Creedy Number 1 Limited

Creedy House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 February 2017 and was unannounced.

Creedy House is registered to provide personal and nursing care for up to 44 people. There were 31 people using the service during our inspection. People were living with a range of nursing and care needs. These included: diabetes, catheter and continence management, pressure wounds, mobility support; and many people were living with different types and stages of dementia.

Creedy House is a large, detached premises situated in a residential area in Littlestone-On-Sea. The service was divided into two areas: The House which accommodated people requiring nursing as their primary need and The Lodge where people living with dementia had their bedrooms.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. The manager had applied to the Commission to become registered and the application was being processed at the time of this inspection.

This service was last inspected in August 2016 when it was rated as inadequate overall and placed into special measures. Eight warning notices were issued to the provider following that inspection and the provider sent us regular action and improvement plans to document positive changes.

At this inspection we found significant improvement in most areas, with a small number of issues which still required further attention.
Assessments had been made about different risks to people; and in most cases staff acted consistently to minimise those risks. However, there were two occasions when actions to reduce known risks did not happen all the time.

The management of medicines had improved overall but the storage and recording of prescribed creams needed addressing to ensure people received them safely and consistently.

There were enough staff on duty and they had received relevant training and supervision to help them carry out their roles effectively. Staff were observed putting their training into practice in a safe way. Most recruitment files contained all the required information about staff, but the minority needed further detail about past employments.

Staff knew how to keep people safe from abuse and neglect and the manager referred any incidents to the local safeguarding authority as appropriate. Incidents and accidents had been properly recorded and preventative actions taken. The safety of the premises was assured by regular and routine checks on utilities and equipment.

People received a choice of nutritious meals and were supported to eat and drink. Some recording of people's intake needed improvement to ensure it was clear and consistent.

A range of professionals were involved in people's health care and individual plans of care were in place if people had catheters or pressure wounds. Care plans about diabetes were updated during our inspection as they did not properly reflect people's needs.

Staff and managers worked within the principles of the Mental Capacity Act 2005 (MCA) which ensured people's rights and wishes were protected.

Staff were caring, supportive and kind. People's dignity was protected by considerate acts to make sure people had privacy when they needed it.

Complaints had not all been logged, creating a risk that they could be overlooked. However, the provider's complaints policy was publicised and people and relatives knew how to raise any concerns.

Care planning was person-centred, reflected people's individual personalities and highlighted their past achievements. A range of activities were on offer with specific sessions and groups designed for people living with dementia.

Provider and management oversight of the service had increased significantly since our last inspection. Most audits and checks had been effective in identifying and remedying shortfalls, but further input was needed in some areas. Feedback had been sought from people, relatives and staff and there was evidence that this had been acted on to improve the service.

We recommend that the provider ensures that quality and safety checks include observation of staff practice to see that it reflects care plan guidance and consistently minimises risks to people.

We recommend that the provider considers using a recruitment checklist to ensure that all areas are addressed for every applicant, in line with Regulation.

We recommend that the provider continues to use a dependency tool to determine the number of staff required to meet people's needs appropriately.
We recommend that the provider expands audits and management checks to include all medicated items, observation in relation to risk mitigation and complaints recording.

As this service is no longer rated as inadequate, it will be taken out of special measures. Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We will continue to monitor Creedy House to check that improvements continue and are sustained.

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 safety of the service had improved overall.

Actions to reduce known risks to people were not always taken by staff.

Medicines were managed safely but the management of creams needed further improvement.

People were kept safe from abuse or improper treatment.

There were enough staff on duty to support people and keep them safe.

Recruitment practices had improved but still required greater input to ensure all the appropriate information was held about staff.

Is the service effective?

Requires Improvement

The service was mostly effective but required improvement in some areas.

Food and fluid recording was not always consistent, but people received enough to drink. Picture menus had not been made available to support people to make choices.

People's health care needs had been appropriately met but blood monitoring had not been recorded for people with diabetes.

People's rights had been protected by proper use of the Mental Capacity Act (MCA) 2005.

Staff training and supervision was effective in equipping staff for their roles.

Is the service caring?

Good

The service was caring.

Staff acted sensitively to protect people's privacy and dignity.

Staff engaged well with people.

People were supported to be independent where possible.

Adaptations had been made to the service to support people living with dementia.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints had not all been formally logged and filed.

Care planning was person-centred and people's individual choices and preferences were observed in practice.

The activities provision had improved to include sessions and equipment for people living with dementia to enjoy.

Is the service well-led?

Requires Improvement

The leadership and culture of the service had improved significantly; with greater provider oversight and employment of a dedicated quality manager.

Most auditing had been effective but some areas needed greater input to ensure all shortfalls were identified and remedied.

Most records were well-maintained and kept confidentially. Staff daily notes however needed greater organisation to make them accessible.

Feedback had been sought from people, relatives and staff and suggestions for improvement were acted on.

Creedy House

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 8 and 9 February 2017 and was unannounced. Two inspectors, a specialist nurse advisor and an expert by experience took part in the inspection. The specialist advisor was an experienced nurse and the expert by experience had personal understanding of older people and those living with dementia. Before our inspection, we asked the provider to complete 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 reviewed the PIR and other information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with eighteen of the people who lived at Creedy House. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We spoke with five people's relatives. We inspected the environment, including the bathrooms and some people's bedrooms. We spoke with the manager, the operations manager, the clinical nurse manager, the quality manager, eleven care staff and two nurses.

We 'pathway tracked' ten of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included six staff training and supervision records, six staff recruitment records, medicines records, risk assessments, accidents and incident records, quality

audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

One person told us "I haven't seen any bad staff and that makes me feel safe" and another person said "They [staff] make me feel comfortable with them" and a relative commented "[Person's name] has always been safe; they had a couple of falls that were dealt with very quickly and if medical help was needed they got it. That gives me peace of mind".

We found that there had been many improvements overall to the safety of the service since our last inspection.

At our last inspection, assessments about a range of risks to people had been made, but actions to reduce the risks had not always been taken in practice. At this inspection, there was a mixed picture. Risk assessments were very detailed and contained a good level of guidance to staff about what the risks were and how these should be minimised. In most cases, we observed that staff followed this guidance when delivering people's care. For example; one person sometimes showed agitation and could hit out at staff. We witnessed a minor incident where this person lightly slapped a staff member. That staff member immediately moved away from the person and another stepped in and offered distraction. These actions were taken seamlessly and worked well in calming the person and protecting staff. Other people were at risk of falls and staff supported those people to move about the service in line with care plan instructions and using any necessary equipment.

However, some people's assessments highlighted risks which were not consistently addressed during the inspection. For example; one person's care plan detailed that staff should not push them in their wheelchair without footplates being attached to it. This was to prevent the person's feet dragging on the floor, which could cause injury. Although we generally observed staff following this guidance, there were two occasions when this did not happen. On one occasion senior staff intervened to remind staff about attaching footplates but at another time this did not happen. Another person was supposed to use pressure-relieving equipment at all times to help prevent pressure wounds developing. On the first day of our inspection this happened but on the second day it did not, until we raised the matter with senior staff. They told us that they thought this person no longer needed the equipment as they had no current wounds. However, the care plan stated that the equipment should be used as a preventative measure. All other pressure-relieving equipment such as air flow cushions and mattresses were being used appropriately for people.

We recommend that the provider ensures that quality and safety checks include observation of staff practice to see that it reflects care plan guidance and consistently minimises risks to people.

At our last inspection medicines had not been managed in a safe way. This included creams that had been prescribed to people. At this inspection medicines were now managed properly to ensure that people received them as prescribed. However, there continued to be an issue over the management of creams. This is an area which requires further improvement.

Some prescription creams were stored in people's bedrooms in lockable wall cabinets. However, most of

these cabinets were unlocked and open when we checked. Many people were living with dementia and there was a risk that they might apply more of the creams than they should; as they were easily accessible. There had been no assessment of the risks until we brought the situation to the manager's attention. However, assessments were carried out during the inspection and keys were provided to staff to enable all creams to be locked away between applications and where deemed necessary.

Records about the application of people's creams showed that they had not always been applied in line with instructions. For example, one person's chart stated they needed Sorbaderm to be applied to twice daily. Records showed that it was applied only once daily on 4 days in the week leading up to our inspection and not at all on another day. Another person's cream charts documented that a cream for twice daily applications had only been applied once on three days in the previous week and not at all on four other days. A further person's steroid cream had not been applied for two days because staff recorded that they could not find it in the medicines trolley. However, this cream was stored in the fridge in accordance with manufacturer's guidelines. People had not received their creams as the prescriber had intended, but the manager introduced a new checking system during the inspection to ensure applications were consistent in future.

At our last inspection, medicines had not been stored in line with the manufacturers' advice because the medicines room was too warm. At this inspection temperature recordings had been made daily and showed that the medicines room was now consistently below 25 degrees; which is the maximum temperature at which many medicines should be kept. At our last inspection there had been no guidance to staff about the management of medicines to be taken by people as and when needed (PRN). At this inspection, protocols were in place for each person with a PRN medicine; which highlighted the reason it had been prescribed and the situations in which a person might need a dose of it. Information was documented about the maximum doses to be taken in any 24 hour period; which meant that PRN medicines were managed safely. Staff recorded when PRN medicines had been offered but declined so that a full picture was maintained about people's needs in relation to them. Staff told us that this would help them spot if a person suddenly began accepting more PRN pain relief than previously for example; when the GP would be informed.

At our last inspection there had been missing staff signatures on medicines administration records (MAR) which made it difficult to determine if people had received their medicines appropriately. At this inspection there were no missed signatures and MAR had been neatly and clearly completed to evidence that people consistently had all their prescribed medicines. We observed staff administering medicines and saw that they carefully checked MAR details before giving people their medicines and remained with them until they had swallowed them. Only then did they sign off the MAR to show people had received their medicines. This was good practice and an improvement since the last inspection.

At our last inspection, recruitment processes had not been robust enough to ensure that job applicants were suitable for the roles to which they were appointed. This included criminal records and identity checks, acceptable references and evidence of the right to work in the UK. At this inspection there had been improvements in the way that recruitment systems were followed. We reviewed six staff files and four of these had all the appropriate checks and documentation in place. In the remaining two files, there were gaps in applicant's employments histories, which had not been explored by the provider. This was an area which required further input to ensure that the provider holds sufficient detail about applicants to be able to reach a decision about their suitability to work with people living in the service. The manager said that full details would be sought for the two staff where there were gaps in their employment histories.

We recommend that the provider considers using a recruitment checklist to ensure that all areas are addressed for every applicant, in line with Regulation.

At our last inspection violent or aggressive behaviour shown by some people had not been properly managed. At this inspection, we found an improved picture. Most of the people who had shown these behaviours had moved to other, more suitable placements. The service was calmer and had a more relaxed atmosphere because staff were not trying to deal with behavioural outbursts throughout the day. Staff had now received training about managing challenging situations and we observed that they put this into practice effectively when minor behaviours were shown during the inspection. Staff were able to describe the different forms that abuse can take and knew how to report it. All staff had received recent training about keeping people safe from harm and neglect and people looked relaxed and comfortable with them. The manager made referrals to the local authority safeguarding team appropriately, so that they could consider carrying out independent investigations where necessary to help keep people safe.

Incident reports and behaviour charts had been completed thoroughly by staff and these were reviewed by the manager. Preventative actions had been taken so that the likelihood of reoccurrences was minimised. For example the community mental health team had been involved for one person and regular observations were recorded following an incident. The manager gave us an undertaking that robust pre-admission assessments would be undertaken by themself and the clinical manager before people came to live at Creedy House in future. In this way they could ensure that only people whose needs could be safely and appropriately met would be accepted.

At our last inspection there had not been enough staff to keep people safe and meet their needs appropriately. At this inspection care staff numbers had been increased from eight to ten during the daytime, and to five care staff at night. There were two nurses on day shifts and one at night with a clinical nurse manager also in place. Staffing numbers had increased even though the number of people using the service had reduced to 31 from 41 at the last inspection.

Our observations at this inspection showed that there were sufficient staff deployed to ensure that people's needs were met. Call bells were answered promptly and people received support when they needed it, for example to eat their meals. People who were able and wished to get up were supported to do so at a reasonable time in the mornings and appeared nicely turned out in clean clothes and with their hair brushed. Staff encouraged people to drink and were frequently seen visiting people in their bedrooms to offer snacks or to check on them. There were staff available and visible throughout the service during both days of our inspection.

We reviewed rotas for the eight weeks prior to our inspection and found that the increased staffing levels were met for most shifts. A recruitment campaign had resulted in new staff being employed to support the existing team and three staff were being inducted during the inspection. The manager told us that people's care needs had been assessed and reviewed monthly and we saw evidence of this. A number of factors were used to determine whether people's needs were high, medium or low. However, there was no dependency tool in use to show how these needs translated into staff numbers. Following the inspection and our feedback about this to the manager, they sent us evidence to show that they had started using a dependency tool which calculated the staffing numbers required to meet people's needs and demonstrated that there had been enough staff on duty during the inspection.

Staff told us that the staffing situation had been "So much better" since the last inspection. They described how the increased numbers enabled them to spend time talking with people and to respond more quickly to calls for assistance. Most of the people and relatives we spoke with felt there were generally enough staff on duty; but some staff said that they were concerned that staffing levels would not be increased when more people were admitted to the service.

We recommend that the provider continues to use a dependency tool to determine the number of staff required to meet people's needs appropriately.

At our last inspection, environmental risks had not been adequately assessed or minimised to ensure people were safe. At this inspection the premises were generally clean and well maintained but we found that a visiting contractor had covered the smoke alarm in one bedroom with a latex glove. This would have prevented the sensor being activated in a fire and posed a safety risk. The manager arranged for the glove to be removed immediately and told us that thorough checks would be made following contractor visits in future. At our last inspection we highlighted the risk of some people climbing the stairs. However, at this inspection there was only one person who sometimes wished to use the stairs. There was a detailed risk assessment in place about this and we observed that staff were vigilant to prevent this person from attempting the stairs alone.

Other routine checks took place to help ensure the safety of people, staff and visitors. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been identified. Records showed that portable electrical appliances and fire-fighting equipment were properly maintained and tested. Equipment for hoisting people had been routinely serviced; as had the passenger lift. Regular checks were carried out on the fire safety systems to make sure it was in good working order. Records showed health and safety audits were completed monthly and that these were reviewed by management to see if any action was required. Fire risks had been assessed and people had individual emergency evacuation plans. These gave details of the assistance each person would need in an urgent situation. Staff had fire safety training and could describe the way in which people would be supported in the event of fire or an emergency. These checks enabled people to live in a safe and suitably maintained environment.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that many people had not received adequate fluid to keep them well. At this inspection, individual target daily fluid amounts had been assessed based on people's weights so that staff knew how much people should be drinking. Records showed that people were taking reasonable amounts and that total intake was routinely added up at the end of each day so that any shortfalls would be highlighted. Senior staff reviewed the fluid charts daily and weekly to ensure that people were drinking sufficient, or to take action if not. Staff told us that they would refer to a nurse any person who had drunk less than expected. Plenty of drinks were available to people throughout the inspection and we observed people being supported to drink at regular intervals. There were minor inconsistencies in the way that some staff completed fluid charts which is an area for improvement; to make sure that records are clear and not open to interpretation.

At our last inspection, food charts had contained insufficient information about what people had eaten to be able to monitor their intake properly. At this inspection food charts had been consistently completed to show how much people had eaten. Snack boxes had been introduced for people since the last inspection and contained an assortment of freshly-prepared nibbles for people to enjoy. On some occasions 'Snacks' was entered onto food charts without any information about what these consisted of; this could be improved so that there is clarity about people's total intake. Other food had been appropriately recorded onto charts and demonstrated that people had eaten well-balanced meals.

Where people had lost weight, dietician input had been arranged promptly for them and any prescribed meal supplements were provided. Weights were monitored closely and the manager told us that they could contact the dietician again at any point to seek further advice if they had concerns. People who were able to speak with us told us they had a choice of meals each day and this was the case during the two days of the inspection. There were no picture menus however for people living with dementia who might find it difficult to visualise what was on offer. The manager placed an order for picture menus after we brought this to her attention.

People appeared to enjoy their meals and the feedback we received about them was generally positive. Responses to a recent food questionnaire showed that the majority of people rated the meals as good to very good. Lunchtime was a relaxed, social experience for people. Staff sat and ate alongside them in some cases while other staff supported people to eat and drink with gentle encouragement and engagement. On the first day of our inspection one person did not have the special adapted cutlery recorded as necessary in their care plan, but this was provided to them on the second day. Staff told us that this person sometimes chose to use an ordinary spoon to eat, but their care plan did not mention this. The manager updated the care plan during the inspection to include this information.

At our last inspection there were no care plans about the management of people's catheters. At this inspection individual catheter care plans were now in place to detail how often catheters and bags should be changed, and how to identify any blockages. Nursing staff were knowledgeable about catheter care and explained how they monitored urinary output to check for any signs of infection so that this could be

addressed promptly.

At our last inspection pressure wound management had not always been effective. At this inspection, detailed records had been made about people's wounds which had been photographed and measured to document their progress. Nursing staff were knowledgeable about dressing types and records showed that wounds were regularly monitored. A tissue viability nurse (TVN) had been involved where necessary and where people had experienced wounds, they had healed or were healing successfully with the treatment plans in place. When people were identified as at risk of developing pressure areas, special equipment was in place to relieve pressure and people were regularly supported to reposition so that pressure was not placed on any one part of the body for too long.

We looked at care plans for people with diabetes. These instructed that random blood monitoring should take place but there was no evidence of any recordings. The clinical manager told us that not all people with diabetes required random blood monitoring and the care plans were updated during the inspection. Where people took blood-thinning medicines, there was detailed information in their care files about the signs of under or over dosing and how any bruising or bleeding should be closely monitored to ensure that people were kept safe.

People told us that they could see a GP if they needed to. Other care professionals such as dieticians, community mental health team speech and language therapists, podiatrists and chiropodists visited the service to provide clinical support for any particular needs people had. This meant people had access to a range of specialists to support them in maintaining their health and well-being.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. At our last inspection assessments made about people's mental capacity were not decision-specific but covered a range of day-to-day activities. There was a risk from this approach that people might have capacity for some parts of those daily activities but not others. At this inspection, assessments had now been made about the individual decisions people needed to make. We observed staff providing care and support to people throughout our inspection. Staff adapted the way they approached and communicated with people in accordance with their individual personalities and needs. The staff team knew people well and understood how they liked to receive their care and support. The management and staff were aware of the need to involve relevant people if someone was unable to make a decision for themselves. If a person was unable to make a decision about medical treatment or any other big decisions then relatives, health professionals and social services representatives were involved to make sure those decisions were made in the person's best interest.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Applications had been made and authorised for (DoLS) authorisations for people who needed them. These authorisations were applied for when it was necessary to restrict people for their own safety. These were as least restrictive as possible.

The manager had knowledge of the MCA and the recent changes to the legislation. Staff had knowledge of and had completed training in the MCA and Deprivation of Liberty Safeguards (DoLS).

At our last inspection, staff had not received effective training to help them carry out their roles. At this inspection staff had received training in a range of subjects in order to perform their jobs safely and to provide the right care and support to meet people's needs. Training in mandatory subjects was up to date. Our observations found that staff were both competent and confident in delivering care. The manager told

us that training was delivered in a variety of ways; including online, workbooks and classroom based. They told us that they had recognised that staff learnt differently and required training to be delivered in different formats. Staff told us that they completed training that was relevant to them and the needs of the people they supported, such as, courses to increase their knowledge and understanding about dementia, stroke awareness, managing behaviours which may challenge others, palliative care and catheter care.

New staff received an induction into the service which included; 'office' time where they read people's care records, e-learning, policies and procedures and getting to know the service. They would also spend time shadowing experienced colleagues to get to know people and their individual routines. During the inspection we observed new staff being supported to complete an induction booklet and getting to know people. The manager told us that they had introduced the Care Certificate for new staff and showed us the workbook that they would be using. We were also shown a new competency framework and assessment that had been introduced to assess that staff were competent in all areas. Staff were supported through their induction, monitored and assessed to check that they had attained the right skills and knowledge to be able to care for, support and meet people's needs effectively.

Staff had individual supervision meetings with an allocated supervisor. Structured supervision arrangements were in place so that all staff received appropriate support. For example; all nursing staff received clinical supervision from an allocated supervisor. Supervision provided an opportunity for staff to discuss any issues or concerns they may have about caring for and supporting people, and gave them the support that they needed to do their jobs more effectively. The manager showed us that they planned to introduce appraisals for all staff in the coming months so that staff could give and receive feedback on their performance throughout the year.

Good

Is the service caring?

Our findings

One person told us "They [staff] are very caring. I've never had a problem and they're excellent". Another person said" Very civil staff in their approach to you and they make sure your clothes are nice and clean every day". A relative commented "Staff here are really good. They try their best always and it's not an easy job".

At our last inspection we reported that the service was not consistently caring and that people's dignity was not always considered or respected. At this inspection there had been great improvement in the way people were treated. People looked clean, tidy and well-kempt and some ladies had been supported to use a little make up. Gentlemen had been shaved if they wished and people appeared generally well. Staff were observed offering people manicures and hand massages to keep their nails trimmed and give them an enjoyable experience. One person told us "This is lovely, I feel like a queen". The increase in staff numbers since the last inspection meant that staff had more time to spend with people doing things which improved the quality of their lives. Staff were less rushed overall, which created a sense of calm in the service and made it a more relaxed place for people to live.

We observed only kind and gentle interactions between staff and people throughout the inspection. This was particularly noticeable at lunchtimes, when staff enthusiastically engaged with people who mainly sat at large tables together, like a large family. This gave the opportunity for lively conversation and we heard people laughing and joking with staff. Tables had been laid with bright coloured cloths to make the experience of eating at them pleasurable. Some staff ate meals at the tables alongside people and this act encouraged people to eat too. At other times we observed staff supporting people to drink in their bedrooms or stopping for a chat when people wanted to talk. The staff team were polite and cheerful and those we spoke with were positive about working in the service. One staff member told us "I've seen a lot of improvement and staff morale is now a lot better". Another staff member said "The home is better run now, laid out differently and things are more organised because we now have enough staff". A happier staff team translated into a better atmosphere in the service for people living there.

Staff were considerate of people's dignity and treated people with respect. For example, staff knocked on people's bedroom doors before entering and asked permission before placing a food protector around them. Staff were mindful about people's state of dress and quickly acted to rearrange people's clothing in a discreet and thoughtful way if it became necessary. At our last inspection we found that people's continence pads were frequently showing above their waistbands, but this issue had been resolved at this inspection. Screens were used to offer people privacy when they were being supported to move with a hoist, and staff were sensitive when quietly asking people if they needed to use the toilet.

At our last inspection some staff had long fingernails that had sometimes been manicured to points, which could create a risk for people with fragile skin. At this inspection we saw that staff now had short nails which were easier to keep clean and were less likely to catch people's skin. Staff told us that it was now a requirement for them to have short nails at work and they understood the reasons for this instruction. At our last inspection staff had not always been responsive to people's calls for attention and support. At this

inspection staff reacted quickly and kindly when people needed assistance. We observed several occasions when people called out while staff were walking through the corridors and on every occasion staff diverted into peoples' rooms to see what they could do to help. One relative told us "If [person's name] calls, they come running" and a person said "They do come quickly and I don't have to wait long unless they're with someone else". We looked at call bell data which showed that most calls were answered within five minutes or less. Staff told us that the increased staffing levels since the last inspection had "Made all the difference" and they could now reach people sooner as there were "More staff to go round".

At our last inspection people had not always been encouraged to be as independent as possible. At this inspection we read detailed care plans about the ways in which people should be supported with some aspects of their care, but allowed to retain their independence in others. These were headed 'What I can do for myself' and 'What I need assistance with' and showed that consideration had been given to people's individual dependencies. One person told us "I can't do a lot for myself these days, but they [staff] let me do what I can, like washing my face and hands. I want to carry on doing as much as I can for as long as I can". Other people were encouraged to be independent in making straightforward choices about what they wanted to wear and when they liked to get up. A relative told us "Mum can choose when she wants to get up; some days it's later than others but the staff just go with what she wants which keeps her happy". Staff knew people's preferences about times to get up and respected their freedom to choose and their right to a degree of independence.

At our last inspection the service had not been adequately adapted to take account of people living with dementia. At this inspection improvements had been made to help people recognise their bedrooms and other rooms. All bedroom doors had been painted in different colours to act as a memory jog for some people. A photo of the person had been placed on their bedroom door to further assist them. Toilet and bathroom doors had clear picture signage and were painted a separate colour to differentiate them from bedrooms. Memory boxes had been introduced on the walls outside people's bedrooms. These contained items that were relevant to people now or in their past and were helpful in reminding people of the things that were important to them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection complaints had not been managed in line with the provider's own policy. At this inspection there had been improvements, but we found that not all complaints had been formally logged by the manager. Two complaints had been received but had not been entered into the complaints log. Copies of these complaints were not held in the complaints file but the manager had sent initial responses to them. There was a risk these could have been overlooked because they were not registered properly. In the most recent survey of residents carried out in September 2016, 50% responded that their complaints had been dealt with appropriately and one respondent commented 'Complaints are not always answered'. In action plans submitted to the CQC following the last inspection, the provider stated 'All complaints will be managed and overseen by the Senior Managers of the service to ensure due processes have been followed'. This had not been effective in ensuring complaints protocols were consistently observed.

We recommend that the provider increases oversight of the complaints process to ensure it is suitably robust.

At our last inspection the people and relatives we spoke with said that they did not know the process for making a complaint. At this inspection complaints procedures were displayed throughout the service and people and relatives mainly said they knew how to complain. One person said "First move is to approach management but it's not something I've had to do" and other person said "Always ask to see the manager". In the resident survey of September 2016 70% of respondents stated that they knew how to complain. One person told us about a complaint they had made which had been resolved to their satisfaction through a number of meetings.

We read a number of thank you cards and letters in which the service had been complimented by people or their relatives. One of these read 'Thank you for all the loving care you gave [person's name]. It was obvious she felt she was 'home''. Another said 'Staff are always happy and cheerful and sympathetic' and a relative wrote 'Our experience of Creedy House is of continuing improvement, a caring environment with hard-working, dedicated staff. We would recommend it'.

At our last inspection, the choices people had expressed were not always provided to them. At this inspection this situation had changed for the better. Care plans were written in a person-centred way and contained very detailed accounts of the ways in which people liked their care to be provided. 'Head to toe' assessments had been made about every aspect of the care and support individuals received to highlight their preferences and needs. Staff knew people well which helped to ensure people's choices were respected. Our observations showed that staff supported people to do what they wished, for example one person liked to have their radio on during the day and this happened during the inspection. Another person liked to talk about a particular subject and staff made sure they engaged this person by referring to it in their conversations.

Information had been compiled about people's lives before they lived in the service. This was very detailed and painted a sensitive picture of people's personalities, families and working lives. Staff were able to tell us

about individual people and what they had done previously. They said that this information helped them to understand people better and to appreciate that they had led full and interesting lives. One staff member told us how they were able to comfort a person living with dementia by reminding them of happier times. Most people's rooms had been personalised with their own photos, pictures and effects which gave them an individual appearance and made them homely.

At our last inspection there had not been sufficient or appropriate activities to involve people living with dementia. At this inspection there had been improvement in this area. An activities co-ordinator was employed at the service; to work full time on weekdays. They also had an assistant who worked mornings. Various activities were offered for people to participate in and some of these were enjoyed by people living with dementia. We observed a reminiscence activity specifically designed to prompt memories, where people talked about their pets and Princess Diana. Most people engaged with the activity and there was some lively discussion. The activities coordinator also led a sing-along with a small group of people who really seemed to enjoy recalling "All the old songs" and were joining in and laughing at some of the lyrics. There were sensory stations available which had attachments for people to touch and move to provide focus and distraction. One person liked to carry a baby doll and we observed that staff involved 'baby' in their conversations with them. A small dog was brought in and visited people who wished to see it. Some people living with dementia became very animated and interested when they saw the dog and it clearly provoked good memories for them. The activities coordinator had received specific training around suitable activities for people living with dementia. They also told us that an NHS occupational therapist had visited and provided them with ideas and guidance.

There was a range of organised activities available to people which included visits from outside entertainers such as singers and musicians. Bingo, quizzes, armchair exercises and sing a longs were also on offer. During the inspection we observed a variety of activities which included; art and crafts, quizzes and tasting sessions. No formal activities were planned at weekends because staff told us there were usually lots of visitors to the service and therefore activities were delivered around this. One member of staff told us; "We see who's around and ask what they want to do - it may be a movie session or some kind of games." Some people told us they went out to the pub once a week which they enjoyed. The activities staff visited people in their bedrooms to provide social stimulation if they were unable to get up. One person told us "They come and see me so I'm not on my own all the time, just to keep me company". This helped to prevent people becoming lonely and people looked forward to these visits.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that the service was not well-led. At this inspection there had been much improvement overall with further work needed in some areas to ensure consistently better standards of quality and safety were achieved.

Following our last inspection we issued eight warning notices about areas which required urgent action in the service. The provider sent us an improvement plan and weekly updates to this; which stated that all areas had been addressed. At this inspection most of the issues highlighted in the warning notices had been fully and satisfactorily addressed. However, actions to minimise known risks to some people had not been consistently taken; although other risks were appropriately reduced. People's prescribed creams had not always been properly managed, but the management of other medicines was safe and well-organised. The manager had highlighted poor recording practices of creams applications at a recent staff meeting and extra checks had been due to take place. Complaints processes needed to be strengthened to ensure all concerns were logged, but there had been improvement in the publicising of the complaints procedure and people and relative's knowledge about how to complain. The registered manager told us that an enormous amount of work had taken place in order to make the service better, but acknowledged that these areas should have been addressed prior to our inspection. The manager took immediate action when we brought these matters to their attention during the inspection and there was clearly the will to drive improvement.

At our last inspection there had been inadequate oversight by the provider but at this inspection this had increased significantly. The provider had employed a quality manager since our last inspection who carried out a wide range of audits and checks to test the safety and quality of the service. These were in addition to a suite of checks and assessments made by the manager, clinical nurse manager and in monthly provider visits. Monthly management reports were compiled and reviewed with the provider and the management team to determine any necessary actions.

This increased oversight and auditing had generally been effective in identifying any shortfalls, and actions had been taken to put these right. For example, robust auditing of medicines meant that poor practice had been eliminated in administration and the likelihood of errors had been minimised. However, medicines audits did not look closely enough at how prescribed creams were managed. Similarly, checks made about risks to people had not included physical observations to ensure staff were consistently reducing risks in everyday practice. Auditing of complaints documented the numbers, types and responses but had not included checking that all concerns were registered formally.

We recommend that the provider expands audits and management checks to include all medicated items, observation in relation to risk mitigation and complaints recording.

At our last inspection, records about people's care were not always up-to-date or accurate. At this inspection people's information was kept confidentially and records were accurate. However, we sometimes experienced difficulty in finding evidence to support staff actions. This was because daily notes made by staff had been filed in different places. Daily notes appeared to have non-consecutive pages missing at times

but we were later able to find those pages and the information we needed amongst archived papers. This is an area for improvement, although other records were well-maintained and easily accessible.

At our last inspection there was no evidence that feedback had been sought from people or their relatives about their experiences of the care provided in the service. At this inspection surveys of people and relatives had been undertaken to glean this information. The responses had been analysed and were mostly positive. Actions had been taken where shortfalls were noted. For example; not all people and relatives reported knowing how to complain so the service displayed new posters about the procedure and reinforced the right to complain at resident and relative meetings. This action had been effective because the majority of people we spoke with now knew how to raise concerns. A comments and suggestions box was also available for people to use and the manager told us that she regularly emptied this and responded to any points raised.

Resident and relative meetings had taken place but the attendance had been very low. At the most recent meeting there were only three relatives and no residents present. The manager said she was investigating ways of encouraging greater attendance in future. Minutes of this meeting recorded that everyone agreed that staffing levels had improved since the last inspection and that relatives felt the service was getting better. Some comments about meals were fed back to the chef but the meeting had been positive overall and people had been offered an opportunity to have their say about their home.

A staff survey had also been conducted so that staff views about the service could be taken into account. Most of the responses were positive or very positive and actions arising from the survey were a team-building day and an undertaking to keep staffing levels under review. We also read minutes of staff meetings and saw that staff were invited to give feedback or raise concerns and that these were acted on. One staff member had suggested that fleecy blankets could be provided for people when they sat in lounges, and the manager purchased these as a result. The manager used the opportunity of staff meetings to thank them for their commitment to the service.

Staff told us they worked well as a team and felt supported by the clinical nurse manager and manager. They reported being able to speak out with any concerns or ideas and that these were listened to. Staff understood their responsibility to 'whistle blow' to external bodies should the need arise.

Staff told us they had "A lot of respect" for the manager and the work she had driven forward to make improvements in the service. People said that the manager was approachable and "Often seen round and about", so they felt they could speak with them if they wished. The manager described an improving culture amongst staff and had taken disciplinary action where performance or standards had dropped. Our observations showed that staff were more professional, caring and respectful during this inspection which supported that there had been a positive cultural change. We received positive feedback from a number of professionals who have regular involvement with the service, all of whom felt it had improved significantly.

The manager was applying to become registered with the CQC which is a requirement of the provider's registration. They told us that they felt supported by both the management and staff teams and the provider. They said that the provider would supply any equipment needed and that requests for extra staffing had been met, for example to provide continuous care and company to a person was receiving end of life care in previous months.

The manager attended monthly meetings with other managers of the provider's services; in order to share good practice and learning. They also attended care home forums in Shepway which offer support and learning opportunities for managers and providers. The manager told us that they were "Determined to

continue and sustain improvements" in the service.