Camelot Care (Somerset) Limited

Acacia Nursing 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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was unannounced and took place on 7 and 8 June 2017.

Acacia Nursing Home is a care home which is registered to provide care including nursing and accommodation for up to 41 older people. The provider was applying to CQC to reduce this to 39 people due to recent renovations at the home; 27 of the bedrooms were going to be for people with dementia and 12 bedrooms were going to be for people with general nursing needs. At this inspection there were 33 people living at the home with one of these people in hospital during the inspection. The current provider started running the home from September 2016 and specialise in supporting people with dementia. There were people with various stages of dementia living in the home during the inspection with limited verbal communication skills. The home had a number of people who wished to live a more independent lifestyle within the safety and security of the care home.

The building is purpose built and has a courtyard garden in the middle. There are three floors with communal spaces such as lounges and dining rooms on each floor. At this inspection everyone had their own individual bedroom. The provider has some people completing periods of respite as part of a pilot scheme with a local hospital.

There is 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.

People were not always kept safe at the home because staff did not have access to the most recent records for some due to a transfer to electronic care plans. Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. However, the ones in use by staff were not always complete or the most up to date version. People were not always protected from abuse because external agencies had not always been informed and actions taken had not been recorded.

Most medicines were managed safely and stored appropriately including those requiring additional security. However, some improvements were needed for when a medicine was mixed in with food or drink and some people's medicine stock being transferred to other services.

The home had not always been well led. People told us the management was supportive and had made positive improvements to make the home a happier place. The registered manager and provider had some systems to monitor the quality of the service and made some improvements in accordance with people's changing needs. However, some concerns found during this inspection had not been identified by the registered manager or provider. They had not completed statutory notifications in line with legislation to inform external agencies of significant events.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. However, when people lacked capacity the statutory principles had not always been followed. People who required special diets had their needs met and meal times were treated as a social opportunity. Staff had the skills and knowledge required to effectively support people. People told us their healthcare needs were met and staff supported them to attend appointments.

People and their relatives told us, and we observed that staff were kind and patient. People's privacy and dignity was respected by staff and their cultural or religious needs were valued. People, or their representatives, were involved in decisions about the care and support they received. People who had specific end of life wishes had their preferences respected by staff to help provide a dignified death.

Care and support was personalised to each person which ensured they were able to make choices about their day to day lives. A programme of activities was in place to provide a range of opportunities. People were encouraged to suggest activities and trips which would respect their hobbies and interests. Complaints were fully investigated and responded to in a timely manner.

We made a recommendation about making decisions for people who lack capacity.

We have found one breach in the Care Quality Commission (Registration) Regulations 2009 and two breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 always safe.

Some people could have been put at risk because their current care plans were not being kept up to date with changes and reviews which had occurred.

People could expect to receive their medicines as they had been prescribed. Some improvements were required for medicines hidden in food or drink and stock transferred to other locations.

People had some risks of abuse or harm minimised because staff understood the correct processes to be followed. However, the management were not always informing external agencies and actions taken had not always been followed through.

People were protected from the risks associated with poor staff recruitment because a safe recruitment procedure was followed for new staff. However, there were not always enough staff to meet people's needs at key times of the day.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always respected because the principles of the Mental Capacity Act were not always followed. People's choices were respected.

People benefitted from good medical and community healthcare support.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

People were supported by staff who had the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People were able to exercise their religious beliefs. Visitors were welcome at any time, and people's routines were personalised to allow this.

People's privacy and dignity were respected and supported.

People had a dignified death because staff were respecting their end of life wishes.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff because their care plans contained important information which was personalised to their needs.

People benefitted because staff made efforts to engage with people throughout the day. Activities were in place in accordance with people's interests.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were not being kept safe because notifications were not being sent in line with legislation.

People were not always kept safe because the provider and registered manager quality assurance had not identified concerns found during the inspection.

People benefitted from living in a home where the provider and registered manager supported staff and there was a staffing structure to provide lines of accountability.

People and others were able to make changes at the home as they were consulted about their views on how the service could be improved.

Acacia Nursing 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 7 and 8 June 2017 and was unannounced. It was carried out by two adult social care inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As this inspection was brought forward following concerns received the provider had not completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the provider's action plan, spoke with other health and social care professionals and looked at other information we held about the home before the inspection visit.

We spoke with eight people that lived at the home in detail and four relatives. We also had informal conversations with people at the home as we walked around and completed the inspection. We spoke with one of the providers, the registered manager, operations manager, deputy manager and eight members of staff including nursing staff, activities staff and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine people's care records in various depth and observed care and support in communal areas. We looked at staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints and complements files, staff and resident meeting minutes, medication files, people and staff questionnaires, environmental files, activity records, person information guide, statement of purpose, provider internal communication documents and a selection of the provider's policies.

Following the inspection we asked for further information including provider's policies and actions taken by the registered manager and provider. All these were responded to in the time frame we asked for the

information.

Requires Improvement

Is the service safe?

Our findings

Records relating to possible risks to people were not consistently completed to ensure these were accurately monitored and mitigated. People were not always protected from accidents and incidents being repeated because there was a mixed approach to how the management responded to accidents and incidents. We found five recent accidents or incidents recorded which had an incomplete manager's section. For example, one person was hit with a television remote by another confused person. There was another incident with no management follow up about a problem with a hoist during a transfer. The registered manager was verbally able to tell us some actions which had been taken to keep people safe and mitigate risks of reoccurrence. For example, one person whose behaviour had related to two of the incidents had recently had a medicines review. Their care plan contained no information about this medicines review. This meant records were not always updated to ensure the information was being shared with all staff to keep them informed of the person's changing needs.

People's care plans had risk assessments relating to areas of their care such as the risk of skin breakdown, falls, nutrition and medicines. When a risk was identified, a plan of care was created to mitigate or reduce an identified risk. For example, if a person was identified at risk of falls guidance on how to support the person safely when they mobilised was recorded. In addition, an equipment safety care plan was created when equipment such as a hoist or stand-aid was used. However, we found one example where risk had not been fully assessed. Their assessment of risk of developing a pressure ulcer had not been correctly completed; it did not have the person's nutritional risk score so did not accurately reflect the level of risk. The person's nutritional risk plan from the same date was also incomplete. Although there was no clear impact on the person, the person was exposed to risk due to incomplete risk assessments. We spoke with the operations manager who showed us this person's new electronic care plan which had completed risk assessments; these were not accessible for the staff because they had not been printed out and put in people's current care plans.

Other people had risks which had not been reviewed in a timely manner. For example, three people at high or very high risk of pressure related wounds had not had their risks reviewed every month as the care plans instructed. We spoke with the operations manager who showed us risk assessments had been completed and reviewed where necessary as part of the transfer to an electronic care plan systems. They acknowledged part of this should have included the print out of the reviews and completed risk assessments. By not doing this care staff were unable to access the latest care these people should receive which placed them at risk of harm or inappropriate care. One member of staff confirmed with us they looked in the paper care plans for the latest information about pressure care. As not all of these records were up to date there was a risk that care would not be provided in a safe way to people.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found people were not always kept safe from the risk of abuse and harm. Staff told us, and records seen confirmed, most staff had received training in how to recognise and report abuse; the

operations manager explained all the gaps. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. They thought concerns reported would be fully investigated and action would be taken to make sure people were safe. One staff member told us, "The [registered manager and deputy manager's names] would straight away go and do something".

However, we found one person had a record demonstrating in March 2017 they had multiple bruises and a cut thumb. Staff had reported this to the nurse in charge. The registered manager told us the record had been part of a process of recording all marks on each person to provide a baseline. They told us a doctor had been consulted about the bruises and said it was a result of their medication. A cut on the person's hand was not explained. The incident form did not explain how the cut occurred or "Possible nail imprint" nor was there a record of communication with the doctor. They confirmed this concern had not been shared with the local authority safeguarding team nor CQC. This meant the system the provider had in place to protect people from harm or abuse was not always being followed. Following the inspection we spoke with the local authority safeguarding team to raise our concerns.

People were not always supported by sufficient numbers of staff at key times of the day such as meal times and early morning. One person said, "They really need more staff. They don't have time to stop and chat ever". Other people told us about their experiences of how quickly call bells were answered. For example, one person said, "It depends on when it is, sometimes it can be a while if they are busy. But mostly it's ok." One relative said, "If there is a down side it is the staffing. They are always so busy". Six people received little social interaction from staff at lunchtime once their food had been served because the two members of staff were not always present. One of the staff explained they had to provide support to people in their bedrooms at the same time. On another occasion we saw a person had to wait twenty-minutes to receive a drink as they were unable to get it themselves.

All staff we spoke with felt the current staffing levels did not give them time to provide personalised care. One staff member told us recently some people had moved in requiring higher levels of support. They said, "We currently can't attend to everyone's needs on time." Other staff said, "Some people have come in recently and we don't have the staff" and "Lots of pressure, we can't attend to everybody's needs on time". Three people told us their medicines can be late especially at night. We saw the medicine rounds did take most of the morning which meant the nurses were unable to be disturbed or complete other work. Due to staff absences the registered manager and deputy manager had been working additional hours in a nursing role. This meant their time had been split between managing the home and delivering hands on support so were unable to finish all their work.

A dependency tool was used by the provider and management to determine how many staff were required. This tool demonstrated there had been an increase in hours of support required by almost double between January and June 2017. The level of staff working had not changed between these times. By not increasing the levels of staff there was a risk people's care needs would not always be met. The operations manager told us they had been overstaffing the home in January 2017 so staff could complete training. They informed us they would reflect on our findings and take action to review staff levels at key times of the day.

People told us they were happy with the way their medicine was given. One person said, "We get the right medication". We saw staff waited until they were sure the medicine had been swallowed before moving on. The medicine administration records gave clear instructions how people liked to take their medicines and staff knew these. There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately

stored and clear records were in place. Staff told us and records confirmed there were observations to ensure people administering medicine were competent.

However, we found three people had begun to have difficulty swallowing their tablets or their tablets were mixed in with food or drink the pharmacist had not been consulted. On two occasions the doctor had been consulted. By not speaking with all health professionals they had not followed their own policies to ensure it was safe and the efficacy of the medicine had been considered. We spoke with the registered manager who said they would review one person's medicines who was seen chewing their tablets during the inspection and they were in the process of reviewing their pharmacist.

There was a system in place to record the stock of most medicines including those requiring secure storage. This included returning medicines which required safer storage following a person's short stay at the home. However, there were occasions when people would leave the home and there was no record some of their medicines had left the building. For example, one person had returned to hospital following an incident. Some of their medicine had been taken by ambulance staff to the hospital. There was no record this medicine had been handed over so the stock record was incorrect. This meant the record did not match the medicine in stock. We spoke with the deputy manager who told us they would put a system in place to record these transfers of medicine.

People told us they felt safe at the home and with the staff who supported them. Some people said, "I feel safe knowing they are there when I need help" and "I do feel safe. It's knowing someone is there if I need them". Relatives told us, "Before the change [meaning of provider] it was bad, really dire, but under the new ones it is better - ten times better than before" and "Oh yes, definitely" when asked if people were safe.

People were being kept safe because recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. In addition, the service had ensured that where necessary, a staff member's registration with the relevant body was current. This included nursing staff being correctly registered with the Nursing and Midwifery Council.

Requires Improvement

Is the service effective?

Our findings

Many people had limited capacity due to their illnesses such as dementia. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lacked capacity had not always had decisions made on their behalf following the principles of the MCA. Some documentation was historical and had been completed by the previous provider who owned the service. For example, within one person's file we saw mental capacity assessments and best interest decision processes had been completed in relation to the use of bedrails and lap straps which are restrictive practices. These had been completed in June 2016, prior to the new provider having legal responsibility for the service. In addition, the best interest decision for this person relating to the covert administration of medicines was dated July 2015, again completed by the predecessor provider. Without regular review of these decisions the provider could not be assured that these restrictive practice continued to be in the person's best interest. We spoke with the operations manager who showed us some reviews had occurred during the swap to electronic care records. These had not been made available for all staff to follow. They told us they would print them out.

Where people had been assessed as lacking capacity, best interest decisions were not consistently made in line with legislation. For example, during the inspection we identified two examples of where people had pressure mats within their bedrooms. Staff confirmed these pressure mats were used at night. A pressure mat is primarily used to help keep people safe, as it alerts staff via an alarm when people get up from their bed or a chair. Although in place to support the person, the use of a pressure mat is a potentially restrictive practice as it meant staff were monitoring the person's movement to reduce the risk of falls. Due to this, a best interest process should be followed to record if any other least restrictive options were available for consideration. When we reviewed the care records for both of the people we saw had pressure mats, there was no documentation to support the decision making process to use them.

We recommend that the provider seeks national guidance relating to the MCA and updates their current practice accordingly.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is 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.

There was a system in place that showed who had a DoLS application and the status of their application. Records showed that applications had been made for 23 of the 33 people living at the service. Records showed that 21 DoLS applications had been made on the same day in March 2017 and two made on the

same day in April 2017. All of the applications were currently with the relevant local authorities pending an assessment.

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. This included completing the Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the Care Certificate. In addition, the provider had an internal induction to ensure staff were familiarised with the service and key policies relevant to the new staff member.

People were supported by staff who had received training to understand their care needs and keep them safe. There was a training schedule that ensured staff received appropriate training to carry out their roles. Staff felt they were given sufficient training to effectively support people and meet their needs. This included moving and handling, health and safety, fire and safeguarding. Additional training was available to ensure staff could meet the needs of people they supported, this included training in dementia, challenging behaviour and nutrition. Nursing staff received training in clinical areas such as syringe driver training, catheterisation and tissue viability. The provider had systems in place to ensure staff received regular supervision and appraisal including the registered manager.

People were supported to have enough to eat and drink. They had a choice to stay in their bedroom, use the main dining room or one of the smaller dining rooms upstairs. One person said, "Most of us have lunch together at the tables. You always get a choice and the food is good". One relative said, "[Name of person] enjoys the meal and when I am here they always seem nice and hot too". We saw some people had chosen their food earlier in the day so when it was brought to them they had forgotten. We spoke with the registered manager, provider and operations manager who agreed this could be a problem so they would review how people chose their meal.

People had been assessed for the risks of malnutrition and dehydration. When risks were identified, care plans guided staff on how to ensure people received enough to eat and drink. When people had a special diet such as requiring a liquid meal we saw the feeding regime was recorded accurately and followed by staff. The guidance within the person's records was reflective of the guidance and instruction given by a specialist nurse.

Key information was held in the kitchen that related to people's medical conditions, for example any food allergies or if the person was diabetic. We saw that when people had specific dietary requirements, for example modified consistency food, this was highlighted within the kitchen. We saw that people's requirements were delivered in line with people's assessed needs over the lunch period.

The home arranged for people to see health care professionals according to their individual needs. There was always at least one qualified nurse on duty to make sure people's clinical needs were monitored and met. When people's health declined or they required specialist advice related to their health this was arranged. For example, one person was having an assessment during lunch from a speech and language therapist (SALT). Staff had recognised the person was coughing a lot when they were eating. The SALT was determining whether a special type of diet was going to be required.

Good

Is the service caring?

Our findings

We found people and their relatives said there were kind and caring staff. People told us, "They look after us very well. They get us to do what we can and then help with the rest" and "The staff are great, if you ask for something and they haven't got it they will go and get it for you if possible. Some relatives told us, "Staff have the patience of a saint. Loads of patience. Just lovely" and "The staff are so dedicated to the job they do. They are always happy".

We reviewed some compliments that had been received by the service since they opened in September 2016 that showed very positive feedback. This was consistent with people's views about the staff employed at the service that we obtained during the inspection. For example, one compliment said, "Please would you pass on my heartfelt thanks to the staff who were so generous with their time to my mother". Another relative wrote, "Wanted to write and thank all Acacian's for the excellent care you are taking of my Mum. I can see she is genuinely fond of her carers".

People's privacy was respected and all personal care was provided in private. When people required support with intimate care they took people to their bedrooms or a bathroom. Staff knew to keep the doors closed in order to protect the people's dignity. For example, one member of staff prompted another member of staff to close the bathroom door. The other member of staff smiled and explained the person had not gone into the bathroom yet. They confirmed the door would be shut as soon as the person had got there. Another member of staff told us they would respect a person's privacy by leaving the room during intimate care if they were asked to provide space.

People told us and we saw they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. We saw some visitors met their relatives in communal areas whilst others went to their bedroom. One person told us they were visited every week by their family member who brought them new books each time. One relative was positive about the staff and management making them feel welcome when they moved into the home. We saw staff including the management welcoming visitors to the home.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the main lounge areas and spent time in their bedrooms. Others preferred to remain in quieter lounges on different floors. We saw staff checked on people if they were in other areas of the home. For example, one person was in a quiet lounge on the top floor reading their book. A member of staff came in after about 20 minutes to check they had enough to drink. The staff member asked if the person was alright at the same time. The provider told us they had spent a lot of time restructuring the ground floor. This was to increase the communal spaces and give people choices of where to be. We saw they had decreased the number of bedrooms to make this change. People and their relatives were positive about this change.

People were able to make choices about the care they received. One person said, "I don't ever shower or bath but that's my choice" and staff respected their decision to wash daily instead. People were given options throughout the day including at mealtimes. One person chose when to have their glass of wine

during lunch. If people were struggling to communicate verbally staff tried to find alternative methods for them to communicate their choice. For example, during lunch a member of staff asked a person which drink they would like. They realised the person was struggling to understand and communicate so took each option to show them. The person then made a selection by pointing at a box of cranberry juice.

Most people were from a similar cultural or religious background. When they had specific wishes these were respected and recorded in their care plans. For example, one person's care plan informed staff about their strong Baptist upbringing. It continued to say they may want to attend church services. Staff told us there were opportunities for this person to attend the church services at the home on a regular basis. Staff had arranged the opportunity for people to have holy communions once a month.

During our conversations with staff it was clear they understood people's care needs well. Staff were able to explain people's individual care and support needs together with their social and lifestyle preferences. For example, staff told us people's preferred daily routines, for instance where they spent their day and what they wished to do in relation to activities. Staff commented on people's behaviours and told us how they managed them to reduce anxiety or distress to others living at the service. By understanding people's needs staff were able to provide kind and caring support for them.

People's end of life decisions were respected and followed by staff. When people were unable to express their choices their relatives had been consulted. For example, one person's care plan had clear instructions they wanted to remain at the home and not go to hospital. This was based on conversations they had with their relatives prior to moving into the home. Another person at the home was currently receiving end of life care. The staff were respectful and ensured the person was kept comfortable. The nurses had consulted with their doctor to prepare a special pack of appropriate medicines should they be required.

Good

Is the service responsive?

Our findings

People were able to take part in a range of activities according to their interests. One person told us there were trips which people go on. The activity timetable showed recently there had been trips to the seaside, museums and a local shopping centre. There were photographs of people enjoying these trips around the house. One relative said, "The Activities programme is constantly stimulating [person's name]. She enjoys doing everything. Anything that makes her think stimulates her mind". Other relatives told us, "The only thing that hasn't changed [meaning since the new provider] is the activities. They have always been good. The two activities people are really good, so patient and kind" and "They do so much with the residents and always have done. It is marvellous to watch".

We saw a range of activities happening throughout the inspection including games with a parachute, an entertainer visiting, a therapy dog visit and games of dominos. During the activities staff supported as many people to join in who wanted to and at their level of ability. For example, in the game of dominos one activity coordinator spent time helping people count the numbers on each domino during their turn rather than just saying if they had picked a domino which could be played. When the entertainer was about staff sung and danced with people and they were joining in. People were smiling and looked happy to be part of the activities. There were opportunities to decide future activities during the residents meetings. For people who chose to stay in their bedroom the activity coordinators would deliver individual sessions throughout the morning.

To inform people what was going on there was a monthly timetable. This showed two main activities each day. Some of the activities reflected discussions from the previous resident meetings. This meant people's suggestions had been listened to. On days a trip was planned both activity coordinators worked so one could lead the trip whilst the other stayed at the home. This meant people did not miss out on an activity.

People received care that was responsive to their needs and personalised to their wishes and preferences. For example, one person's care was being delivered in line with their assessed needs. This included the setting of their air mattress and being repositioned at a specific frequency to reduce their risk of skin breakdown. The same person's records highlighted the person was at high risk of choking, and provided guidance on the angle the person should be resting at to reduce their risk. We saw staff were following this guidance, and the emergency suction equipment listed as being required next to the person at all times was available. Staff we spoke with were knowledgeable about the person's needs.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. They contained additional information about people's life histories including previous employment and current or past interests. There was also guidance to staff about what was important for that person. For example, one care plan explained to give the person a sense of security they required their electric blanket and family photo albums in their bedroom. We checked and these were in place. Information of this nature can guide and aid staff when communicating with people living with dementia or a cognitive impairment as it may trigger memories and encourage the person to communicate.

There were monthly meetings for people who lived at the home and their relatives. These provided opportunities for people to discuss a range of topics including, the kitchen and mealtimes, the cleanliness of the home, the care they received and the activities. When suggestions were raised or concerns discussed we could see action had been taken. For example, one person in January raised they would like to know what the meal options were in advance. During the inspection we saw all meal options were shared on a whiteboard near the dining room.

The provider and staff were responsive to the needs of people and their relatives. Within the entrance foyer of the service there was a 'You said - We did' board. This was an information board that summarised action which had been taken by the service following meetings and suggestions in person. For example, the board showed people had complained of an odorous smell from old carpets when the provider had taken over and in response they had replaced them with specialist flooring. People had said the service was overcrowded in places and as a result the provider had reduced the service by two bedrooms to increase communal space. A further person had identified areas in the home the wireless network did not reach, so additional wireless access points were installed.

People had access to the provider's complaints policy and felt able to complain should they need to. One relative said, "I've never had to make a complaint to the new registered manager, but all the staff are very approachable. I wouldn't have any trouble in going to any of them and I am sure it would be dealt with straight away". The provider's policy was within people's welcome packs they received before moving into the service and explained the process to undertake. From reviewing the complaints log for 2017 it showed the service had received one complaint which had been responded to by the registered manager in line with policy. It was noted the current policy information in place for complaints did not contain information on how people could contact the ombudsman should they wish to escalate their complaint.

Requires Improvement

Is the service well-led?

Our findings

We saw they were approachable and greeted people and their relatives. For example, the registered manager walked into a lounge and said "Good morning" to each person in the room. One relative said, "[The registered manager] is very nice. They enquire if I am feeling alright. Very easy to approach and lovely". Staff told us, "I can speak about everything with management, they are supportive" and "The manager is very good, very kind and we can say anything to [them]".

However, we found the registered manager was not ensuring they were following the provider's policies and procedures. For example, the medicine policy said, "If the [person] has difficulties in swallowing medication the pharmacy should be contacted for advice". This had not happened for one person during the inspection to find if their tablets could be given as a liquid. They were not following the safeguarding procedures which stated, "Communicating concerns to the appropriate officers of the local safeguarding board and Care Quality Commission, in accordance with relevant legislation". Notifications had not been made to external parties. By not following the provider's policies and procedures there were inconsistencies in the care and safety people received.

We found there were quality assurance systems in place to monitor care and plan ongoing improvements; these had not always been effective in identifying concerns found. For example, there were audits and checks in place to monitor accidents and incidents, safeguarding and training. These were electronic so both the registered manager and provider could access them. However, these had not always identified concerns found during the inspection. For example, they had not identified the issue we found with risk assessments, lack of updates to capacity assessments or concerns with care records. Nor had they identified the inconsistencies with accident and incident records and a safeguarding matter not being reported. This meant not all concerns had been resolved by the registered manager or provider to keep people safe and meet their care needs.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. There had been seven safeguarding alerts reported to the local authority safeguarding team; two recorded CQC had been informed. We found none of these had been notified to the commission in line with their statutory obligations. A further safeguarding alert was found during the inspection which had not been reported to the local authority safeguarding team and CQC as required. By not notifying external bodies responsible for monitoring provider's people's safety could not be monitored. We spoke with the registered manager and operations manager they said this had been an oversight due to thinking other people had completed them. The registered manager informed us they would now ensure all significant events were correctly notified to CQC.

This is a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The new provider had set up an action plan identifying shortfalls when they had begun operating the home in September 2016. They had demonstrated how they had resolved some of these. For example, addressing the quality and amount of staff training and improving the downstairs environment to make it more dementia friendly. Further shortfalls identified by the management had been resolved. For example, setting up a medicines error book following mistakes with medicines so they could monitor future errors and identify possible patterns to prevent further occurrence.

There was a staffing structure in the home which provided lines of accountability and responsibility. Staff said they felt supported by the provider, the operations manager and the registered manager of the service. One member of staff explained how the management had supported them through training and said, "The management are very supportive, If I need anything I am happy to ask". The only less positive comments we received in relation to the management was that communication could be improved. For example, receiving more information when a new person moved in. The registered manager explained due to an illness the provider had been helping more than usual and this caused some differences in communication. They told us this should now be resolved because their health had improved.

The provider and registered manager had a system of monitoring concerns and implementing solutions. They used supervisions including group ones as an opportunity to discuss the work staff were delivering and highlight any training or development needs. Recently supervisions had been used as an opportunity to remind staff about their conduct and people's specific needs following concerns being received. For example, a group supervision in April 2017 reminded staff about being respectful to people including using English in communal areas and valuing their choices.

The provider and registered manager had developed links with a local college to provide opportunities for school leavers to begin a career in care through completing apprenticeships. Apprenticeships are work-based training programmes which allow staff to complete on-the-job training and gain relevant, nationally recognised qualifications. Their intention was to improve their workforce and the quality of staff they employed. They highlighted this was the first time the apprenticeships had been for non-care staff. The provider shared with us the positive news which had been covered by the local press and a specialist care industry publication.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to notify CQC without delay of significant incidents. This is a breach of Regulation 18 (1) (2)(e) of the Care Quality Commission(Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that all risks had been mitigated. This is a breach of Regulation 12 (1) (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people received safe care because records had not been accurately maintained and they had not fully put in place systems to monitor the quality of care people received. Those which were in place had not operated effectively to ensure compliance. This is a breach of Regulation 17

(1) (2)(a)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.