Compleat Care (UK) Limited

Five Bells Residential Care Home

Inspection report

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Date of inspection visit:
14 September 2016

Date of publication:
06 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 September 2016 and was unannounced.

We previously inspected the home on 21 December 2015. At that inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have enough staff to meet people's needs, infection control processes were inadequate, the environment was not adequately maintained and the provider was not identifying risks to the quality of care people received.

The service is located in an old building in the centre of the village of Folkingham, Lincolnshire. Accommodation is provided within the main building, in apartments in the garden and in flats adjacent to the home. The home is registered to provide personal care for a maximum of 28 older people or people living with a dementia. There were 19 people living at the home when we inspected.

At the time of our 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 home is run.

At this inspection we found that the provider, registered manager and deputy manager had made significant improvements to the care people received. The care was meeting the requirements of the legislation. However we found that more improvements were needed before people could be certain of receiving good quality care.

Care plans did not fully record the care that people needed. Changes in their care and information about their daily lives was recorded in a way that would not always be accessible for staff and healthcare professionals when they reviewed people's needs. In addition, risk assessments did not contain all the information staff needed to ensure that the care they provided protected people from harm. Risk monitoring forms did not always support staff to recognise issues.

We also saw that mental capacity assessments had not been completed when decisions had been for people who were unable to make choices for themselves and that while decision had been taken in people's best interests it was not clear why the decision had been made and who had been involved in making the decision.

While there had been some improvement in the systems to monitor the quality of service people, we saw that more work was needed to ensure that the systems were fully embedded into the management of the home. This meant that while some issues were identified and rectified we could not be confident that this was always the case. People were not always sure on how to raise complaints and verbal complaints had not been recorded. Furthermore the provider had not taken any action to gather the views of people living at

the home about the quality of care they received.

The staffing levels had improved and that there were now enough staff to meet people's needs. In addition, staff had received appropriate training and support to enable them to care for people safely and to raise concerns with the management team if they were worried about the standard of care people were receiving.

Staff spoke with people in a kind and caring manner and responded appropriately to verbal and non-verbal requests for support. Staff respected people's privacy and dignity by speaking to them quietly when discussing personal care and by protecting people's dignity when they were unable to do so for themselves. People's end of life wishes were known and recorded.

Staff monitored people to ensure that they were happy and made sure that people were always able to access hot and cold drinks. People were happy with the meals provided and were able to personalise them to their individual tastes. People received their medicines in a timely manner and staff supported people to understand what medicine they were taking and why. Staff ensured people had access to healthcare professionals for planned healthcare and when they were unwell.

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.

Staff had an understanding of the risks to people while receiving care. However, care plan did not fully describe the actions needed to keep people safe.

There was enough staff available to meet people's needs.

Medicines were administered to people safely and accurate records were kept.

Staff knew how to keep people safe and how to raise concerns about people's safety.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were offering people choices when providing care, however capacity assessments had not always been completed and records did not show if decisions had been made in people's best interest.

Staff had received training and supervisions which supported them to provide safe effective care for people.

People were supported to stay maintain a healthy weight and hot and cold drinks were offered to people regularly throughout the day.

People were able to access healthcare professionals for planned care and when they were unwell.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and understood people's individual needs and methods of communication.

People's privacy and dignity were supported.

People wishes at the end of their lives were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs were not fully recorded in their care plan and the care they received was not fully documented in their daily records.

Staff were responsive to people's needs and took action when people were unwell. There was a good handover when shifts changed to ensure people received consistent care.

People were not always sure on how to raise a complaint and verbal complaints were not recorded or investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had made some improvement to the systems in place to monitor the quality of care people received. However, more work was needed to ensure audits were regularly reviewed.

Staff had a positive culture and felt supported by the management team.

The provider had not gathered the views of people using the service.

Five Bells Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 home under the Care Act 2014.

This inspection took place on 14 September 2016 and was unannounced. The inspection team consisted of an inspector, an inspection manager 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 home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with five people who lived at the home and spent time observing care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with spoke with the nominated individual, the deputy manager, two senior care workers and three care workers.

We looked at six care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 21 December 2015 we found the infection control processes in the home did not keep people safe from the risk of infection. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Following the inspection the provider sent us an action plan telling us they would provide staff with further training on infection control and review the audits used to monitor infection control processes in the home. Equipment needed to maintain infection control standards would be monitored and replaced when needed.

At our inspection on 14 September 2016 we found the provider was meeting the requirements of the regulation. Staff had received further training and were now able to work in a fashion which minimised the risks of infection for people. We saw the senior member of staff completing the medicine round followed infection control processes which included washing their hands and using appropriate protective equipment when needed.

In addition, the registered manager and deputy manager had liaised with the local authority infection control leads and completed the audit used to monitor infection control in the home. We saw that the audit was now effective and was regularly identifying issues in the home. Monthly action plans showed that effective action was being taken each month and was monitored by the deputy manager. An example of this was a sign at the entrance which requested that people wash their hands when entering the home. However, there was no signage showing people where the most appropriate place to do this was. The deputy manager had completed an infection control audit the day before our inspection and identified that this was an issue and the action plan showed they would replace the sign and provide appropriate anti-bacterial hand gel for people to use. One person living at the home had been identified as having an infection. Therefore specific infection control processes were required and we saw that these were in place.

The laundry environment had been reviewed and systems had been put in place in the laundry to better manage the risk of infection control. In addition, some of the clutter had been removed from the laundry meaning more room was available to better separate the clean and dirty flows.

While the provider had made good progress with the infection control processes in the home we saw there were still some areas which needed attention. An example of this was some toilets which still had large deposits of lime scale which increased the risk of infection as it prevented through cleaning. We also saw in the upstairs toilet that it had a flip top bin not a pedal operated one. This meant that people would have to touch the bin to use it which increased the risk of infection The hand towels were on the toilet cistern where they might be splashed when the toilet was flushed and so increase the risk of infection.

At our inspection on 21 December 2015 we found there was not always enough staff to meet people's needs. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

Following the inspection the provider sent us an action plan telling us they would review the needs of the people living at the home then ensure that there were enough staff available to meet those needs. They told us they would review the night time risks and audit the length of time it took to answer call bells.

At our inspection on 14 September 2016 we found the provider was meeting the requirements of the regulation. We found the registered manager had completed a staffing tool to help them identify the numbers of staff needed to provide safe care for people. The deputy manager told us that since our last inspection staffing levels had increased with four care staff during the day and two or three at night. The provider had agreed to increase the night staffing levels to three every night when more people were living at the home.

There was a calm atmosphere in the home and even though the staff were busy with various tasks it was easy to find a member of staff when need. Staff had time to engage and chat with people as they went about their work. There was a call bell system in place and throughout the day it was answered promptly when people rang for support. One person who lived at the home told us, "In the morning I get ready and ring my bell for someone to take me to breakfast in my wheelchair." They said that their bell was usually responded to quite quickly but would depend on how busy the carers were in the home. They went on to say that any delays had not caused them any problems.

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment at the home. However, when we checked the files for two members of staff we saw that there were some checks missing. For example, for one member of staff we could only find one reference instead of the required two and for the second member of staff there was no disclosure and barring check recorded on their file. We raised these concerns with the deputy manager who told us they would ensure the checks had been completed.

Care plans contained some information regarding risks to people's health and safety. For example, there were risk assessments in place for malnutrition and pressure damage. Where needed appropriate equipment was in place to support people. An example of this was moving and handing equipment such as hoists. We saw one person being assisted to move using equipment. We saw that the staff gave the person clear instructions and carried out the move safely. However, there was not always a corresponding care plan to show how care could help keep the person healthy and well. For example, we saw one person who was at risk of developing pressure ulcers had appropriate equipment in place,but there was no recording to show if they needed extra care, such as regular turns.

We saw that there were personal evacuation plans in place to support staff and the emergency services in an emergency. They include information on people ability to understand the emergency and their mobility and how many staff would be needed to support them. During our visit there was a fire alarm. We saw how people were evacuated from the building and were supported to remain calm.

A staff member we spoke with told us told us that they were aware of the whistle-blowing and safeguarding policies that were in place. These policies supported staff to raise concerns if they felt that people might be at risk of harm. They told us that they could access all the information that they needed to raise a concerns on a noticeboard. They were able to describe a situation when they had spotted an error and they were able to raise this with the registered manager. This resulted in an investigation and everyone was retrained to ensure that the risk of the error recurring was minimised. This also meant that the staff member could be confident that concerns were addressed. Staff also used handovers to share concerns about any risks to people as well as sharing risks with team leaders.

People told us that staff supported them to take their medicines at regular intervals. One person said, "[A member of staff] brings them in a plastic cup with some water and always stays with me while I take them." Another person told us that they had never had a problem with their medicine and a third person said that they were offered their medicine at the same time each day.

We spent time watching a senior member of staff administering medicines. They supported people to take their medicine at their own speed. They explained to us that one person who did not have capacity would often spit medicine out or take a long while to swallow. They told us that they would leave the person until the end of the medicine round as they were more receptive after they had finished their breakfast. We saw the member of staff approached this person in a calm manner and engaged them in conversation before offering them their medicines. We saw that the calm approach worked and the person was offered and took their tables one at a time. One of the medicines was a liquid and the member of staff showed they understood why the person did not like taking it and helped them by saying, "I know you don't like the taste, I'll get you a drink when you are done, what would you like?"

Staff showed an understanding of people's needs around medicines prescribed to be taken as required. For example, they knew which people could verbalise their need for pain relief and which people needed monitoring for signs that they might be in pain.

We checked the medicine administration records and could see that they had been fully completed. Records also recorded when people had refused to take their medicines and there were systems in place to dispose of medicines safely. For example, on the morning of our inspection staff had found a tablet on the floor of a person's room. It was bagged, labelled and put with other medicine for disposal. Where people needed to take their medicine son certain days of the week the medicines administration charts were marked so that it was clear for staff when they should be taken. Where people wanted to take homely remedies such as cough mixture the appropriate permissions from healthcare professionals were in place.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 21 December 2015 we found environmental risks to people had not been properly identified. This was a breach of Regulation 15(1)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 premises and equipment.

Following the inspection the provider sent us an action plan telling us they would complete an environmental audit and develop an action plan for any areas which needed improvement.

At our inspection on 14 September 2016 we found the provider was meeting the requirements of the regulation. We walked around the home and could see that areas of concern which we had identified at our previous inspection had been actioned. For example, one person had a new bathroom light and another one had their room decorated so that the repair to a wall was not so obvious.

We did identify that there were still an unpleasant smell in the living room, dining room and corridor. However, the deputy manager told us this was from the carpet and provided evidence that the provider had made arrangements for new carpets in the lounge and dining room. These were scheduled to be fitted the week of the 19 September 2016. In addition, new chairs had been ordered to replace those in the home which were not able to be cleaned effectively. The deputy manager told us that the provider had agreed to purchase anything they had identified as being needed.

A staff member told us that they had received in-house training such as medicines management to support them in their role. They said they had undertaken a comprehensive training package before starting and were also able to request further training. They told us, "I'm very impressed with how they have helped me." We were told that all new staff members, no matter how qualified, had to complete The Care Certificate, a nationally recognised award. The training had been designed to be relevant to the home and the needs of the people who live there. Staff told us that they had formal supervision every six months but that there was an open door policy that enabled staff to address their needs and concerns with the management. An example of this was one member of staff had asked for more training about Deprivation of Liberty Safeguards and this had been arranged.

Training was cascaded through a policy of 'see one, do one, teach one' and a staff member told us that they shadowed more experienced staff to learn from them when they started at the home. They were given quizzes to test their knowledge around subjects such as fluid intake and dementia. Another member of staff told us that if there was something they were unsure of they would always be able to raise it with a team leader. A staff member who had been at the home for a few years told us that there was refresher training available and that this was helpful.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with a staff member who able to describe the importance people being able to consent to their care and treatment. They understood how people with verbal communication difficulties might consent to or decline treatment through other means such as their body language. They knew what they would do if people declined care. For example, they would respect their decision and then offer the care again at a later time, or perhaps a different member of staff might offer the care. The staff member we spoke with understood that sometimes decisions might be made in people's best interests if they were unable to understand the decision themselves and that sometimes there might be a Lasting Power of Attorney in place.

A Lasting Power of Attorney is when people make formal arrangements for family member or friends to make decisions on their behalf when they were not longer able to make the decision themselves. We saw where they were in place that this was recorded in the person's care plan. However, copies of the legal paperwork confirming this were not always available. This meant that the registered manager and their staff could not be certain who had the legal authority to make decisions for a person.

However, the care plans did not always contain documentation to demonstrate that the provider was compliant with the Mental Capacity Act. For example, one person had a pressure mat beside their bed. This would alert staff if they got out of bed. There was a note on file to say that the person could not understand the decision to use the pressure but there was no note of the best interests decision to demonstrate how the decision to use the pressure mat had been reached. In one file there was an indication that the person had made an advance decision to refuse treatment, but it would not be located on the file. This meant that the person's end of life wishes may not be known by staff and other health care professionals.

People told us that they enjoyed the food at the home. One woman said "It's very good and well cooked." While another told us, "The food is good, the staff are very good at knowing what people like." This was confirmed by a person who told us that they did not like liver or curry and the cook would prepare them something different if they were planned on the menu.

Care plans contained appropriate information on people's ability to eat safely and what support they needed at meal times. We saw where people were unable to maintain a healthy weight they had been referred for support and some people were prescribed calorie rich drinks to help them maintain their weight. Staff knew who would need prompting with food and fluids and told us that special diets were catered for. They told us that two people needed their food pureed to enable them to eat it more easily. We spoke with a staff member who also worked in the home as a cook. They stated that a notice board in the kitchen told them who needed their diets managed as they had diabetes and they would also check people's care plans. There was a set menu for each day but people were able to have alternatives to what was on offer. The staff member knew which people needed soft or pureed diets and would try and display the food so that it was more appealing.

We saw that people always had fluids in reach. Throughout the day we saw that people had hot drinks and various cold drinks placed on tables next to them. In the lounge there was a selection of diluted squash

drinks on a side shelf and we heard members of staff offering drinks through the day. In the afternoon we saw one carer talking to people in the lounge and encouraging them to have a drink. One person told us, "If I come and sit down someone will come and say 'do you want a cup of tea?'" One person who lived in one of the apartments told us that they can ring for someone to bring them a drink but they also had a small kettle to make their own drinks. Records showed that food and fluid charts had been completed but fluid charts had not been totalled, so it was not obvious how much a person had drank each day.

A staff member told us that they had a good relationship with the local GP surgery and good support from other local agencies. Staff would contact other agencies promptly to ensure that people's needs were being met. For example, one person had a malfunction of their pressure mattress and the district nurse had been contacted the same day with a new mattress due to arrive.

One person told us that the doctor comes in once a week and more often if called to see someone. There was also an optician who visited periodically to see people. Another person told us that if they wanted to see the doctor they would tell a senior member of staff who would arrange it for them. Individual care plans included all the information needed to support people's day-to-day health needs.

Good

Is the service caring?

Our findings

People we spoke with were positive about the care they received. One person said, "They are very good and on the whole I'm treated very well." Another person told us, "The staff are very good, they like caring for us and giving us the opportunity to do what we want." A third person explained, "The staff are very accommodating, if you need anything they'll get it for you." They added "Some are exceptional, the ones who have been here the longest and know you the best."

Staff were caring and respectful towards the people who lived at the home. One person stated that they wanted to get up and the staff member knew them well enough to recognise that this might mean they needed support to get to the toilet. The staff member checked in a low tone that respected the person's privacy and then, while they supported them out of the room, took the opportunity to chat with the person and compliment them on the clothes they were wearing. One person derived a lot of comfort from a toy dog which they had named. We observed a staff member inviting them and their dog to sit outside in the sunshine with them. The staff member inhabited that person's reality, calling the dog by its name and chatting with them about the garden. We saw how happy and relaxed the person was, while undertaking this activity.

We saw that the menu was displayed on the lunch tables. However, the writing was small and there were no pictures so some people living at the home might not have been able to access the information which may impact on their ability to make choices. At lunchtime we saw that the tables were nicely set and had condiments for people to help themselves. Each person was given a plate which the carer explained were quite warm and them were able to personalise their meal as they were offered potatoes and vegetables individually and so could choose what they wanted. We saw that a member of staff gently encouraged one person to eat their meal. Another member of staff suggested to a person that they might manage better with a spoon which she proceeded to do.

We saw that two people struggled to not spill food down themselves and were only offered aprons after that had eaten half their meal. At this time the member of staff also offered one of the people a pillow under their arm to enable them to reach their food more easily. However, this support had not been offered to the person at the start of their meal.

We saw that people had been supported to personalise their bedrooms and some people had chosen to bring their own bedding into the home.

Staff respected the privacy and dignity of people who lived at the home. We saw that staff were observant and when a person stood up, a staff member was on hand to support them with straightening their clothing. At lunchtime we saw a member of staff offer a person their medicine. The person asked what it was for and the member of staff whispered the answer in their ear so that other people could not hear.

One person was poorly and was moving towards the end of their life. The staff were monitoring them hourly to ensure that they were settled and comfortable. We saw that every effort was being made to keep the

person happy. For example, the day previous to our inspection they had requested a fast food meal and this had been obtained for them.

It was clearly recorded where people had expressed a choice not to have resuscitation attempted at the end of their life. The appropriate paperwork was in place to support the home to communicate their wishes to other health professionals who might be involved in their care. We saw one person had made the decision to donate their body to medical research after their death. There were clear instructions in their care plan on the steps staff needed to take to make this happen.

Requires Improvement

Is the service responsive?

Our findings

When people moved into the home they had their needs assessed and a care plan was developed to help staff provide safe effective care. Staff we spoke with were able to tell us about the care that people needed. For example, they knew who needed to be helped to move regularly and who needed equipment to support them to move.

Although care plans were person-centred, they were not always up to date. We saw that one person had a Do Not Resuscitate form on their file which meant that in the event they suffered a cardiac arrest, emergency services would not perform resuscitation. However, this had not been reviewed for nearly two years and although the responsibility to complete the form was usually the GPs, the provider should ensure that these were regularly reviewed as people's circumstances might change. We saw another example which described how someone who was living with dementia liked to share meals and time in the lounge with their spouse. However, their spouse had since passed away and there was no advice to carers about how to support the person in the absence of their spouse.

The daily notes did not reflect the care needed by people and there was poor recording of visits from healthcare professionals in people's notes. We found that a lot of information which should have been available in people's care plans was noted in the handover book in the daily notes. The deputy manager could not assure us that this information was also recorded in the care plan so there was a risk that important information about a person's care could be lost. Care plans had been amended but none of the changes had been dated. Therefore it was impossible to know if changes to care had been made in a timely fashion.

Staff were responsive to people's needs. We observed a staff member speaking with a person who lived at the home and during the conversation the person commented that their hearing was bad. When we sat in on the staff handover meeting we noted that the staff member remembered to report this to the team leader. One person had become very unwell and was at the end of their life. At the handover staff were given very detailed instructions on how to support the person to ensure that they were well cared for and as comfortable as possible. Staff were also told about a person who might be feeling agitated as a result of the earlier fire alarm so the new staff on shift knew to pay special attention to the person.

We saw that where people had diabetes there were systems in place to ensure that appropriate monitoring took place in a timely manner. In addition, the monitoring results were transferred in to the handover book so that staff at the start of each shift had the information available to them.

Staff were monitoring people's health and taking appropriate action when needed. For example, one member of staff explained that a person's eczema had flared up and they were recording the extent of the eczema to pass the information over to the GP to get some more treatment for them.

Where people used a frame to help them walk we saw that they were positioned near them in readiness for walking around. Staff assisted some people to walk using their frames offering reassurance and guidance as

to where to go. However, we did see one person being mobilised in a wheelchair that only had one footplate. The member of staff supporting the person placed both their feet on that one footplate. There was a risk that the person's feet might come off the footplate and this might cause the person an injury.

One member of staff told us that since our last inspection there were more activities offered to people and that activities were now available three times a week. One person told us that there were no planned outside activities for people but that entertainment was provided every month. They said a singer visited the home and this was something that they enjoyed. During the inspection staff asked people if they would like to go for a walk to see the animals in a nearby field.

Where people had the ability, they had chosen how to occupy themselves. In the lounge there was a large television on the wall with people's chairs positioned so that they could see it. One person told us, "I'm an addict as far as the telly is concerned." They also showed us that they were in charge of the remote control. One person was busy in the dining room with their own arts and crafts they told us they usually did this every day. Another person was knitting a scarf in the lounge. They told us, "I like knitting, sewing and reading books". However, people who were unable to make decisions on how to occupy themselves were not supported to be as active or to engage in the activities they might have done at their own home. While there were some people who had memory problems, the provider had not positively engaged with them. For example, there was little evidence of any memorabilia and sensory items around that could help to engage with people.

People told us that the management had not been stable so that were not always clear on who they should complain to and there was no information available on display in the home to tell people how they could raise a concern. However, people were happy to raise concerns with which ever member of staff was available. One person said they had no complaints and added, "If I was worried I'd speak to the senior staff." Whilst another said they would speak to the registered manager if they were worried about anything.

We looked at the complaints file and saw that there had been no formal complaints recorded since our last inspection. However, one person said that there were several problems with the laundry which had worsened over the last six months. They were aware that there was not a specific worker to deal with this so the laundry tended to pile up and clothes disappeared or went to the wrong people. While they had not made a formal complaint they said that they had raised this with staff. this showed that the registered manager was not recording or investigating verbal complaints made to them

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 21 December 2015 we found the systems in place to monitor the care people received and the environment were ineffective. This was a breach of Regulation 17Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

Following the inspection the provider sent us an action plan telling us they would review their audit systems and ensure that action was taken to keep the home providing good quality care.

At our inspection on 14 September 2016 we found the provider was meeting the requirements of the regulation. We saw that more audits that were being undertaken to monitor the quality of the care provided. For example, we saw infection control, hand hygiene audits and a mattress audit had been completed. We saw where issues were identified appropriate action had been taken. However, some of these audits had not been regularly completed to ensure that improvements were maintained.

We saw that the provider had not displayed their current rating on their website. Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 applies to all providers when they have received a CQC rating. Providers must ensure that their ratings are displayed conspicuously and legibly at each location delivering a regulated service and on their website. This should be done within 21 calendar days of the report being published on the CQC website.

The registered manager had been away from the home for periods of time and the new deputy manager had stepped in to support the staff and to ensure that people were provided with a high quality of care. The deputy manager had a clear understanding of the work that was need to develop a more robust quality assurance system which covered all aspects of the care. The new deputy manager had been in post for two months and had a nationally recognised qualification which showed they had received training in the skills needed to drive improvements in the home.

There had been a positive change in staff culture since our previous inspection and staff told us that they were able to approach the deputy manager and registered manager for support. Both the managers had been open with staff around the improvements needed. One member of staff told us the managers and the team supported and helped each other when on shift. They told us that both the registered manager and the deputy manager would work a shift and so had a good understanding of people's needs. Staff told us they were given the skills needed to further their career while working at the home and they told us that this made them feel appreciated.

While improvement had been made the provider had not yet gathered feedback from the people living at the home and their relatives. One person told us that there used to be residents meetings at the home but they couldn't remember any happening for a long while. They said that people were occasionally given questionnaires about the home but didn't think there had been one for a year.

The provider was supporting staff to engage with external agencies to help them improve the quality of care

they provided and to ensure that they were working to the latest good practice guidelines. An example of this was the deputy manager and a senior member of staff attended an infection control meeting run by the council to support homes to achieve and maintain appropriate infection control standards. During the meeting they had discussed the condition sepsis. When they returned to the home they reviewed one of their people as they were concerned that they had sepsis. They contacted the GP and asked them to review the person. The GP confirmed sepsis and started the person on appropriate treatment.