Care UK Community Partnerships Ltd

Farm Lane

Inspection report

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15 November 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7, 8 and 15 November 2016. The inspection was unannounced on the first day and we notified the provider we were returning on the second and third days. At our previous inspection on 25 and 26 November and 8 December 2015 we found the provider was in breach of regulations in relation to ensuring people were protected by proper and safe management of medicines, operating an accessible system for managing complaints, ensuring that systems were operated effectively to assess, monitor and improve the quality of the service, maintaining an accurate, complete and contemporaneous record in respect of each person using the service, operating effective staff recruitment procedures and ensuring the deployment of sufficient numbers of competent staff. The provider sent us a plan following the inspection explaining how they intended to address these breaches of regulation. We carried out this inspection to check that improvements had been achieved and sustained in line with the provider's action plan. At this inspection we found that satisfactory progress had been accomplished in relation to all breaches of regulation.

Farm Lane provides accommodation for up to 66 people on three separate units, which includes 14 rehabilitation beds on the ground floor unit. Central London Community Healthcare NHS Trust are commissioned to provide the therapy for the rehabilitation patients on this unit. The remaining 51 beds are used to provide nursing care for older people with healthcare needs due to frailty and older people living with dementia.

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 the time of the inspection the registered manager had resigned and was no longer working at the service. Farm Lane was being managed by an operations support manager (interim manager). People and relatives commented on the recent significant changes in management at the service, as the clinical lead (deputy) had also left the service since the last inspection.

People said they felt safe and staff competently discussed with us their understanding of how to protect people from abuse. Risk assessments were carried out and risk management plans were appropriately developed.

Sufficient numbers of staff were deployed in order to meet people's needs, and they were provided with relevant training, supervision and support. Staff recruitment was thoroughly conducted so that people received their care and support from staff who were suitable for employment at the service.

Satisfactory processes had been implemented to ensure the safe management of people's prescribed medicines.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act

(MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on our findings. DoLS are in place to protect people where they do not have the capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. The provider demonstrated that people's rights were protected and staff had received training to understand their responsibilities. Staff understood how to ask people for their consent before providing personal care and other support.

Systems were in place to support people to access health care, including specialist care and support to meet their end of life care needs. Positive comments were made in relation to the quality of the food and we observed that people were supported in a patient and kind manner.

We saw caring and respectful interactions between staff and people. Staff told us about how they supported people to promote their dignity, which was observed during the inspection.

People's needs were assessed before they moved into the service and further assessments were conducted once they moved in. This information was used to develop individual care and support plans that evidenced consultation with people and their relatives.

The activities programme provided people with social stimulation and opportunities to meet members of the local community, including young volunteers. There were specific activities offered to people living with dementia, for example music therapy.

People and their relatives were provided with information about how to make a complaint. There were effective systems to investigate and resolve complaints, and where applicable learning took place.

There were quality assurance systems in place to monitor the quality of the service and seek the views of people and their representatives. This monitoring had identified and addressed shortfalls in the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe and staff understood how to protect people from abuse.

Risk assessments were in place and written guidance informed staff how to mitigate the risks.

Safe recruitment practices were used to ensure people were supported by suitable staff.

Medicines were safely managed.

Is the service effective?

Good

The service was effective.

People were supported by staff who received suitable training and support for their role.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were provided with the support they needed to receive a balanced diet and access health care services.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and caring.

Staff ensured people were provided with care and support that was respectful and promoted their dignity.

People's wishes, likes and dislikes and choices were sought and acted on.

Systems were in place to liaise with external professionals in order to meet people's end of life care needs.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and this information was used to develop individual care and support plans.

The preferred routines, aspirations and wishes of people were reflected in the care planning process.

Activities were provided to support people with their social and spiritual needs, and some were designed to promote people's mobility.

People and relatives knew how to raise concerns and felt any concerns would be taken seriously.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager or clinical lead in post at the time of the inspection, which impacted on the sense of continuity experienced by people and relatives.

There were systems in place to promote good communication with staff.

The provider had taken clear actions to improve the service since the last inspection, which included regular audits and actions to seek feedback from people, relatives and stakeholders.

Farm Lane

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. The 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 2008.

This inspection was unannounced and was conducted on 7 November 2016, and we advised the provider that we were revisiting on 8 and 15 November 2016. The inspection team comprised two adult social care inspectors. Before the inspection we looked at information the Care Quality Commission (CQC) held about the service, which included the last inspection report of November and December 2015 and statutory notifications of significant incidents, which the provider is required by law to report to us. We contacted the local authority safeguarding team and Healthwatch Central West London in order to obtain their views.

At the time of this inspection 58 people were living at Farm Lane. We spoke with 12 people who use the service, 10 relatives, and 11 members of staff including care workers, senior care workers, staff nurses, an operations support manager (interim manager) and the regional manager. During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people living with dementia who were not able to fully share their views with us. We looked at seven care plans, six staff files containing recruitment, training, supervision and appraisal documents, health and safety records, a range of policies and procedures, quality assurance audits and minutes taken at different meetings for people who use the service, their relatives and friends and staff.

Following this inspection, we received comments from three health and social care professionals about the quality of the service.

Good

Is the service safe?

Our findings

At the previous inspection in November 2015 we found the provider was insufficient staffing, which had negatively affected the quality of people's care and impacted on the safe completion of records required to demonstrate that care was being delivered in line with people's identified needs. We had observed at the previous inspection that staff appeared to be task focused rather than spending time engaging in conversation with people and staff had stated there was limited interaction with people who spent all or a considerable amount of time in their bedrooms due to their healthcare needs, or through personal choice. Following the inspection, the provider wrote to us with a plan of actions they would take in order to make the necessary improvements.

At this inspection we received mainly positive remarks about staffing levels and how staff met people's needs. Comments from people using the service included, "I have to call staff every time I need to go to the loo, sometimes they are busy and I have to wait a bit longer but when they are not busy they come straight away. They are nice"; "Staff go out of their way to help you. The nurses are always here 24 hours a day" and "I was here a few years ago and asked to come back after an operation. The physios (physiotherapists) and OTs (occupational therapists) are marvellous. Support from the care assistants has been very good, they assist me to wash." However, one person told us, "The staff are smashing but they are overworked" and a relative said, "Staff are run off their feet, it feels short staffed. I don't have any complaints about how they look after [my family member], the care is alright." A second relative stated that their family member chose to stay in their bedroom, "Staff go in to see him/her, the care is good and they do what they can. One or two of the care workers are exceptionally good." A third relative informed us their family member had recently been to hospital and described how relaxing it was for their family member to return to the service, "There is a super atmosphere here, the staff are wonderful and such a help. It was so hectic at the hospital but here staff have time to be helpful and make [my family member] happy."

From our observations there appeared to be sufficient numbers of staff deployed to meet people's needs and we noted that the number of staff on duty was in accordance with the staffing rota. Staff told us they had previously experienced problems when the provider utilised agency staff, for example some agency staff had appeared to lack motivation and they were concerned about the consistency of care and support for people who use the service. We were informed the provider now used a vacant shift sheet so that permanent staff could apply to do overtime in the first instance before shifts were passed on to bank staff and finally agency staff, if necessary. This system enabled people to more regularly receive care and support from staff who were familiar with their needs.

At the previous inspection we had found that the provider was not demonstrating that appropriate measures were consistently used to protect people from the risk of unsafe staff recruitment. Following the inspection, the provider wrote to us with a plan of actions they would take in order to make the necessary improvements.

At this inspection we found rigorous recruitment procedures in place to make sure staff had the required checks before they commenced employment at the service. All of the files we viewed had a document

checklist in place confirming which records had been seen. There was an application form and interview record, which demonstrated that prospective staff were given questions and scenarios to establish their knowledge, experience and approach. Each file had two references in place which had been verified and there were documents to determine proof of identity and address, and right to work in the UK. Disclosure and Barring Service (DBS) checks had been conducted. The DBS identifies prospective employees who are prohibited from working with vulnerable adults and children and informs the provider of any criminal convictions recorded against the interviewee. Systems were in place to ensure that staff practicing as qualified nurses evidenced that they held current registration with the Nursing and Midwifery Council (NMC). These findings showed the provider took appropriate steps to ensure people using the service received their care and support from staff who were suitable for employment at the service.

We asked a registered nurse how they had been recruited. They told us they had been recruited from overseas and stated that it had been a very positive experience. They described how the provider had ensured they received good professional and practical support, "We had to complete interactive training in safeguarding, medicines administration and human rights. We had interviews on line, and had to provide references and education information. They explained how to register with the NMC. It was great and I'm very happy here."

At the previous inspection we found that the provider was not ensuring that people's medicines were consistently addressed in a safe way. Our findings were in relation to how the provider had given insufficient medicines support for two people who used the service. Following the inspection, the provider wrote to us with a plan of actions they would take in order to make the necessary improvements.

At this inspection we found that people were safely supported with their medicines. We observed that medicines were kept in a designated secure room and all controlled drugs (CDs) were stored within an alarmed and locked cabinet. We checked the stock levels of CDs received from the supplying pharmacy and found the quantities we checked reconciled with information recorded in the CD log book and were within their expiry dates. However, on the day of our visit, the first floor fridge thermometer used to monitor and record correct storage temperatures for certain types of medicines was not working. This issue had been recorded and reported to management and the service was awaiting the delivery of a replacement. Medicines administration records (MAR) we looked at were completed appropriately. We observed a nurse administering medicines to people with patience, taking the time to reassure and encourage where this support was needed and making sure people had water or fruit juice to hand. Staff told us they asked people if they were in pain and made sure they received pain relieving medicines and PRN medicines appropriately. (PRN refers to 'pro re nata', which means to give as needed). One person using the service told us, "I tell the staff if I'm in pain and they give me my medication on time." Staff demonstrated an excellent knowledge of people's prescribed medicines and were able to tell us why they had been prescribed specific medicines and in what quantities. Nurses told us they asked the visiting GP to review people's medicines if they had any concerns or queries. A visiting GP confirmed that they were consulted regularly about people's medicines and suggested that nurses could increase their responsibility when PRN medicines required adjustment. Staff told us they received medicines training, which was confirmed when we checked training and development records.

People who used the service told us they felt safe and well cared for. One person told us, "I want to stay here, I feel safe, there are staff on duty 24 hours and I'm quite happy." Another person said, "I have a bell I can ring here and staff come and help me. It's a good place and I'm doing very well." Care staff knew about the different types of abuse and what actions to take if they suspected that a person was being abused. Staff told us they had received safeguarding training and understood how to 'whistle-blow' about poor practice. A unit manager told us, "Safeguarding is about protecting vulnerable adults from abuse, physical, mental,

psychological, sexual and financial." Care staff told us they would report any concerns they may have to their managers, the local authority and the Care Quality Commission if required. (Whistleblowing is the term used when a worker passes on information concerning wrongdoings). We had noted at the previous inspection that some staff had not fully understood about how to whistleblow, however at this inspection visit we found that staff had been provided with additional guidance to gain a more comprehensive knowledge about how to avail of this process in order to protect people who use the service.

Staff used a comprehensive range of standardised health and well-being assessment tools in order to identify any risks to people's safety and/or that of others. These included; Frase (Falls Risk Assessment Scale for the Elderly), the Barthel scale to assess self-care, mobility and activities of daily living, the Waterlow score to estimate the risk of the development of pressure sores and CAPE (Clifton Assessment Procedures for the Elderly), used to assess people's quality of life and their physical and cognitive dependency levels. Other assessments addressed areas such as moving and positioning, nutrition and hydration, night care and fire evacuation. Where people had complex healthcare needs, further specific assessments were completed, for example, we saw that assessments had been completed in relation to catheter care, diabetes management and the use of supplementary oxygen. Risk management guidelines were clear and provided staff with sufficient information as to how to promote people's safety while encouraging them to be as independent as possible. Risk assessments were up to date and had been reviewed in line with the provider's policies and procedures.

We asked staff how they managed people who were at risk of developing pressure sores. A member of the care staff team told us, "We observe the correct moving and handling techniques, check pressure points regularly and reposition people. We keep an eye on people's fluid and food intake and check people's Waterlow scores. We have air mattresses and use protective dressings and barrier creams." Staff told us they had recently completed training in pressure area care from a tissue viability nurse. We checked one person's turning and repositioning charts and saw that this was being completed on a four hourly basis and comments added when this assistance had been refused. Body maps indicating the area of the body where pressure sores had developed were in use although we did not always see photographic evidence to support care delivery.

Records showed there were well organised procedures for ensuring the safety of the premises so that people, visitors and staff were not exposed to unnecessary risks. We noted that regular checks were carried out on a wide range of equipment and facilities, which included testing of fire alarm points, fire drills, water temperature checks and the checking of wheelchairs, hoists and window restrictors.

There were systems in place to ensure staff understood and followed appropriate infection control practices, in order to protect people from the risk of acquiring infectious diseases due to cross infection. Staff informed us they were provided with protective aprons and gloves and their training included guidance about appropriate hand washing techniques with liquid soap and/or antiseptic solution. We observed the premises were clean and free from any offensive odours. Sluice rooms and cupboards used for the storage of cleaning materials and Control of Substances Hazardous to Health (COSHH) items were kept locked when not in use by staff.

Good

Is the service effective?

Our findings

People and their relatives were generally positive about whether staff had the correct knowledge, skills and approach to meet their needs. Comments from relatives included, "The care is fantastic, we give it ten out ten", [My family member] is very well looked after" "Staff are wonderful and [my family member] is doing very well, he/she is even up and about which they weren't at home" and "It's not as good here as it used to be, staff don't manage his/her incontinence needs properly."

Staff were provided with an annual training programme to give them the skills and knowledge they needed to deliver appropriate care and support. Records showed that newly appointed staff undertook induction training, which included shadowing more experienced staff. The staff training matrix showed that staff attended mandatory training, for example health and safety, moving and handling, basic food hygiene and fire safety. Other training was provided that was pertinent to the health and social care needs of people who use the service, for example training to support people living with dementia and training about the prevention of pressure ulcers. The provider had implemented monitoring systems to identify if staff had not completed their required training within the established timescales and actions were taken to support staff to achieve full compliance. The provider's system for monitoring attendance at training and participation in online training produced instant reports that showed the percentage of staff that had completed the training. We noted that for some courses the percentages appeared low and discussed this with the regional manager. The provider demonstrated that this was being addressed, for example additional training courses had been scheduled to ensure that all staff completed their training programme within the designated period.

Records demonstrated that staff received regular supervision sessions and annual appraisals, to support them to meet people's needs and constructively review their own performance. Staff informed us that their individual and group supervisions provided an opportunity to discuss any training requirements, people's well-being and care delivery along with any work issues or concerns they might have. One staff member told us, "[Senior staff] always help me, we help each other. If you have a problem you get to express it and find solutions." Staff told us they were given opportunities to complete training and were due to complete a basic life support module on the second day of our visit. Staff told us they felt confident that they would be able to respond appropriately in an emergency situation. A member of care staff told us, "We check for danger, check people's airways and pulse, call for assistance, dial 999 and start rescue breaths and compressions if we need to. We were told that the service had a defibrillator on site although staff had not recently received training in its use.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making 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 people lack capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had a good working knowledge of current legislation and guidance in relation to the principles of the MCA. 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 Deprivation of Liberty Safeguards (DoLS).

The provider had identified people who they felt were being deprived of their liberty and had submitted DoLS applications to the appropriate authority. Systems were in place to monitor that any DoLS authorisations were in date. Staff demonstrated their understanding of the necessity to assess whether a person had capacity to make a specific decision and they were aware of the process they needed to adhere to if a person lacked capacity. We observed staff asking people what they wanted in terms of their support. Staff told us that if the person could not make certain decisions then they would have to think about what was in that person's "best interests" which would involve asking people close to the person as well as other professionals. Staff understood that people's capacity to make some decisions fluctuated depending on how they were feeling. The importance of always asking people for their consent before providing personal care and other support was understood by staff.

People's nutritional needs were assessed and when they had particular preferences regarding their diet, these were recorded in their care plan. Information was available in the serving areas in relation to special diets, diabetic food requirements, pureed meals and recommended drinks. Staff were observed to be following these guidelines. People using the service told us, "The food is marvellous", "I like the roast on a Sunday best, I used to work in the hospitality industry and the food is quite good here" "I had a very nice lunch" and "We have a very good breakfast. We can have what we like. I have boiled eggs and toast." Staff were able to explain the dietary needs of people who had diabetes or were on soft or pureed diets. Different meal choices were available and people were asked what their preferences were.

At lunchtime staff were available to assist people to eat and drink when they needed support to do this. We saw staff supporting and assisting people with meals taken in their own rooms. Staff sat next to each person and supported or fed them in an unhurried and respectful way, encouraging people to be as independent as possible and chatting to the person in an appropriate manner. A member of care staff told us, "I like to see that [the person] swallows at least twice so that there is no choking. It's not a race, we've got lots of time." We saw this staff member maintaining this person's dignity by wiping their face with a napkin when this was needed, offering drinks and explaining the menus and what meals were available. Snacks, hot and cold drinks and fresh fruit were available throughout the day and we observed people being supported by staff to access these items if they were not able to independently do so.

People and their relatives expressed their confidence in the how the provider supported them to maintain good health, and access other health care professionals and services to meet their needs. One person using the rehabilitation service told us, "I came here for physio and OT to try to get walking again. The staff are friendly and have given me a plan for the week with my exercises, I like the group exercise sessions." A relative commented, "I am here frequently and have spoken with the doctors that come here. They seem thorough and get things sorted." A GP visited the service three times a week and more often if required and care plans showed that other health care professionals, for example, palliative care and tissue viability nurses, chiropodists, nutritionists and dietitians had been consulted about people's needs. Copies of hospital discharge letters were kept in people's care records. A visiting speech and language therapist told us they worked with people with neurological impairments or following a stroke to support their rehabilitation. Therapists provided staff with guidelines or made recommendations as to how people's independence, health and well-being could be promoted. We were shown communication tools which were being introduced for one person following a stroke. Staff were aware of this person's particular needs and we observed them talking to this person gently and encouraging them to express themselves despite obvious difficulties.

Good

Is the service caring?

Our findings

Most people and their relatives told us that staff were caring and pleasant. Comments from people included, "I like the nurses, I get on with them and they seem friendly enough. It's very nice, I would recommend", "All the staff here are good, I have no problems at all", "It's very good, I am happy here", "If I'm cold I ask for another blanket. If you want a cup of tea or something to eat they make you a sandwich and bring it to you", "They wash me clean, they go out of their way to help you. They are very kind" and "I'm doing very well, the physios and OTs are very helpful."

People described specific care and support they had received from staff, which they regarded as thoughtful and considerate. One person told us they had lived and worked in the UK for many years and enjoyed British culture and food. They had appreciated how staff on their unit had introduced them to a member of staff on another unit who had also moved to the UK from the same country as a young adult. Although the person acknowledged that did not require any support with communicating in English or accessing foods from their homeland, they welcomed the friendly gesture to promote their wellbeing and comfort during their stay at the service. A relative told us they had looked after their family member at home for several years and had been reluctant to relinquish aspects of their role, for example laundering and ironing their family member's clothes. They praised the sensitive approach of staff, who had gently persuaded them that the service could take over this responsibility so that they could focus more on supporting their family member with their social needs.

At our inspection in November 2015 we had heard that there were some staff who could appear curt in the way they spoke with people and their relatives. Although many positive remarks were received at this inspection, we were informed by people and their relatives that specific members of staff required ongoing monitoring and guidance in relation to how they ensured that their interactions were consistently polite, obliging and compassionate. One person stated that particular staff could present as "up and down" in terms of their courtesy and two relatives told us they had experienced isolated incidents when staff had not conducted themselves in a helpful and professional manner. A person using the service and the relative of another person had found that staff did not always adhere to people's chosen routines, for example one relative told us that their family member was woken early in the morning although they had stipulated they did not want to be disturbed.

The staff we spoke with during the inspection demonstrated a keen wish to provide a caring and supportive service. One staff member told us, "I have compassion for people; I say to everyone, remember the 'Mum test'. Just imagine this is your mother or a person you care for. It's not about sympathy, its empathy." Another staff member said, "I loved this job from the beginning. You can make someone happy and see them smiling. You ask people how you can help, you can do something good for people" and a third member of staff remarked, "We receive cards and sweets all the time from relatives. They get in touch to say thank you. It's like a family, I love working here." We saw that staff were kind, professional, motivated and engaged well with people using the service. There were positive interactions observed between staff and people using the service during meal times, when people passed in the corridor or entered the unit offices to

speak with staff. Staff had the time to stop and talk or ask people if they needed any help.

Care records briefly set out people's preferences and the things that were important to people and how best to support them. For example, a one page profile explained how one person liked to go out into the garden and take their meals in the dining room and reminded staff of what this person did and didn't like to eat. There was also written guidance for the staff team to encourage this person to socialise with others to prevent isolation. The staff members we spoke with demonstrated a good understanding of people's likes and dislikes and their life histories. For example, one person using the service at the time of the inspection spoke limited English and had difficulties expressing how they wished their care and support to be delivered. The person was supported by relatives who visited daily and translated for their family member. We observed staff speaking with the person and their relatives, so that they could develop an individual plan to meet the person's needs and wishes.
During the inspection we saw people were treated with dignity and respect. We observed staff knocking on people's doors before entering their bedroom. Staff described to us how they respected people's rights to privacy, confidentiality and respect. One staff member told us, "We check with people if it is alright to come into their rooms after we have knocked unless there is a reason why we are unable to." Staff demonstrated an awareness of the importance of ensuring that people's dignity was maintained, for example staff told us they ensured people were not unnecessarily exposed when they were being hoisted in a communal area or being supported with personal care in a private room.

The provider had resources in place to ensure people experience a comfortable and dignified death. Staff informed us that the service benefitted from its professional relationship with the Trinity Hospice, which enabled them to access support and guidance from palliative care nursing specialists. Other appropriate support was provided by the GP, who made referrals to local health care professionals with expertise in meeting the different needs of people when they were approaching the end of their life. For example, a staff nurse told us about a person who had been supported by a dietitian when staff observed that their dietary and fluid intake was decreasing due to their increased frailty. During this inspection we did not have the opportunity to speak with any relatives who were in a position to comment on how the provider was supporting their family member with end of life care; however, relatives told us they would wish for their family member to remain at the service if at all possible for their end of life care rather than an admission to hospital.

Good

Is the service responsive?

Our findings

At the previous inspection we had found that the provider was not demonstrating that written records for people who use the service accurately reflected how the service met people's care and support needs. For example, we had found that although repositioning charts had been established for people at risk of developing pressure ulcers, these had not always been maintained correctly and we had found significant gaps in the recording of when people were repositioned. We had also noted that there was incomplete information and discrepancies with end of life care planning documentation, for example one person who was receiving end of life care did not have a specific plan in place, there was no relevant medical background in their care plan and visits from the palliative care professionals had not been documented in their care plan, although there was information recorded in the 'multi-disciplinary team' folder. Following the inspection, the provider wrote to us with a plan of actions they would take in order to make the necessary improvements.

At this inspection we found the provider had achieved and sustained improvements with the quality of record keeping in regards to the assessment of people's needs, the care planning and the documentation to demonstrate that care was being delivered in accordance to people's identified needs and their wishes. The care and support plans showed that people's needs were assessed prior to them moving into the service, and their care and support plans were developed in line with this information and other information acquired through additional assessments conducted when people commenced living at the service. The care and support plans provided clear information for staff to enable them to support people in accordance with their own wishes. Care planning took into account essential information gathered from people's clinical risk assessments, for example people identified as being at risk of developing a pressure ulcer had an individual care plan in place to detail the various measures staff needed to implement in order to protect people from developing a pressure ulcer.

We received positive comments from people and relatives about how the service ascertained their needs and wishes, and provided appropriate individual care and support. One person told us, "I broke my hip in two places and had an operation so I came to live here. It's a good place, the food is marvellous. My friends come to see me anytime they want. I go out in the garden in my wheelchair, they put a jumper on me and I have a cup of coffee." A relative described how their family member was provided with pressure relieving equipment and a high protein diet because of the known risks associated with their delicate skin and reduced mobility. The relative told us they felt well informed by staff about their family member's needs and were pleased to find a marked improvement in how the repositioning charts were kept up to date by staff. It was noted that the person did not always agree to allow staff to change their position; however, the relative was satisfied that staff consistently recorded how they endeavoured to support their family member to comply with the recorded guidance for repositioning in the care and support plan.

At the previous inspection we had found that the provider was not consistently ensuring that complaints investigations were well documented and properly concluded. Following the inspection, the provider wrote to us with a plan of actions they would take in order to make the necessary improvements.

At this inspection we found that improvements had been made and there was now a clear audit trail to demonstrate how the provider had processed and resolved complaints, and where applicable how issues within the complaints had been evaluated to identify what learning had been made. This showed that the provider understood the importance of listening to and responding to complaints, in order to meet people's individual needs and wishes and as part of their range of actions to improve the quality of the service. People and relatives told us they knew how to make a complaint and thought the provider would take complaints seriously. Information about how to make a complaint was given to people and their supporters in the Service Users Guide. People and their relatives and friends were also encouraged to raise any issues that could be improved on during the residents and relatives meetings. Two relatives informed us that they sometimes raised minor day to day concerns about the wellbeing of their family member and found that the management team and/or unit staff promptly addressed matters.

We found that people were supported by staff to pursue their interests and hobbies, and participate in social activities. Information about people's previous interests and their current preferences were recorded in their care and support plans, and each person was provided with a weekly activities programme. This included sessions such as quizzes, ball games, crafts and one-to-one time for people who needed to or chose to stay in their bedrooms. At the time of the inspection there were two activities organisers in post, as the third post was vacant. We were informed by the provider that interviews for the positon had been arranged and have subsequently been advised by the provider that a candidate had been offered the role, subject to the completion of recruitment procedures. We observed people taking part in activities during the inspection, which included a discussion session about articles in the daily newspaper at morning coffee time and a visit from a group of young students from a local school's sixth form. In addition to the close link with the local school which provided daily weekday visits during term-time, other positive relationships had been developed with religious ministers and organisations, and local groups such as the Brownies.

The service had arranged a series of music sessions for people with dementia, which was delivered by an external organisation 'Music For Life'. This is a project run jointly between the charity Dementia UK and the Wigmore Hall classical music venue in London, which aims to use music to enhance the quality of life for people living with dementia. We observed part of a session, which brought together people who use the service, their relatives, care staff and professional musicians. Following each session there was a reflection meeting attended by care staff, a member of the management team and the musicians in order to discuss what had been learnt in the session, and how that knowledge could be used to help plan people's future care and support. We saw people demonstrate personal skills and abilities that might not have been as evident in their daily lives, for example one person was a very accomplished singer. We later spoke with the person and learnt they had prior experience of singing with a group. One of the aims of the project was to also improve the morale of other people connected with the person living with dementia and improve the morale of staff. We observed staff showing their delight when people engaged with the music, either by singing, playing an instrument or sitting in quiet and meaningful way. One member of staff told us they had never experienced such beautiful and inspiring music in a small and informal setting, and they felt honoured to share the experience with people and their relatives.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in November 2015 we had found that the provider was not ensuring that systems were operated effectively to assess, monitor and improve the quality of the service. We had found the provider had not addressed issues of concern, for example inadequate staffing levels and the absence of a permanent staff nurse on the rehabilitation unit for six months. Following the inspection, the provider wrote to us with a plan of actions they would take in order to make the necessary improvements.

At this inspection we found improvements had been made to how the provider audited the quality of the service and implemented improvements. In addition to its own quality assurance systems such as written surveys and telephone monitoring calls to relatives, the provider used feedback from statutory health and social care organisations. The relatives of two people told us they had received telephone calls from an independent company commissioned by the provider to check if they were happy with the quality of the service. We noted that the provider had talked with relatives in an open and transparent manner at a meeting held soon after the publication of the previous inspection report and explained how they proposed to make the required improvements specified by the Care Quality Commission (CQC). Minutes for the residents meetings showed that people using the service were consulted about issues raised in the inspection report, for example people were asked about how they found the nursing and care staff in terms of their courtesy and approach. Feedback from people was satisfactory and included, "lovely carers", "they are ok", "very helpful" and "they are my friends."

Records showed that the provider had carried out a wide range of clinical audits since the previous inspection, which included the management of medicines, infection control, testing of competencies of registered nurses, care and support plans and associated documents, including repositioning charts and fluid balance charts. Unannounced monitoring visits were being conducted by the provider and the reports produced showed that documentation was looked at in addition to physical observations and discussions with people, visitors and staff.

There were clear measures in place to communicate with staff, which included daily short meetings conducted by the management with heads of department and the registered nurse in charge of each unit. Care staff told us they thought their line managers kept them up to date with any relevant changes they needed to know to ensure they appropriately undertook their duties. Staff told us they felt consulted and more valued.

At the previous inspection staff had told us that the staff turnover was high which they felt was unsettling for people who use the service and it impacted on their ability to provide a constant and consistent service. At this inspection we found staff were more positive about how the provider was taking suitable action to fill vacancies and ensure a stable environment. However, at the time of the inspection the service did not have a registered manager in post, as they had resigned and completed their shifts at the service. We noted the clinical lead (similar role to a deputy manager) had left in August 2016. The service was being managed by an operations support manager and we were assured that arrangements were in place to recruit a new manager and clinical lead. The absence of a registered manager impacted on people's ability, and their

relatives and friends where applicable, to comment on the leadership of the service. People and relatives conveyed that it was currently a difficult phase for the service due to the lack of a registered manager. A few relatives told us they felt that although the communal areas within the premises were welcoming and pleasantly decorated, the bedrooms had been overlooked and now needed attention. One relative stated it was difficult to know who to approach to discuss this as they were aware that the operations support manager was at the service on a temporary basis, hence it was important for people and relatives to establish a new relationship with a permanently appointed manager.

Records showed that the management team maintained records relating to accidents and incidents, which were checked by the provider to ascertain if there were any patterns of concern that needed to be addressed. The Care Quality Commission was appropriately notified of any events at the service that the provider was required by legislation to inform us about.