YMICARE Limited

Parklands Residential Home

Inspection report

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Date of inspection visit:
28 January 2016
02 February 2016

Date of publication:
07 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Parklands Residential Home provides personal care for a maximum of 27 older people, some living with dementia and other mental health conditions. The home specialises in the care of older people but does not provide nursing care. People's health care needs are met through community health care services. There were 21 people using the service at the time of the inspection. One room was not available as being or re-decorating.

At the last inspection in March 2015 we found the service required improvement in all the areas we inspect; safe, effective, caring, responsive and well-led. The issues related to management of behaviour which could be challenging for staff, infection control, training, maintaining dignity, activities and audits. We received a satisfactory action plan reassuring us that the service would address these issues in a timely way. In September 2015 we received concerns about inadequate staffing levels. The manager left the service at this time. We met with the provider and registered manager of their other care home, who was supporting a newly appointed manager for Parklands. We were assured that staffing levels were adequate and issues had been due to holiday and sickness and were now resolved. The new manager also left after three months. Therefore, at the time of this inspection, there was a new manager at Parklands who had been employed since December 2015.

We found during this inspection that all the areas identified in the last report and in the meeting with the provider had been addressed or were being addressed. However, we have noted that these improvements are very recent and although actions show that improvement has been made, we were not able to see sustained or embedded practice yet. For example, at the last inspection we found improvements were needed to make sure quality assurance systems were effective in identifying shortfalls in the service offered. At this inspection we found more robust quality monitoring had been put in place but it was too early to establish the effects of this over a period of time. The registered manager of the provider's other service was working with the new manager and the deputy manager at Parklands to ensure that improvement continued in a timely way and they would inform us of their progress.

At present there is no registered manager who is responsible for the home at Parklands. The newly appointed manager said it was their intention to register in the near future. 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 and associated Regulations about how the service is run.

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. There were sufficient numbers of staff to meet people's needs. During the period of concern about inadequate staffing levels the service had worked with the local council quality assurance team to ensure they were admitting and caring for people with less complex needs. At the time of this inspection, people's dependency levels were relatively low, with only one person requiring a hoist to mobilise for example. People were encouraged and supported to maintain their

independence. They made choices about their day to day lives which were respected by staff and their needs were met in a timely way.

People said the home was a safe place for them to live. Staff had received or were booked to receive training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected.

People said they would not hesitate in speaking with staff if they had any concerns. People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. One person said

People were well cared for and were involved in planning and reviewing their care. Care plans were person centred and reflected people's care. A new activity co-ordinator was getting to know people so that stimulation and leisure activities met people's preferences. People were provided with a variety of activities and trips. People could choose to take part if they wished. Records of activities were recorded under each activity although did not ensure staff could monitor each individual's activity experiences activities. The new activities co-ordinator was arranging a meeting with staff to discuss future plans and how care staff could be more involved in activities. They were also starting individual records for each person rather than records based on the activity. Staff at the home had been able to start building links with the local community, such as the library.

There were regular reviews of people's health and staff responded promptly to changes in need. The district nurse who visited regularly told us that they were impressed with the level of health care and that the service worked in partnership with them in a timely way. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

Staff had good knowledge of people including their needs and preferences. Staff had received recent training or were booked for training in a wide range of topics in the near future. There were good opportunities for on-going training and for obtaining additional qualifications. The new manager had previously been the service national vocational qualification assessor so had good knowledge of standards of care and training competencies.

People's privacy was respected. Staff ensured people kept in touch with family and friends. Each relative we spoke with told us they were always made welcome and were able to visit at any time.

There was a new management structure in the home which provided clear lines of responsibility and accountability. The new manager was well supported by the registered manager of the provider's other service and was keen to provide the best level of care possible. Staff said there had been a period of change and unrest but that the service was now more settled and things were a lot better. They showed care and respect for people and clearly were knowledgeable about who people were and how they liked to be cared for.

There were quality assurance processes in place to monitor care and plan ongoing improvements. These had not been kept up to date until recently during the period of change but the systems were now up and running and appeared to be effective. For example, falls risk audits had been completed and showed appropriate actions being taken to keep people safe. There were systems in place to share information and seek people's views about the running of the home such as quality assurance surveys. These had just been started and responses were being collected.

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

The service was safe.

There were systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them.

Staff were aware of how to recognise and report signs of abuse. They were confident that action would be taken to make sure people were safe if they reported any concerns.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Good

The service was effective.

People were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs. Staff received on-going training to make sure they had the skills and
knowledge to provide effective care to people.

People saw health and social care professionals when they needed to in a timely way. This made sure they received appropriate care and treatment.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff had understanding of people's legal rights and the correct processes had been followed regarding the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect. When people were in any pain or distress,

the staff took appropriate action.
People were consulted, listened to and their views were acted upon.

Where people had specific wishes about the care they would like to receive at the end of their lives these were recorded in the care records. This ensured that all staff knew how the person wanted to be cared for at the end of their life.

Is the service responsive?

Good

The service was responsive.

People were involved in planning and reviewing their care. They received personalised care and support which was responsive to their changing needs.

People made choices about all aspects of their day to day lives. People took part in social activities, trips out of the home and were supported to follow their personal interests.

People shared their views on the care they received and on the home more generally. People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Requires Improvement

The service was well led.

There was an honest and open culture within the staff team who had been through a period of change and uncertainty without consistent leadership. This had resulted in some systems being re-started or implemented very recently so we could not comment on sustainability and whether systems were embedded in practice.

There were clear lines of accountability and responsibility within the management team. The new manager, deputy manager or a senior carer led each shift to ensure the quality and consistency of care.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

There were quality assurance systems in place to make sure that any areas for improvement were identified and addressed.

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

This inspection took place on 28 January and 2 February 2016. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by one inspector.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the home such as quality concerns.

At the time of this inspection there were 21 people living at the home. During the day we spoke with ten people who lived at the home, two relatives who were visiting and one health care professional. We also spoke with eight members of staff, the registered manager from the provider's second service and the provider. We looked at a sample of records relating to the running of the home and to the care of individuals, including four care plans, three staff files, medication records and audits.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and with the staff who supported them. Staff told us they had received training in safeguarding adults or were booked for training. Safeguarding training was booked for the following day and in April. In between these dates staff were able to watch a safeguarding DVD with short refresher training. The staff had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The registered manager from the provider's second service told us how they had alerted the local safeguarding team appropriately concerning issues identified when receiving a new admission. One member of staff said "We used to have people who walked around and were at risk of falling, now there are not so many and it's safe here."

Each relative said they felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any, they felt they would be listened to and action would be taken to address any issues raised. One relative said, "It's an old fashioned home but in a good way. We have developed a good relationship with staff. They're very kind and there's certain warmth here. [The person's name] is very happy and I'm sure they are safe here."

There had been previous concerns raised about the management of infection control. We found the home to be clean and free of offensive odours. The provider had addressed the issues raised at the last inspection. One of these had been to complete records of regular times that people were assisted to the toilet. Another domestic cleaner was being recruited as at present the care workers did the laundry. A relative said, "No, it doesn't smell here. I usually find it all clean." There had been a concern about the appropriate disposal of waste. However, this had been discussed during infection control training and staff were following safe procedures. There was a contract for collection of sharps bins (for needle disposal).

A recent visit from a fire safety officer had resulted in the service receiving an enforcement notice. This had included action to be taken such as installing a compliant fire alarm, new fire-fighting equipment, ensuring doors could be opened easily and up to date risk assessments. The provider had been given a time scale until May 2015. They had started fire training and drills and the fire alarm panel and extinguishers had been upgraded and serviced. They felt confident they would have completed all identified areas within the timescale. They said they would keep us informed.

Staff encouraged and supported people to maintain their independence. There were risk assessments in place which identified risks and the control measures in place to minimise risk. The balance between people's safety and their freedom was well managed. One person liked to go out to the greenhouse independently. They had their own key to the back door and were able to make their own tea and breakfast. They said, "The staff keep an eye on me but I'm happy pottering by myself." Staff were happy to help them if they needed assistance.

Another person said they liked to go out in the garden most days and this was encouraged by staff. At the time of the inspection people had to ask staff for the patio door to be unlocked. We discussed the reasons

for this and the manager said they would look at the real risks and assess whether this could be changed. The manager was aware risk assessments had not been up to date previously and were working through them. However, staff were able to tell us about people's risks. One person was at high risk of falling so staff ensured they could be supervised or a staff member was in the lounge. The care plan showed clear instructions for staff about how to minimise risk including an assessment by an occupational therapist. Staff used a slips, trips and falls recording sheet in each care plan. We saw how this person had fallen less since the OT referral, use of a pressure alert mat and carer vigilance.

Staff were receiving manual handling training, which most staff had completed or were booked to do. Some practical training had been delivered by an occupational therapist recently. The new manager was qualified to deliver manual handling training and said they would do so in the future. We saw staff used appropriate techniques to assist people, explaining what they were doing and moving at the person's pace. We saw that individual risks to people had been discussed with people wherever possible including with people who were living with dementia. Staff recorded people's level of understanding at the time and also used the reviews for one to one time with people.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. There was a senior care worker and four care workers working in the morning supported by the deputy manager and manager who were in addition to the staff on the rota. The registered manager from the provider's second service was also supporting the new manager. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. We saw how staffing was increased to support a new admission who appeared to be settling in well. Staff had already got to know them and had built a good rapport with them. Another person was unwell and required increasing care. At night there were two staff on duty. One was awake and the other was on sleep-in duty. Staff were aware they needed to wake the second care worker if they required assistance. Staff said this worked well with current dependency levels. The manager said they would monitor this according to needs at night.

Dependency levels were low at the time of this inspection. For example, only one person required two care workers to assist them mobilise with a hoist. Another person used a stand-aid with one care worker to mobilise. All other people required assistance from one care worker. This had been the case since the inadequate staffing levels concern in September 2015. The provider had ensured the manager assessed potential new admissions with consideration to the level of need and whether their needs could be fully met at Parklands.

We saw that people received care and support in a timely manner. We saw staff checked on people who were in their own rooms during our inspection. One person said, "I like to spend my time in my room. I'm ok, the staff check on me. It's a lovely place. I'm very comfortable, I've no complaints." One person received a particular treatment which was managed safely with clear signage.

The senior care staff and deputy were trained in medication administration and had their competency assessed before they were able to do so. The service had invested in a new medication trolley on the ground and first floors. There was also a new system with support from a local pharmacy. We saw medication administration records and noted that medicines entering the home from the home's dispensing pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

We saw medicines being given to people at different times during our inspection. Staff wore a "do not disturb" tabard to enable them to concentrate on the task fully to minimise the risk of errors. Staff were competent and confident in giving people their medicines. They explained to people what their medicines

were for and ensured each person had taken them before signing the medication record. They knew what allergies people had, for example one person could not have a certain fruit. Staff recorded different sites used for medication skin patches to ensure rotation. The manager was adding more details to "as required" medication information so that staff could clearly see when and why these were given, for example what pain any pain relief was given for.

A medicine fridge was available for medicines which needed to be stored at a low temperature. There were no fridge stored medications at the time of this inspection. Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. We saw that these were stored and records kept in line with relevant legislation. The stock levels of these medicines were checked by two staff regularly. We checked some people's stock levels during our inspection and found these tallied with the records completed by staff and a sample of medication records showed no gaps in recording.

Good

Is the service effective?

Our findings

Although there had been a period of change and staff said it had been unsettling they said things were, "a lot better". Each staff member had a good knowledge of people's needs. For example, a staff member recognised when one person's body language was showing they would like to go and lie down. They responded to the person who was clearly happy to go to their room. Staff were able to tell us t how they cared for each individual to ensure they received effective care and support. People spoke highly of the staff who worked in the home. One person said, "I see carers sitting with people from time to time. They really are a lovely bunch."

We looked at three staff recruitment files. These were all completed and checks were made to ensure new staff were safe to work with vulnerable people. These included For example, interview records, Disclosure and Barring (DBS) police record checks, two references (one from the previous employer) and employment records. These were completed before any staff worked alone unsupervised. The new manager was aware they needed to include a copy of new staff curriculum vitaes (CVs) in the future.

New staff completed an induction programme. The new manager was looking at this to ensure it was in line with national induction guidelines. New staff completed a workbook to ensure they were competent with care standards. Regular staff one to one supervisions had fallen behind recently but this was being addressed. We saw staff names and dates for supervision in the near future were booked. There was a clear format to enable staff to raise any training needs, how their work was going and check on competency, for example. We saw that issues raised about staff were followed up such as a medication error and staff not attending training, which they were paid to do.

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. There had been a lack of staff training in recent months so staff were attending a wide range and number of training sessions. These included infection control, food safety, fire safety, person centred planning, safeguarding and dementia awareness. Fire warden training and verification of death training had been done. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care. There was a staff matrix programme to make sure staff training was kept up to date which showed gaps but we were assured all staff would be up to date by May 2015. The manager was keen to invite external professionals to run additional training sessions for staff such as the district nurse and occupational therapist.

People had access to health care professionals to meet their specific needs. During the inspection we looked at four people's care records. There were regular reviews of people's health and staff responded to changes in need. Care records showed people had access to appropriate professionals such as GPs, dentists, district nurses and speech and language therapists. People said staff made sure they saw the relevant professional if they were unwell. One care worker told us how a person had seen their GP for review due to increased aggression which was distressing for the person. One health care professional said, "The staff are absolutely lovely here. Any concerns are reported. I come in most days and I've never had any problems. Staff are open and honest, they are not afraid to ask us to see anyone if needed." This

demonstrated the staff were involving outside professionals to make sure people's needs were met.

Some people who lived in the home were able to choose what care or treatment they received. The manager and staff had an understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Throughout the day staff demonstrated that they were familiar with people's likes and dislikes and provided support according to individual wishes. Choices such as what food and drink and clothes people wanted to wear were given each time. Staff realised that people living with dementia could have different views at different times as well as having knowledge about their usual routines.

Some people required some restrictions to be in place to keep them safe. The registered manager from the provider's second service had made appropriate applications to the local authority to deprive these people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and the person's advocate. We read that the applications had been approved. Staff were aware of the implications for this person's care. The provider kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. Health professionals had been asked to review people's mental capacity and this was on-going. The manager had made appropriate DoLS applications and was waiting for the best interest assessors to approve. Training had not yet been received by all staff but was booked. Staff had good understanding of what issues required best interest discussions but more improvement was required in ensuring areas relating to the use of locked doors and consent to night checks (these records stated 'agreed by' but only included a staff member. The manager was already looking at these areas.

There were risk assessments in people's care records relating to skin care and mobility. One person had been assessed as being at high risk of pressure damage to their skin. They had the identified pressure relieving equipment in place such as a specialist mattress and cushion and they were being seen regularly by the local district nursing team. One person received care from the district nurse and there was a folder about their care but this needed to be also added to the care plan to clearly inform staff. Overall, care meant people's health needs were assessed and met by staff and other health professionals where appropriate.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Where people were at risk of losing weight this was monitored.

Everyone we spoke with was happy with the food and drinks provided in the home. One person said "The food is good and we can have seconds." There were four people on special diets and the kitchen and other staff were clear about how they needed to be served their food. There was some confusion about kitchen ordering and a lack of communication. This had not affected people in the home. This was discussed with the manager who then planned a meeting with the kitchen staff to discuss their concerns and clarify what they could order and what the kitchen staff needed. People could choose what they wanted for breakfast including cooked breakfasts and porridge. The kitchen staff knew that some people loved a boiled egg.

We observed the lunchtime meal being served in the dining room. People sat at tables which were nicely laid and had condiments for people to use. People chose meals in advance from a menu but could also choose an alternative when they chose their meal or at the time of the meal. People were able to be

independent with staff available to assist them discreetly when required. Staff assisted people in a kind way, at eye level and chatted with them during the meal. There was a variety of drinks available. People were able to choose where they wanted to sit. Some people preferred their rooms, others the lounge or in the dining room. Staff were aware of who liked to sit with who. One person liked to have their radio headphones on. We saw that throughout lunch people were treated with respect and dignity. They were not rushed. There was friendly banter between people. This helped to make lunchtime a pleasant, sociable event.

The home was well maintained and provided a pleasant and homely environment for people. The property was in a very rural location next to a farm with extensive views of the country side. The provider was aware there was sometimes a fly problem which relatives had noticed. They were doing all they could to rectify this and would communicate with visitors through the newsletter and monitor the issue. They had made improvements following the last inspection. For example, there was a new laundry ceiling and a new roof was planned. All equipment had been checked by professionals such as the lift, hoists and stand-aid. People who lived in the home were involved in choosing colour schemes and furnishings. Some planned redecoration was in progress when we inspected and there was a maintenance man who worked between the two provider homes who was present. One comment in the recent quality assurance survey said, "I find the home a nice place to be."

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home. This was an old lift and sometimes had problems but these were rectified as soon as possible. The lift was very small but just big enough to enable one person and a care worker to support them. People had individual walking aids, wheelchairs or adapted seating to support their mobility. One family had provided a specialist wheelchair for their loved one and this was used.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff talked with us about individuals in the home. They had an excellent knowledge of each person and spoke about people in a compassionate, caring way. One person said "The staff are all lovely." Relatives spoke positively about how caring the staff were. One told us "It's nice to know you can go home and know [person's name] is being looked after well." One person had visited the home from the provider's second service. They had liked it so much they had asked to stay and now lived there. A recent thank you card stated, "Thank you so much for looking after us especially at the funeral. You made it so much easier for me and I enjoyed you being there. They thought the world of you all."

Throughout the day we saw staff interacting with people who lived at the home in a caring and professional way. One staff member said "It's really changing here. There's a positive vibe now." There was a good rapport between people, they chatted happily between themselves and with staff. One person took a long time eating. The same care worker sat patiently encouraging them at their own pace. They said they sometimes re-heated their food so they didn't get their meal cold.

We saw that some people used communal areas of the home and others chose to spend time in their own rooms. People had a call bell to alert staff if they required any assistance. Staff knew who could not use a call bell and regularly checked them. They told us these were answered reasonably quickly and we saw they were during our inspection. We saw that staff always knocked on bedroom doors and waited for a response before entering. One person was privately using the phone in the office which staff respected.

People told us they were able to make choices about their day to day lives. People said they chose what time they got up, when they went to bed and how they spent their day. Choices were reflected in their care records. One person living with dementia was recognised as becoming very tired and they liked to go to bed early. Staff said if they went later they became distressed and refused care so they made sure they assisted them early.

Relatives told us they were always made welcome and were able to visit at any time. They were offered tea and biscuits. People were able to see their visitors in communal areas or in their own room. There was a large bright dining room, a snug area which the manager said they would make into a reminiscence area, a large TV lounge and a sunny adjoining conservatory area with wonderful views.

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. We saw that bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. There were a lot of institutional notices for staff around the home which the manager agreed to remove.

There were plans for people to be more involved and their relatives in decisions about the running of the home as well as their own care. The manager was starting the resident's meetings again which had fallen behind. The new activities co-ordinator had already started meeting with people individually to see what they would like offered.

Care records included information about the way people would like to be cared for at the end of their lives. There was information which showed the provider had discussed with people if they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff were able to give us detailed information about how people liked to be supported and what was important to them.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. The registered manager from the provider's second service had been doing the initial assessments. They now used a form to record these and the new manager and deputy would take on this role. Staff considered the needs of other people who lived at the home before offering a place to someone. People were involved in discussing their needs and wishes, people's relatives also contributed. One relative said, "They seem to know all about [person's name] and they ask us for input too so I feel involved."

During the inspection we read four people's care records. All were personal to the individual, which meant staff had details about each person's specific needs and how they liked to be supported. People who were able to told us they were involved in planning and reviewing their care. We saw people's care plans were discussed with them each month and changes were made if necessary. People had signed some of their care records and the record of each monthly review. Where people lacked the capacity to make a decision for themselves staff involved other professionals and family members in writing and reviewing plans of care. Reviews had fallen behind due to lack of consistent leadership but these were systematically being completed. This included ensuring future reviews were more meaningful as most daily record entries were not very detailed and some older reviews had included new details not transferred to the care plan. However, the new manager was aware and addressing this.

Staff were aware of people's care plans and risk assessments and provided care in line with these. One person had a risk assessment in place regarding their mobility. The assessment said the person should use a walking frame to aid their mobility. We saw staff gently reminded them to do so when they began making their way to the dining room for lunch. One person was unwell and staff assessed their needs each shift as sometimes they could move in bed and at other times felt too unwell. We saw staff asked for additional staff appropriately to assist them.

There was good documentation and staff knowledge about people's needs who could display behaviour which could be challenging for staff. There were "ABC charts" which detailed triggers for such behaviour, changes in medication and what to do about it. For example, if someone did not feel like having personal care, staff returned at a later time. This person liked only male staff and this was accommodated.

Staff at the home responded to people's changing needs. The district nurse said staff were "excellent in recognising changes in health." The described how staff had noticed when someone had been increasingly not "right". They had correctly identified a health problem and informed the nurse very quickly. The district nurse commented, "It was not an easy thing to recognise. They did very well. I was impressed." Staff had also identified when people needed specialist equipment. The nurse said staff had put one person onto a

specialist mattress without prompting which meant they understood how to identify risks and what actions to take to minimise these.

There was a new activities co-ordinator who currently worked two full days a week which were flexible. For example, they were coming in the following Sunday to support people to enjoy a visit from a local choir. They led on providing activities and meaningful occupation for people. People were supported to maintain contact with friends and family. Relatives said they were able to visit at any time and were always made welcome. People continued to be involved in the local community such as the church.

The new activity co-ordinator encouraged people to use local facilities such as shops, library and community cafes. The provider had recognised that the staff culture in previous times had been more task orientated rather than person centred and was trying to address this. Staff had not previously been very involved in meeting people's leisure and social needs. The activities coordinator had already started some lovely activities to ensure people received stimulation and leisure time that suited them. They were meeting with staff to discuss how to improve person centred care in this way and providing suggestions. During a recent staff meeting issues had been addressed such as allocating breaks so staff did not taken breaks together, ensuring people went to bed at a time they preferred and spending more time with people when they were not busy.

People said activities were getting better and there was a variety of activities and trips were now provided. The provider was aware there was a need for improvement. Therefore, the activities co-ordinator was starting individual activity records to ensure everyone had some "one to one" time on a regular basis. At present there were still some days where there was little going on. People could choose to take part in activities if they wished. One person said "It's getting better." There were now discussions about topical news, looking at newspaper articles, coffee mornings, singers, visits form local musicians and films.

There was a regular hairdresser who visited which people enjoyed. There was a "Weekly Sparkle" newletter which was used to promote discussion. Picture books for people who were no longer able to read were available. The activities co-ordinator was taking one person up to the local community café that afternoon and they had done some cooking and brass rubbing with people. One relative said, "The activities co-ordinator is wonderful. She suggested we arrange some photos and text to help staff get to know [person's name] better." People were encouraged to fill in a "This is Me" document all about themselves to inform care. For example, one person loved gardening and they were able to continue with this at the home. The activities co-ordinator said the provider had been "Brilliant" in supporting their ideas and supporting staff to be more involved. They said the home felt more relaxed and open.

People said they would not hesitate in speaking with staff if they had any concerns. People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. Information was displayed on the notice board and there was a clear complaints policy. One person said "I wouldn't hesitate to raise anything."

Requires Improvement

Is the service well-led?

Our findings

There was a now a management structure in the home which provided clear lines of responsibility and accountability. The new manager had been in post since December 2015 and had spent time at the provider's second home to learn the systems. The registered manager at the second home had been very supportive and worked extra hours to ensure the new manager settled in. They were also supported by a deputy manager and a small team of senior care workers. The services worked together to do "mini inspections" which could use a fresh pair of eyes and identify any areas for improvement.

The registered manager of the second home, the provider, the new manager, senior care workers and the deputy manager were available throughout the inspection. We observed that all took an active role in the running of the home and had a good knowledge of the people who used the service and the staff. They were also aware there had been a time of change and inconsistent leadership and we working together to provide a stable environment for the future. We saw that people appeared very comfortable and relaxed with the management team. We saw members of the management team chatting and laughing with people who lived at the home and making themselves available to personal and professional visitors. Staff told us, and duty rotas seen confirmed, there was always a senior person on each shift and an on-call system for advice out of hours. Staff said there was always a more senior person available for advice and support.

All of the people spoken with during the inspection described the management team of the home as open and approachable. The manager showed they wanted to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way that they cared for people. They were aware that the service had previously been more task focussed rather than person centred and were working to address this. For example, discussing this in staff meetings, meeting with the activities co-ordinator and adding a further domestic to free up staff for care delivery. One staff member said, "It's been difficult with all the changes but we all work well as a team and I think the best staff are working here."

The new manager worked occasional care shifts and at weekends to see what happened "on the floor". They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. They had also been trained as an assessor and trainer in safe manual handling techniques and were previously a national qualification assessor. Due to areas of quality assurance and management not being up to date they knew they had some areas that needed doing and were focussing on getting those systems right.

Staff had started to build links with the local community. The activities co-ordinator said, "I want to ensure people have the same opportunities to be able to take part in activities they like to do. My aim is to get the community to know we are here. We are starting to use the garden and make plans for using the outbuilding for something that will benefit people."

There were now effective quality assurance systems in place to monitor care and plan on-going improvements. These had been re-started and although recent were being carried out. For example, we saw the quality assurance surveys had started to be sent out to people, relatives and health professionals. These

were comprehensive and would be collated to show any patterns and what could be improved. There were audits and checks in place to monitor safety and quality of
care. For example, maintenance, falls, pressure area care, care plan reviews, training and staff supervision. We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example, actions were taken to address falls. We looked at care plan audits that had been carried out and saw that any shortfalls had been addressed with staff. Daily records would be addressed to make them more meaningful and the new manager was working through the care plans to review them all. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had re-instated a culture of continuous improvement in the quality of care provided.

However, as this was so recent we could not ensure that these systems were sustained or embedded in practice. The new manager said they would keep us regularly informed of progress.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. For example, there had been a police incident and this had been handled well.