Mr Paul Bliss

Leonard Elms Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 29 and 31 January 2018 and was unannounced.

At our last inspection in July 2017, we found breaches of legal requirements. This was because we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .These related to unsafe care and treatment; poor governance and the need for consent.

This service has been in Special Measures since June 2016 and at least one domain has been rated Inadequate since October 2015. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. However, it is rated as Requires Improvement as further time is needed to demonstrate the improvements can be sustained.

Following the inspection in November 2016, we imposed a condition on the provider's registration. This was to prevent new people from being admitted into the home. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and when. We found that during this inspection the action plan had been followed and improvements had been made.

Leonard Elms is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service comprises two units, the Cherries and the Elms. The Cherries unit specialises in dementia care and the Elms unit is for general nursing care. The home can accommodate up to 73 people and on the days of our inspection, there were 31 people living at 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, people were not always receiving safe care and treatment as medicines were not consistently managed safely. At this inspection, we found sufficient improvements had been made. Medicines were stored and administered safely to people living at the service.

At our previous inspections, people who lacked capacity did not always have decisions made following the principles of the Mental Capacity Act 2005. Improvements had been made. Staff understood the importance of seeking people's consent to care and treatment in line with legislation and guidance. Information about the service was made available to people in user-friendly formats and staff communicated with people in the way best suited to their needs.

We have made a recommendation to the provider regarding the involvement of people's legal representatives, when people cannot make decisions for themselves.

At our previous inspection, we found that people were not always receiving individualised care. At this inspection, improvements had been made. People received care that was responsive to their needs. Staff worked in a flexible way in response to people's needs. Some people preferred to spend time in their rooms rather than the communal lounge and this was respected. Staff learnt about people's needs from reading their care plans and talking with them and their relatives. However, not all care plans reflected this.

At our previous inspection, we found that people's records were not always completed correctly or monitored to manage their health conditions. At this inspection, we found improvements had been made. Staff worked together as a team to ensure people received consistent person-centred care. The staff were well trained and knew how to support people effectively. They understood people's physical, mental health, social and cultural needs and ensured they received a personalised service. For example, staff assisted people to move safely, make choices, and have their medicines when they needed them.

We have made a recommendation about the detailed recording of support for people whose behaviour challenges the service

At our previous inspections, we found that the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Their audit systems had not identified that the continued breaches of the regulations had failed to be sufficiently rectified. At this inspection, we found that improvements had been made, as quality assurance systems and process were now in place to monitor the service and drive forward improvements. Following the providers action plan, required actions were completed in a timely manner and lessons learned were shared with staff to help improve the service.

People felt safe at the service because the staff were competent and caring and the environment secure. Relatives said staff were vigilant about people's safety and prevented or minimised the risk of falls.

Staff protected people from harm and knew whom to contact if they had concerns about a person's wellbeing.

There were enough staff at the service to meet people's needs. The names of staff on duty each day were displayed on a wall so people and their relatives could see who they were.

The staff employed were suitable and safe to work with people using care services.

People told us that the food was good, they had a choice, and there was enough food available for them. Menus were based on healthy eating choices and people's dietary needs and preferences. Mealtimes were relaxed and staff socialised with people while assisting them with their meals. Staff encouraged people to drink and remain hydrated.

Staff supported people to maintain good health and access healthcare services in the local community when they needed to. They understood people's healthcare needs and knew when to refer them for specialist support. Relatives said staff kept them informed about their family members' health and communicated any concerns quickly.

Staff knew how to support people if they needed end of life care and understood their roles in providing comfort, mouth and other types of care, and pain relief medicines where necessary.

There were items of interest and reminiscence in the communal areas and corridors following different themes including gardens and the seaside. All areas were clean, fresh, and hygienic.

The staff were caring and understood the importance of treating people with dignity and respect. They took the time to sit with people and chat to them about the things that were important to them such as their families and the things they liked to do. People's relatives and friends could visit at any time and were made to feel welcome.

People told us that if they had any complaints they would tell one of the staff on duty or the manager. The service's complaints procedure was displayed at the service and people were given a copy of this when they began using the service.

People were encouraged to participate in both one to one and group activities depending on their preferences. The service's activity organisers planned activities based on people's choices and were available over a seven-day period.

People and relatives told us the service was well led and the staff provided good quality care. Staff told us morale at the service was high, communication good, and teamwork effective. The atmosphere at the service was positive. The provider had systems in place to quality assure the service and help ensure a high standard of care and support was provided.

Significant Improvements have been made since the previous inspection. We found no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 mainly safe but the provider now needs to demonstrate that the improvements can be sustained.

People had risk assessments in place identified and provided guidance to staff and how to reduce and/or mitigate identified risks.

People's medicines were managed and administered safely.

People were protected from harm, as there were effective safeguarding policies were in place. All staff were able to demonstrate a clear understanding of safeguarding and whistleblowing.

People were protected as the service followed an effective recruitment processes to ensure appropriate recruitment of staff.

People were cared for by sufficient staff to meet their needs.

Accidents and incidents were recorded, investigated and analysed to ensure lessons were learnt to prevent any further reoccurrences.

Is the service effective?

Requires Improvement

The service was effective.

The service was working within the principles of the Mental Capacity Act (2005). Best interest's procedures were followed when people lacked capacity to make informed decisions. However, not all decisions involved people's legal representatives.

Staff had received a range of training to ensure they could effectively meet people's needs.

People were provided with a wide variety of nourishing meals. Their food and fluid intake was monitored to ensure their nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People who lived in the home and their visitors spoke very highly and consistently of the care provided.
Staff were caring and kind and treated people with compassion.

Staff communicated with people in a way that was accessible to them.

Staff respected people's privacy and dignity and involved them in decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was mainly responsive.

Care plans were regularly reviewed, however not all contained sufficient details for staff to deliver care effectively.

There was a suitable complaints procedure for people to voice their concerns.

The manager of the home responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

Is the service well-led?

Requires Improvement

The service was mainly well led but the provider now needs to demonstrate that the improvements can be sustained.

Changes had been put into place following the last inspection to make improvements and meet legislation. Regular and effective audits had been implemented.

People felt able to express their views.

Relatives were involved in the service and staff felt able to engage with the management team.

The management team understood their role and responsibilities and had developed a culture, which encouraged

learning and good practice.

The quality of the care people received was monitored and the manager had checks in place to ensure people were supported effectively.

The coordination between staff and other agencies was effective and people received consistent care.

Leonard Elms 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.

This inspection took place on the 29 and 31 January 2018 and was unannounced. It was carried out by two adult social care inspectors, a pharmacist inspector and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, there were two adult social care inspectors.

Before the inspection, we reviewed information we kept about the service, including previous inspection reports and compliance monitoring reports from the local authority. We also reviewed the provider's action plans, which were regularly submitted to CQC.

During the inspection we used a range of methods to help us make our judgements. This included talking to 11 people, three relatives and three health and social care professionals who were visiting the service. We also spoke with nine members of staff, the registered manager, the training manager, the operations manager and Dementia Lead nurse.

Some people at the service may not be able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us. We observed care and support in the communal areas. We reviewed seven people's care and support records and eight staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies and audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2017, we found that the provider had not met the regulations in regards to the management of medicines. Staff were not recording the administration of medicines correctly. In addition, the provider had not met the regulations in regards to having effective risk assessments in people's care plans, especially where people were at risk of developing pressure damage to their skin. The home did not have an effective cleaning schedule, which meant people were at risk of infection as the home was not routinely cleaned. The provider had sent us an action plan and we checked if measures implemented were effective.

At this inspection although we found improvements had been made we have rated this key question requires improvement as further time is needed to demonstrate the improvements can be sustained. The service has been rated Inadequate in this key question since October 2015. The home has a significant number of vacancies and the provider needs to demonstrate that safe care can be provided when the numbers of people accommodated increases.

During our inspection, we looked at the systems in place to manage medicines. Improvements have been made since our last inspection and the medicines policy has been updated to reflect these changes.

At this inspection, we found, people were receiving their medicines safely. Medicines were stored securely. Temperatures were being recorded daily to ensure medicines were kept at appropriate temperatures. However, we found one fridge was not set as required to keep medicines at the optimal temperature. Staff confirmed the fridge was new and in the last five days, the temperature had not been reset back to zero so the records could not provide assurance that medicines were always stored within the range specified by the manufacturers. We fed this back to the registered manager and they arranged for a new fridge to be delivered. There were suitable arrangements for storing and recording medicines that required extra security. There was a system in place for the ordering and disposal of medicines and appropriate records were kept.

Records showed that all nurses had completed medicines management training and that medicines competency assessments had been completed for those staff who administered medicines. Nurses and suitably trained care staff gave people their medicines and recorded this on medication administration records (MARs). We reviewed 22 people's MARs. All MARs charts had an up to date photograph of the person, how they liked to take their medicines and any allergies.

All MAR charts were completed and recorded that people had received their medicines. Stock amount was carried over and reflected the accurate amount of medicines carried over. If a medicine was not administered the reason why was recorded. These records showed that people were given their medicines in the way prescribed for them. Care staff applied creams and other external preparations and records showed they were being applied as directed. Protocols for medicines, which are to be taken when, required were available and specified when a dose should be administered.

Where people required their fluids thickened staff were aware on how they should be prepared according to the manufacturer's guidance. However, during the first day of the inspection we found people's fluid thickener was not being stored as required to prevent accidental ingestion. This meant it could pose a risk to people's safety. There was no risk assessment that identified the risk or what measures had been taken to reduce the risk. We fed this back to the registered manager on the first day of our inspection. They took action to safely store the fluid thickener in a locked cupboard where access was limited to authorised staff.

People were administered 'homely remedies' if needed. These are non-prescription medicines that allow staff to respond to people's minor symptoms appropriately. There was a policy in place that staff followed and an accurate record kept when medicine was given.

Internal medicine audits were being completed on a weekly and monthly basis. The provider had also recently had an external audit completed by the supplying pharmacy.

Medicines that required greater security were being safely stored. Controlled drugs were stored and managed appropriately.

Care plans contained risk assessments for areas such as falls, skin integrity, choking and malnutrition. These were reviewed regularly. When risks were identified care plans provided clear guidance for staff on how to reduce the risks. For example, mobility plans detailed any equipment that was needed to move people safely, such as hoists and slings. Where people were able to mobilise with the use of mobility aids, these were listed, including details such as, 'give calm instructions.' In addition, 'give reassurance to ensure [individual] feels safe.' When people had fallen, incidents had been reported and advice had been sought from the Falls Team. This advice had been incorporated into the care plans. We observed staff following care plan guidance when supporting people to move around the building.

Some people had been assessed as being at high risk of developing pressure ulcers. In these cases, the plans detailed any pressure relieving equipment in use, such as air mattresses and specialist cushions. When people needed to have their position changed regularly, in order to avoid skin soreness, the required frequency was documented. Position change charts showed that people had their positions changed in accordance with the care plans. All of the air mattresses we looked at were set correctly and there was a clear process in place for checking these.

During the inspection, one person started coughing after eating some cake. Staff were quick to respond and sat with the person to ensure they did not choke. Two other members of staff discussed the person and one said "I will make a referral for a swallowing assessment." This showed that staff responded swiftly to concerns about people's safety.

At this inspection, we found that all areas of the home were clean. Cleaning schedules were in place with a list of cleaning duties to be completed. A team of cleaning staff were also visible throughout the day in all areas of the home. We walked round the home and looked at all bathrooms and shower rooms and found them to be clean and accessible. We were told by the registered manager that there was a comprehensive redecoration plan in place that will transform the communal areas and make them more dementia friendly where appropriate.

People and relatives told us that they felt safe living at Leonard Elms Care Home, and were happy with the care and support that they received from staff. Comments included, "I find it very nice here"; "I think they're marvellous here- all the staff. I don't know how they find me though!"; "I'm ok here" and "Staff are kind and treat me well". One relative told us, "She is safe here. I've never really considered she would be anything

else".

The provider had a safeguarding adult's policy in place, which gave information about the different types of abuse and staff members' roles and responsibilities when identifying, and reporting suspected abuse, people were protected from avoidable harm and abuse. All of the staff we spoke with said they had attended safeguarding training. Through scenario - based questions all demonstrated that they knew how to recognise signs of abuse and how to report any concerns about abuse. Comments included "I would report it immediately." In addition, "I would speak to the nurse. Then it gets reported, and then goes to the safeguarding team." One said "Because we know people well, we understand the triggers that might make people get agitated so we can step in."

Staff also said they felt able to raise any concerns about poor care. All were familiar with the term "whistleblowing" and all knew how to report internally using the provider's procedures as well as knowing they could also contact the commission.

During the inspection, we found sufficient numbers of staff to meet people's needs. A process for allocating staff specific people to support each day had recently been introduced and staff spoke highly of this. Comments included "It's so much better now. We all know who we are looking after each day. Its more organised and we get more time with people." All of the staff we spoke with said they felt there was enough staff. One said "It's a lot better, we hardly use any agency staff", another said "Yes, we always have enough" and "Staffing levels have got a lot better". Throughout the inspection, staff were visible and call bells were answered swiftly. Staff did not seem rushed and were able to attend to people's need in a timely manner. Rotas seen for the days of the inspection confirmed that the stated number of care staff were present in the home. Relatives told us that they thought that there were enough staff on duty, comments included;"There are enough staff here to manage. There is never a shortage" and "There is a good call bell response ".

The provider had safe recruitment processes in place to ensure staff recruited and employed were safe to work with vulnerable adults. A number of checks and assurances were required including criminal record checks, written references, proof of identity and confirmation of nurses and Nursing and Midwifery Council registration and validation.

The provider recorded all accidents and incidents through an electronic system. All information relating to an accident or incident was recorded on the system with details of the person, details of the incident or accident that had taken place, the actions taken, any investigative action taken and any lessons that were learnt. The registered manager reviewed all accidents and incidents on a daily basis and also produced management reports on a monthly basis to review all accidents and incidents for trends and patterns in order to implement improvements to prevent re-occurrences where possible.

Records confirmed that all care staff had received food hygiene training. All food preparation and storage areas were clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures.

The home had a 'grab bag' for use in the event of an emergency. This is a bag that contains items such as high visibility vests, a torch and spare batteries, a mobile phone with emergency contact numbers, blankets, water, people's medication and mobility details and staff contact details. The home had a business continuity plan in the event of evacuation.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in July 2017, we found that the provider had not protected people against the risk of poor nutrition and hydration, as accurate records were not being maintained, especially concerning food and fluid charts. This meant people were at risk of not having enough to drink. At this inspection, we found the provider had made the required improvements.

During this inspection, we found people were supported to have enough to eat and drink. Nutritional care plans were detailed and included information for staff on people's food and drink preferences, the type of cup or beaker they preferred to use and any specific positions people needed to be in when eating and drinking. People's weight was monitored and when people lost weight they had been reviewed by the dietician. Some people were having fortified diets or had specialist dietary needs when required. In these instances, the care plans detailed the specialist textured diets that people required and when people needed thickener added to their drinks, the required amount was documented.

Where people were having their food and fluid intake monitored all charts had been completed in full. Charts had daily targets written on them and staff had documented how much fluid people were offered, alongside how much they had drank. When people refused food or drinks, this was also documented. The charts were totalled at the end of each day and records showed that these were monitored. Staff said they had worked hard to ensure accurate food and fluid intake was recorded.

We found that improvements had been made to the way in which fluid charts were completed. We looked at all of the current charts and all of these had been completed and totaled correctly and where people's fluid intake had been below the recommended daily intake, appropriate actions had been taken which included regular monitoring and where required, referrals had been made to the appropriate healthcare professional.

During the inspection one member of staff was heard informing an agency worker, "Make sure you write down how much you offered people and don't take away any cups without checking exactly how much people have drank." Team leaders said, "We check the charts throughout the day. If someone is below target, that means we've got time to encourage more fluids before the shift ends." Throughout the inspection, people were regularly offered drinks and snacks.

People were positive about the meals. One person told us "The food is great". Another person told us, "(The food) Is fine, plenty of choice". Another person told us, "How can you complain when you're spoilt?" One relative told us, "Food is good; she has had no weight loss. I often eat here as I visit every day"
We observed lunch on both days of the inspection. On our first day we observed lunch in The Cherries which was served in both lounges. This was not a positive experience for all people.

We observed that people who chose to eat in the smaller lounge, which was used by people as a smaller dining room, lunch was not as positive as it could be. We saw that there was no menu for people to choose from, people had to wait for their meals, no visual choice was offered to people and a new member of staff

who was supporting someone with their meal did not interact with the person.
We fed this back to the registered manager and the dementia lead and they assured us that this was not what they expected from their staff and they would conduct a staff meeting to re iterate what is expected of staff to ensure a positive meal time experience for people, for example, when staff are supporting someone with their meal, to talk with them, offer choice even if staff know what the person likes to eat.

In the larger lounge, two people were seated on separate tables; six people were seated in armchairs with small tables. All ate independently apart from one person who was supported with their meal by a member of staff seated next to them. The staff member maintained eye contact with the person, explained what the food was, did not rush them, and made conversation throughout the meal.

People were all offered clothing protectors and consent was gained before putting them on. Staff all wore appropriate protective clothing whilst serving lunch. There was a large pictorial menu on the wall, which was new, staff told us how useful it was for people and how the food cooked in the kitchen looked like the pictures. We noted that a choice of drinks was offered before and throughout the meal.

When the food arrived, staff showed people a choice of meals so they could choose what they liked and it was well organised an efficiently delivered.
On the second day of our inspection in the Cherries we saw an improvement, in the small lounge. One person sat at the table and was supported to eat their meal. Two other people sat in armchairs and two members of staff assisted them. They gave encouragement such as "Look what I've got; it's your lunch and it's your favourite", "Is it nice?" and "Would you like a cold drink or a cup of coffee with it?" We found it a more positive and appropriate mealtime experience for people.

On The Elms more people sat at the dining tables. The tables were laid, and people had access to condiments and drinks. We observed many positive interactions. For example, staff asking people if they were enjoying the food and "Would you like some more?"

People's nutritional status was monitored with referrals for additional support from professionals, such as dieticians and SALT when required. People who experienced difficulties with swallowing were well catered for. The chef told us they were due to go to specialised training, which would enable them to provide tasty and appealing food for those people who required a puréed diet. At present, they bought meals in from a specialised outside caterer.

At our previous inspections, people who lacked capacity did not always have decisions made following the principles of the Mental Capacity Act 2005. 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.

At this inspection, we found the provider had made improvements to people's care plans in order to ensure that people's human rights were promoted. Staff had received training on MCA so they understood their responsibilities.

We found that consent to care was sought in line with legislation and guidance. Staff understood the principles of the MCA. . They said, "I always offer choice to people. Every day is different for them so, for example, I would show someone a choice of clothes, or meals. Even if I know someone prefers tea, I still offer them coffee in case they fancy a change." In addition "We ask families what people prefer, but I always offer

people choice." During the inspection staff regularly offered people choice. For example, we heard a member of staff say to one person, "Would you like to go in the big lounge? I can show you the quiet lounge too and then you can choose which you'd prefer."

People's mental capacity to consent to aspects of their care had been assessed. When people lacked capacity, best interest decisions had been made. Best interest decision recording had been undertaken for the use of bed rails, sensor mats and covert medicine administration. The documentation in place showed who had been involved in these decisions and how the decision had been reached. However, there was one instance where one person had a named lasting Power of Attorney (LPA) in place for health and welfare. Although best interest decisions had been made, the LPA had not been involved in the decision making process. Staff had documented that they had tried to contact the LPA by phone, but had been unsuccessful. However, no other methods of contacting the LPA had been made. We discussed this with the Dementia Lead and suggested they write to the LPA. This is because the LPA is the legal decision maker and therefore must be involved in the decision making process.

We recommend that the service seek advice and guidance around the involvement of people's legal representatives in decisions regarding their health and welfare.

Some people were receiving medicines without their knowledge, known as covert administration. Records confirmed the provider had followed the Mental Capacity Act and had undertaken a best interest decision that included a GP, who agreed that this was the most effective way for people to receive their medicines, and family members. During the inspection, staff were reminded by notes in the care plans and in handovers by the deputy manager to try to give people their medicines without disguising it in food or crushing it. However, it was noted that one person had requested it be given to them in yoghurt or honey.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager understood their responsibilities in relation to DoLS and actively submitted applications to the local authority when this was required, to ensure people were only deprived of their liberty lawfully and in line with current legislation.

We found that staff training was up to date with annual refreshers provided to enable them to maintain their skills. An induction programme was in place for new staff that was aligned to the Care Certificate. The Care Certificate is a nationally recognised qualification that ensures workers have the introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care. Staff said they had access to training and development in order to undertake their roles. Several staff said they were due to commence dementia training later in the week; all staff felt confident this would enhance their roles. They also said they had regular face-to-face training and one said, "The training we get now is more in depth." One staff member said, "I know we're getting up to date training." Nurses said they had access to ongoing professional development. One said, "I've done epilepsy training, and syringe driver training. We've also got access to the local hospice for training."

All staff said they had regular supervision sessions. One member of staff told us, "We're having supervision sessions a lot more often now. But any problems we can speak to our line manager." Another member of staff told us, "Supervisions are regular, and we can go and see a nurse or the manager in between if we need to." There were also annual appraisals in place, which enabled staff and the registered manager to track progress throughout the year and set the goals and training needs for the following year.

People had access to medical professionals when this was required to ensure their health status was maintained. People told us staff were prompt to obtain medical assistance when it was required. A GP visited every two weeks to review people's needs. There was evidence of liaison with a range of health professionals in people's care records to ensure they were involved and kept up-to-date about changes in people's medical conditions. One person told us, "I see the nurse first, and then it gets passed down the system". Another person said, "They call the doctor when required and I see the chiropodist who cuts my toenails." There was evidence the needs of people living with dementia had been considered. We observed use of tactile objects and signage and the registered manager told us that the provider was planning to overhaul the decoration of the whole service and make the Cherries more dementia friendly. They wished to provide bespoke nursing and dementia care in the future.

Good

Is the service caring?

Our findings

People told us that they were treated with dignity and respect at all times. People also felt staff were kind and caring. Comments included: "Staff look after me very well here" and "Staff are alright. They are kind to me. They look after me well". Relatives told us "Leonard Elms have been very good. They cared for Mum after she had been ejected from two other homes for biting and scratching. They have coped and were willing to try. It was a great relief for all the family". Another stated "Staff are wonderful- very caring I can't praise them highly enough. The care is consistently good" and " She is as happy here as she can be"

During the inspection, we observed many positive interactions between people and staff. The atmosphere was relaxed and staff did not appear rushed. Staff spent time with people; they sat with them and had meaningful conversations. Staff used people's first names and staff we spoke with were able to tell us about personal likes and dislikes and about people's backgrounds and history. For example, one member of staff said. "Hi [name] how are you today? OK?" The person responded by saying, "No". The member of staff then asked, "oh dear, what's the matter?" The member of staff tried to cheer the person up by playing music. The member of staff said, "What do you fancy? Johnny Ray? I'll see if I can find it on my phone and play it for you". This demonstrated a positive interaction where the member of staff spent time understanding why the person was not feeling okay and what might cheer them up.

However, on one occasion we observed two staff moving one person into an armchair using a hoist. When they had finished the procedure, one member of staff said to the other "Do you think they are comfy?" rather than asking the person themselves. The other staff member did say "Ask them." We spoke with the registered manager about this incident and they told us that the Dementia Lead would conduct supervision with the staff member and remind them of their responsibilities. Apart from this one incident all interactions between staff and people, both social and task orientated, were caring, kindly, patient and non-patronising.

Staff understood the importance of providing discreet care to people, maintaining confidentiality in line with the provider's policies and procedures, and protecting people's privacy and dignity. Staff were able to give examples of how they kept doors and curtains shut, covered people up, and spoke to people whilst supporting them at all times. Staff meeting minutes showed that privacy and dignity issues were regularly discussed and good practice promoted to help ensure staff were aware of their responsibilities. Staff spoke passionately about their roles. One member of staff said, "It's the residents that have kept me working here. I never thought the care was bad before, but I do feel we're meeting people's needs more now; we have more time to sit and chat" to people. Another member of staff said, "I absolutely believe that people get good care here, staff have a great rapport with people". Another member of staff told us, "We do provide excellent care here. I would put my parents here."

People's relatives and friends could visit at any time and were made to feel welcome. One relative said, "I can come when I want, there's no restrictions, the staff are friendly, they make me welcome, offer me tea, and talk to me and I can have a meal if I want too." During our inspection, visitors were welcomed, offered refreshments, and asked how they were.

Staff were quick to respond if people appeared distressed or confused. We saw one person becoming very agitated and shouting out. Staff came promptly and reassured them. They told them what they were going to do to help and the person calmed down very quickly. Another person became distressed and a member of staff appeared at her side but the person wanted to see a specific member of staff, they were quickly found and came to see them, which calmed them.
All people looked well cared for with clean clothes, hair and fingernails. Nails were short and well cared for. People were all smartly and appropriately dressed and glasses and hearing aids were being worn. Some people had items with them for comfort. Everyone who was sitting down were in comfortable chairs and many had blankets round their legs. Those people who were unable to walk without the use of a wheelchair and were not wearing shoes or slippers had thick cosy socks on their feet.

Some information about the service was made available to people in user-friendly formats, for example in large print, pictorially, or with the use of symbols. The registered manager told us that they were planning to have all information in accessible formats. We observed staff communicated with people in the way best suited to their needs. Staff used a variety of communication methods including touch, facial expressions, and spoken English. This helped to ensure people were kept informed about events at the service and able to play an active role in these if they wanted to. Records showed people, and their relatives where applicable, were involved in making decisions about care and support. Assessment and care planning documentation showed people were consulted about their wishes when they first came to the service and then on an ongoing basis. Relatives told us staff contacted them if there were any changes to their family member's care or if any issues arose. One relative said, "If there's anything wrong they'll get in touch with me."

The service had received cards and letters thanking staff for their care, kindness and support, which showed relatives and friends' level of satisfaction with the service.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in July 2017, we found that people were not always receiving responsive care, as the care plans relating to people's needs were not up to date or lacked sufficient detail. There was a continued breach of Regulation 9 of the Health and Social Cate Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had made the required improvements.

People's care plans were person centred and detailed people's preferences and choices. However further development was needed to ensure people's psychological needs would be met consistently. People's care plans did not always detail clearly people's mental health needs. For example, in one person's plan it was documented that, "there should be no reference to war, violence or any distressing event" and "see mental health section", but there was nothing documented to explain why this was. Records also confirmed the person experienced hallucinations. Staff should, "explore the contents" [of the hallucinations], but gave no further information on why or how this should be done. However, other mental health plans had more detailed information. For example, behavioural strategies for people who experienced periods of agitation were clear and informed staff how to support people when this happened. In one person's care plan, it was documented that the person experienced less agitation when their personal items were close by. In the same person's care plan it also confirmed a change to the person's normal routine could increase agitation.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning around specialist behavioural support for people.

People's care plans included details of people's preferred routines for getting up and going to bed. People's preferences in relation to their food and drink were documented. Personal hygiene plans contained important information such as the brand of toothpaste people preferred. Most plans contained details of people's social preferences In one person's plan it was documented that they liked opera music and enjoyed attending church services at the home. In other plans, this level of detail was missing. For example, in one person's plan it was documented they liked to watch TV and listen to music, but their preferred programmes and preferred music was not recorded. People's preferences for the clothes they preferred to wear had also not been documented, although staff were able to demonstrate they knew people's preferences well. Staff, knew who preferred to listen to which type of music and which television programmes they liked to watch. One member of staff said, "We do read the plans. It helps us get to know people". Another member of staff said, "The nurses have started asking us for more detail now when the plans are reviewed." We fed this back to the registered manager and they acknowledged that there had been a great deal of progress since the last inspection but it was on going and the managerial audits of the quality of care plans were now highlighting issues such as these, which we saw in their care plan audits. The registered manager assured us that they would ensure all the omissions were written into the plans asap.

People care plans had support plans that detailed how staff should support the person and what to do if they had concerns relating to their diabetes or bladder care

People had advanced care plans in place. These included details about whether people wished to be buried or cremated for example. Care plans had been regularly reviewed. However, it was unclear how often people or their advocates were involved in these decisions because none of the plans we looked at contained this information. The registered manager confirmed this would be rectified by the second day of our inspection. Action had been taken by the second day.

At the beginning of each shift, there was a staff handover. At every shift change, the nurse in charge of each unit, held a handover meeting to discuss the care of people on their unit or if there were any problems with the running of the service to keep the registered manager up to date. Staff confirmed they attended handovers on their particular unit

There was a suitable complaints procedure accessible to people who used the service and their relatives. The complaints procedure told people how to complain, whom to complain to and the timescales for complaints. This procedure included the contact details of the Care Quality Commission. The registered manager recorded any complaints and the outcome of any investigation. This showed the registered manager responded to any concerns raised. People told us staff listened to them. One relative told us "Staff are reactive and responsive- they ask if you have any concerns".

The provider employed two activities co-ordinators who ensured that there was someone available seven days a week. There was a full and varied activity programme. This was split between communal activities and 1:1 time for people. There appeared to be a lot of emphasis and time spent doing 1:1 especially on the Cherries unit, the registered manager told us that people enjoyed having time with staff or the activities co-ordinators and it ensured that no one was isolated if they chose to stay in their room or not participate in the group activities.

During our visit, one of the activities co-ordinators spent most of the day playing their guitar and singing to people either in their bedrooms or in communal areas. They did a lot of reminiscing about old songs and this led to conversations about other life experiences people have had. A lot of music was played here and varied from classical to popular music, which people appeared to enjoy. People were asked by staff what they would like to listen to. People appeared engaged with the live music on both units by joining in and recalling their memories. People told us, "I don't really get too much involved with the activities here, but staff comes along to do things on a 1 to 1 basis with me". Another person told us, "I don't do a lot really. I sit in here in the warm". Another person told us, "I like to sit in the garden when the weather is nice". Another person said, "I watch TV and read and join in with the music ". Where service users did not want to engage in activities we saw that staff engaging with people in communal areas throughout the day, reading books, doing puzzles or just reminiscing. Entertainers, we were told came in every month.

Staff gave mixed feedback in relation to whether people had access to meaningful activities. Comments included "I think it's a lot better now. People have singing, reading, one to one". Another member of staff said, "I think there's enough for people to do." One member of staff said, "I don't think there is enough for people to do. I know we have another activities person now, but I do not feel that what is provided is stimulating enough for all of the people living here. It would be nice for people to go out more." We spoke with the management team about this and they explained that they were looking at buying a home minibus for more trips out.

One person told us that they are regularly supported to go to church and are actively involved in the church community. The registered manager told us that the local Methodist minister regularly comes in to perform services for those people who wish to worship in the home. They explained that they did not have anyone living at Leonard Elms at present from any other faiths however if there were, they would make sure that

person would be able to access that.

Children from a local preschool had come into the home to provide entertainment at Christmas and birthdays and special days were celebrated with cakes, a party and cards.

Requires Improvement

Is the service well-led?

Our findings

At this inspection although we found improvements had been made we have rated this key question requires improvement as further time is needed to demonstrate the improvements can be sustained. The home has been in Special Measures since June 2016. The home has a significant number of vacancies and the provider needs to demonstrate that safe, good quality care can be provided when the numbers of people accommodated increases.

At the last inspection in July 2017, we found the service was not well led, as the systems had not identified the concerns we found during the previous inspection in February 2017. These include: safe care and treatment; need for consent; person centred care; and good governance. The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Their audits had not identified the shortfalls. At this inspection, we found the provider had improved the audits although there were still actions required. The operations manager showed us the action plan for the coming year, which built on progress made since the last inspection.

The registered manager and the operations manager confirmed the vision and plans for the service. This was following feedback on the service and improvements required since the last inspection. For example, an audit of infection control was carried out regularly. This had identified where an area of flooring requiring attention. Action had been taken to address this problem. Other quality audits looked at care delivery. The registered manager used this to inform the changes they needed to make. This meant people received care and in a safe clean environment that was good quality

We found there were systems in place to check the quality of the care people received. Since the last inspection, changes had been introduced such as the way staff recorded where people had topical pain relief patches applied. Areas had been introduced for staff handover to take place and there were increased activities for people. The registered manager told us about their plans for the future. These included a continued focus on staff recruitment, consideration of improving their electronic care planning and look at train the trainer courses to improve access to some training. This showed there were plans in place to improve the quality of life for people using the service.

There were systems in place to check medicines were being administered as prescribed. The system ensured people received medicines as prescribed and checked medicine storage, ordering and stock. We found staff had regular updates to their training and could access refresher courses. The training manager had a training matrix in place, which helped them to plan and schedule staff training when it was required. Staff told us they had regular opportunities for supervision and team meetings.

All staff said there was an open and supportive culture where they were encouraged to make suggestions and be involved in improvements. They said "We've all been involved. We've been asked for our views on new things" and "It helps that the team are willing to change. We can get it right and we want to get it right." One said "It's so much better. We [the staff] are more involved. There's better communication." Staff said morale was "a lot better than it used to be" and "Morale is good now. I feel really valued." Several staff said

the provider always made of point of thanking them for their work when they saw him. Records confirmed this. People received support from staff that had been trained and were well supported. Management audits were carried out to ensure the environment was safe and the policies and procedures were being followed.

Everyone we spoke with during the inspection visit told us the manager was accessible and they felt able to approach them about any issues or concern. One person said, "The manager is good, they are here most days and always have a walk around and ask how you are". A relative told us, "The manager is really good, they always ask how I am and seem to know how [person's name] is doing". Staff spoke highly of the registered manager. Comments included "The management team are all really good, they listen." And "The manager is fair and approachable. You can go to her with anything and she really listens." Other comments were "The manager wants high standards of care and so do I." and "I feel really supported by the manager. We work closely together and I feel respected, supported and listened to."

All of the staff we spoke with were aware of previous inspection reports and were familiar with the service's improvement plan. Comments included, "We've been waiting for CQC to come in. We're in a much better place now" and "We're more on the ball now". Another staff member told us "We've made massive changes. We've got more structure now" and "It's a totally different home now."

Staff told us that the provider was investing in new technology. The operations manager explained that for those people who were living with dementia, the provider was committed to buying a "Magical Table", which is a light animation system. The activity system offers meaningful games for people living with moderate to severe dementia, by encouraging them to participate in games consisting of interactive light animations which are projected on to any table and which motivates and stimulates those living with a dementia to be active. We spoke with staff who had attended the demonstration with people, and they told us that people became really animated and others who did not usually join in with activities joined in. One member of staff said, "It was lovely, seeing people moving and taking part, I hope we get it soon."

People had residents meetings where issues were raised by people. Action plans were drawn up by the registered manager after these meetings demonstrating how and when they were actioned. Records confirmed this. One relative told us about meetings which were held for relatives and how the registered manager shared their vision for the future at the meeting. The relative felt, the meetings enabled people to make suggestions and hear about any changes. They told us, "Yes I find the meetings useful" and that "Communication has improved recently" We saw there were notes from these meetings were available for people, which showed how individual issues were discussed and plans were shared for the service. This meant people and relatives views were sought and used to shape the service. If relatives were unable to attend those meetings, emails of the minutes were sent them.

The registered manager told us there was a system in place to regularly check care plans were up to date, people's preferences were understood and clearly recorded and their rooms were safe. Checks were recorded on people's care plans and were identifying where things needed to change. For example, one care plan had been updated following a discussion with the person about their meal and activity preferences. Staff were becoming more involved in this process and could describe how this provided assurance people were getting the care they needed. In another example, the manager told us they had a system in place to monitor people's weight and track for any weight loss; this was then reported to the doctor and advice sought on improving the person's diet.

All Deprivation of Liberty Safeguards applications were being reviewed by the registered manager to make sure they were still in date and relevant for the person. The operations manager had introduced a range of systems to ensure the staff worked collaboratively for example by introducing a new management structure

and new clinical leads. Both deputy managers were clinical leads and had oversight of people's clinical needs. They gave direction to the nursing staff and provided guidance on the deployment of staff. There was also a dedicated Dementia Lead Nurse, who provided support and guidance to staff as they had had specialist training via Stirling University, that specialises in innovations in the care, support and treatment for people living with dementia

The operations manager told us that they were redesigning the questionnaires for people, relatives and staff to make them more relevant to the service and more user friendly. They showed the staff questionnaires that had been sent to staff the month before. They also told us that they were looking into using technology to support those residents who were unable to complete the questionnaires.

Handover meetings were held and staff were updated on any changes with people's care. The registered manager had engaged with external professionals and had accessed good practice networks to improve the care people received. This meant the registered manager had systems in place to provide consistent care and sought best practice from other professionals

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications.