Reason Care Limited

Elm Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 23 June 2016.

Elm Lodge Care Home provides accommodation and personal care for up to 40 older people living with dementia. At the time of our visit, there were 32 people living at the service. There was a registered manager at this service. 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 last inspection of the service in July 2015 we found the provider's arrangements to obtain consent for people's care, for staffing and cleanliness at the service and for effective governance were not sufficient to ensure that people received safe and effective care. These were respective breaches of Regulations 11, 18, 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breaches. At this inspection, we found that improvements were made were sufficient to rectify the breaches but further improvements were needed in the quality of people's care.

Significant improvements were made to the provider's arrangements for the management and oversight of the service and to check the quality and safety of people's care. Additional improvements were planned from this which helped to protect people against the risk of unsafe or ineffective care and treatment. Further improvements were needed in relation to the quality, approach and timeliness of people's care and to demonstrate the provider's ability to sustain continuous service improvement.

People, relatives and relevant external authorities had increased confidence in the management of the service. The registered manager told us about important events that happened at the service when required. Staff generally understood their role and responsibilities for people's care. They knew how and were confident to report any significant incidents or changes relating to people's health or safety needs. Improvements to ensure a more thorough and consistent approach to staff supervision arrangements were in progress.

Staffing arrangements were mostly sufficient to provide people's care. However, senior staff did not always have time to supervise staff and monitor people's care, which meant that people did not always receive timely care and support. The provider's action to recruit additional senior care and provide additional care staff at busier times of the day, helped to mitigate the risk to people's safety from insufficient staffing arrangements.

The home was generally kept clean and odour free. Systems improvements had been made for infection control, prevention and cleanliness at the service, but staff did not always follow safe practice to ensure this. Further improvements were identified through the provider's revised management checks in relation to

cleaning records, staff practice and use of personal protective equipment. This helped to protect people from the risk of acquiring a health associated infection.

The service ensured people's rights and best interests by working within the principles of the Mental Capacity Act (MCA) to obtain people's consent or appropriate authorisation for their care.

The provider's safeguarding and staff recruitment procedures helped to protect people from the risk of harm and abuse. Information from visiting professionals and the provider showed that staff did not always follow people's care plans to support people safely when they provided care. The provider's action plan to address this with staff helped to protect people from unsafe care.

People's medicines were safely managed but not consistently recorded. Improvements were identified and planned from the provider's management checks to ensure accurate record keeping for people's medicines.

Emergency planning, care equipment and environmental servicing and maintenance arrangements helped to ensure people's safety at the service. The local fire authority's report of their visit to the service in June 2016 showed that satisfactory fire safety improvements had been maintained at the service.

People were supported to maintain and improve their health and nutrition. People were supported to access external health professionals when they needed to and staff followed their instructions for people's care.

People were positive about the food provided; they enjoyed their meals and were appropriately supported to eat and drink sufficient amounts. The registered manager agreed measures to develop catering staffs knowledge of specialist diets to improve and enhance people's dietary experience.

Staff were mostly trained and supported to perform their role and responsibilities. Additional bespoke staff training was identified and planned to improve and enhance people's dementia care experience and positive behaviour support. The registered provider agreed to review care apprentices' support arrangements against recognised government guidelines for this.

People were appreciative of staff who were caring, respectful and promoted people's dignity, privacy and rights when they provided care. Staff often ensured people's independence, known wishes and choices for their care and they supported people's contact and appropriate involvement with family, friends and others who were important to them.

People's care was not always consistently provided in a timely, observant or personalised manner. People were not consistently supported to engage in meaningful social and recreational activities and participate in home life at the service.

Some improvements were made to the décor and environment to aid people's mood, orientation and recognition around the service; but these were not fully considered and did not consistently support people in this way.

People were informed and knew how to make a complaint or raise any concerns they may have about the service. Complaints were recorded and accounted for, but people were not always satisfied with the way their complaints were handled and or responded to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People felt safe at the service and relatives felt they were safe there. Improvements were made to the safety of people's care and staffing arrangements. Further improvements were needed and planned to ensure consistent staff deployment and timeliness of people's care.

The provider's emergency, safeguarding and staff recruitment procedures helped to protect people from the risk of harm or abuse and ensure their safety.

Is the service effective?

Good

The service was effective.

Staff sought people's consent or appropriate authorisation for their care. People were supported to maintain and improve their health and nutrition in consultation with external health professionals when required. Additional improvements were planned to enhance people's nutritional experience.

Staff were mostly trained and supported to perform their role and responsibilities. Additional bespoke training to enhance people's dementia care experience and to review the support arrangements for care apprentices at the services were confirmed.
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Is the service caring?

Good

The service was caring.

People received care from staff who were caring and helpful.

People and their relatives were appropriately involved, informed and supported to agree care provision and maintain their relationships with each other.

Staff understood and promoted people's rights, choices and known wishes relating to their care

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Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff mostly understood and often promoted people's preferred daily living routines and lifestyle preferences. Staff were not always responsive when people needed assistance and their care was not consistently delivered in a timely, observant or personalised manner.

People were supported to participate in home life and engage with others, often in a way that was meaningful to them, but this was not consistently achieved.

Aids, adjustments and adaptations were not fully considered or provided to ensure people's orientation and recognition of their environment.

People and relatives were informed and knew how to make a complaint but were not always satisfied with the provider's handling or response to this.

Is the service well-led?

Requires Improvement

The service was not wholly well-led.

Improved governance and management systems helped to ensure the safety and effectiveness of people's care. However, they did not fully account for ongoing quality improvements needed or demonstrate the provider's ability to sustain continuous service improvement.

People, relatives and relevant external authorities had increased but not full confidence in the day to day management of the service. The registered manager told us about important events that happened there when required.

Staff generally understood their role and responsibilities for people's care. Improvements to staff supervision arrangements were in progress.

Elm Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection visit 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.

We visited Elm Lodge Care Home on 23 June 2016. Our visit was unannounced and conducted by two inspectors. There were 32 people living at the service receiving personal care.

Before this inspection we looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law. For example, a notification of a person's death. We spoke with local authority care commissioners and also Healthwatch Derbyshire who are an independent organisation that represent people who use health and social care services.

Before this inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. The completed PIR was returned to us.

During our inspection we spoke with ten people who lived at the service and four people's relatives. We also spoke with the registered manager, registered provider and seven care staff, including 1 senior, three care staff and three care apprentices. We also spoke with four domestic staff, which included a cook, two kitchen assistants and a cleaner. We observed how staff provided people's care and support in communal areas and we looked at three people's care records and other records relating to how the home was managed. For example, medicines records, staff rotas, training records and checks of quality and safety. As many people were living with dementia at the service we carried out Short Observational Framework Observations (SOFI). This is a way of helping us to understand the care experiences of people who are not able to talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service in July 2015 we found the provider's arrangements for staffing and cleanliness at the service, were not sufficient to ensure that people received safe care. These were respective breaches of Regulations 18 and 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breaches. At this inspection, we found that improvements had been made to rectify the breaches, but that further improvements were needed.

People told us there were enough staff to meet their needs and they usually did not have to wait too long for assistance. One person told us "There's always someone around." Staff told us that staffing numbers were mostly adequate to meet people's needs, but that staff skill mix did not always ensure that people's care could be delivered in a timely manner. They explained that when this occurred, people sometimes had to wait for assistance. This meant that staff felt they were often rushed to provide people's care and not always able to spend time with people to support them at their own pace. They also said that when this occurred it sometimes had a negative impact on people's general wellbeing. For example, because of their dementia, some people could easily become frustrated or upset when they were rushed because they didn't understand what was happening.

We saw that the provider used a staffing tool to help them calculate the staffing hours needed to support people's care needs. Staffing rotas showed there were there were mostly at least one senior and two care staff providing people's care on each floor of the home throughout the day. An activities care co-ordinator and the registered manager worked Monday to Friday along with catering, domestic and administrative services staff. There were also care apprentices who were provided daily and four care apprentices were undertaking work supervised work placements at the home via a local college to support their health and social care certificate studies.

We found that staffing arrangements did not always ensure appropriate levels of supervision for care staff including apprentices. For example, one of the care apprentices had recently commenced their placement at the service in April 2016, which meant they needed to be fully supervised by senior care staff. However, there was only one senior care staff member working across the service throughout the day; to supervise all of the care and apprentice staff, co-ordinate people's care and give their medicines to them. The senior care staff member felt and we observed; that they were rushed and unable to consistently fulfil their role and responsibilities.

We discussed our findings with the registered manager, who told us about their action to address this. They advised that following recent staff changes, two senior care staff had been employed, who were taking previously planned and honoured leave at the time of this inspection. The registered manager also told us that additional care staff had been rostered to support people's care at busier times of the day. For example, at mealtimes, which we observed. We also saw that care staff cover was sourced for the afternoon shift during visit, following a notified care staff absence. This helped to mitigate the risk of people receiving unsafe care from insufficient staffing arrangements.

People receiving care felt the home was kept clean and odour free. We found that some improvements had been made since our last inspection for infection control, prevention and cleanliness at the service. Information we received before our inspection from the local authority from their recent contract monitoring visits at the service also showed this. For example, general levels of environmental cleanliness and repair had improved and toilets, bathrooms and communal areas were clean and odour free. We also observed that staff used personal protective equipment (PPE), such as disposable gloves and aprons, when they provided care or handled waste and soiled personal items, such clothing. However, three visiting professionals told us they had witnessed recent occasions when staff had not worn appropriate PPE when required.

We spoke with the registered manager about this, who told us they had recently revised their management checks to monitor and ensure staff used of PPE when required. We saw that records of their related checks carried out in May 2016 showed that the overall, standards of cleanliness at the service had improved since our last inspection, but that further improvements were needed. This included staff adherence to uniform and the use of PPE, bed mattress checks, waste management systems and cleaning records. An action plan was devised to address this, which included training for an infection control staff lead and ongoing monitoring arrangements. This helped to protect people from the risk of infection of acquiring a health associated infection.

People and relatives told us they felt people were safe using the service. People also said they felt safe when staff assisted them with their personal care. One person said "I definitely feel safe here." Another person told us, "Staff are good; I feel safe." During our inspection we saw that staff supported people safely. For example, when they helped people to move, to eat and drink or to take their medicines.

People were usually supported safely by staff. Feedback we received from two external visiting professionals and a written notification of abuse from the provider, told us staff did not always support people to move safely in relation to their mobility needs. For example, by not ensuring that people wore appropriate footwear, which increased risks to their safety from falls. The provider told us about the action they were taking to address this, which included staff disciplinary measures, additional staff training, instruction and regular management checks. Records showed further improvements in progress from the provider's recent management checks to ensure that risk assessments in relation to the equipment used for people's care were consistently recorded. This helped to make sure that people were safely supported when staff provided care.

Otherwise, risks to people's safety from their health condition and environment were assessed before they received care and regularly reviewed. People's care plans showed the safety measures that staff needed to take when they provided people's care to help mitigate any risks that were identified. For example, risks from falls and from skin sores because of poor mobility. This helped to make sure that people were safely supported.

Staff and care apprentices received training and understood how to recognise and report any suspected or witnessed abuse of a person receiving care at the service. People and relatives were confident to raise any concerns they may have in relation to people's safety. The provider's written procedures helped them to do this or to contact relevant external authorities concerned with protecting people's safety if they needed to.

New staff did not provide care to people at the service until full employment checks had been carried out to make sure staff were experienced and safe to provide people's care. For example, checks of staffs' most recent employment, their qualifications and experience and from the appropriate national vetting and barring scheme, known as the Disclosure and Barring Service (DBS). DBS checks are carried out to support

employers to made decisions that prospective staff are safe to work with vulnerable people who receive care and treatment at the service. This helped to protect people from the risk of harm and abuse.

People's medicines were mostly safely managed but records to show whether people's medicines had been given to them were not always properly recorded. Records kept of medicines received into the home and given to people mostly showed that they received their medicines in a safe and consistent way. However, records to show the administration of people's prescribed skin creams and lotions were not consistently maintained. The provider's recent checks of people's medicines also showed this and the registered manager told us about their action plan to address this, through staff instruction and monitoring to ensure that people's medicines records were accurately maintained.

People who were able to tell us felt they received their medicines when they needed them. We observed that staff administered and supported people to take their medicines safely and in a way that met with recognised practice. Senior care staff responsible for administering people's medicines told us they received medicines training, which included an assessment of their competency. Related records of staff training showed this for all but one person, whose training was not up to date. However, the registered manager showed us evidence of their arrangements to ensure this. The provider's medicines policy was subject to a periodic review and provided key guidance for staff to follow. This helped to make sure that people's medicines were safely managed.

Emergency plans were in place for staff to follow in the event of a foreseeable emergency, which they understood. For example, in the event of a person's sudden collapse or the procedure to follow in the event of a utilities failure. Clear information was also provided and displayed for people about key safety procedures such as in the event of a fire alarm.

Records showed the regular servicing and maintenance of equipment at the service. Following our inspection visit, Derbyshire Fire and Rescue Service advised us that the provider's improvements to fire safety arrangements at the service had been maintained since their previous visit in June 2016. This helped to ensure people's safety.

Good

Is the service effective?

Our findings

At our last inspection of the service in July 2015 we found that staff did not always understand or follow the Mental Capacity Act 2005 (MCA), to obtain people's consent or appropriate authorisation for their care. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breach. At this inspection, we found that required improvements had been made.

People were provided with personal care in line with legislation and guidance in relation to consent. 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 deprive do 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 home and hospitals are known as Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that staff received training and they understood and followed the principles of the MCA to obtain people's consent or appropriate authorisation for their care. Further bespoke training in the MCA was planned at staffs' request to help support and further their knowledge. Related records that we looked confirmed this.

We saw that staff supported people to make choices and asked for their consent before they provided care whenever people were able to give this. Many people were not always able to consent to or make important decisions about their care and treatment because of their health conditions. People's care plans showed an assessment of their mental capacity and a record of any decisions about people's care and treatment when these were made in their best interests. They also showed appropriate checks and consultation with people's relatives and relevant health professionals to support people's rights and best interests. For example, in relation to any legally appointed attorney powers that enabled relatives to act and make decisions on people's behalf; or for any advanced decisions made about people's care and treatment in the event of their sudden collapse.

Some people's freedom was being restricted in a way that was necessary to keep them safe, known as a Deprivation of Liberty Safeguard (DoLS). For example, when people were not able to independently choose whether or not to live at the home. We found the provider had followed the law by submitting applications to a relevant 'Supervisory Body' for authority to restrict people's liberty in this way when required. We found one formal authorisation had been recently issued and all relevant documentation was in place. We saw the conditions of the authorisation were met.
This meant that people were protected from the risk of receiving care without appropriate consent or authorisation.

People told us they saw a doctor or nurse when required and confirmed that their health needs were met.

One person said, "I see the doctor when I want." A relative told us they were pleased about the way their family member's health care needs were met and said they were better as a result of using the service.

People were supported to maintain and improve their health and nutrition. Staff understood people's individual health conditions and their related care needs, which were recorded in their written care plan. People's care plans showed that staff consulted with external health professionals and followed their instructions for people's care when required. This included following any changes in people's health or nutrition and their related care needs. For example, one person's care plan showed specific instructions to support their nutritional requirements following advice from a speech and language therapist, which staff understood and followed. People were also supported to access external health professionals when they needed to the purposes of routine health screening; for example, for eye and foot care.

People were supported to maintain good nutrition. People were positive about the food provided and said they enjoyed their meals. One person said "The food is good" and another person told us, "The meals are 100%." Relatives also told us they thought the meals were good and one commented that their family member was 'eating better since using the service.' People told us drinks were readily available and they were served with their preferred beverages. One person said "I get plenty of cups of tea" and another said, "There's more than enough to drink." We saw that drinks were available at all times and staff checked whether people had sufficient to drink. Staff also offered people snacks with their mid-morning and mid-afternoon drinks.

People's records showed that their nutritional status, body weight and dietary requirements were assessed before they received care and regularly reviewed. Records showed that appropriate responses were made following any changes in this. For example, one person's records showed that referrals were made to obtain advice from a community dietician.

Some people had difficulty eating and drinking because of their health condition. Where this occurred staff ensured that people were provided with the support they needed and the correct consistency of food. For example, if people had difficulty swallowing and needed pureed or fork mash-able food. Catering staff generally understood people's dietary needs and they knew how to cater for diets relating to people's medical health, such as for diabetes. However, there were no standardised recipes to follow and the cooks had not undertaken any specialist training to increase their basic knowledge of people's specialist dietary needs. For example, portion sizing, gluten free, vegan or vegetarian diets and food fortification. We saw that people were not always offered portion sizes of their choice. One person told us "There's too much for me; I keep telling them to give me less, but they don't; it puts me off then." We discussed our findings with the registered manager and they agreed to take the action required to address this to enhance people's mealtime experience.

Staff received the training they needed to perform their role and responsibilities. Staff confirmed that essential health and safety training was up to date and said they were encouraged and supported to undertake national vocational qualifications relevant to their role at the service. The Care Certificate was also introduced for new care staff to complete. This identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care.

Training records we saw showed staff had received essential health and safety training in the last twelve months as well as courses specific to people's health needs. For example, in relation to the prevention of people's skin damage from pressure due to reduced mobility. However, we did not see any records that

showed relevant training in dementia had occurred in the last twelve months, although care apprentices told us this was covered in their college course. One care staff member told us that supporting some people with behaviours that had the potential to challenge others, was "Taxing," to them, as they had not received training to support their practice in this way. All care staff we spoke with said that they did not receive any bespoke training in relation to this, which training records confirmed. We discussed our findings with the registered manager who agreed to address this. Following our inspection they sent us written confirmation and supporting evidence to show that training in dementia and positive behaviour support had been subsequently arranged for staff.

Staff received support and guidance to perform their role. One staff said "The manager's door is always open to us." Records and care staff confirmed their individual management supervision often took place. Records of management checks showed a revised supervision plan to ensure this was regularly provided.

Good

Is the service caring?

Our findings

Staff were caring and people were generally appreciative of staff, their helpfulness and friendly attitude. One person told us "The staff are marvellous" and another said "They are very helpful." People told us their privacy and dignity was respected by staff when they received care and support. They told us they were treated with respect and approached in a kind and caring way. One person said, "If I need them, they're there." Another said "They keep you private." Relatives also confirmed that people's privacy and dignity was maintained. We also saw some positive written compliments from people's relatives, which said that staff, "Show care and kindness" and were "Pleasant and welcoming".

Staff respected people's dignity, privacy and choice when they provided care. Staff we spoke with showed they understood the importance of ensuring people's rights in care. They were able to describe how they did this. For example, by closing curtains and covering people when they provided people's personal intimate care and supporting people to do as much for themselves, as they were able.

We observed that staff supported people discreetly and ensured their privacy when they provided care. For example, supporting people to take their medicines or to change their clothing. We saw that staff explained what they were going to do and always asked people before-hand. This included when they supported people to move to different areas of the home, such as from the dining room to the lounge. Staff also checked that people were comfortable before during and after they supported people to move.

Throughout our inspection, we observed staff were courteous, polite and consistently promoted people's choices. For example, people's choices about their meals and drinks or where, how and who they wished to spend their time with.

People's care plans showed their agreement to their care, where they were able to provide this. They also showed peoples' known wishes, choices and preferences for their care, which staff we spoke with understood. One person told us about one of their daily living choices that was important to them and said, "Staff are very good, they don't bother me with what they think I should be doing; they encourage me and let me do things my way."

People were supported to maintain contact with family and friends who were important to them. People's care records showed contact arrangements for friend and family who were important to them. During our inspection we spoke with some people's relatives, who told us staff always welcomed them to visit at any time to suit the person receiving care. Relatives also said they were appropriately informed and involved in people's care. This included care review meetings, which were detailed in people's care plan records, together with the involvement and contact details of family, friends and others who were important to them, such as their doctor or social worker.

Requires Improvement

Is the service responsive?

Our findings

People's care was not consistently provided in a timely or personalised way. People, relatives and professional visitors told us that people's care was often but not always individualised or provided in a timely manner.

Staff did not always observe or respond to people in a timely manner when they needed assistance. For example, at lunchtime we observed staff did not provide one person living with dementia, with the appropriate crockery or utensils to aid their recognition and support them to eat their main meal independently. However, when staff provided the person with their pudding in a bold coloured dish and spoon set against the white table cloth; the person said, "The lights gone on!" They then proceeded to eat their meal independently. The person's care plan showed they experienced difficulties communicating their needs verbally because of their health condition. After the person had finished their lunch, staff did not recognise their attempts to explain how they were feeling or respond in a timely manner to the persons' obvious need to use the toilet until it was too late.

Care staff told us they tried to be responsive to people's needs. We observed many instances during our inspection when staff were responsive and supported people in a timely manner when they needed assistance. For example, supporting people to eat and drink or to move. One care staff member described how they supported one person living with dementia who could sometimes become anxious or confused. This was because they didn't always understand what was happening around them. We saw the care staff member supported this person appropriately and in a way that was meaningful to them when this occurred. Another care staff member showed how they supported one person's independence to enable them to hold a cup more firmly and thereby drink independently. This showed that people's care was sometimes individualised and provided in a way that was timely meaningful to them.

People were supported to engage with others and participate in home life at the service but this was not always consistently achieved, personalised or timely. An information board showed that group and individual activities were organised on each floor of the home most days, although these were limited to the availability of the activities co-ordinator. For example, reminiscence, gentle physical activities, quizzes, dancing, hand manicures and massage.

During our inspection we observed that some people had no access to formal activities and there was little interaction with them from staff on an individual basis. We did observe that staff ensured one person had their newspaper to hand, which they like to read each day. This person told us they were also 'trying out' large print books from the local library. We also saw later in the afternoon that staff supported another person to move to a quiet area to speak with their relative on the telephone, which staff said the person regularly liked to do. Staff checked the person was comfortably seated and had a drink to hand when this occurred. This showed staff understood what was important to some people for their daily living arrangements.

Most people were living with dementia at the service. During our inspection we saw that efforts were made

to support people living on the first of the home, to participate, engage and interact with others in a way that was meaningful to them. We observed the activities co-ordinator facilitated three small group activities with people in communal lounge areas, which they mostly enjoyed. We saw this helped to stimulate and promote people's speech and language skills, their memory and also their recognition of objects and past times. During the sessions, we saw that people were encouraged and supported to engage in a way that was meaningful to them. For example, some people participated through observation, listening and positive facial expression, whilst others were able to do this more actively through speech and language or by singing. This helped to promote people's sense of personhood, their inclusion in daily life at the service and their engagement with others.

However, during the group activity sessions, we saw that other care staff burst into room; loudly, inappropriately and with disregard to people participating there. This disruption had a negative impact on people's engagement within the group, resulting in three people withdrawing completely and one person shouting because they did not understand what was happening and became anxious as a result. This showed that staff were not always mindful of people's care because of their inappropriate response to this.

Care records we saw contained relevant information about people's known lifestyle preferences and daily living routines. Information was collated about people's life histories to help inform this, although one person's we looked at was not completed. Their relative told us that staff were 'usually very good' but sometimes did not respond to provide care in either a timely manner or in the way they knew the person preferred. For example, to ensure the person was clean shaven each morning or receive their main meal at tea time rather than lunch time. This showed that care staff were not always mindful, timely or responsive to people's needs in relation to their dementia experience.

We saw that some thought had been given to the décor and environment since our last inspection to aid people's mood, orientation and recognition. For example, by the use of sensory items, colour schemes and some appropriate signage. However, this was not consistently provided to ensure people's support in this way. Our general observations found a 'tired' environment, with some shabbiness. For example, scratched paintwork, a toilet seat not aligned properly and a garden overgrown with weeds with no planting, which was uninviting. Two people commented they would like to go out into the garden as the day was sunny and warm, but felt it was, 'Off putting' and 'not particularly nice.' The provider's recorded checks to improve the quality and safety of people's care showed some environmental improvements were needed but did not account for all of the areas that we found. For example, in relation to people's orientation and recognition or the garden area. Following our inspection the registered manager advised that the garden area had been tended to and secured, to enable people's access this when they chose.

Information about how to make a complaint or raise concerns about the service was displayed at the service. People and relatives told us they knew how to make a complaint and were confident this would be dealt with in a courteous manner. They told us they had not needed to make any complaints. One relative told us, "If needed, I'd go to the manager." Complaints records showed four formal complaints received in the previous twelve months, three of which showed a perceived lack of responsiveness or timeliness to people's care. These had been addressed and a written response provided. However, one person's relative told us that improvements from this were not consistently sustained and another had not been satisfied with the response they received and had taken their complaint to an external authority.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2015, we found that the provider's checks of the quality and safety of people's care were not always effective to protect people against the risk of unsafe or ineffective care and treatment. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breach. At this inspection we found that improvements had been made to rectify the breach, but that further improvements were needed in relation to the quality, approach and timeliness of people's care.

People who were able to express their views, relatives and staff were more confident about the management of the home. Local care commissioners felt that the service had generally improved since our last inspection with some areas that still needed to be addressed in relation to the quality and consistency of people's care. People, relatives and staff said the registered manager was approachable and open to listening to their suggestions or concerns. One relative told us "The manager is approachable and helpful."

The registered manager told us that a revised system for the regular checks of the quality and safety of people's care had been introduced. Records showed this included a range of checks. For example, checks of the environment, cleanliness and equipment, checks of care plan records, medicines and staffing arrangements. Checks were also made of complaints, accidents and care incidents, such as pressure sores, infections and weight loss. The results were formally analysed by the registered manager to help identify any trends or patterns that may inform improvements for people's care. The provider had recently appointed an external senior manager to support this.

We found the provider had made significant improvements to the safety and effectiveness of people's care since our last inspection. This included improvements to staffing and medicines arrangements; for the prevention and control of infection and cleanliness at the service and for obtaining people's consent or appropriate authorisation for their care. Additional improvements were planned and imminent in relation to staff skill mix and training, medicines recording and waste management and infection control systems and to enhance people's meal time experience. However, we found that further improvements were needed to ensure the consistent quality, approach and timeliness of people's care and in relation to the environmental orientation and repairs. The provider also needed to demonstrate their ability to sustain and show continuous service improvement to ensure people consistently received safe quality care. The provider had recently appointed an external senior manager to support and monitor improvements needed.

The provider sent the Care Quality Commission written notifications informing us of important events that had happened in the service when required. However, there was an unnecessary delay in sending one notification, which the provider did not send us until we asked them to. The notification showed they had otherwise taken appropriate action as a result.

Staff were positive about working at the service and mostly understood their role and responsibilities for people's care. One told us, "I like it here; we work as a team." Staff told us they were often asked for their views about people's care and were mostly confident, supported and knew how to raise any concerns they

may have about this. For example, through regular staff meetings and care handovers, or at their one to one supervision meetings. One care staff member said "The manager's door is always open." Most staff we spoke with said they received individual management supervision at regular intervals. The provider's recent management checks showed this was not consistently or thoroughly achieved. A supervision plan was in place to help ensure this.

Relevant policies and procedures were in place for staff to follow to report significant incidents or concerns, such as in the event of an accident or serious incident, which staff understood. This included a whistle blowing procedure if serious concerns about people's care need to be reported to relevant outside bodies to protect people from harm or abuse. Whistle blowing is formally known as making a disclosure in the public interest. This helped to promote an open and transparent culture.