

Buckland Care Limited

Merry Hall Nursing and Residential Care Home

Inspection report

30 Kiln Road
Fareham
Hampshire
PO16 7UB

Tel: 01329230024
Website: www.bucklandcare.co.uk

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 11 and 12 December 2017 and was unannounced.

The service has a history of breaching legal requirements. Following an inspection in February 2016, the Commission took enforcement action against the provider for failing to meet the requirements of the legislation relating to safe recruitment processes, safe care and treatment of people, person centred care and governance. In addition, requirement notices were issued for failing to ensure people were safeguarded against the risk of abuse or harm; failing to ensure appropriate numbers of skilled and trained staff were available; failing to ensure appropriate consent was sought; failing to ensure complaints were responded to and failing to ensure people were treated with dignity and respect. At this inspection the service was rated overall inadequate and placed into special measures.

We carried out a further inspection in October 2016. Whilst some improvements had been made and the service was rated as overall requires improvement, the key question well led remained inadequate. The improvements made were insufficient to take the service out of special measures. The provider remained in breach of the regulations regarding the safe management of medicines, recruitment, staffing levels and support, gaining consent and governance of the service. Requirement notices were issued and the Commission considered the previously imposed condition remained appropriate.

Following information of concern received in March 2017 a further inspection was carried out. We found serious concerns about the safety of people living at the home. The provider was failing to keep people safe because risks were not adequately assessed and staff did not have the training, skills and knowledge to support them safely. In addition they continued to provide insufficient numbers of staff, they had failed to ensure staff treated people with dignity and respect at all times and their governance system remained ineffective. The overall rating for the service had returned to inadequate and we did not remove the service from special measures. The Commission took enforcement action and cancelled the registered manager's registration.

In September 2017 a further inspection was carried out and we found improvement had been made. Whilst breaches in relation to safe care and treatment and good governance remained these had very little impact on people. The service was rated as overall requires improvement, but the key question well led remained inadequate.

This inspection was carried out to ensure that the improvements found in September 2017 had continued and been sustained. We found significant improvements had been made at this inspection. All legal requirements had been met and no questions were rated as inadequate. Therefore the service has exited special measures.

Merry Hall Nursing and Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC

regulates both the premises and the care provided, and both were looked at during this inspection. The home accommodates up to 32 older people and some who require nursing care, across two adapted buildings. At the time of the inspection there were 20 people living in the home.

A registered manager was not in post during the inspection. 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. A manager had been appointed and started working in the home approximately four months before our inspection. They had submitted applications to become the registered manager and were awaiting CQC assessment and decision. Throughout the report we refer to this person as the manager.

Further changes had been made to the systems used to monitor and assess the safety and quality of the service. Some of these required review to ensure they were fully effective but the manager was aware of this and planned to look at these during the week of our visit. The provider audits produced clearer action plans which we could see were being acted upon. The manager had a clear plan to develop the service further. They were working well with a clinical governance consultant and had engaged an external company to provide advice on how to make the service more dementia friendly.

Some records needed further work to ensure they were completely accurate. The provider delivered training and ensured support and supervision was in place to enable staff to undertake their roles effectively. However, some staff had not received the training needed to manage choking risks for people.

Staff had a good understanding of the needs of people and worked well as a team. They understood the risks associated with people's care needs. Medicines were safely managed. People were protected against abuse. The manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Systems to ensure staff recruited were of good character were operated effectively and staffing levels were based on individual's needs.

Staff understood the need for consent and demonstrated the principles of the Mental Capacity Act 2005 were understood and applied appropriately. They ensured people were involved in all aspects of the care and support. Where necessary they involved others such as families to aid the development of clear support plans. Other health professionals were accessed to ensure people's health care needs were met.

Staff provided compassionate and kind support which respected people's dignity and privacy. People were very comfortable in the company of staff. Care plans were more person centred and we saw staff responded to people's changing needs. Activities were based on individual preferences.

Staff were confident that the manager was knowledgeable and would take appropriate action if any concerns were raised. They felt supported and that the manager was easy to approach. The manager operated an open door policy in order to provide clear leadership.

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.

People were protected against abuse by staff who understood their responsibility to safeguard people.

Risks associated with people's needs were assessed and action was taken to reduce these risks.

Medicines were managed safely.

The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work with vulnerable adults.

Staffing levels were based on individual needs and systems were in place to ensure that ongoing learning took place when things went wrong.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People told us they were always asked for their permission before personal care was provided. Where needed people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). However, the records did not reflect this.

Staff received supervisions, appraisals and training to help them in their role. However, some training to ensure risks for people were understood and could be managed had not been completed.

People were supported to ensure they received adequate nutrition and hydration.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good ●

The service was caring.

People were supported by staff who were kind, caring and supported their independence.

People were involved in decisions about their care and the home.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Good ●

The service was responsive.

Staff understood people's needs and responded appropriately when these changed.

People were provided with appropriate mental and physical stimulation.

There was a process in place to deal with any complaints or concerns if they were raised.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Systems were in place to ensure a quality service was being provided and developed further. These had improved since the last inspection but further improvements were needed.

Staff felt supported and confident to raise concerns with the manager who they felt would take all necessary action to address any concerns. The provider's values were clear and understood by staff.

People, their families and staff had the opportunity to become involved in developing the service.

Merry Hall Nursing and Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 11 and 12 December 2017 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people living with dementia.

Before the inspection we reviewed information we held about the service. We looked at notifications. A notification is information about important events which the service is required to send us by law. We reviewed the provider information return (PIR) document. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In addition we sent out questionnaires to people, staff, relatives and other professionals. We received feedback from one person and 13 staff. This information helped us to identify and address potential areas of concern.

During the inspection we spoke with 10 people and four visitors. We spent time observing staff interacting with people. We looked at the care and medicines records for nine people. We looked at four staff recruitment files and eight staff supervision and appraisal records. We looked at all staff training records as well as management records such as complaints, safeguarding, incident and accident records, rotas, policies and procedures and governance records.

We spoke to the deputy general manager, the manager and seven staff.

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said "I feel absolutely safe here. I've lived here for ages and they help me when I need it". Another said "Safe? Yes I do. I was on my own for a long time, but I've got people around me now".

At our inspection in September 2017 we found the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because not all known risks for people were managed well. We identified concerns regarding the management of diabetes, skin integrity and there was a lack of information for staff to help them identify risk associated with certain medicines. At this inspection, this had improved and was no longer a breach.

People could be confident they were supported by staff who understood any risks associated with their needs and how to reduce these risks. Records showed that for one person living with diabetes, good day-to-day care was in place to manage this including referrals to podiatry for foot care and regular eye checks to maintain health. The person had blood glucose levels taken and recorded appropriately. There was guidance in the care plan to aid staff in the management of possible emergencies. For example, the care plan described the symptoms and management of both hypoglycaemia and hyperglycaemia. There was a detailed flowchart for staff to use, describing what actions staff should take and when. The care plan focused on other potential risks of diabetes, such as poor circulation and the risk of pressure sores developing. For a second person, staff had been working with health professionals to manage their diabetes. The care records had been updated to reflect their current needs and provide appropriate guidance to staff. Staff knowledge of diabetes and the risks this posed was good.

Skin integrity care plans had been developed further since our last inspection. A new, recognised assessment tool had been implemented to assess the level of risk a person may have of developing pressure sores. Care plans continued to outline what actions staff should take to reduce the risk, such as supporting people to move position and the use of specialised pressure relieving equipment. Since the last inspection these now included an 'Escalation Process' should the person's skin show signs of breakdown. The escalation process described actions staff should take in the event of a pressure sore developing, such as the use of photography of the affected area, plus the introduction of body mapping and potential referrals to outside agencies, such as the person's GP or NHS Tissue Viability Nurse.

At the last inspection we were concerned that daily records showed that repositioning took place or was offered and encouraged, however this was inconsistently recorded and the checking of pressure relieving mattresses remained inconsistent. At this inspection the manager had introduced a different method of recording and monitoring this as they had found that staff were finding this difficult. This tool had only just been introduced and the manager and clinical governance officer had a meeting booked for the week following our inspection to review the introduction and effectiveness of these. From review of these records it was evident that the checking of pressure relieving equipment had improved.

At the last inspection we were concerned that people who were taking anti-coagulant medicine (a medicine

which thins the blood to prevent it from clotting) were not known to care staff and no guidance was in place to ensure that staff could identify the increased risk of bruising and bleeding. This had improved at this inspection. Risk assessments detailed the medicine and all associated risks, including what staff should look out for. The handover sheet given to each member of staff on duty also provided the information to alert staff to those people taking these medicines.

Care plans and risk assessments for those people who had been identified as at risk of choking remained accurate and detailed. Staff were seen to be adhering to these throughout the inspection visit and people were provided with support and observation where this was needed to reduce the risks. In addition, where there was a specific health need, for example seizures, clear care plans were in place which provided guidance for staff about how to manage the risks these posed. Another person had a percutaneous endoscopic gastrostomy (PEG) in place. PEGs involve the placement of a tube through the abdominal wall and into the stomach through which nutritional liquids and medicines can be infused, when taking in food and drink orally was limited or no longer possible. Clear guidance was in place and staff were knowledgeable about the management of these; all nursing staff had been trained in this area.

Where people needed the support of equipment this was regularly checked by staff to ensure it was safe and working. Each person had a personal emergency evacuation plan (PEEPS). This outlined the method of assistance, evacuation procedure and safe routes available for a safe evacuation. We found one person's room number was not accurate but the manager took immediate action and amended this.

People were protected against abuse. The provider had introduced a new set of policies and procedures into the home. The policy for safeguarding helped to ensure people were protected from abuse and harm. Staff had completed safeguarding training and were able to correctly identify categories of abuse. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let you (CQC) know if I thought there was abuse if the manager wouldn't act. I know they would though". Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any safeguarding concerns they may have in confidence. We saw records showing how concerns that had been raised with the manager had been investigated and action taken to address the findings of these. For example, one concern suggested some dignity issues and the manager had met with staff and undertaken some training around this subject with them. People were confident to raise concerns. One told us "I'd talk to [the manager] perhaps, the manageress depending on what the matter was, I'd have to think about it". Another told us how they would speak to the nursing staff.

People could be confident their medicines were safely managed and administered. People told us they received their medicines as they needed them.

Medicines continued to be stored in locked trolleys, rooms and fridges. The checking of the temperature of medicines storage had improved and was undertaken daily. Creams, dressings and lotions were labelled with the name of the person who used them, safely stored and signed for when administered and, although some Topical Medicine Administration Records (TMAR) would benefit from more detail about when to apply the creams. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised. Staff checked the records before administering the medicines and then electronically signed for these once the person had taken them. Where people required their fluids to be thickened to enable them to take their medicines safely, this was done. Where people needed their medicines crushed to be able to take these, consultation with GP's and pharmacists had been undertaken, although the date this took place had not been recorded.

Where people were prescribed medicines given on an 'as needed' basis (PRN), PRN protocols were in place. They outlined how, when and why they should be taken and included maximum doses over a 24 hour period. We noted where a person could be given varying numbers of tablets, for example one or two painkillers, that this was clearly recorded on the electronic MARs. We also noted that 'time-critical' medicines were given at the appropriate time.

The monitoring of therapeutic drugs was undertaken to ensure the level of the drug in the person was safely maintained. This was done either in the form of blood tests or in monitoring the person themselves, for example, glucose levels for those living with diabetes. We also noted there was clear guidance for staff concerning the management of people taking other types of medicines such as anticoagulant therapy and medicines for the treatment of acute angina. These included when taking the medicines was indicated and the signs and symptoms of potential side effects.

The recruitment process continued to remain safe. Pre-employment checks were conducted including obtaining full employment history, checks on identification, references from previous employers, professional registration checks and Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults. Where these checks identified potential concerns they had been explored although the records were not always clear about the action taken. As there had been previous concerns about recruitment, the manager had completed an audit of all staff files and an action plan was in place to ensure all required records were available.

The manager had introduced a new dependency tool. They told us how this had been used to assess the levels of need of people and then plan the staff rotas. They planned to do this on a monthly basis but said that they would assess staffing levels day-to-day and make changes as needed. People told us staffing levels were sufficient although one person did say they sometimes needed to wait. All staff we spoke to said there were plenty of staff to meet people's needs. We did not observe any concerns about the staffing levels throughout our inspection. Observations showed that staff responded promptly to call alarms and people's requests. Additional staff had also been made available to support people to access an outside activity safely.

The premises were cleaned daily to ensure the risks of infections spreading were controlled. One person told us "I think it's better now it's improved. They do a lot more cleaning now after all the inspections". Cleaning records were maintained and the manager had recently introduced a monthly infection control audit. All nurses, 19 of 26 care staff, and all housekeeping staff had received infection control training. Personal Protective Equipment (PPE) was available and in use. We observed the home to be clean, tidy and odour free. Staff used personal protective equipment, such as gloves and aprons, when providing personal care and serving meals. Staff were aware of their responsibilities in regard to infection control.

Documentation related to accidents and incidents was maintained. Information contained details of the concerns and the action taken as a result. We saw immediate action had been taken to ensure risks for people were minimised. For example, one person had been referred to a GP for a medication review as it was thought this might be a contributing factor to their increased incidence of falls. The manager told us that they were looking at a system which would help with an overarching analysis of these to enable them to identify trends and patterns.

Is the service effective?

Our findings

People spoke positively about staff and felt staff were knowledgeable of their needs.

Since our inspection in September 2017 further training had been delivered to staff and staff told us they had done lots of training which helped them in their roles. Staff were required to complete mandatory training such as safeguarding and moving and handling. Additional subjects were also available for staff to complete. This included the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, falls awareness, dementia, managing the risk of choking and Dysphagia (the medical term for difficulty in swallowing). At our inspection in March 2017 we had raised significant concerns about the management of people who were at risk of choking. Staff had not received training to support them with this. At our inspection in September 2017 this had improved. Whilst staff we spoke with had a good knowledge of the risk of choking and how to manage this, since the inspection in September 2017, no further training had been completed and the training matrix showed that 12 staff and the manager had not received this. Of these 12 staff four had also not undertaken any first aid training.

People were offered support by staff who received a comprehensive induction which equipped them to work safely with people. The manager told us how the induction had been developed further since our last inspection. Each new member of staff was required to complete a workbook over a period of six weeks. This involved demonstration, assessment of competence and review by the manager. However, not everyone's records reflected this had been completed. Staff said their experience of induction when first coming to work at the service was positive. One staff member told us, "It was really good. I shadowed other staff until I felt comfortable". Another staff member said, "When I first started I wasn't used to doing the medicines round with the electronic system. One of the other nurses stayed with me until I felt comfortable".

The service used the Care Certificate framework as their induction tool. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Since our last inspection six new care staff had commenced work in the home and all were in the process of completing the Care Certificate.

Staff confirmed they received ongoing support through one to one supervision sessions and appraisals. One member of staff told us "Yes, I've had supervision a couple of times since I've been here. I think it's open and honest". Another staff member told us, "I feel that I can speak to my senior at any time. The supervision is good because it's time used to talk about how I am doing". Supervisions involved discussion about people they supported, their own welfare, any concerns or training needs they may have. They provided the staff member with opportunities to feedback to management and for management to feedback to the staff.

In order to ensure registered nurses received clinical support and supervision, the provider had engaged the support of an external clinical governance consultant who visited the home every fortnight but who was available on a daily basis. The staff we spoke with were happy with this process.

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.

Staff were aware of the need to ensure people were involved as much as possible and supported to make as many decisions as they were able to. Where appropriate, and if able, people were asked to provide their consent and this was recorded. Throughout the inspection we observed consent being sought on a daily basis for all activities such as whether people wanted to get up, have personal care and sit in the dining room for their meals. Staff were seen to respect people's decisions. Most staff had received training in the principles and operation of the Act and were able to tell us about people's rights to take risks when they had capacity.

It was evident that the principles of the Mental Capacity Act were applied and best interest decision making was undertaken, although the records of the assessments did not always reflect that the two stage test was applied. For example, we could see that the use of bed rails for one person had been implemented. The manager told us this person's capacity fluctuated day to day but no capacity assessment had been completed. Consultation with others, including an advocate, had taken place and it had been agreed that this was in the person's best interest to stop them from falling out of bed. However, the consent form regarding the use of specialised equipment had not been reviewed to reflect the person's fluctuating capacity.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. People's capacity to agree to staying at the home had been assessed and where appropriate DoLS applications had been submitted. The week before the inspection one person was approved with conditions. The manager was aware of the conditions and had begun to take action to ensure these were met.

Since our last inspection the provider had begun to admit people to the home. Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. The manager told us that currently no one with nursing needs was being admitted to the home. As such, they were undertaking the assessments. They confirmed that a nurse would be involved in the assessment process if this was required. Although not everyone could remember the assessment process, we saw they and where relevant their families had been involved. One person told us "They came to the hospital to see me. I couldn't agree to stay permanently so we agreed on a temporary stay. We shook hands on it".

The preadmission assessment process identified the areas of support people needed in relation to their health, their social needs and their personal needs. The provider had introduced new policies and the policy for care planning guided staff to ensuring a person centred service in which people's diverse needs were considered. Following admission to the home care plans were developed. The manager had changed this process to ensure that on admission all staff had access to the essential information they needed to support and get to know a person. The manager had introduced the use of a "This is me" document. This is a document developed by the Alzheimer's Society and included details on the person's cultural and family background; preferences, routines and their personality. This information was then used to develop care and support plans for people.

The manager and staff were aware of places to go to ensure they had the most up to date evidence based guidance that would aid them. We saw the manager had introduced assessment tools which supported

guidance produced by the National Institute for Health and Care Excellence (NICE).

Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. Married couples were supported to remain living together if they chose to. The manager and staff were aware of equality and diversity (E&D) issues. We could see that people were receiving care and support which reflected their diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there which included age, disability, gender, marital status, race, religion and sexual orientation. This information was appropriately documented in people's care plans where needed. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

Staff were knowledgeable about people's differing dietary requirements. Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. People were offered a choice of two main meals and alternatives if they did not want what was on the menu. People provided positive feedback about the food and said they could request an alternative if they wanted it. One person said "Foods very good here, I'm never hungry. There's always an alternative if you want one". A second person told us "Food? I'm not a good eater so don't want either of the main courses today. The chef's going to make me something else with bacon". We saw this was provided.

Staff were aware of those people who needed support and those who needed to be observed while eating. Observations demonstrated people received the support they needed to eat and drink. Care plans reflected people's needs.

Drinks were readily available throughout the day with squash and juice available for people to help themselves if they wanted to. Staff were seen to be continually asking if people would like a drink and encouraging people to have one.

A variety of referrals and assessments had taken place, including those involving speech therapists. Staff monitored people's weight and if this was a concern made referrals to other professionals to ensure this was managed. This included ensuring supplements were provided and their meals fortified.

Staff and the manager spoke with us about how they worked as a team to ensure everyone was aware of any changes in a person's support needs. Internally, they used a verbal and written handover system between shifts. The written handover provided sufficient detail to give staff an overview of people's needs. A diary was used each day to share messages and ensure that where a person needed something, such as a health professional appointment, this was booked and staff were aware of when they were visiting so they could ensure staff availability.

People were confident they could access a GP if needed. People were supported to maintain good health and had access to appropriate healthcare services. People's records confirmed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. In addition, referrals for some people had been made for specialist advice and support, including tissue viability and older person's mental health. Arrangements were made where needed to ensure people had support to access appointments. At the time of our visit, arrangements were being made to ensure a relative could provide support to their loved one at a hospital appointment.

People were cared for in an environment where some adaptations had been made to meet their needs. Some information was provided in pictorial format such as the activities plan. Equipment to meet people's needs was available. People's rooms were personalised. The environment was regularly checked for safety

and maintenance issues. The manager told us how they had recently engaged the support of an external company who would be delivering dementia training and offering advice on how to make the environment more dementia friendly in January 2018.

Is the service caring?

Our findings

People and their visitors told us the staff were kind and caring. One visitor said "I think they do a good job, they are caring and look after you well". A person told us "I've been here 2 years. I came in for 2 weeks and I'm still here. I'm spoilt and happy here". A second person said "I came in about a year ago. It took me a while to settle in. They were very nice to me".

Staff spoke with people with kindness and warmth and engaged positively throughout our visit, laughing and joking with them. We heard good natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. We found the atmosphere in the service was warm and friendly.

Staff recognised when people needed reassurance and provided this in a positive manner. For example, for one person who had recently moved into the service, staff knew the support they needed to provide them with comfort when they needed it. They were aware the family were very tactile and as such it was important this person had a hug when they were upset. Staff were seen to provide this level of comfort during the inspection when it was needed. For another person who found the use of the hoist anxiety provoking, we observed staff providing very clear instructions and reassurance throughout.

People were encouraged to express their views and to make their own choices. This was evident in many aspects of their care; for example supporting people to choose the clothes they wished to wear, where they wanted to eat their meals, and how they wanted to spend their time. We observed staff offering choices throughout the day. People told us they felt staff respected their decisions and we observed this. For example, we observed one person telling a staff member that they did not want personal care. The staff member respected this and offered again at a later time when the person then agreed.

People told us how they felt listened to by staff. One told us how staff ensured they had access to pen and paper to help them communicate their views and wishes. Care plans and risk assessments were reviewed monthly by staff but it was not always evident how people were included in this. The manager told us how two weeks after moving into the service, they met formally with the person and their family, if appropriate. This meeting was held to discuss how the person felt the placement was going and look at ongoing development of their care plans. The manager told us they intended to look at people's involvement in care planning becoming more frequent and structured.

The manager told us they were not aware of the Accessible Information Standard (AIS). However, they told us that they used a lot of easy read leaflet to talk to people recently about DoLS and voting. In addition the policy system used enabled them to produce easy read and large print versions for people if needed. For one person with limited eye sight, they told us how they read the relevant information to them.

Resident meetings took place and minutes of these reflected people's involvement in discussions about the environment and their care. For example, discussions took place about the upcoming Christmas party and what people wanted. People had chosen a buffet and the time of the party. They had chosen an external

musician to attend and this had been arranged. The resident meeting now involved relatives which the manager told us helped them to ensure that those people who were not able to communicate verbally could have someone present to speak on their behalf.

People and their relatives described staff who respected people's privacy and dignity. Staff did not rush people; they took time to engage with people in a meaningful way. They referred to people by their preferred name. We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the action they took to ensure people's privacy and dignity was respected when supporting them with personal care. Records were stored confidentially and securely.

Is the service responsive?

Our findings

Prior to using the service an initial assessment of people's needs was carried out with the person and /or their families and other professionals, as appropriate. The assessment identified the person's needs, wants and wishes. Care plans were then developed based on the information gathered. Where it was appropriate people and their relevant others were involved in the process.

It was apparent throughout our discussion with staff about people that they knew people well. Staff were aware of people's histories, their likes and dislikes. It was apparent that staff responded to people's changing needs. For example, on the second day of our visit staff had contacted the GP for home visits as two people were showing signs that they may be unwell. Following the home visit, the manager remained concerned for one person and referred back to the GP surgery for further input.

For another person, we saw that a change in their needs had prompted the staff to request input from a specialist. Following this input changes to the support they received with their meals was implemented and their care plans were updated to reflect this.

Planned activities were available if people wanted to join in with these. One of the activities was a visit from a Reverend. One person told us "He's fantastic-the best of the lot. He brings a keyboard and prints out the hymn sheets". Other activities involved games which we saw people engaged with and enjoyed. Some people told us how they preferred not to join in with activities. One person told us how the activities coordinator had spent time chatting with them and painting their nails. We observed the activities coordinator spending one to one time with people on an activity they preferred. The activities coordinator was new in post and told us that they planned to spend time getting to know people and understanding what they wanted before putting together a structured plan. They told us how they intended to plan a 'Burns' Night as one person was Scottish. They also, at the request of people, were looking into a quiz night.

People appeared confident in the presence of staff and seemed willing to approach them to discuss any issues. The service had a clear complaints policy and procedure which the manager was aware of. The manager told us this could be made available in any format, including audio, easy read or large print if people needed this. There had been no complaints since our last inspection but the manager told us they would keep a log and investigation records of all compliments and complaints.

At the time of the inspection one person was receiving end of life care. However, each person had an end of life care plan. These contained information about the management of pain, dietary information and a description of the level of family involvement, in addition to the person's wishes concerning treatment in their final days. For example, the person did not wish to die in hospital if at all possible but in the home surrounded by family. The manager was aware that these plans could be developed further. They had undertaken training in end of life care and planned to look at how they could use the learning from this to develop their end of life care.

Is the service well-led?

Our findings

At our last inspection in September 2017, although systems had been implemented to monitor and assess the quality and safety of the service, these were not embedded. We continued to find some concerns about the management of risks for people and the accuracy of care records. The systems implemented and ongoing weekly audits had not always identified the concerns we had. This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection improvements had been made and this was no longer in breach. However, some additional work needed to be done to ensure that audits were fully effective at all times. The manager was aware of this and had plans to implement further audits and review existing ones.

The manager had continued to undertake weekly audits of all people's care records and medicines management. Action plans were developed following these audits and the action needed was emailed to the member of staff responsible for completing them. We saw these were mostly effective in driving improvement, although the manager was aware of those staff that required additional time and support with these. In discussion with the manager, they told us they had identified that the tool used for auditing people's care records was not as effective as they would have hoped. This was because it had not always identified issues that we did with the records. For example, for one person we found that the care plan and risk assessment for their health condition gave slightly conflicting information. For another person the audit had not identified that the care plan referred to the use of a mattress that was no longer in use. The audits had not identified the tool used for assessing capacity did not ensure the Mental Capacity Act was followed. The manager planned to meet with the senior manager the week of our inspection visit to review the audit tool and make changes to this to support them to identify all the issues.

Since our last inspection, a person had been employed to undertake maintenance work. They were completing regular audits of equipment, for their safe use. This included bed rails, window restrictors and pressure relieving mattresses. Any issues that were identified were acted upon. In addition, the manager, along with the clinical governance consultant, had reviewed some documentation being used by care staff and in recognising that this was not effective they had developed a new tool. They had met with the staff to discuss this and implement it. They had planned a follow up meeting with staff for two weeks after this commenced to review progress with the staff's involvement. The manager and clinical governance consultant were looking at clinical audits that could be introduced which would enable them to have a clearer oversight and analysis of clinical needs in the home. This work had not yet started.

The provider employed a quality assurance manager who undertook monthly audits at the home. This tool had not changed since the last inspection, however the action plan provided clearer instruction and we saw where actions had been identified these were being worked on by the manager. For example, the audit in November 2017 detailed a full audit of staff recruitment files was required. The audit had been completed and the administrator was working thought the action at the time of our inspection. The audit identified the need for room risk assessments. This had been incorporated into individual care plan audits and was being worked on.

The manager advised that the provider did not hold any manager meetings so they had engaged in local forums such as the care homes forum, in addition to working on an informal basis with another of the provider's home managers to learn from experiences and share good practice. The provider held meeting with senior managers which we were told were used to discuss services, share learning and look at development. We asked to see the minutes of the last meeting however the provider would not share the full set of minutes and sent us an extract relating to the home. Whilst we could see that this meeting discussed the progress of the home we could not see how this meeting was used to share learning and practice across the organisation.

The manager had produced their own action plan which looked at the areas that they wished to develop further within the home. This included the introduction of champion roles and additional audits analysis systems. Following the last inspection the provider had agreed to submit on a voluntary basis a monthly action plan to demonstrate what they were doing to continue to make improvements in the service and to sustain these improvements. The manager was working with both these action plans and we could see the progress being made. For example, the provider action plan detailed the introduction of infection control audits and the reduction in agency staff to ensure consistency. We saw these had been completed.

At this inspection the manager had been in post for approximately four months. They had applied to become the registered manager and were awaiting CQC assessment and decision. They had made significant changes in the service and were spoken of very highly by all the staff and by people who lived in the home. The manager was aware of the changes that had been needed and told us how they had spent time ensuring staff were aware of their roles and responsibilities as well as being clear about expectations. There was a clear staffing structure in place. The manager was supported by a senior management team, a head of care, registered nurses, senior care staff and care staff. Staff we spoke with were clear about their roles and responsibilities. Observations reflected they were comfortable and confident in the presence of management. They spoke freely and at ease.

One member of staff told us "It's five stars for the manager. It's amazing how someone so young can know so much. She's firm but fair and gives her heart and soul to this place. She's changed the atmosphere completely; it's so much better now. The whole management team are like that; there's no them and us at all". A second staff member said "It's the best decision I ever made, coming here. A lot of that is down to the manager. She's very approachable and easy to talk to". A third told us "I don't work here permanently but if I did want to, it would be because of the manager". People were aware of who the manager was and visitors told us how they felt improvements had been made since the manager had started. Everyone we spoke with was confident to talk to the manager and raise concerns. They were all confident that if any action needed to be taken, the manager would do so.

The manager operated an open door policy and had a visible presence in the home. Staff were encouraged to contribute and make suggestions through informal discussions, staff meetings and supervisions. Staff meetings included discussions about people and the service. Staff were able to discuss what was working well and what could be improved on. The manager had held residential meetings to gain feedback from people but planned to send out surveys to gather more anonymous feedback. They said they would include any actions in their action plan.

Registered persons are required to display the rating given to them by the Commission following an inspection. The rating given following our inspection in September 2017 had been displayed on the provider's website and was on display in the entrance hall.