Mr Farhad Pardhan

Meadowview Nursing Home

Inspection report

48 Rackend
Standlake
Oxfordshire
OX29 7SB

Tel: 01865300205

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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 was carried out on 4 January 2018 and was unannounced. At our last inspection on 7 and 11 August 2017 the service was rated as inadequate overall and was placed 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 provider 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.

At the previous inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements and met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider was meeting the regulations we have rated the service as Requires Improvement as we need to be sure the service can sustain the improvements.

Meadowview Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide care for up to 42 people. On the day of the inspection there were 18 people using the service.

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. 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 home manager told us they were applying to CQC to become the registered manager. Following the inspection we saw this application had been submitted.

People, relatives and staff were positive about the significant improvements made in the service since the inspection in August 2017. The service was clean and bright and there was a welcoming atmosphere. Staff were friendly and approachable.

The provider and home manager had worked with people, relatives and staff to identify and implement

improvements in the service. This had resulted in an open and inclusive culture that valued everyone and promoted a person-centred approach to care. Methods of communication had improved and relatives felt involved and informed about people's care and what was happening in the service.

Leadership had improved and staff were clear about their roles and responsibilities. The home manager had implemented effective systems to monitor and improve the service. This included improved engagement with people, relatives and staff.

Improvements made had resulted in people feeling safe in the service. Risks were assessed and there were plans in place to manage the risks. People's medicines were managed safely and people received their medicines as prescribed.

People's needs were met by staff who were kind and compassionate. Most staff communicated well with people and it was clear people had developed meaningful relationships with some of the staff. Where staff did not have English as their first language the provider was supporting staff to access additional help.

The food in the service had improved and people were consulted about their likes and dislikes. The menu choices reflected people's preferences.

The service worked closely with health care professionals and had developed positive relationships with them. This ensured people had access to healthcare support when needed.

Staff were well supported through regular supervision and were positive about the improved support from the current home manager. Appraisals had enabled staff to identify development needs and a training plan identified staff had access to training to ensure they had the skills and knowledge to meet people's needs.

People had access to improved activities and had been supported to enjoy outings. The service had also arranged visits from outside entertainers.

Peoples' care records had improved and included person-centred information that guided staff to ensure people's unique needs were met. Regular reviews were completed and relatives and representatives were invited to be involved in reviews.

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.

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 had improved to Requires Improvement.

Risks to people were assessed and there was clear guidance for staff in how to support people to manage the risks.

Medicines were managed safely and people received their medicines as prescribed.

The environment was clean, bright and was well maintained.

Is the service effective?

Requires Improvement

The service had improved to Requires Improvement.

People were supported in line with the principles of MCA and their rights were protected.

Staff were supported through regular supervisions. Staff had access to training to ensure they had the skills and knowledge to meet people's needs.

People received food and drink that ensured their nutritional needs were met.

Is the service caring?

Good

The service had improved to Good.

People were supported by staff who showed kindness and compassion.

Staff supported people with dignity and respect and recognised them as individuals.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service had improved to Requires Improvement.

Care plans were person-centred and included information about people's life histories and interests.

Relatives and representatives were involved in regular reviews of people's care where appropriate.

Complaints were responded to in a timely manner and to the satisfaction of the complainant.

Is the service well-led?

Requires Improvement

The service had improved to Requires Improvement.

The provider and home manager had made significant improvements in the service.

There were effective systems in place to monitor and improve the service.

The provider and management team promoted an open culture and communicated effectively with people, relatives, health professionals and staff.

Meadowview Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The service was previously inspected on 7 and 11 August 2017. The inspection resulted in an inadequate rating and the service was placed in special measures. CQC considered action in line with their enforcement policy. This inspection was unannounced and took place on 4 January 2018. It was carried out in response to written representations received from the provider in relation to CQC's proposed enforcement action. This inspection has enabled CQC to make decisions based on accurate, timely information.

The inspection was carried out by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held about the service which included notifications. Providers are required to notify CQC of specific events as part of the conditions of their registration.

The provider was not asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

During the inspection we spoke with three people and eight relatives. We spoke with the provider, the home manager, the deputy manager, the clinical lead, five care staff, the chef and one housekeeper. We also spoke with one visiting health professional.

We looked at seven people's care records, five staff files and a range of records relating to the management

of the service.

Requires Improvement

Our findings

At our inspection in August 2017 the service was rated inadequate in Safe. The concerns we found in relation to people's safety resulted in two breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the regulations.

At the previous inspection we found that risks were not accurately assessed and there were not effective plans in place to manage identified risks. At this inspection we found improvements had been made. People's care records included risks associated with mobility, falls, mental health, nutrition and skin damage. Where risks were identified there was clear guidance for staff in how the risks should be managed. For example, one person required the support of two carers and a hoist when transferring. The risk assessment identified the person could be anxious when being transferred. The care plan guided staff in the correct hoist and sling to use and to offer reassurance to the person when using the hoist. We saw two staff using the correct equipment to support the person to transfer, providing reassurance to the person. The transfer was carried out safely.

Another person was identified as at risk of skin damage. The person's care plan identified that pressure relieving equipment was in place and the person required repositioning when in bed to manage the risk. We saw the pressure relieving equipment was in place and was regularly checked to ensure it was at the correct setting. Records showed the person was repositioned in line with their care plan and they did not have any skin damage.

Relatives told us they thought people were safe. One relative told us, "Yes it is all safe for her there". Relatives gave examples of actions the service had taken to improve people's safety. For example, equipment had been purchased and installed to reduce the risk of falls for a person who had experienced a fall.

At the inspection in August 2017, we found that medicines were not managed safely. At this inspection, we found improvements had been made. People received their medicines as prescribed. Medicine administration records (MAR) included details of all prescribed medicines. This included the strength, dose, times of administration and any specific information relating to the administration of the medicine. MAR included details of the person, which included any allergies. Where people were prescribed medicines 'as required' (PRN) there were clear protocols in place identifying how the medicines should be administered to ensure they were effective. MAR were accurate and fully completed.

People received their topical medicines as prescribed. MAR relating to topical medicines included body maps to identify where the medicines needed to be applied and how often they should be applied.

We saw staff administered medicines in line with national guidance and with regard to people's wishes. For example, the nurse asked a person "Can I give you your meds now or do you want to finish breakfast"? The nurse checked MAR carefully for ensure people received their medicines as prescribed.

Staff responsible for the administration of medicines had completed training and had their competency checked. Records showed that staff competency checks had been completed by the home manager. The nurse told us competency checks were carried out annually or more often if there were any concerns.

Medicines were stored safely in a locked medicines trolley, which was secured to the wall in a key coded room when not in use. Temperatures were monitored daily to ensure medicines were being stored at an appropriate temperature. Records showed that the temperature remained within the required limits.

Where people were receiving their medicines covertly the provider had been unable to obtain advice from the dispensing pharmacist to ensure that it was safe to administer the medicines in a covert manner. Covert administration of medicines means when medicines are administered in a disguised format without the knowledge or consent of the person receiving them. The provider had worked closely with the prescribing GP to ensure that medicines were being administered in a safe way. Where possible, covert medicines had been prescribed in a liquid format and there was detailed information about the ways individual medicines could be administered covertly.

At the inspection in August 2017, areas of the service were not clean and there were unpleasant odours. At this inspection the home was clean with no unpleasant odours. Some areas of the service had been redecorated. There were detailed cleaning schedules that identified what tasks should be completed daily, weekly and monthly. Records showed that these schedules were being followed. Areas that had been cleaned were checked by senior staff to ensure cleaning was completed to a high standard. We saw a written compliment from a relative acknowledging the improved cleanliness in the service.

Relatives told us the cleanliness of the service had improved. Comments included; "The room is nice and clean and tidy" and "Yes, her room is always clean now".

During the inspection in August 2017 people's requests for support were not always responded to in a timely manner and we could not be sure there were enough staff deployed to meet people's needs. At this inspection we found there were sufficient staff to meet people's needs. Throughout the inspection staff responded promptly when people required support. For example, one person stood up and started to walk unsteadily to the door. A member of staff immediately approached them and offered an arm and steadied them. Staff had time to sit and speak with people. Throughout the inspection staff responded in a timely manner to call bells.

Relatives told us there were enough staff to meet people's needs and that the response from staff had improved. Relatives' comments included: "There is always someone in the lounge and around"; "I think there are enough staff, yes" and "Obviously given the lower resident numbers there are more than enough staff".

Staff told us there were enough staff to meet people's needs. One member of staff told us, "At the moment it's enough for the residents we have. We're fine with two carers on each side". Another member of staff told us senior staff "are able to cover" in the event of sickness.

The home manager used a dependency assessment tool to identify the number of staff required to ensure people's needs were met. Staff rota's confirmed planned staffing levels were consistently maintained.

At the previous inspection, we identified concerns relating to the systems in place to manage the risk of fire and to respond to an outbreak of fire. Following that inspection a representative from the local fire and rescue service visited the service and made recommendations. At this inspection we found the provider had completed all of the recommendations made which included replacing some fire doors. Records showed there were effective systems in place to monitor the fire systems, which included regular fire drills. Staff had completed training to ensure they understood the action to take in the event of a fire. There was a 'grab box' clearly indicated near the main entrance, which contained up to date information relating to people's mobility needs, medicines and contact telephone numbers of appropriate family and representatives.

Staff had completed training in safeguarding vulnerable adults and understood their responsibilities to identify and report any concerns. Staff told us, "If I see something, I stop them. Then I'd go to the senior carer" and "I would report it (safeguarding concerns) and could come to you guys (CQC), the police or social services".

The provider had a safeguarding policy and procedure in place. Records showed that concerns raised in relation to safeguarding had been fully investigated and appropriate action taken. The home manger had notified external agencies appropriately.

There were effective systems in place to monitor equipment to ensure it was in good working order and safe to use. For example, hoists and assisted baths had been regularly serviced.

Recruitment records showed relevant checks had been carried before staff worked in the home. Checks included employment and character references and Disclosure and Barring Service (DBS) checks. This enabled the provider to make safer recruitment decisions and ensure staff employed were suitable to work with vulnerable people. Where staff were employed through an agency the provider ensured relevant checks had been completed by the agency before allowing the staff to work in the home.

The service has now been rated as requires improvement in this key question. This is because the service was previously rated as inadequate. Therefore, we need to be satisfied that these changes are being sustained. We will do this by following up these concerns at our next full comprehensive inspection, which will look at the five key questions we ask about services, which are: is the service safe, effective, caring, responsive and well-led.

Requires Improvement

Our findings

At our inspection in August 2017 the service was rated inadequate in Effective. The concerns we identified in relation to the effectiveness of the care provided resulted in two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made and the provider was meeting the regulations.

At the previous inspection we found people were not supported in line with the principles of the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection, we found people were supported in line with the MCA and their rights were protected and upheld.

Staff we spoke with had completed training in MCA and gave clear examples of how they supported people in line with the principles of the act. Staff comments included: "People have a right to choice. It is important to explain care to be offered"; "You have to have consent"; "Everybody has to be considered to have capacity"; "We need to assess first that they have the capacity to take their own decisions" and "If people lack capacity to make a decision then any decisions must be made in their best interest. Just because a decision is unwise it doesn't mean someone lacks capacity".

Care records included information relating to people's capacity to make decisions and where people had been assessed as lacking capacity to make a decision there were records to show a best interest process had been followed and recorded. Records relating to best interest decisions identified that appropriate representatives had been consulted. For example, one person enjoyed a particular food that had been a lifetime favourite. The food could not be prepared in a way that enabled it to be provided in the consistency recommended by the speech and language therapist (SALT). The person was assessed as lacking capacity to make the decision to stop eating the food. A best interest process was followed that involved the person's legal representative, the home manager, the person's GP and SALT. A decision was made in the person's best interest that they should continue to be allowed to enjoy the food with supervision.

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. The home manager had made a DoLS application to the supervisory body where people were assessed as lacking capacity to consent to any restrictive elements of their care. Where DoLS authorisation had been granted this was identified in people's care plans.

At our inspection in August 2017, we found staff did not always have the skills to meet people's needs as they were unable to communicate effectively with people. At the inspection in January 2018, we found staff communicated well with people.

We observed staff taking time to speak with people to ensure they understood what was being said. Staff made sure they were at eye level and repeated questions, rewording them if necessary to ensure people understood.

One member of staff we spoke with had difficulty communicating with people and was unable to answer all of the questions we asked. However, the member of staff had only been working in the home for one week and was working under the supervision of a senior member of staff, who we saw guiding and prompting them. The member of staff was able to tell us they had completed training and was completing a 'training book'. The member of staff told us they were supported by the staff team and senior staff.

We spoke with the home manager regarding the actions they had taken to improve the communication skills of staff. They told us staff had been supported to access lessons to improve their English skills and received supervision and support to ensure their communication skills improved.

Staff told us they had completed a range of training to ensure they had the skills and knowledge to meet people's needs. One member of staff said, "The training here is good. We have a good trainer". Training included: safeguarding, moving and handling, fire safety and infection control. Training was delivered in a range of ways and included practical face to face training. Training updates were completed regularly. One member of staff told us, "I have completed training in MCA, dementia, DoLS, safeguarding, fire safety, catheterisation and venepuncture".

Staff were supported through regular supervision and received an annual appraisal. One nurse told us they had recently had an appraisal. A care worker told us they had supervision with the manager or the nurse "Every month". Where there were concerns about staff performance, records showed these were addressed through supervisions in a supportive and constructive way.

People told us the food had improved. People's comments included; "I enjoyed my lunch" and "It [lunch] was very nice".

Relatives told us people ate well. Comments included: "Food and drink are all good and there is usually plenty of it"; "The food is okay" and "Yes, I think [person] eats well"

People had completed a survey in relation to the food offered. The home manager had worked closely with the chef to incorporate people's likes and dislikes into the menu offered. The home manager told us there had been an improvement in the chef's involvement with people. This included the chef going round the home to ensure people were enjoying their meals.

The lunch looked appetising and people ate with enjoyment. Where people required support this was given in a calm way, enabling people to eat at their own pace and enjoy what they were eating. For example, one person was being supported to eat in their room. The member of staff explained what the meal was and continued to explain what was happening throughout the mealtime. The person responded to the meal saying, "Wow. That is lovely, thank you very much" and "This pudding is amazing. [Chef] has done that well".

Where people had specific dietary requirements we saw people received food to meet their needs. For example, one person had been assessed by Speech and language therapy (SALT) who had recommended "Fork mashable, stage 1 fluids". The assessment also identified safe posture while eating and drinking. We saw staff supporting the person in line with the guidance.

Drinks and snacks were available throughout the day. Staff offered people hot and cold drinks regularly and people in their rooms had drinks to hand.

The chef had written, up to date information about people's dietary needs displayed in the kitchen. The chef told us this was updated when anything changed. The chef knew people's needs well and was able to tell us who required fortified food and how this was achieved.

Where people were at risk of weight loss this was identified in their care plans and there was guidance to staff on how to support the person to maintain and increase their weight. This included regular fortified drinks and monitoring their food and fluid intake. Nursing staff, the clinical lead and the home manager monitored people's weight loss and where there were concerns people were referred to health professionals.

People were supported to access health services when needed. The service had recently accessed support for people from a new G.P. It was clear a positive relationship had been developed between the service and the G.P. This ensured people had prompt and effective support with their healthcare needs.

The service referred people to other health care services and supported them to attend appointments. This included access to Care Home Support Service (CHSS), SALT, podiatry, diabetic nurse, stoma nurse and mental health professionals. For example, on the day of the inspection one person was supported by a care worker to attend a podiatry appointment.

We spoke to a visiting health professional who told us the service referred people to them appropriately and followed advice and guidance.

Parts of the home had been recently decorated and provided a clean pleasant environment. We saw that some rooms had been personalised for people and that where people required equipment this was provided in their rooms.

The service has now been rated as requires improvement in this key question. This is because the service was previously rated as inadequate. Therefore, we need to be satisfied that these changes are being sustained. We will do this by following up these concerns at our next full comprehensive inspection, which will look at the five key questions we ask about services, which are: is the service safe, effective, caring, responsive and well-led.

Good

Our findings

At our inspection in August 2017, we found that staff were not always caring and people were not always treated with dignity and respect. These concerns resulted in a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the regulation.

There was a caring culture that was promoted by the home manager, deputy manager and clinical lead. We saw them encouraging and promoting a caring approach to people.

People told us staff were caring and this had improved. People's comments included: "There have been a lot of changes for the better and they try to look after you now"; "The staff are good. They all try to help me to walk"; "They are very nice staff here" and "We're being looked after very well".

Relatives were positive about the staff and the caring nature of staff. Relatives comments included: "She always tells me how nice the staff are"; "Carer is very patient with mum"; "The carers for the most part have a good attitude and demonstrate that they are in control"; "It is homely, an atmosphere from the staff that indicates that they genuinely care" and "For mum they are just so caring. They all make sure that they explain things to her".

Staff spoke about people in a caring manner. One member of staff told us, "They [people] can be like my grandmother or mother". They added "In my opinion we are brilliant. We try hard to do the best we can". Another member of staff said it was important to speak in a "Gentle, calm voice" and to "Listen to their stories".

We saw many kind and caring interactions. For example, one person was being supported in the hoist to transfer from their wheelchair to an armchair. The two staff explained what was going to happen, provided reassurance and checked the person was comfortable throughout the transfer. When the person was sat in the chair a member of staff checked they were comfortable, offered to clean their glasses for them and asked what they would like to eat.

Another person liked to walk around but could be unsteady on their feet. We saw a member of staff supporting the person by walking arm in arm along the corridor. It was clear they had a positive relationship as they walked along chatting and laughing together.

Staff asked people's permission before supporting them and took time to explain what was happening and what the staff member was going to do. For example, a member of staff asked the person if they would like to wear a protective cover for their clothes before eating. The person agreed and the staff member showed them the covering and explained how they would place it around their neck.

Staff supported people to be as independent as possible. One member of staff said, "We must maintain people's skills for as long as possible. If we deskill them they will deteriorate quicker".

Staff understood the importance of communicating effectively with people. One member of staff said, "It's important to let people know what is happening so we don't scare them. Communication is key".

Care plans identified people's communication needs and gave clear guidance to staff in how to meet those needs. For example, one person's care plan identified the person wore glasses which they needed to be able to see who was speaking with them. The care plan also stated, "It can help to ask direct questions that require a yes or no answer. Explain things simply". We saw the person had glasses on and staff followed these guidelines.

People received emotional support. Where people could become anxious we saw staff responded to their anxiety in an understanding and compassionate manner. For example, one person living with dementia was asking for a family member and was worried about their money. The member of staff sat with the person and touched their hand gently. The member of staff reassured the person and said, "It's OK, your money is safe and so is [family member]". The member of staff then distracted the person by talking with them about their past interests.

People were treated with dignity and respect. Staff ensured people's rights were upheld. Staff treated people as unique individuals and spoke with and about people in a respectful manner. One member of staff told us, "Everyone is different. What one person likes another person may dislike. Everyone has their own beliefs and needs".

People and their families were involved in the development of peoples care plans to ensure their wishes were identified and upheld. Records showed that regular reviews had been held and people or their representatives had been consulted and agreed to the care plan.

Requires Improvement

Our findings

At our inspection in August 2017 the service was rated inadequate in Responsive. The concerns we found in relation to the responsiveness of the service resulted in three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the regulations.

At the previous inspection, we found people were not always supported in a way that met their needs. Care records were not always up to date and accurate. Since the inspection in August 2017, people's care plans had been rewritten and included detailed, accurate information relating to people's individual needs and how these needs should be met. Care plans were person-centred and included information relating to people's life histories, significant relationships, people's past hobbies and current interests. Care plans included an "All about me" document that was used to develop care plans that recognised people as individuals. For example, one person's care plan stated, "I like reading, looking out of the window at the garden, listening to music and singing". We saw the person's room was arranged so that they could look out of the window and the person had music playing in their room.

People's personal preferences were detailed in their care plans and were respected. For example, one person's care plan identified the person preferred female care staff when receiving support with personal care. Staff we spoke with knew this information and ensured that only female staff supported them with their personal care.

People's health conditions were detailed in people's care plans and included details of how health care needs should be met. For example, one person had a percutaneous endoscopic gastrostomy (PEG) in place. A PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach to provide a means of feeding when oral intake is not adequate. The care plan detailed the feeding regime developed by the dietician. This gave clear directions for maintaining the equipment and how dietary needs were met. The care plan gave instructions on how to meet the person's oral care needs including the use of an artificial saliva spray prescribed to keep their mouth moist. Records showed the person was receiving support to meet their needs. Staff we spoke with were knowledgeable about this person's needs and how to ensure their needs were met.

Relatives told us the service was responsive to people's changing needs and kept them informed of those changes. Comments included: "The Home is very proactive in sorting out any problems"; "Yes, two of the carers are very good at keeping us up to date with how mum is doing. She had a urine infection recently and

they rang up to tell me" and "I visit once a week and I find now that they are active towards me whenever I go. The staff give me a complete rundown on how she has been. They even phoned me up when mum had a UTI [infection]".

Staff were responsive to people's changing needs and took steps to achieve the best outcomes for people. A visiting health professional told us, "They are always looking for ways to improve people's lives". The health professional gave an example of the support given to a person who was extremely anxious when they first moved into the home. The person was now settled and was confident enough to spend time in communal areas of the home.

Staff were responsive to people's request for help and support. For example, one person said they were cold. A member of staff immediately fetched a blanket to help the person keep warm. The member of staff showed their knowledge of the person by providing a blanket the person clearly liked and recognised. The person smiled as the blanket was wrapped around them.

Where people were in their rooms staff visited them regularly to check whether they needed anything. We heard staff chatting and spending time with people when they visited them.

People had access to some activities that interested them. We saw that people had enjoyed trips out, which had included a visit to an Inclusive Care & Education Centre where people visited the sensory room. There were photographs showing people enjoying the experience. There was also a visit to a local pottery planned.

People had also enjoyed performances from visiting entertainers, flower arranging, gardening, painting and making bird feeders. The activity coordinator had completed activity profiles for each person, which identified what they enjoyed. Where people preferred one to one activities we saw people were visited in their rooms and enjoyed activities, which included: having their nails painted; looking at pictures of family members and doing puzzles.

At the previous inspection people and relatives were not confident to raise concerns and told us the complaints process was not always effective. At this inspection people and relatives felt confident to raise complaints. The provider had a complaints policy and procedure in place which had been highlighted in a recent newsletter sent to people and relatives. Complaints records showed that complaints and been fully investigated and responded to in a positive manner. Responses included apologies and detailed the action taken to resolve the complaint. For example, one complaint related to family member being concerned whether a person's food intake was meeting their dietary requirements. The response to the complainant gave a detailed explanation of the person's dietary needs and reassurance that included referring the person to SALT for a reassessment. We also saw feedback from one complainant that they were happy with the action taken to resolve their complaint.

At the time of the inspection, there was no-one receiving end of life care. Care plans contained Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), which had been discussed with people or their representatives where appropriate. One person's care plan included an end of life plan which stated, "End life in a dignified, pain free way". The care plan also included a proactive care plan completed with the person's GP that identified the person did not wish to be admitted to hospital unless their symptoms were uncontrollable in the service.

The service had received positive feedback from a relative in relation to the end of life care provided. The feedback stated, "The journey has been one of excellent care, compassion and kindness. Your staff have

been outstanding in meeting [person's] needs and ensuring that end of life care has been filled with dignity and warmth".

The service has now been rated as requires improvement in this key question. This is because the service was previously rated as inadequate. Therefore, we need to be satisfied that these changes are being sustained. We will do this by following up these concerns at our next full comprehensive inspection, which will look at the five key questions we ask about services, which are: is the service safe, effective, caring, responsive and well-led.

Requires Improvement

Our findings

At our inspection in August 2017, we found the service was not well led. Systems to monitor and improve the quality of the service were not effective. The consistency of the quality of the governance systems operated by this provider has been a concern since 2015. The provider consistently failed to meet the requirements of the regulations and the service was rated inadequate as a result of our findings in August 2017.

At this inspection we found improvements had been made and the regulations were being met.

People and relatives were positive about the improvements made since our inspection in August 2017. Comments included: "I walk in here each day now and it seems, I don't know, that it has changed for the better"; "The Home has improved these last few months"; "The Home is definitely improving their communication"; " I can't think of anything that's not going well here"; "The Home calls me now. [Person] is a lot better now, before she was in bed all the time" and "I've noticed a general improvement".

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. 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 home manager told us they were applying to CQC to become the registered manager. Following the inspection we saw this application had been submitted.

The home manager provided weekly reports to the provider to ensure the provider had oversight of the service. The reports included: outcomes of audit, staffing levels and any issues; complaints; safeguarding and falls. The provider completed a monthly quality assurance visit and provided a report to the home manager. The quality assurance report included: reviewing care plans; speaking with people; speaking with staff and looking at the cleanliness of the service. However, there was no record of action being taken as a result of the report. We spoke with the provider and the home manager who told us they would introduce a written record of the actions taken as a result of the report.

The home manager had introduced a range of audits to monitor and improve the quality of the service. Audits included: weight loss; care plans; medicines; falls; observation of staff and cleanliness of the service. Where issues had been identified, action had been taken to address the issues. For example, a weekly care plan audit had identified that wording used in recording had not been appropriate. The home manager

spoke with the member of staff and had introduced a system for senior staff to check the recording daily to pick up on any issues immediately.

There was an effective system in place to monitor accidents and incidents. For example, the system looked at the time of falls, where they had occurred and the person involved. This enabled the home manager to identify any trends and patterns and take action to reduce the risk of further falls.

Staff were positive about the changes made by the home manager. Staff comments included: "It is more relaxed. [Manager] is more proactive. The changes have made it better for relatives"; "[Manager] is really good. She is strict but fair"; "We are working better as a team. The communication seems to be a lot better and it feels organised" and "I feel more supported now. Things seem to be acted on quicker".

A visiting health professional told us, "There are definitely improvements. The manager, clinical lead and deputy work well together".

The provider and manager promoted an open culture that encouraged people, relatives and staff to raise issues with them. Following the last inspection, in August 2017 the provider held a meeting with relatives and spoke of the CQC report and potential CQC action. The provider advised relatives what action they planned to take to improve the quality of the service.

The provider had sent out a quality assurance survey to relatives. The responses were used to improve the quality of the service. For example, the survey results showed concerns raised regarding the cleanliness of the service and rushed mealtimes. The home manager had introduced improved cleaning schedules and increased monitoring of the cleanliness. A discussion was held at a senior staff meeting regarding the accountability of senior staff to manage staff deployment and ensure appropriate staff allocation throughout the day. We saw that the cleanliness of the service had improved. The mealtime was calm and organised. People were able to eat at their own pace.

The provider and home manager had looked at ways to improve communication with people and relatives. A newsletter had been introduced that reported on activities that had taken place and those that were planned. The newsletter was also used as an opportunity to share additional information. For example, details of the provider's complaint policy were included. Relatives were advised they would be invited to attend care reviews with people to ensure they were involved in people's care.

We saw the service had received several compliments in relation to improvements made in the service. This included acknowledgement of improvements in the laundry service, cleanliness of the service and improvement in the food.

There were systems in place to ensure the confidentiality of people's information. People's care records were stored in the main office and nurses station. Offices included key coded locks, which were activated when the office was not manned.

The service worked closely with health and social care teams and had developed positive working relationships. The home manager, deputy manager and clinical lead were positive about their relationship with the new G.P who supported the service and how this had improved outcomes for people.

The service has now been rated as requires improvement in this key question. This is because the service was previously rated as inadequate. Therefore, we need to be satisfied that these changes are being sustained. We will do this by following up these concerns at our next full comprehensive inspection, which

will look at the five key questions we ask about services, which are: is the service safe, effective, caring, responsive and well-led.