service was responsive. People's needs were assessed before they came to live at the service. Their needs were monitored and reviewed accordingly and staff responded promptly when there were changes to people's health or wellbeing.

The home provided activities that met people's needs and interests whilst reducing the risks of social isolation.

People and their relatives were confident to raise any complaints or concerns. Arrangements were in place for dealing with complaints and responding to people's comments and feedback.

Is the service well-led?

Good

The service was well-led. The changes in management had resulted in some inconsistency although the new manager knew what was required to develop the service.

Systems to monitor the quality of the service were in place and used effectively. Where improvements were needed, these were addressed and followed up to sustain continuous development.

People, their relatives and staff were positive about the way the home was run. There were arrangements for them to express their views and opinions about the services provided.

Communication was open and inclusive between management and the staff team.

Morven House

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 7 February 2017 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 11 people living at the home and seven visiting relatives or representatives. Due to their needs, some people were unable to share their direct views and experiences. Along with general observation, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the new manager, a consultant manager, five members of care staff including a senior, the activities coordinator, chef, office administrator and registered provider. We reviewed care records for seven people using the service and checked personnel records for three staff members. We looked around the premises and at records for the management of the service including quality assurance systems, audits and health and safety records. We also reviewed how medicines were managed and the records relating to this.

Following our inspection, the consultant manager sent us information we had requested about complaints, quality assurance findings and planned improvements.

Good

Is the service safe?

Our findings

At our previous inspection in November 2015 we found the management of medicines was not always safe. At this inspection we found the provider had made improvements.

Since our last inspection, regular checks were being carried out to make sure people received their medicines as prescribed. For example, staff completed daily recorded checks on balances and administration of medicines. All medicines were checked and counted once a week by the manager or senior staff. The most recent audit showed there had been no errors or discrepancies. The service had recently been audited by the pharmacy that supplied people's medicines. Their report identified one recommendation which the home had addressed.

All medicines, including controlled drugs, were stored securely in a designated room and administered by appropriately trained staff. Staff were supported with clear policy and procedures covering medicines management. The manager had started observational checks to assess staff practice and competency in medicines administration. We discussed medicines management with a senior member of staff. They showed knowledge about the reasons why people were prescribed their medicines and how to administer medicines safely.

People told us they received their medicines when they needed them. One person said," I'm on (name of medicine) once a day in the morning, they bring that. I have my inhaler twice a day." People had regular medicine reviews with relevant professionals to promote good health. We saw that a medicine for one person had been reduced and eventually discontinued, resulting in a positive impact on their well being.

People had individual medication administration records (MAR). Alongside the MAR, each person had a photograph, details of their GP, information about their health conditions and any allergies. The MARs we sampled for people were fully completed and corresponded with their medicines supply. The records were up to date and there were no gaps in the signatures for administration. We looked at references to medicines within care plans. Some people were taking specialised medicines and guidance was available to staff to ensure these medicines were administered correctly. For example, some types of medicine must be given at particular times for them to be effective. There was information about the use of topical medicines (medicines which are applied to the skin) and how often they should be applied. Dates of opening were recorded appropriately on medicines such as eye drops to ensure they were not being used past their expiry date.

Protocols for 'as required' (PRN) medicines were in place. A PRN protocol describes the circumstances when a person can take a certain medicine so that it can be administered safely and consistently. Two people were prescribed sedating medicines to reduce their levels of anxiety. We found that these medicines were not overused and staff had recorded on the back of the MAR when they needed to give a dose, and the reason. The protocol information was limited however with directions for administration recorded as "for agitation." We discussed this with the manager who agreed to update the protocols to reflect people's individual needs and how staff should support a person with their behaviour before PRN medicine could be

administered. A senior staff also told us they were waiting for new PRN recording forms from the pharmacist.

Room temperatures were monitored and recorded daily to make sure that medicines were stored at the correct temperature. There was a system for checking all prescribed medicines and records for their receipt and disposal. At the time of our inspection, no one using the service was prescribed medicines covertly but the service had an appropriate procedure in place. (Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving it.)

Appropriate recruitment checks took place before staff worked at the service. Checks included taking up references regarding previous employment and undertaking Disclosure and Barring Service (DBS) identity checks. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record. Application forms had been fully completed, proof of identity and eligibility to work in the UK (where applicable). We saw that staff records were organised and the manager used a recruitment checklist to support this.

People and relatives felt there were enough staff and they did not have to wait for attention. One person told us, "There's ample people here" and another person commented, "I've got my little bell, they come in a few minutes, it depends on the time of the day." Another person said, "They are very prompt; if they're tied up with somebody else it takes a bit longer, but its fine. They come in less than a minute if they are free." One relative who visited regularly told us, "It's better than it used to be, especially recently." Another visitor said, "There's always plenty of people, they're always in and out round and round." Another relative commented, "They seem to answer them (call bells) within a minute or so." Our observations supported what people told us. There were always staff in the communal areas and the call bells were answered promptly. People who were unable to use the call bell system were checked by staff at regular intervals to ensure their safety and well being.

Daytime staffing allocation included a minimum of four care staff with three carers available during the night. Ancillary staff including domestic staff, two chefs and an activities co-ordinator complemented the staff team so that care staff could focus on the delivery of care. When we inspected staffing levels were sufficient for the number of people using the service. Management were aware of their responsibility to review staffing levels once more people moved in. They told us they planned to recruit more staff in line with levels of occupancy in the home and people's assessed needs. Recruitment was also underway for a deputy manager and two care staff.

Risks associated with people's care were identified and addressed. Care records included risk assessments in relation to falls, developing pressure sores and risks associated with eating and drinking. People had risk plans specific to their needs such as smoking or increased risk of urine infections. Staff showed knowledge of the risks people faced. For example, the importance of making sure people had their walking aids and using food and drink charts to monitor intake if a person's appetite was poor. We observed safe manual handling practices when staff assisted people to transfer from their chair to wheelchair as well as from chair to walking aid.

Accidents involving people were clearly recorded and body maps were used to identify where injuries were. The manager maintained an analysis of falls or accidents to determine patterns or trends and take preventative action. We saw that actions to reduce risks to individuals were taken. For example, staff were reminded to be alert for changes in one person's behaviour as this was a known trigger for signs of infection.

People and their relatives told us that they felt safe living at the home and could talk to a member of staff or

the manager if they had concerns about their safety. Staff had been trained in safeguarding as part of their induction, knew about the different types of abuse they might encounter and how to report any concerns. There were procedures for ensuring allegations of abuse or concerns about people's safety were correctly reported. Records held by CQC showed the service had responded appropriately to allegations of abuse. Referrals had been made to the local safeguarding authority when required and action had been taken to reduce the risks of incidents happening again. Where safeguarding concerns had been raised, we found that the service had worked effectively with the local authority safeguarding team and commissioners. For example, practice had improved around pressure ulcer prevention and management.

There was an ongoing refurbishment plan to improve a number of areas in the original part of the building. In response to our last inspection, one of the ground floor toilets had been refurbished and the flooring replaced. Further improvements had taken place including the redecoration of a number of bedrooms and relocation of a medicines room and staff office. At this inspection, refurbishment was taking place in some of the vacant bedrooms. A handyman was employed to undertake essential repairs and maintenance where necessary. They also completed health and safety checks around the premises. Records confirmed that equipment was regularly checked for safety and routine servicing was undertaken when needed.

The home was clean and hygienic. Anti-bacterial hand gel was available throughout the building. Protective clothing was available to staff and appropriate arrangements were in place for the safe storage and disposal of clinical waste. People confirmed that the domestic staff came in daily to clean their rooms. A visitor told us, "Definitely all the way through, this place has struck me with their cleanliness."

There were evacuation plans and policies in place to ensure people's safety in the event of a fire or other emergency at the home. Appropriate numbers of staff were trained in first aid and management on-call available in the event of emergencies or if staff needed advice and support.

Requires Improvement

Is the service effective?

Our findings

At the inspection in November 2015 we asked the provider to review people's mental capacity assessments as they did not fully meet the principles of the Mental Capacity Act 2005. The Mental Capacity Act (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.

Mental capacity assessments had been completed as part of the assessment process when people moved in. Where people did not have capacity to make certain decisions, records showed that relevant healthcare professionals and those close to the person had been consulted. This was so their views could be sought and any decision they made on behalf of the person was in their best interests. We saw an example of this where one person required support with their personal care. Relatives confirmed they were involved in decision making where people were unable to contribute. One relative told us, "Yes we have, every single time they come to us if any decisions have to be made about (my relative)".

Staff understood the need to obtain consent and people's right to refuse. We saw and heard staff explain what they were going to do before support was provided. People's feedback also confirmed this. One person told us, "They always ask me before they help me with anything." Another person said, "They do all that when they come in the morning."

'Do not attempt resuscitation' (DNACPR) agreements were in place. These decisions are made in relation to whether people who are very ill and unwell would want to be resuscitated or would benefit from being resuscitated, if they stopped breathing. Records we sampled evidenced that decisions had been made appropriately and in agreement with the person's family and GP. However, not all DNACPR records had been fully completed or reviewed in some cases. We brought this to the attention of the manager. They told us they would contact the relevant health care professionals to review these records.

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 any conditions on authorisations to deprive a person of their liberty were being met.

The manager had assessed where people were being deprived of their liberty and made appropriate referrals to the supervisory body. For example, where people required staff supervision because it was unsafe for them to access the community unaccompanied. Records confirmed that DoLS applications had either been authorised or were in the process of being assessed by the local authority. There was information and guidance available to staff about the MCA and how this legislation impacted on the care they provided to people.

Relatives we spoke with felt staff provided effective care. One visitor said, " Staff are well trained" and

another relative told us, "I think they know what they're doing." Staff told us they had been on training courses relevant to the needs of the people they supported. This included training in dementia awareness and learning how to support a person to move safely using a hoist. Two members of staff had completed a course to deliver moving and handling training for the staff team.

Individual staff records included certificates for online training in areas such as food safety, safeguarding, MCA and DoLS, nutrition and hydration, pressure area care and infection control. Induction records were available for new staff. The manager used an electronic plan which identified when staff had completed training and when it was next due. This helped the manager prioritise and plan training that the staff needed. We noted that fire safety training was overdue for some staff and one senior staff had not updated their practical training in moving and handling within the required timescale. At our second visit, the manager confirmed that this had been addressed. There were also plans for staff to attend further training through the local authority around mental capacity, dementia and person centred care.

Due to recent staff recruitment and change in management, the new manager advised that staff had not always received the expected level of formal supervision. We saw that they were working to improve this and had scheduled one to one meetings with all staff and work performance appraisals. There was a yearly planner to support this.

We received mixed views about the quality and choice of food. One person said, "It's a very nice meal, the proportion of vegetables is very nice." Another person told us, "It's nice but very repetitive, we've had this day after day." A third person commented, "At times I think not again, there's no choice really. They just say it's going to be so and so. The quality is not too bad." People said they were offered an alternative if they did not like what was on the menu. One person said, "They're good because I can just ask them for something else for lunch and they prepare it, for instance today, I had steamed fish."

We observed how people were being supported during lunch and found further work could take place to enhance the mealtime experience. People were served the same meal and dessert with no choice given as to the food or quantities being provided. Everyone was served the same drink of orange squash. One member of staff was busy serving meals to people in their rooms. Another two members of staff gave two people one to one assistance to eat their meals and provided support in an unhurried manner. Other people were able to eat independently and on one table, we saw three individuals chatting together. At other tables however we did not see any meaningful interaction as staff did not sit with people.

Daily menus were written on a board and not available at tables where people could see the options available to them. We discussed whether the menu format could be made more accessible to people, particularly those people living with dementia. Management told us there were plans to introduce pictorial menus and improve the dining experience. We noted that menus had been discussed at a residents and relatives meeting in January 2017.

The chef was familiar with people's dietary needs and their personal preferences. Care plans recorded when people had specific needs and how staff should support them at meal times. For example, there was information to prepare meals to the right texture where people were at risk of choking. A relative explained their family member required a pureed diet and told us, "They're very understanding because (person) takes a while to eat, so they got her a heated plate so that her lunch wouldn't get cold. They take it all on board."

Where there were concerns about people's weight or appetite, staff maintained records so this information could be shared with relevant professionals, such as the doctor or dietician. Fluid and food record charts were used and nutritional assessments were in place to support this. A care plan we reviewed showed that

one person had been at risk of malnutrition in the past. Charts showed this person's dietary intake had been monitored and their weight had been checked on a regular basis.

We observed people were offered hot and cold drinks throughout the day. One relative told us, "I think they're pretty good at making sure everyone stays hydrated." Another visitor said, "Whenever I'm here I always see everyone with teas or coffees."

People told us they received effective support with their health care needs. A relative told us, "The GP comes in when (my relative) isn't feeling well and he speaks to us over the phone. The chiropodist comes every 6-8 weeks and the hairdresser every 2-3 weeks."

Care records showed that staff monitored people's health and wellbeing. They also showed that staff had followed the guidance provided by health and social care professionals. Records of all health care appointments were kept in people's files. These records detailed the reason for the visit or contact and details of any treatment required and advice given. We saw how additional support helped people maintain good health. For example, people had visits from the community mental health team, district nurses and GPs.

We found that further work could take place in the home to promote engagement and wellbeing for people living with dementia. There was limited signage to help people orientate with their surroundings. Aside from door numbers, there were no photographs or other objects of reference for people to recognise their own private rooms. Two people told us that other people using the service wandered into the rooms on occasions. The lounge and dining areas were homely but there were few pictures, objects or accessories that provided people with stimulation or links to past memories and activities. We recommend that the service consider current guidance on improving the environment for people living with dementia.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that staff were caring. Comments from people included, "The staff are very good, the only thing is they keep changing here, I get used to certain people and they get to know you you see, so it's frustrating when they leave", "All great big mixtures of cultures and so forth. They do their best, the men are more careful than the ladies" and "They're alright, I'm still settling in, I talk to all the girls." Comments from relatives included, "They're doing a good job here, they really look after (my relative), no faults at all", "Staff treat residents with lots of dignity and respect. When the maintenance man had to change (person's) chair, even he spoke to her for 10 minutes, he didn't have to do that, that's not even his job but he did " and "The staff are really friendly, everyone's approachable." Another relative complimented the staff team for their "good attitude" and said all were "very patient."

We observed care interactions were sensitive and patient. Staff members spoke clearly and kindly with people and took time to sit with them for a chat or accompany them with walking. When people needed assistance to walk or transfer from their chair, staff explained what they were doing, at the same time checking that the person was comfortable.

Staff were attentive and recognised when people needed reassurance. On one occasion, a person tried to snatch a doll from another person who became distressed by this. We observed a member of staff calmly approached the situation and spoke in a soft and caring voice to ask the person not to take the doll as it would upset the other person. During evening tea, a person repeatedly called out for staff while they were sitting in the lounge. Staff responded promptly, knelt down in front of them and provided reassurance which comforted the person. We also noted that staff used gentle touch and clear language when communicating with people living with dementia.

People's plans included information about how people preferred to be supported. For example, what time people preferred to get up in the morning and go to bed at night and whether they preferred a shower or a bath. People's independence was promoted and the care records explained the level of physical support people needed and what they could manage on their own. A 'My life story' document included important information about people's background such as their childhood, education, career and work, significant relationships/ places and memorable occasions in their life. Relatives were also asked for details their family members' personal histories and interests. Our discussions with staff showed they knew people's preferences and routines well. The manager shared an example where one person used to have a job as a seamstress and told us staff provided sewing patterns for them to cut up when they were upset or confused.

Visitors we spoke with felt welcomed at the home and were invited to social events such as parties and other celebrations. During our inspection, one person celebrated their birthday with their family. Staff had decorated the lounge with balloons and encouraged other people to join in with singing and sharing cake. A relative of the person commented, "The staff have been incredibly good, they offered to make a cake but we already bought one so we said not to worry, (the activities coordinator) even organised a card from the home."

People felt that staff respected their privacy and dignity. One person told us, "Yes I like to stay in my room and they let me do just that, they keep my door shut and knock before they come in." Another person said, "I'm sure there is when you need it. I haven't really needed a lot of privacy." A visitor told us, "The extension has brought in extra space, so if we wanted some private family time we could always go and sit in the conservatory bit and pull up some chairs."

On the wall in the dining area there was a display made for "dignity day". This was arranged to promote awareness and understanding of dignified care amongst people using the service and staff. Each paper heart on the wall had a comment written on it about what dignity meant to each person. People had been asked what was what important to them. Their comments included, "To treat people as you'd like to be treated yourself", "to be cared for and spoken with respect" and "manners."

During our inspection, staff addressed people by their preferred names and demonstrated a courteous and respectful attitude. People received personal care in the privacy of their bedroom or bathroom with doors closed. Staff knocked on people's bedroom doors, announced themselves and waited before entering.

We noted that some of the language used in care records did not always uphold the individuality and dignity of people using the service and reflected a task orientated approach. One person's night routine included, "Staff will prepare her for bed. Staff will toilet her and give her a wash." The night staff undertook two hourly observational checks and recorded if people were "bathed" or "showered." The manager agreed to review these records and acknowledged they could be more person centred.

There were examples in people's care records of discussions about how they wanted to be cared for at the end of their lives. Staff were in the process of undertaking end of life care training and supported by specialist staff from the hospice team. They also assisted staff to develop their competence in delivering good end of life care and provided on-going training and advice.

Good

Is the service responsive?

Our findings

People and relatives told us the service they received was flexible and they had been involved in the decisions about the care and support they wanted.

Assessments took place before people moved in to determine if the service could meet their care needs and expectations. Relatives were involved and had been asked about people's care, including their likes, dislikes and life history or background. Health and social care professionals provided additional information where appropriate.

The assessments included a dependency score that took account of a person's needs relating to physical health and care, and activities of daily living. Care plans were based upon the activities of daily living and reflected a generic nursing care model. For example, care aspects such as breathing, eliminating, personal cleansing and dressing. As Morven House provides a service to people living with dementia, we discussed the use of a more suitable assessment that considered needs associated with cognitive impairment or memory loss. The manager agreed to review this.

Care records reflected how health conditions might impact upon people's care and how this affected their daily lives. For example, guidelines about nutrition or management of pressure sores were available to support staff to provide appropriate care. Short term care plans were written when people developed an acute condition such as a urinary infection.

People's religious, cultural and personal diversity was recognised and reflected in the care plans. Staff knew how to respond to individual needs and gave examples of meeting these such as providing preferred cultural meals and respecting people's faith or beliefs. The manager shared an example where they had provided a large print bible for one person whose faith was very important to them.

People were involved in reviewing their care along with their relatives and other professionals as necessary. The care plans were reviewed at least monthly or more frequently where a person's needs had changed. For example, following an illness, an incident or accident, a medicines review or a period of hospitalisation. The manager was in the process of reintroducing a named key worker system so that each person had a dedicated member of staff to support the process. Key worker responsibilities had also been updated. Review meetings were held every six months to evaluate people's care and support needs and involved people's family, care managers and other representatives.

Staff completed daily records which reflected people's day to day experiences and gave a good overview of their health and wellbeing and any other significant issues. Monitoring sheets for weights, food intake and positional changes were maintained for people as necessary. Staff shared information at each shift change to keep up to date with any changes concerning people's care and support.

A co-ordinator had recently been employed to provide activities at Morven House. Our discussion with the activities coordinator showed their understanding of the importance of activities to promote people's well-

being and avoid social isolation. This included providing one-to-one activities where people were reluctant to engage in a group setting. The coordinator told us they were trying out different activities to find out what people liked and planned to introduce outings and events outside the service. They had also begun consulting with people and their relatives to find out what hobbies and interests they had.

We received positive feedback about the activities provided. One person said, "I like getting involved in anything that's going on, right now I'm doing these arts and crafts. I like reading the newspaper when I have time and they bring it to me" Another person told us how they had enjoyed a recent visit from a pet therapy person. A relative told us, "(Activity coordinator) is lovely, there's something going on every day. My mum gets together with these two ladies and have a cup of tea and a laugh. I take mum out a lot too." Another relative said, "Things will be improving soon as (the activity coordinator) has started here, she's got the ball rolling already."

During our inspection we observed the activities coordinator was busy and engaged with people. In the lounge there were soft toys and dolls for people to touch and hold. We saw one person enjoyed helping fold laundry items. A balloon game and clay activity was organised. People who chose not to participate enjoyed watching what was going on and chatted happily to each other or with staff. The activities coordinator told us they planned to introduce further activities that would be meaningful for people living with dementia.

People and relatives told us they felt comfortable to raise a complaint and knew how to do so. One person said, "I certainly do, I haven't made one officially." Another person told us they had not needed to make a complaint saying, "I'll let them know if I did." A relative told us, "I'd go straight to the top, I wouldn't muck about. If I wasn't happy I would take her out of here, if I thought she was being neglected or anything."

A complaints procedure and suggestion box was available in the entrance area at Morven House. One relative told us they had raised a concern recently and felt confident the matter would be resolved. Another relative said they had made a complaint in the past and this was promptly dealt with. We looked at the complaints' records and found that complaints were investigated appropriately and in a timely manner.

Family meetings had recently started and enabled relatives to put forward their views as well as hear about developments in the service. At the latest meeting people were encouraged to give their feedback about the catering, activities and keyworkers. The management team shared information about changes and improvements in the home including new staff appointments and ongoing renovation in the premises.

Good

Is the service well-led?

Our findings

As part of the provider's conditions of registration, the service is required to have a registered manager in post. There had been a change in leadership since the last inspection and the new manager had started at the service in November 2016. The manager confirmed they were in the process of submitting their application to register with CQC. An external consultant with experience in the care sector was also supporting the manager. They had been appointed by the provider and had knowledge of the service due to previous involvement.

People and their relatives told us they were satisfied with how the service was being run. Comments included, "It's not too bad because they've changed. They're trying" and "It's alright I suppose. So far so good." A relative said, "It's getting there, there's been vast improvement since (the manager) has come on." Another visitor told us, "I think it is now yes, the only criticism is the repeated changes in management." Two relatives spoke positively about improvements in the environment.

Morven House maintained an open door policy and feedback comments from relatives supported this. They included, "They're open and flexible, that office door is never shut" and "There's always someone you can talk to, they're not hiding if you know what I mean. I've got no worries, I can phone up and they answer any questions I have." We observed interactions between people, their relatives and visitors, the staff and management were friendly and welcoming. One relative described the manager as "very pleasant; asks if everything is ok."

Some people and relatives told us they weren't informed about the change in management and felt that this aspect of communication could be improved. Their comments included, "Not really, you just find out as and when things happen", "Nobody told me when they changed managers" and "No I hadn't heard when the old manager left, I only found out when there was a new manager."

The provider and management were aware of this and had set up further systems for improving lines of communication. Relatives meetings had recently started and questionnaires were offered to people and their relatives. The results from the latest survey in November 2016 were displayed in the reception area and shared as "You said"," We did." The plan outlined actions the service had taken to address any issues raised. This included recruiting an activities coordinator, new care staff as well as uniforms and identity badges for staff.

The manager told us about the work they had been doing to improve the quality of the service. This had included reviewing staff training and supervision and undertaking more audits. We saw that people's care plans were reviewed for accuracy every month and additional competency checks of staff practice had recently started. The manager told us there were plans to assign staff as champions in areas such as dignity, safeguarding and dementia care.

Methods for monitoring and assessing the quality of service had been strengthened. The provider had appointed an external consultant who assisted the provider to develop an action plan following our last

inspection. The plan identified where improvements were needed, the actions to be undertaken, by who and by when. We saw that progress was kept under review and actions were monitored until completion. The most recent plan evidenced improvements in areas such as cleanliness, care planning and medicines management. Due to the management changes there were a few outstanding actions with revised timescales to address these. For example, some staff needed to update their infection control training.

We noted that the manager's monthly audit reports followed a tick box approach and did not always capture people's views and experience of the service. We discussed the inspection approach and fundamental standards set by the Care Quality Commission to check the quality of care of people received. Management agreed to look at further ways of reporting people's experience of the service.

Staff had designated responsibilities to help monitor the quality of service in the home. These included weekly and monthly audits on health and safety, cleanliness, care plans and medicines. These audits and checks enabled the service to evaluate what was working well and what needed improving in the home. When improvements were needed, action plans were developed.

All accidents and incidents were checked monthly. This enabled the manager to identify any patterns or trends and recognise where people's general health and mobility was improving or deteriorating. There was evidence that learning from incidents took place and changes were implemented to minimise the risks of a re-occurrence. For example, when a person lost weight, experienced more falls or acquired a pressure sore, appropriate professionals were involved.

Staff meetings took place every month and the minutes of these meetings were shared with staff for discussion and learning. In a recent meeting staff were reminded about sitting with people at mealtimes, keyworking responsibilities, supervision meetings and some aspects of record keeping around people's care. Staff were encouraged to share their views about working at Morven House and had completed a recent survey. Outcomes were positive with a plan to improve team building and provide staff with further training.

The service worked in partnership with other professionals to help ensure people received the most appropriate support to meet their needs. Records showed how the service engaged with other agencies and specialists to respond to people's care needs and to maintain people's safety and welfare. We found that safeguarding concerns, incidents and accidents were managed effectively. The provider used learning these to make changes and improvements to the service.

Following our inspection the consultant manager told us that the environmental health officer had visited later in the month and improved the home's food safety rating from one star to four stars.

Registered persons are required by law to notify CQC of certain changes, events or incidents that affect a person's care and welfare. For example, when a death or injury to a person occurred. Before our inspection we checked the records we held about the service. We found that the manager had notified us appropriately of any reportable events and provided additional information promptly when requested.