# Avon Lodge UK Limited

# Avon Lodge

## Inspection report

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## Ratings

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

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|---|---|
| Is the service safe? | **Requires Improvement** |
| 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

Avon Lodge has been inspected three times in the past 18 months. Significant issues and shortfalls in care were identified and the service was rated inadequate and placed into special measures following our inspection on 15, 16 and 17 September 2015. Enforcement action was also taken by the Care Quality Commission to impose conditions upon the provider's registration. A second comprehensive inspection was carried out on 14 and 15 April 2016. Avon Lodge had still failed to improve standards of care and remained rated as inadequate and in special measures.

At our last inspection on 25 and 26 October 2016 we found that Avon Lodge had continued to fail in improving standards of care to a level that met the regulatory requirements. We found significant on-going shortfalls in the care provided to people and identified breaches of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to risk assessments, staff not receiving regular supervision or appraisal to monitor performance and overall good governance of the service. However, the service had improved and was rated requires improvement overall. Well-led remained rated as inadequate and the service was kept in special measures. At this inspection we found that the provider had addressed these breaches and was now meeting the regulatory standards.

Avon Lodge is a residential care home that provides personal care and support for 36 people, some of whom have dementia. However, following our inspection and findings in September 2015, the local authority placed an embargo on Avon Lodge accepting any new referrals. This meant that the service was not allowed to admit any new residents. At the time of this inspection, there were 21 people using the service.

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

People and relatives were positive about the home and told us that they and their relatives felt they were safe and well cared for.

There were enough staff to ensure that people were provided with care that met their needs. The service assessed staffing levels using a dependency level assessment tool. Staff did not appear rushed and spent time talking with people. There was a homely atmosphere at the service.

The service had introduced new risk assessments. Risk assessments were tailored to the individual and gave staff detailed guidance to ensure that risks were mitigated against in the least restrictive way.

Staff had received training on medicines administration and people were supported to take their medicines safely. Medicines were accurately recorded on medicine administration (MAR) sheets. There were staff on

duty every night that were assessed as competent to administer medicines.

Falls were actively monitored. There were monthly falls audits and analysis and people were referred to a local falls clinic where appropriate. Accidents and incidents were documented and followed up.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).□

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Staff received regular, effective supervision and attended regular team meetings. All staff had received an annual appraisal which reviewed their work and training needs.

People were given a choice of foods each day and menu options were clearly displayed in the home. People that required specialist diets were catered for and the chef and staff were aware of people's dietary needs.

People had access to regular healthcare appointments and referrals were made when necessary. Relatives were positive about the healthcare referrals and care that people received.

People were able to get up and go to bed when they wished. Waking and sleeping preferences had been recorded in people's care plans and staff were aware of those preferences.

End of life wishes had been documented in collaboration with relatives and, where appropriate, healthcare professionals.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity and respect when caring for people.

New care plans had been implemented which were individualised and were written from the point of view of the people that were supported. Care plans were detailed, person centred and provided enough information for staff to support people.

The service was providing activities every weekday from 10:00 until 17:00. People were engaged and encouraged to participate. We observed staff encouraging people to engage in the activities. The service has planned to extend the activities programme to seven days a week.

Audits were being completed for various aspects of these service which included action plans and records of how the identified issues had been addressed.

The management structure was more stable and staff were aware of managers roles and responsibilities.

Staff had regular team meetings where they were able raise any concerns. Management also used tis as an opportunity to share information.

Services that have been given a rating following an inspection are legally obliged to display their rating on their website, if they have one, and at the registered location where care is provided. The service was

displaying its rating provided by the Care Quality Commission at the last inspection in clear view by the front door of the home.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Whilst improvements have been made we could not improve the rating for safe or rate well-led as more than Requires Improvement as it needs to be demonstrated over time that these improvements have been embedded.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe. Whilst improvements have been made, the service has not satisfied the Care Quality Commission that improvements to the quality of care have been embedded and sustained.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

Accidents and incidents were clearly documented and referrals made where appropriate.

Medicines were being managed safely and people received their medicines on time.

### Is the service effective?

**Good**

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Staff received regular supervision and appraisals. People were supported by staff whose work practices were regularly reviewed.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink so that their dietary needs were met. Where people had specialist dietary needs, these were understood and catered for.

### Is the service caring?

**Good**

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People and relatives were encouraged to have input into their care.

Staff treated people with dignity and were patient and kind in their interactions.

End of life care was documented and people and relatives were involved in end of life care planning.

## Is the service responsive?

**Good**

The service was responsive. People's care was person centred and planned in collaboration with them. Care plans were person centred and noted people's preferences.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

There were activities every weekday and people were encouraged to participate.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led. Whilst improvements have been made, the service has not satisfied the Care Quality Commission that improvements to the quality of care have been embedded and sustained.

There was a clear management structure and staff were aware of managers roles and responsibilities.

Audits were completed for various aspects of the service and improvement plans put in place to address any issues found.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Staff had regular team meetings where they were able to raise concerns and discuss the quality of care.

# Avon Lodge

**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 21 and 22 March 2017 and was unannounced. We planned this inspection as a result of the service receiving an overall rating of requires improvement with well led remaining as inadequate at our last inspection. The service had remained in special measures. When a service is placed into special measures, it must be re-inspected within six months.

The inspection was carried out by two inspectors and two experts by experience. On the second day, an inspection manager with the CQC also attended the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One expert attended day two of the inspection and the second expert made telephone calls to relatives to gain their views of the home.

Before the inspection we looked at information that we had received about the service and formal notifications that the provider had sent to the CQC.

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at nine care records and risk assessments, six staff files, 13 people's medicines records and other paperwork related to the management of the service. We spoke with 15 people who used the service, eight staff and 10 relatives. We also spoke with a GP who was visiting the home during the inspection.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe and cared for at Avon Lodge. People told us, "Cannot complain about anything. They help you in every way. Very nice people", "I'm always safe" and "Staff make sure I'm ok." Relatives were positive about people's safety and commented, "The ones [staff] I have seen are wonderful and they seem to like my mum", "Yes, we have not had any problems" and "Yes, they are alright. I think they [staff] know what they are doing."

At our last inspection we found that people's personal risks were not always being assessed. At this inspection we found that the provider had addressed this issue. The provider had introduced new, detailed risk assessments. As part of the care planning process the service assessed each person's identified risk associated with their health and support needs. This included falls, moving and handling, pressure sores, nutritional risks as well as risks associated with specific health conditions such as choking, hypertension, chronic kidney disease, dementia, diabetes and iron deficiency. Each risk assessment outlined the risk, if the risk was a health condition, the nature of the condition, how it would affect the person, symptoms and signs to be aware of and the action staff should take to mitigate or reduce the risk to keep people safe. There were also risk assessments in place if people were on high-risk medicines such as blood thinning medicine. Staff were able to tell us what side effects to look out for and how to report any issues if they arose with high-risk medicines. All information provided on the risk assessments directly followed through into the care plan document under the relevant corresponding section. Risk assessments were detailed and person centred.

The home assessed people's potential for developing pressure ulcers by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. If an individual is classed as medium or high risk their pressure mattress suitability was re-assessed. Records showed that Waterlow assessments were completed each month for people. Where a higher risk was identified, people were referred for further assessment by a tissue viability nurse and consideration to be given for appropriate pressure-relieving equipment to be provided. The home currently had no people with pressure ulcers.

Staff members were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. The home had a detailed safeguarding policy that staff had access to and provided guidance around safeguarding. One staff member told us, "If anything happens, like abuse, it is safeguarding. It protects the vulnerable people against all forms of abuse. I would report it to my manager and if they didn't take any action I would call the Care Quality Commission (CQC)." Staff understood what whistleblowing was and how to report concerns if necessary. Whistleblowing is where staff are able to report concerns within the organisation, often to the local authority or CQC, without fear of being victimised.

The home closely monitored any falls that people had. Records showed that there were monthly audits of any falls that had occurred. There was a falls management investigation form which was completed for every incident of a fall. The form required the staff to assess why the fall had occurred, for example; spillage, resident tired or wearing improper footwear. Forms also recorded whether there had been a change in the

person's health status and the action taken at the time of the fall and any follow up. From November 2016 until the time of our inspection there had been 14 falls. All falls were documented, investigated and any follow up recorded. People who had experienced falls were referred to the local falls clinic to be monitored and equipment such as sensors put in place if necessary.

At our last inspection we found that the home was managing medicines well. At this inspection we found that this had continued. Staff had access to a medicine administration policy. People's medicines were recorded on Medicines Administration Record (MAR) sheets and a blister pack system was used which was provided by the local pharmacy. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one-month supply. People's medicines were given on time and there were no omissions in recording of administration on any of the 13 people's medicine records that we checked.

Some people were prescribed 'as needed' medicines (PRN), 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. Where people had been prescribed PRN medicines, a PRN protocol was in place for each prescribed medicine which indicated what the medicine was for, when to use it and how often it could be administered. This information was clearly available for staff in the medicines folder and had also been carried through into people's care plans. Care plans also contained a list of all medicines the person had been prescribed and gave names of each medicine the person had been prescribed, what they was for and any possible side effects.

At our last inspection we found that there were times when no staff competent to administer medicines were on duty at night. The provider had put an on-call system in place to help address this. However, this meant that people would have to wait for medicines until a staff member that was able to administer medicines could attend the home. At this inspection we found that the provider had addressed this issue. All team leaders had received training in the safe administration of medicines and had undergone a medicine competency assessment confirming they had the required skills and knowledge to safely administer medicines. Rotas for February and March 2017 showed that there were staff able to administer medicines on duty every night.

Each person had their own section within the MAR folder. Each section contained a front cover, a photo of the person, their date of birth and any known allergies. Each person where required had also been assessed for their pain levels using the Abbey Pain scale. By using this method of recording pain, the level of pain, where the pain was and the signs and symptoms the person may communicate when in pain was recorded. A body map had been also been completed to indicate the area of pain.

There were daily, recorded checks of medicines by the team leader on duty. This included checking all loose stock that was not contained within blister packs. For example, as required medicines, controlled drugs and any loose stock. The registered manager and provider then carried out monthly audits which had been implemented since January 2017. We saw audits for January and February 2017. Each audit looked at the whole medicines cycle, each person's MAR, and stock balances. After each audit, the registered manager or provider had made notes of where issues had been found which then followed through into an action plan with a list of recommendations. On the action plan the registered manager had signed off that all actions had been completed and the date of completion.

Records showed that returns, unused or refused medicines were all documented and returned to the pharmacist on a monthly basis.

Controlled drugs were checked and corresponded with the recording book. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. We checked controlled drugs for two people. Recording was correct, totals of stock were correct and two staff always signed when a controlled drug was administered.

The home did not administer any covert medicines at the time of this inspection. Covert medicines are where the home administers medicines without the person's consent and requires authorisation of the GP and dispensing pharmacist.

At our last inspection we found that where people had been prescribed pain relief patches or patches containing other types of medicine, the home had not recorded the site of application every time the patch was changed. At this inspection we found that the provider had addressed this issue. Where people had been prescribed patches to be administered to the body, the home had a four site patch application map so that the patch was rotated every week to a different site.

Daily temperature checks of the medicines room and the medicines fridge were recorded to provide assurance that medicines were kept at the correct temperature and were safe to use.

Two people were on food and fluid charts to monitor their hydration and food intake. Charts were fully completed and included the daily recommended food and fluid intake for the person within a 24-hour period. Staff were aware of the each person and their requirements and what to do if the person was not meeting the stated requirements.

For one person there were records of the monitoring of continence management to ensure that the person was being supported appropriately. Recording included observations of how often the person went to the toilet independently, whether they were compliant with the use of incontinence pads, when the person had been supported to go to the toilet and where the person had refused. Any issues were noted and followed up by staff on duty.

There were four people that required the use of a hoist. Each person had their own individual slings based on their weight and the type of sling required. Slings were labelled and clean. We observed three hoisting procedures throughout the inspection. Staff communicated well and explained what they were doing to people and ensured that people understood and felt safe. Records showed that hoists received regular maintenance checks to ensure they were in good working order. For people that required manual handling, there were also instructions on correct manual handling procedures in people's bedrooms and within their care plans.

There were appropriate levels of staff on duty observed throughout our inspection. Staff did not appear rushed and spent time interacting with people and chatting. One person said, "This is a quiet place. People [staff] not rushing about". At our last inspection we found that the provider did not complete dependency scores for people to help decide staffing levels required. At this inspection we found that the provider had addressed this issue. Each person had a dependency level assessment completed which was reviewed every month. The tool calculated a total score based on the assessment of each person's needs in specific areas. All scores were fed into a formula that calculated the number of staff required during the day and night. We noted that the assessment tool recommendations were followed through and reflected on the actual rotas seen for November 2016. Where the tool had calculated that only two staff were required at night based on people's needs, the provider had overruled this and taken into consideration the environment and layout of the home and had allocated three staff members for each night shift. A relative commented, "This [staffing]

was an issue we had. There doesn't always appear to be someone around. Recently I think it has improved."

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records were detailed and noted the issue, if there had been any investigation, the outcome and any learning from the accident or incident. Staff meeting records showed that incidents and accidents were discussed at team meetings.

Relatives were positive about communication with the home if there had been an accident or if there had been an issue with their relative. Relatives said, "Yes, every time my dad is ill with something like a urinary tract infection (UTI) or chest infection they will phone me and let me know", "Yes, if anything does happen like my mum has had a slip they will phone me", "Yes, I will get a phone call right away telling me what is going on" and "Over the past few months things have really improved, they really seem on the ball."

The service followed safe recruitment practices. Staff files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Each person had a detailed personal evacuation plan (PEEP) in place in case of a fire. This gave information about the person and their moving and handling needs especially during an emergency and the directions staff were to follow. PEEPS were reviewed monthly and updated if there were any changes to people's needs. Records showed that there were weekly fire alarm tests.

The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

The home employed cleaners and we observed cleaning going on throughout the two days of the inspection. The home was clean and tidy and smelled pleasant. Records showed that there was a plan of works to decorate specific areas of the home which had already commenced. During the inspection we observed that hallways were being prepared to be decorated.

There have been significant improvements made around risk assessments and monitoring of people's health conditions since our last inspection. However, we could not improve the rating for safe from Requires Improvement as it needs to be demonstrated over time that these improvements have been embedded. We will check this at our next planned comprehensive inspection.

Good

# Is the service effective?

## Our findings

At our last inspection in October 2016 we found that the provider was not providing adequate support and supervision to staff. Staff had not received an annual appraisal. During this inspection we found that the provider had made significant improvements in this area and addressed this issue. Staff files contained evidence that all staff were receiving regular supervision and had also been supported through the annual appraisal process. Supervision sessions with staff looked at the staff members work performance, future work targets, training, support and development. Staff that we spoke with confirmed that they were receiving supervision on a monthly basis.

Staff files contained an individual training record for the staff member that provided an overview of each training course that they had completed. Copies of certificates corresponding to each course were also available. Training had been provided in topics including safeguarding, dementia, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, medicines, behaviour that challenges, fire awareness and moving and handling. Training courses for behaviour that challenges and dignity in care had been booked for all staff for March and April 2017.

Relatives told us that they thought that staff were suitably skilled at caring for their relative and commented, "Yes, I do [think they are skilled]. In fact, I think they are wonderful the way they talk to her and make sure she's calm and happy. We couldn't ask for more" and "I think they all seem to know what they are doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People had a DoLS authorisation in place where appropriate. Each application was tailored to the individual and stated the specific reasons for a DoLS authorisation to be granted. Where people did not have a relative or anyone appointed to advocate on their behalf, the service had referred people to the Independent Mental Capacity Advocate (IMCA) service. An appropriate IMCA had been appointed who supported the person with the process. Where a person's DoLS had expired, a new re-authorisation had usually been requested and agreed prior to the date of expiry of the current authorisation. However, we noted one person who had an expired DoLS and the home had not requested a new authorisation. We discussed this with the registered manager who immediately applied for new authorisation and provided evidence by the end of the

inspection that this had been completed.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). Where staff required refresher training, records showed that this had been booked. One staff member told us that MCA was, "Any adult over 16 and their ability to make a decision. They need an assessment and someone appointed to help them if they are unable to make decisions for themselves in their best interests." Another staff member told us that DoLS was, "I can't take away their liberty. It's about protecting people and making sure they are assessed if we are depriving them of anything such as going out alone."

At out last inspection we found that MCA assessments had been completed for every person. However, these were not tailored to the individual and failed to adequately take into account people's individual abilities and needs. At this inspection we found that this issue had been addressed. The MCA assessments that were seen at the last inspection had been discontinued. New care plans detailed outcomes of DoLS applications, noted what people were able to make decisions about and what they were unable to make decisions about and how staff could best support them as individuals. People's capacity was clearly noted at the front of their care plan and staff were able to tell us individuals needs around their decision making capabilities.

Where people were unable to make decisions regarding their care there were records of best interest meetings. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. For example, 'do not resuscitate' orders were in place where this had been assessed to be required. Each decision had an attached mental capacity assessment and best interest decision in place supporting the decision that had been made.

Where possible people had signed an acknowledgement form confirming that they agreed with the contents of the care plan as well as consenting to the care that they received. The acknowledgement form also confirmed that the care plan had been devised in partnership with the person. Where people were unable to sign, relatives and family members had signed on their behalf. Consent forms had also been signed by people and/or their relatives consenting to taking photographs, sharing information and having the flu jab. A relative said,"For the most part she can [make decisions]. Every now and again she may not be feeling well enough to answer and the carers usually know what to do otherwise they will call me and ask me."

People were positive about the food and told us, "I like the food here it is very nice", "Meals are good. I can always ask for a snack, like a biscuit. I like the food" and "Food is superb. I get a choice. I asked for peas with my fish and chips and I got them. If you want a cup of tea they make you one."

People were given choice about what they wanted to eat. Menus were displayed in the main lounge and there was a whiteboard that was updated each day with breakfast, lunch and dinner options. Some menu options were pictorial to ensure that people with dementia could better understand what was available to eat. Records showed that the chef asked and documented each morning what people wanted to eat that day. If someone required something that was not on the menu, this was catered for. Records showed that one person had requested an omelette for lunch. We observed that the person received their chosen food at lunchtime.

People and staff told us that snacks and drinks were available throughout the day and night if requested. One staff member commented, "If they want cornflakes at 01:00, why not? [Name of person] asked me for cornflakes. I will give."

On the second day of the inspection we observed the lunch period. People were seen to be given a choice of

orange or blackcurrant juice and provided with top-ups to their drinks throughout the meal. We observed warm and positive interactions between staff and people. Staff knew people well and responded to their needs in a calm supportive way. Where people required support to eat, we saw that their meals were served and staff sat with them immediately to ensure that their meals did not go cold. Where people required encouragement to eat themselves, staff were patient and supportive. For one person that needed staff to feed them, staff explained what they were doing and what the meal was. The person was given food slowly and the staff member ensured that they had swallowed their food before offering any more.

There were lists in the kitchen of people who required specialist diets, such as mashed, pureed or vegetarian food. One person had a severe allergy. The chef was aware of this allergy and there was guidance noted on the kitchen wall around what foods needed to be avoided. There was also information in the kitchen regarding a person that was diabetic. We spoke with the chef who was knowledgeable about what types of foods could and could not be given to someone that was diabetic.

On the second day of the inspection, inspectors tasted samples of the lunchtime menu. This included testing the consistency and flavour of both puree and mashed food given to people that had swallowing difficulties. Food was flavoursome and cooked well. Mashed and pureed foods were presented well with each part of the meal being separate on the plate. The consistencies were appropriate for pureed and mashed diets. The chef tried to ensure that people on special diets received a meal that looked appetising.

Care plans showed that people were supported with their healthcare needs and contained records of all visits carried out by external healthcare professionals. This included weekly GP visits where appropriate, and visits by chiropodists, dentists, opticians, physiotherapists, district nurses and the falls clinic. Information included the day and time of visit, why they visited, the outcome of the visit and any follow up required. A healthcare professional told us, "They're [the home] always on the telephone if they need anything. They are very good at keeping us informed." A relative said, "They are responsive to her health needs."

Good

# Is the service caring?

## Our findings

People were positive about the home and the care that they received. People told us, "I like the place not as an institution but a place where you can meet people and get to know them", "Lovely home, nice people. I like it here" and "I love it here. Fantastic. When I talk to staff they listen." Relatives commented, "I haven't seen anything that shows they are not caring. They have gotten better recently as they are more attentive and they are not rushing through things", "The ones [staff] I have met are all very good I am not sure how but they kind of just are" and "Yes, I think they will help out in any way that they can."

We arrived at the home on the first day of the inspection at around 06:15. This was to check that people's waking and sleeping preferences were being adhered to. When we arrived there were five people awake. People confirmed that they had wanted to get up and dressed at this time. People had received their choice of morning tea or coffee. Care plans noted people's waking and sleeping preferences and staff were able to tell us approximate times that people liked to get up or go to bed. We observed one person that was in bed at 10:30 and had chosen to have a lie in as they had had a restless night. Staff told us, "We always check on them but they get up when they want and tell us when they are ready for bed if they need help." Another staff member explained that they offered tea or coffee in bed before getting people up if appropriate.

During the inspection we observed that a person was taken ill in the communal lounge and an ambulance was called. We observed staff supporting the person and calmly talking to them and holding their hand. The registered manager ensured that all relevant documentation was provided to the ambulance crew including a hospital passport, which detailed people's needs and medicines. Where some people became distressed staff sat with them during and after the person had been conveyed to hospital to reassure them and explain what was happening.

On the first day we observed that a person was sick during lunch time. Staff immediately saw this and helped the person whilst reassuring them that everything was okay. This was done in a way that was calm and did not draw attention to the person and ensured their dignity.

Staff were aware of the importance of treating people with dignity and respect. One staff member told us, "When you are giving personal care, close the door. Explain what you are going to do. It's about knowing how to talk to people and giving them choice. I always take them a cup of tea and have a chat if they want before we do personal care." Another staff member said, "If I am going to a resident's room, I would knock on the door. Give them choices such as a shower or a wash. I have to respect his or her decision and act in their best interests. When we are going to the bathroom, even if it is in their bedroom, I make sure they have their morning robe on to protect their dignity." A relative said, "Yes, I think they look after her really well. They always take her into the bedroom when she needs help getting changed."

Staff were positive about working with people of different cultures, faiths and sexual orientation. Staff were aware that discrimination was a form of abuse. One staff member said, "We work with them [people] with love and respect and respect their needs, character, interests and them as individuals. It does not make any difference to the care that I give."

People's faith was noted in their care plan. The home had a priest that visited every Sunday to conduct communion and services. People were reminded and supported to attend if they wanted to. We observed a person receiving a visit from a member of their Muslim community during the inspection. One person told us that they wanted to attend a church as, "It's not the same doing it here." We spoke with the registered manager who told us that this had been planned with the person and a member of staff would be accompanying them to the local church of their choice.

Relatives told us that the home had consulted them on their relatives care needs where necessary. One relative said, "I have helped her with all her planning needs." Records showed that relatives were asked for their opinion and input when care was planned and were also invited to reviews of care.

Advanced care plans were in place in case of a person passing away which had been developed together with external health care professionals, relatives and Independent mental capacity Advocates (IMCA's) where appropriate. Best interest decisions about all future care requirements had been clearly documented.

Throughout the inspection we observed people visiting. Visitors were greeted warmly and we observed two conversations with staff about how their relative was that day.

Good

# Is the service responsive?

## Our findings

At our last inspection we found that the provider had changed the format of the care plans. At this inspection we found that the care plan format had been changed again. However, the newly introduced care plans were much more informative and detailed. Care plans were person centred and detailed and contained in-depth information about the person, their needs, preferences, likes and dislikes. Care plans also stated how the person wished for their care to be delivered. Each care plan had a one page profile which gave information about the person, their personality, what they enjoyed doing, things that were important to the person and things they liked to do.

The home compiled an initial service user assessment for each person that contained key information about the person, medical information, any known allergies and details of their health and support needs. This assessment identified any risks regarding the person's health or wellbeing and guided staff on what risk assessments to complete. Risk assessments then fed into the care plans to ensure that care delivered was not only person centred but also safe. Care plans were reviewed on a monthly basis and risk assessments were reviewed annually and sooner where significant changes were noted.

Each care plan contained a hospital passport and a hospital transfer form which contained all relevant information about the person that would be required if the person was to be admitted to hospital.

Where care plans had noted that specific observations of tasks needed to be completed to ensure the persons good health and wellbeing, this was observed to be happening and recorded appropriately within the relevant care plan records. For example, as part of the Mental Capacity Act (MCA) assessment, one person told the IMCA that they had a medical condition. The IMCA informed the registered manager and this was followed up with the GP. Another example was where one person living with dementia had not been eating or drinking well. They had been assessed to have their weight checked on a weekly basis as well as monitor their food and fluid intake on a daily basis. This was noted to be happening and if any concerns were noted this was referred to the appropriate healthcare professional. Another person had been assessed by a physiotherapist as requiring support with exercising their legs on a bi-weekly basis. This had been recorded as taking place as part of the person's activity records. We spoke with two staff members to check their awareness and knowledge of the exercise requirements. Both knew what they had to do to support the person with their exercises.

We looked at daily recording notes for all nine people's care plans. Each recorded what the person had done during the day, the support they had received and whether they had eaten well throughout the day. Night recording was also clear with hourly checks taking place for those people requiring this and this had been noted in their care plan as part of their monitoring.

Each person had a folder kept in their room which contained the person's one page profile and a copy of their care and support plan. The file also contained, topical cream charts, the person's personal evacuation information (PEEP), food and fluid charts and turn charts where applicable.

Over the past three comprehensive inspections we had raised activities as an area of concern. A survey of quality assurance carried out by the provider in December 2016 found that people and relatives wanted more activities. The survey results noted, 'Activity-wise, more efforts must be brought in to provide more therapeutic, recreational and community integration activities to re-connect service users with the wider community. Their boredom must be addressed immediately'. Part of good care is ensuring that people living with dementia are stimulated and received a good quality of life. At our last inspection we found that activities had improved but were somewhat sporadic. At this inspection we found that the provider was addressing this issue. An activities company had been employed with and activities coordinator attending every weekday from 10:00 until 17:00. Other activities had been contracted such as art therapy and music. The provider told us that they were planning to expand activities to Saturdays and Sundays to ensure that people were stimulated and had something to engage in.

The main lounge, which previously had been used as a dining room and lounge had been changed. The area was no longer used as a lounge and had been converted to a dining area only. Following meal times the area was given over to activities. The change in use of the lounge allowed for more space for activities to take place. If people wished to relax, there was a smaller lounge with armchairs adjacent to the main lounge and a quiet room.

We observed activities happening throughout the inspection. People were encouraged to join in. If they did not wish to they were encouraged to do something else. For example, we observed one person reading. There was a good atmosphere during the activity sessions and people were laughing and joking. On the second day we observed people painting and drawing. The service had purchased individual table top easels that allowed people to relax and draw whilst seated. After the activities coordinator had left for the day on day two of the inspection, a person asked staff if they could do some more drawing. Staff provided the materials and the person appeared happy and hummed to themselves for over an hour. People told us, "I like painting and drawing and singing" and "I like sitting in the garden in the summer. Sometimes I play cards I like watching television, sports."

Each person had a daily activity record where staff recorded all activities that the person participated in throughout the day. Examples of activities included art club, playing ball to help with coordination, quizzes, bingo, exercise classes, sixties themed musical, story-telling, reading, playing cards, carol singing at Christmas, memory groups and discussions. The activity folder also contained a guidance plan for staff to follow with ideas of different activities they could facilitate especially when an activity co-ordinator was not available. The provider told us that they were planning some trips out as the weather was now improving.

The home had a complaints procedure that was available for staff and people to read and was displayed by the front door. This was in a larger font which made it easier for people to read. A pictorial, large font copy of how to complain was in the service user handbook. A copy of the complaints policy was also included. A complaints and compliments box was by the front door for people and relatives to use. There had been no documented complaints since the last inspection. Relatives said that they generally knew how to complain if they needed to and commented, "I guess I would start with the home first then work my way up", I would talk to the manager, he is alright" and "I have no idea it has never happened."

Requires Improvement

# Is the service well-led?

## Our findings

The home had a registered manager. The manger had been in post since the end of May 2016 and had recently been registered with the Care Quality Commission (CQC). At our last inspection we found that there was a confused management structure with staff unsure of managers' roles and responsibilities. There had been a number of consultants employed by the provider which had also created confusion. This had led to instability within the service and slow and inconsistent action to address issues found over the previous three comprehensive inspections. At this inspection we found that the provider had addressed this issue.

There was one consultant that was working with the service on an improvement plan. Staff were aware of who the registered manager, deputy manager and consultant were. Staff were also able to tell us what each managers role and responsibilities were. A new area manager had also been appointed and staff were aware of who this was.

Staff were generally positive about the registered manager and commented, "The changes from before to now, there has been a big change. Our management is much better than before. The manager is working with us. Everything is in order. Paperwork is better and the care is good" and "[The registered manager] is much better than before. He is really supporting. [The provider] is coming every day. He is checking the rooms, medicines" relatives told us, "Yes, I think it is better. [The registered manager] he seems very good and knows what he's doing" and "The manager is good I am glad he joined." People told us that they knew who the registered manager was and commented, "He comes round and asks you how you are. Good governor here" and "I know who the boss is. He comes round and talks to you."

At our last inspection we found that the provider had been completing some audits. However, there had been no action plans in place following audits or records confirming identified issues had been addressed. At this inspection we found that the provider had addressed this issue. All audits contained action plans and records showed when issues had been actioned and what action had been taken.

Records showed that the provider carried out building audits which included checking each person's room and recorded any actions that need to be taken which was then passed onto the registered manager to complete. These audits were completed four to five times a week. The provider also completed cream chart and turning chart audits. The registered manager completed medicines audits. The provider told us that they were in the process of devising forms to complete care plan and staff file audits.

At our last inspection we found that the provider had not been documenting accidents and incidents adequately. At this inspection we found that the provider had addressed this issue. Records showed that the provider had completed a trend analysis regarding any accidents or incidents from May to December 2016. This allowed the provider to see if there were any patterns and address any issues found. There was a monthly accident analysis for each month from May to February 2016. The analysis noted the accident type, whether the accident was witnessed or un-witnessed, if treatment had been provided, such as GP or hospital, the time of the accident and whether the accident was a safeguarding issue.

A survey had been completed with relatives and, where possible, people in December 2016. A positive response had been received and the provider had completed an analysis.

The provider completed an overview training record of all staff training that identified when specific trainings needed to be refreshed and when they had been re-booked. This enabled the provider and registered manager to monitor staff training.

Records showed and staff told us that there were regular staff meetings, often twice a month. Staff meeting agendas included discussions around job descriptions, the CQC report, meal times, residents, food and fluid charts, care plans, issues within the team and the changes within the home. Staff told us that they had an opportunity to raise concerns and felt management listened to them. Night staff told us that, sometimes, the registered manager came in at night to hold meetings with them.

Overall there was a better atmosphere within the home. Staff told us that they felt more confident within their roles and felt that there had been a lot of changes in the past year. One staff commented that care had improved and said, "The service users are happier. You can see it on their faces."

The provider and registered manager held friends and family meetings to ensure that relatives were able to express their opinion. Relatives told us, "I have been to a few meetings but not many" and "My brother usually goes to the meetings I don't have the time." These meetings also looked at the CQC findings and how the home was going to improve upon issues found. Relatives were also asked for their suggestions regarding improvements.

Since the last inspection the registered manager and provider had been proactive and committed to improving the service. Managerial oversight of the service had improved since the last inspection. However, we have rated well-led as Requires Improvement as it needs to be demonstrated over time that these improvements have been embedded. We will check this at our next planned comprehensive inspection.