Dresden House Limited

# Dresden House Limited

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We inspected this service on 8 August 2017. The inspection was unannounced.

Dresden House provides accommodation and personal care for up to 25 people. People who use the service may have a physical and/or mental health need such as dementia. At the time of our visit there were 17 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection in November 2016, we found a breach in the governance of the home and the legal requirements and regulations associated with the Health and Social Care Act 2008 were not being met. We found breaches of the regulations related to managing risks to people's safe care and treatment, safe staffing levels, need for consent, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, ensuring only fit and proper persons were employed, requirement to display performance ratings and notification of incidents. We gave the home an overall rating of inadequate. We added a condition to the provider's registration, to restrict admissions and re-admissions to the home. The service was placed in 'Special Measures'. The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Services in special measures are inspected again within six months following the publication of the inspection report.

At this inspection we looked to see if the provider and registered manager had responded to make the required improvements in the standard of care to meet the regulations. Whilst we found that sufficient improvements had been made to remove the service from 'special measures,' we found further improvements were required to meet the regulations relating to consent and notification of incidents. We also found improvements were required in how senior managers assured themselves they were providing a safe service, that ensured people's health and welfare needs were fully met.

Since our last inspection visit the provider had recognised the registered manager needed more support to improve the quality of the service. A deputy manager was in post and a new care director had been appointed to provide guidance and oversight. Systems and processes had been introduced to monitor the quality of the service, but these needed to become embedded in every day practice to be consistently effective.

Following our last inspection, the provider had increased staffing levels within the home. People felt safe living at Dresden House because there were enough staff on duty to meet their care and support needs safely and effectively. Staff were recruited safely because the provider had checked they were of good

character. However, improvements were needed in the application form so the provider could identify any gaps in employment history.

Improvements had been made in risk management within the home. Staff had an understanding of each person's individual risks and ensured they used the correct equipment to keep people safe. Where people had fallen, this had triggered a review of the risks to the person's safety. Staff had a better understanding of best practice around giving people their medicines and people received their medicines as prescribed. However, further improvements were still required to ensure all risks were managed consistently.

Staff understood their responsibility to record and report any concerns they had about people's health or wellbeing. Safeguarding concerns had been referred to the local authority as required.

Staff had received essential training to meet people's needs safely and effectively. However, further training was required in the implementation of the Mental Capacity Act 2005. Managers and staff did not always follow the principles of the Act to ensure people were always supported to make their own decisions, and any restrictions on people's liberty were the least restrictive as possible.

People were offered meals that were suitable for their individual dietary needs and met their preferences. They were supported to eat and drink according to their needs. Staff monitored people who were at risk of malnutrition and obtained advice and support from other health professionals to maintain and improve their health.

People were positive about their experience of living at Dresden House and told us staff were kind and caring. People valued that staff encouraged them to maintain as much independence as they wanted to. Staff were patient and understanding of people when responding to people's requests for assistance.

Care plans were sufficiently detailed to support staff in meeting people's needs in a way they preferred, taking into account their likes and dislikes. Staff were knowledgeable about people's needs and their wishes and preferences.

Improvements had been made in providing people with activities that were meaningful to them and gave them opportunities for social engagement as a group or on a one to one basis.

People and staff felt the provider had been open about the issues identified at our last inspection visit and managers were available and approachable. They felt able to raise any concerns and were confident they would be listened to.

The provider had improved the governance of the home, but still needed to ensure they notified us of all reportable incidents and events as required under the regulations.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

People felt safe living at Dresden House because there were enough staff to promote their safety and provide prompt care and support. Some risks to people's health and safety had been planned for, but further improvements were required to ensure all risks were managed safely and consistently. People received their medicines as prescribed, but staff needed to ensure they always followed best practice when managing medicines. Staff and managers understood what action to take if they had any concerns about people's health and wellbeing.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Managers and staff were not always following the principles of the Mental Capacity Act 2005 to ensure people were not being unlawfully deprived of their liberty. People were supported to maintain a balanced diet that met their needs and preferences. People were supported to maintain their health through referrals to appropriate healthcare professionals. Staff had received basic training, but would benefit from further training to meet the specific needs of people who lived at Dresden House.

### Is the service caring?

**Good**

The service was caring.

People were supported by kind and caring staff. Staff were patient and understanding and respected people's privacy and independence. Staff recognised the importance of people maintaining meaningful relationships with family and friends.

### Is the service responsive?

**Good**

The service was responsive.

Staff knew people well and were responsive to their individual needs. Staff supported people to spend time engaging with staff or socialising with others according to people's needs and

preferences. People were confident to raise any concerns of complaints with the management team.

## Is the service well-led?

**Requires Improvement**

The service was mostly well-led.

Improvements had been made to the good governance of the home. The management team had been strengthened to provide guidance and support at all levels. Systems and processes had been introduced to monitor the quality of the service, but these needed to become embedded in every day practice to be consistently effective.

# Dresden House Limited

**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 visit took place on 8 August 2017. The inspection visit 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 service.

Prior to our inspection visit, we reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent time with these people and observed the care and support they were given by staff. We observed staff administering people's medicines to them.

We spoke with 11 people and two relatives about what it was like to live at the home. We spoke with staff on duty including three care staff, an agency worker, the activities co-ordinator, the cook, the deputy manager, the registered manager and the care director from the provider company.

We reviewed a range of records; these included three care records, daily records and a selection of medicine administration records. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection in November 2016 we found risks to people's health, safety and wellbeing were not always assessed and planned for and we judged they were in breach of Regulation 12. At this inspection we found improvements had been made in risk management within the home, but further improvements were still required to ensure all risks were managed consistently.

At our last inspection one person told us they did not always feel safe. At this visit, all the people we spoke with told us they felt safe living at Dresden House. Typical comments included: "I feel safe living here because I am well looked after. I never have to lock my bedroom door, nobody touches my personal things", "I am treated very well and always feel safe", "I feel very safe here because there are good people around me to look after me" and, "I feel safe living here as there are plenty of staff to look after me." One relative told us they were confident their family member was safe because they visited regularly at different times of the day and they had no concerns about their care.

We looked at the records of a person who was at high risk of falls because at our last inspection we found this was an area of concern. The person had a clear risk management plan to reduce the risks of them falling. Their plan recorded that a sensor mat should be placed in front of their chair so staff would be alerted when they attempted to move. We saw this sensor mat was placed in front of their chair as planned. The plan also stated staff should check on the person at hourly intervals. Records demonstrated the checks were completed by staff as required, and monitored by the deputy manager.

Records confirmed that another person at risk of skin damage was being re-positioned every two hours in accordance with their care plan. This ensured that pressure to the person's vulnerable areas was regularly relieved. This person confirmed, "I am checked through the night and turned every two hours."

We saw staff ensured people were using the correct equipment to keep them safe. For example, one person needed to sit on a static air filled cushion to prevent them slipping from their chair. We saw this was in place. Another person needed a walking frame to support them when walking. Staff ensured this was to hand to reduce the risks to this person. Another person enjoyed walking, but had severe mobility problems and was often reluctant to accept support. Staff had worked with the person to develop a plan that managed the risks without restricting them unnecessarily. The person now wore a head guard to minimise the risk of serious injury in the event they sustained a fall.

Staff had an understanding of each person's individual risks. For example, staff knew that because one person had restricted movement, they should walk with their walking stick in their right hand. They also knew that this person suffered with swollen legs and needed to have their legs regularly elevated. On various occasions we saw this person sitting with their legs elevated in accordance with their care plan.

However, we found some risks were still not being assessed and planned for. For example, one person was able to self-medicate. There was no risk assessment in place to inform staff how the associated risks with self-medication should be managed.

Another person was at risk of silent aspiration and speech and language therapy (SALT) had assessed how these risks should be managed. Aspiration is when food or liquids are swallowed poorly, and go into the lungs by mistake. Their advice was that the person should have one to one supervision for all oral intake and fluids should be given from an open cup. On several occasions we observed the person was left with drinks with no supervision. Drinks were also given in a beaker with a straw. This meant that SALT advice was not being followed which placed the person at risk of choking.

Improvements had been made in recording accidents and incidents, including falls. Records demonstrated that where people had fallen, this had triggered a review of the risks to the person's safety. Where a need had been identified, further action had been taken to reduce the risk of further falls, such as referring people for a physiotherapy review or reviewing their medication.

At our last inspection we found staff did not consistently follow safe medicine administration guidance. At this inspection we found improvements had been made and staff had a better understanding of best practice around giving people their medicines. People told us they received the medicines they needed when they needed them, particularly pain relief medicine. Comments included: "I get my medication on time and staff give me painkillers when I need it" and, "Staff give me paracetamol if I am in pain."

People received their medicines from staff who had received training and had their competency assessed to manage medicines safely. We saw staff only signed medicine administration records once they had seen people take their medicines and the records showed people had received their medicines as prescribed. There was a process to ensure people who had 'time critical' medicines received them in accordance with their prescription. Where people were prescribed 'as required' medicines for pain or agitation, there were guidelines for staff to follow to ensure they were given safely and consistently.

However, we found that where people were prescribed a variable amount of medicines, staff were not recording how much of the medicine had actually been given. This is important to ensure people do not exceed safe dosage levels and stock amounts can be accurately checked. When we checked medicines that had to be kept at lower temperatures in the fridge, we found one medicine that was not named or labelled. Neither of these issues had been identified in regular medication audits.

At our previous inspection we found staff were not always available to promote people's safety or provide prompt care and support and we judged the provider was in breach of Regulation 18. At this inspection we found improvements had been made. There were enough staff on duty to meet people's needs

Following our last inspection, the provider had instructed staff to update each person's care plan to ensure they accurately reflected the level of care they required. People's abilities and needs for support were reviewed to identify how many staff were needed to deliver care safely. The review had identified that more staff were required to safely and effectively meet the needs of the people who lived in the home. Accordingly, staffing numbers had been increased throughout the day. For example, there were now three care staff on duty at night, where previously there had been two. A deputy manager had been appointed to ensure there was consistent managerial support to lead the care team.

All the staff we spoke with confirmed the increased staffing levels enabled them to provide the full support people needed and spend more time with them. One staff member explained, "Having more staff means there is more time to sit and chat if residents have a problem. It is more relaxed."
People and relatives told us there were enough staff. One person told us, "When I press my buzzer it is answered very promptly." During our visit, we observed staff responded promptly to requests for assistance. Staff also responded quickly to any safety concerns, for example, when alarms or sensor mats went off in

people's bedrooms.

The registered manager assured us that people's needs would continue to be regularly reviewed. They told us staffing levels would be increased if a need was identified and as they moved towards full capacity within the home.

At our last inspection we found systems were not in place to ensure staff were of a suitable character to work with vulnerable people who lived in the home and we judged they were in breach of Regulation 19. At this inspection we found staff were recruited safely because the provider had checked they were of good character. The provider had obtained character references and references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. The registered manager showed us records of the checks that had been made of staff's suitability for their role and explained how they would risk assess any adverse information they received.

However, we identified that the job application form was not sufficiently detailed to identify any gaps in employment. References were not always stamped by previous employers or verified to confirm their authenticity. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires a full employment history, together with a satisfactory written explanation of any gaps in employment. The care director from the provider company assured us they would review the application form and define the standards for the supporting documentation, to ensure a robust recruitment process in line with the regulations.

At our last inspection we found incidents of potential abuse or neglect had not always been reported to the local safeguarding team as required and judged there was a breach of Regulation 13. At this inspection we found improvements had been made in following safeguarding procedures. Staff understood their responsibility to record and report any concerns they had about people's health or wellbeing. Staff told us they were particularly observant for signs that people with limited communication were unhappy or experiencing abuse. One staff member told us they would be aware, "If someone was distressed, isolated or appeared withdrawn." Another said they would not hesitate to report any bruises or changes in mood.

Whilst we were satisfied any issues of potential abuse had been reported to the safeguarding team as required, we found this had not always been done in a timely manner. For example, there had been a delay of 12 days before one incident was reported. The provider was no longer in breach of the Regulation, however, we reminded the provider that local and national safeguarding guidance states that incidents of alleged abuse should be immediately reported in order to safeguard people from further potential abuse.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in November 2016 we found the requirements of the Mental Capacity Act 2005 (MCA) were not being consistently followed and we judged this was a breach of Regulation 11. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we found the basic principles of the Act were still not being consistently followed.

Some care plans contained MCA assessments which were decision specific. For example, in one person's care plan there was a mental capacity assessment to assess whether they had the capacity to consent to live at Dresden House.

However, in another person's care plan there was conflicting information about whether they had capacity or not. The person's GP had assessed the person had capacity to make a fairly complex decision about following advice from the speech and language therapy team. However, four weeks previously a decision had been made in the person's best interests to move their bedroom from the first to the ground floor and to restrict their access to some personal items. There had been no assessment as to whether the person had the capacity to make these decisions themselves, and no record of who had been involved in making the decision in their best interests. These decisions should have been documented to clearly evidence the person had been supported to make the decision by appropriate representatives. A DoLS application had been submitted in respect of the restrictions on the person's liberty, despite no mental capacity assessment in respect of this decision having been completed. The DoLS only apply to people who do not have capacity to make decisions about their care.

When we raised these anomalies, we were told the person had fluctuating capacity. Records showed the person was being treated for an underlying health condition and on the 13 July 2017 staff had been advised the person's prescribed medication would start to have a positive effect within two to three weeks. At the time of our inspection visit, there had been no review to see whether the person could make a decision in respect of their possessions, even though the GP had assessed they had capacity to make a decision in another area of their life. We could therefore not be assured the least restrictive option was being implemented.

Staff we spoke with had a mixed level of understanding of the MCA and how it impacted on their interactions with people. Where staff had made decisions in people's best interests, it was not clear they had considered the least restrictive option available. For example, one person was at risk of self harm from an object in their handbag. Staff had removed the handbag from the person with all the contents, rather than removing the object from the handbag.

The registered manager accepted that both the management team and staff would benefit from more in-depth training so they had a greater understanding of their responsibilities under the MCA. This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found people did not always receive the support they needed to eat and drink and we judged this to be a breach of Regulation 12. At this inspection we found increased staffing levels meant staff had the time to ensure people had enough to eat and drink to maintain their health.

People told us the food was good and they had a choice of what they wanted to eat. One person told us, "It's good food, they give me what I like to eat." Another said, "Cook usually asks me my choice mid-morning for lunchtime. The food is always good, hot and well presented." A third said, "The food is alright, I have enough to eat and drink and there is always a vegetarian option."

People were regularly offered a selection of drinks and snacks. During the afternoon one person said they would like a ham sandwich and salt and vinegar crisps. A member of staff went to the kitchen and returned a short while later with a sandwich and crisps. One person told us, "I've never asked for a hot drink as staff are always bringing drinks out." Another person confirmed, "Sometimes I still feel hungry after I've eaten. I can tell the staff and they'll get me something else."

At our last inspection we found some people's weight was not being regularly checked when they had been identified as being at risk of malnutrition. At this inspection people's records showed that where risks of malnutrition had been identified, care plans were put in place to assist staff in meeting their needs. Information was shared with the cook to ensure staff met people's individual needs, such as who required a diabetic diet or their food softened or pureed. Where people were at risk of losing weight they were weighed regularly so any weight loss could be quickly identified. Where people were at risk of not having enough to eat and drink, food and fluid charts were completed so staff could identify if they needed to be encouraged to eat or drink more. We looked specifically at the records of one person who had previously lost weight. The food and fluid records had been completed and monitored as planned. The person's weight had started to increase and their nutritional risk score had started to decrease. This demonstrated that the actions taken to support this person's nutritional intake were effective.

One relative told us their family member was not eating as much as usual. They felt staff were managing this well and explained, "If [person] refuses her meal, staff offer something else straightaway. Recently she has been asking a lot for [name of cereal] and the staff get it for her. Recently the cook asked me for details of her favourite food so it can be prepared for her to tempt her to eat. I am aware staff are monitoring how much food and drink she has."

At our last inspection we found people were not always supported to maintain good health and we judged this was a breach of Regulation 12. Professional advice had not always been sought in relation to people's health needs and advice given had not always been followed. At this inspection we found improvements had been made.

People told us they were supported to maintain their health and a relative told us they were happy with their family member's healthcare. People told us, "I have struggled with my breathing all my life and needed inhalers. My breathing is now the best it's ever been because they've got it under control. Staff call the doctor when I need it" and, "Staff get the doctor very promptly when I'm unwell. The optician and chiropodists visit regularly." One person told us, "If anyone has a hospital appointment, staff organise everything and you are accompanied by a carer."

Records showed people were supported to access healthcare specialists, such as opticians, dieticians and district nurses, when needed. Where staff had identified a change in people's mental or physical health, advice had been sought from the appropriate healthcare professional. For example, one person had been very low in mood and staff had consulted with the person's GP for a referral to the community mental health team. Another person had been referred for a physiotherapy review following a fall, to ensure they received the support they needed to help manage their risk of falling again.

A visiting healthcare professional told us they had no concerns about the care people received and said staff were supportive when people needed nursing treatment by visiting healthcare professionals. They told us staff shared any information about changes in people's health and followed any professional advice they were given.

However, we identified one occasion when a healthcare professional's advice was not being consistently followed. We alerted the registered manager with our concerns so action could be taken to ensure any risks to this person's health were appropriately managed.

At our last inspection we found training staff had received had not always been effective, particularly when supporting people to move around the home and judged this to be a breach of Regulation 18. At this inspection we found improvements had been made in the implementation and monitoring of training. We did not identify any concerns when staff assisted people to stand, mobilise or transfer from one seat to another.

We spoke with three staff who had recently started working at the home. They all confirmed they felt prepared for their role because they completed an induction programme which included basic training and working alongside more experienced staff. A member of agency staff confirmed they also received an induction so they had an understanding of how the home ran and the individual needs of the people who lived there.

The registered manager kept a list of the training staff attended. They were able to see when staff were due to update specific areas of learning so their knowledge remained up to date. Records showed that staff had received basic training to meet people's needs safely and effectively.

We spoke with the director from the provider company about training specific to the needs of people living in the home, such as training in dementia, Parkinson's Disease and diabetes. They acknowledged this was an area the provider wanted to develop. They explained how the provider had recently observed an incident between two people which they felt staff had not managed particularly well. Training in caring for people with dementia and managing behaviours that challenged, had been provided to support staff understanding of how to respond positively to these situations.

Good

# Is the service caring?

## Our findings

People were positive about their experience of living at Dresden House and told us staff were kind and caring. One person told us, "I have never known a staff member to be unkind." Other comments included; "I'm looked after very well, the staff are very good" and, "Staff are kind, they're never nasty." A visiting healthcare professional described the staff as, "Friendly and good with the people who live here. People always seem happy."

Staff told us they enjoyed their roles, particularly now they had more time to spend with people. One staff member explained, "I like it here because I get to know the clients. I get to know them as individuals and that's important."

During our visit we saw staff spoke respectfully to people, but in a friendly manner. One person told us, "Staff treat me very respectfully, sometimes a bit over the top, but better that than the other way." Another person said they valued the fact their voice was heard and explained, "I'm a straight forward talker and I like the fact I'm listened to."

Staff were patient and understanding of people when responding to people's requests for assistance. One person asked for several changes to the hot drink they were given. The staff member responded immediately and then assisted the person to enjoy their drink when they were happy with it. When supporting people, staff explained what they were doing and did not rush them. For example, we saw one member of staff walking with a person with their arm around their waist to offer support, guidance and reassurance. The staff member walked at the person's pace and chatted with them as they walked along.

Staff had a good understanding of people as individuals and their personal preferences. One staff member described how important it was to know about people's history and background. They explained, "I think you can connect with them on a different level. If you can twig to a little memory they have, they are going to open up to you and feel more comfortable with you. Not everybody is the same."

Staff understood that supporting people to maintain their appearance promoted their dignity and self-esteem. Staff had supported people with personal care in accordance with their individual preferences. For example, some women wore trousers and socks and other women wore skirts and tights. People's hair and clothes looked tidy and well groomed and some women were wearing jewellery such as necklaces and beads.

Staff understood people's preferences for engaging with staff, for spending time alone and for engaging with other people who lived at the home. One person told us, "I prefer to stay in my room, I like to watch my television or listen to the radio….Staff are friendly, they come in to check on me."

People valued that staff encouraged them to maintain as much independence as they wanted to. One person told us, "I am quite independent, I can give myself a good wash down every morning standing at my washbasin. I can get myself ready for bed and get in bed when I like."

People were supported to make their bedrooms their own personal space. When we were invited into rooms we saw they were personalised with family photos, flowers, televisions and personal memorabilia. Some people had keys so they were able to lock their bedrooms if they wanted to.

Staff recognised the importance of people maintaining meaningful relationships with family and friends. One person told us, "Visitors can come anytime and are welcomed."

Good

# Is the service responsive?

## Our findings

People told us staff were kind and responsive if they needed care or support. One person told us, "The staff come in to check on me and if I need anything I can ring my buzzer." Another said, "I am looked after very well here." A relative confirmed that staff were responsive to their requests and explained, "Sometimes I ring up and ask if [name] can be ready in 15 minutes for me to take her out. Staff get her ready immediately."

Care plans were available for all people in the home and regularly reviewed to ensure they reflected people's current needs. The plans were sufficiently detailed to support staff in meeting people's needs in a way they preferred, taking into account their likes and dislikes. For example, one person had a health condition that could sometimes impact on their emotional wellbeing. There was a detailed care plan to guide staff in supporting this person at such times. Speaking with staff and looking at daily records confirmed that all staff who supported the person knew and followed the guidance in their care plan.

However, the care plan stated that any incidents of agitation should be recorded on 'ABC charts'. No charts had been completed although daily records confirmed there had been several episodes of agitation and challenging behaviour. This information could help staff identify if there were any patterns or themes emerging from incidents and therefore identify how to prevent these incidents from occurring again.

Staff were knowledgeable about people's needs and their wishes and preferences. One person told us, "Staff know me and how to look after me…. They bring me a cup of tea in bed every morning. I usually get up after I have had my tea and then staff bring my breakfast of one Weetabix with milk and toast and marmalade." Another told us, "Most of the staff know my needs very well but it's more difficult when it is agency staff as you have to tell them everything. There's been quite a few agency recently." The registered manager acknowledged they had used agency staff to cover a number of shifts, but had now recruited new permanent staff. They were confident that as new staff started work, people would receive more consistent support from staff who knew them well and understood their needs.

Staff were responsive to people's behaviour and requests for help. One relative told us, "I've noticed the staff observing the residents' behaviours. There's no friction, but staff use distraction techniques if anyone is getting a bit upset or in someone else's space."

At our last inspection visit we found the limited provision of activities within the home increased some people's risk of falling, as they spent long periods of time not engaged in meaningful activity. At this inspection we found improvements had been made.

The provider had developed the role of the activity co-ordinator and there were now two activity co-ordinators who worked seven days a week from 8.00am to 3.00pm. We spoke with one of the activity co-ordinators who told us, "I'm there for the stimulation of people. It is challenging to get people involved so I keep changing the things I do to try and encourage them to get involved." They explained how they recorded what activities people had participated in so they could ensure they offered activities that people enjoyed and were meaningful to them. Activities offered included musical bingo, armchair exercise, quizzes

and memory games.

During the morning of our visit we saw people were encouraged to join in a ball game which involved counting. Nobody was forced to join in, but people responded positively when asked if they wanted to participate. Some people moved from the lounge they were sitting in to the lounge where the activity was taking place which encouraged mobility and built up strength. People who chose to participate had some mental, as well as physical stimulation in addition to the social engagement with people. After the game some people enjoyed singing some songs together before it was time for their lunch. At the end of the session we heard the activity co-ordinator say, "Thank you for a lovely morning everybody."

Some people preferred to spend time in their rooms and did not choose to participate in group activities. The activities co-ordinator explained how they used the afternoons to spend time with those people on a one to one basis. They described how one person had a particular interest in music and said, "We are always chatting about music. I am taking them to a local concert in Leek in a couple of weeks' time." People clearly enjoyed their one to one interaction with one person telling us, "I'm 96 years old and too old to join in activities but [name of activities co-ordinator] pops into my room. I've had my fingernails varnished." Another said, "The activity worker pops in to chat to me. Staff are always popping in. A staff member brought me a Kindle to use to read, we've only got it going today. It's good as books are too heavy for me to hold."

People told us they did not have any complaints about the quality of the service. They told us if they had any complaints they were confident to raise them straight away with members of the management team. They told us any complaints were usually resolved promptly and to their satisfaction. One person told us, "If I had any concerns I would tell [name], the deputy manager. Anything I mention gets sorted out." Another said, "I've never had to complain but if I did I would speak to the manager. I would tell her and she would sort it out." A relative confirmed, "I've got no complaints but if I had I would speak to [name], the manager." The provider had not received any complaints since our last inspection visit.

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection we found the provider did not have effective systems in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. We judged this was a breach of Regulation 17. At this inspection we found improvements had been made. Systems and processes had been introduced by the provider to monitor the quality of the service, but these needed to become embedded in every day practice to be consistently effective.

Since our last inspection visit the provider had recognised the registered manager needed more support and guidance to improve the quality of the service. They had introduced a deputy manager role within the home to provide leadership to the care team. The provider had recently appointed a new care director to the provider company who had a clinical background. Their role was to provide oversight and support to the management team at Dresden House. The registered manager spoke positively about the support they now had and said, "Now we can all work together and achieve the best outcomes for everybody."

At the time of our inspection visit, the registered manager had been on extended leave for four months and only just returned to work. The deputy manager had assumed all managerial responsibilities during this period, including the implementation of the new processes and procedures. The care director told us that now the registered manager had returned to work, they would be able to consolidate and build on the progress that had been made in their absence.

Staff and relatives told us the provider had been open and transparent about the issues identified at our last inspection visit. One relative told us, "After the last inspection I received an email from a director asking if I had seen the report on line. Since the last report I have seen some improvements here, I think there are more staff." This openness was apparent in the minutes of a staff meeting after the inspection. The provider had explained how they accepted the report and discussed how the management of the home needed to change to more robust monitoring. The provider had closed the meeting by confirming their 'willingness to improve care practices and more forward to a happier, more organised environment.'

Staff felt supported by their managers. They told us they had regular opportunities to talk about their role and responsibilities and were encouraged to share their views and ideas. Records of meeting minutes showed meetings were an opportunity to discuss developments in the service, best practice and areas of concern. For example, changes in staffing levels during the evening had been discussed with staff to ensure they were effective. Staff particularly valued the support they had received from the deputy manager during a significant period of change within the service. One staff member told us, "[Name of deputy manager] is brilliant. Anything we don't understand, she always tells you what to do. Any concerns, she comes onto the floor and helps us." Another staff member said, "[Name of registered manager] tries to deal with problems and has a lot of compassion."

Staff spoke positively about the new paperwork that had been introduced by the provider to monitor and assess people's health, safety and wellbeing, such as food and fluid charts. There was also a system to monitor the paperwork to check it was being completed accurately and care was being delivered as

planned. Regular checks on records of those people most at risk were being completed to ensure they were safe, had call bells to hand and drinks were available to them. Where any gaps in the records had been identified, these were discussed with the staff involved. For example, one monitoring check had identified that staff had not recorded the outcome of a medical visit by a nurse practitioner. The deputy manager had called the surgery to ensure the information was accurately recorded in the person's file and then arranged for the staff involved to have extra training in record keeping.

On the whole we found the new system of monitoring had driven improvements within the home. People's care plans were regularly reviewed and improvements had been made in how the registered manager and staff responded to accidents and incidents. However, the checks had not identified that one person's ABC charts were not completed as required, that staff were not consistently following the advice of a healthcare professional or that staff were not recording how much medicine people had been given when it was a variable dosage. The registered manager acknowledged there were still some issues, but felt they would be addressed now they were back in their role full time. They explained, "The new system is working better, but we are still picking up on things. We have a rolling rota so we now have a person in a management position on duty seven days a week." The care director confirmed, "It is early days and I think the monitoring has to be embedded, but I think they are on the right track."

At our last visit we identified that the requirements of the Mental Capacity Act 2005 had not been followed in accordance with guidance. At this inspection we found this was still an area where managers and staff needed further training to consolidate their understanding of their legal responsibilities under the Act. Further improvements were needed to ensure staff had the right skills to support people who may lack capacity to make all of their own decisions.

At our last inspection we could not be assured that systems were in place to monitor and improve the quality of the care at the home. At this visit people told us, and records demonstrated, that people had been asked for their views and suggestions about the home. One person told us, "I went to a resident's meeting about a month ago, but my memory is not too good on dates." Another person told us, "I know the manager, she sometimes calls in for a chat." At a meeting to discuss menus one person who followed a vegetarian diet was asked if there were any new options they would like to try. Other people were asked what dishes they would like to see on the menu. Following a meeting to discuss activities, some people were now involved in food preparation after they said this was something they would enjoy. The care director told us this was something they wanted to develop as they moved to more person centred care based on the individual preferences of each person living in the home. They explained, "It was very much everybody was the same and it wasn't individualised care."

At our last inspection we identified that the registered manager and provider had failed to notify us of some safeguarding incidents as required under our registration Regulations. At this inspection we identified that whilst the provider had appropriately reported some incidents to the local authority safeguarding team, they had not always notified us. This was a continuing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection the provider was not displaying the ratings from their last inspection visit as required by the regulations. At this visit the ratings were displayed in a communal area of the home.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify us of some safeguarding incidents as required under our registration Regulations |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was not acting in accordance with the Mental Capacity Act 2005. Mental capacity assessments had not been completed when there were concerns that people were unable to consent, and best interests decisions had not been evidenced. |