Castle Villas Limited

Clover House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Clover House took place on 26 November 2018 and was unannounced.

At our last inspection in March 2018 we rated the service as 'Inadequate' and the service was placed in 'Special Measures'. We identified eight breaches of regulation. These were in relation to staffing, person centred care, safe care and treatment, meeting nutritional and hydration needs, dignity and respect, need for consent, safeguarding service users from abuse and improper treatment and good governance.

Clover House 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 care home can accommodate up to 39 older people who may be living with dementia or other mental health problems. Accommodation at the home is provided over four floors, which can be accessed using a passenger lift. At the time of our inspection there were 18 people living at the service.

The service had a registered manager. 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 at Clover House is also the provider.

There were enough staff to safely meet the needs of people living at the home. Some people told us they felt this varied particularly at weekends but we did not see evidence of this from staff rotas.

Recruitment processes were followed to make sure new staff were safe and suitable to work in the care sector. Staff followed a thorough induction process. Staff had received training including specialist training. However, this was not always evidenced clearly on the training matrix. Staff received support from the registered manager through supervision.

Risks to people's health and wellbeing were managed appropriately, although, the level of observation for a person at risk of leaving the home had not been updated on all related documentation.

Systems for managing medicines were safe. Some improvements were needed for recording the application of topical medicines.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. However, one person told us staff did not always respect their preferred times of getting up and going to bed.

People enjoyed the mealtime experience although better observation of people taking their meals outside

the dining room was needed. Staff supported people to choose and enjoy a nutritious diet but improvements were needed in relation to the provision of special diets. We made a recommendation in regard. People had access to a range of snacks and drinks.

People were supported to access healthcare as the need arose. A district nurse praised the service for the care they provided.

People were treated with kindness, respect, compassion and emotional support. We observed carers interact with people during the day of our visit and they did so in a way that showed they knew people well and cared about their welfare.

We observed some examples of staff not always considering people's dignity. For example, we found underclothing belonging to other people in people's bedrooms and we saw people were routinely given crockery and cutlery suitable for people living with dementia when they didn't need it.

Care records were person centred and there was evidence of people, or where appropriate, their representative, being involved in the development and review of their care plans.

Visitors told us they were happy with the care their relatives received and felt the home provided a good atmosphere.

An activities programme was in place and items such as books, games and rummage boxes were available for people to engage with.

Complaints were not always managed in line with the complaints procedure.

Systems for auditing the quality and safety of the service had improved. The registered manager accepted some further improvements were needed and following the inspection provided us with documentation to show what they were doing to address this.

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.

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 safe but further improvements were required.

Systems for managing medicines were safe. Some improvements were needed for recording the application of topical medicines.

Staff were recruited safely and there were enough staff to meet people's needs

Risks were managed but some improvement was needed

Is the service effective?

Requires Improvement

The service was effective but further improvements were required.

People received a nutritious diet but better understanding of adapting diets to meet individual requirements was required.

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

Staff received the training and support they needed.

Is the service caring?

Requires Improvement

The service was caring but further improvements were required.

People were treated with kindness, respect, compassion and emotional support.

Some improvements were needed to make sure people's dignity needs were respected and met.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Care records were person centred and appropriate people were involved in the development and review of care plans.

People were supported to engage in activities of their choice.

Complaints were not always managed appropriately.

Is the service well-led?

Requires Improvement

The service was well led but further improvements were required.

Systems for auditing the quality and safety of the service were in place but required some improvement to make sure they were effective.

People had confidence in the registered manager.

Clover House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 November 2018 and was unannounced. 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. In this case the expert had experience of services for older people.

Before the inspection, we reviewed all the information we had about the service including previous inspection reports and notifications received by CQC. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. We also contacted the local authority commissioning and safeguarding teams for any information they held which might be helpful to the inspection process.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed how care and support was provided to people. We met and spoke with many of the people who lived at the home, however, due to complex care needs; most people were not able to tell us about their experiences at the home. Three people were able to tell us about living at Clover House. We also spoke with four people's relatives, four members of care staff, the cook, a district nurse and the registered manager.

We looked at four people's care records in detail and checked information in another two people's care records. We looked at three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked around communal areas, bathrooms and some bedrooms.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found there were not enough staff to meet people's needs, risks were not consistently assessed and mitigated and medicines management was unsafe. At this inspection we found improvements had been made in all three areas.

We found there were enough staff available to meet people's needs. The registered manager told us they had increased staffing levels following our last inspection. Since that time the number of people living at the Clover House has decreased but the registered manager told us they had maintained higher staffing levels during day time hours. They showed us the dependency level assessment tool they used to help determine how many staff were needed in relation to people's assessed needs and we saw the staffing levels were calculated at slightly higher than the dependency tool indicated.

The staff rota showed a minimum of four care staff on duty between 8am and 8pm. The registered manager and deputy manager were usually additional to these numbers.

Housekeeping and catering staff worked between 7am and 2pm each day. Care staff were responsible for the serving of tea and suppers and cleaning up afterwards. Care staff also managed any laundry requirements during the afternoon and evening.

Two people who lived at the home thought there were not always enough staff. One said, "The staff are a 'bit thin' at the weekends, I can't get up until 9am when I would like to get up earlier. There's not enough staff, they struggle to do stuff and keep people clean but they do try. It's an awkward place this was not designed as a care home, it's difficult to get around. Another said, "It can sometimes get a bit hectic when there are loads (of staff) off."
Staff told us they thought there were enough staff. A relative told us they visited the home daily and there were always enough staff although at weekends there were sometimes fewer regular staff who knew people well.

Our review of staffing rotas showed staffing levels remained constant at weekends with the only difference being the registered manager not working one of the days at weekend.

The registered manager told us they had recruited new staff since the last inspection. We found recruitment practice was safe. Background checks were made which included relevant references and checking with the disclosure and barring service (DBS). The DBS is an agency which holds information about people who may be barred from working with vulnerable people. Making checks such as these help employers make safer recruitment decisions.

Individual risks to people were assessed within the care planning process and, where required, care plans included a risk assessment. For example, where people were assessed as being at risk nutritionally, of falling or at risk of pressure damage, appropriate assessments and risk assessments had been completed and detail included in the care plan of how to mitigate the risk. These were reviewed monthly or more frequently

if the level of risk changed. We discussed with the registered manager the importance of making sure all documentation related to risks was updated as the level changed. This was because we had noticed the level of observation for a person at risk of leaving the home had not been updated on all related documentation.

We saw Personal Emergency Evacuation Plans (PEEPs) had been updated to include more detail and were available in people's bedrooms as well as in care files. We saw fire drill had taken place and the registered manager confirmed they made sure all staff attended a minimum of two fire drills each year.

Care staff we spoke with had received training to safeguard people from abuse. They discussed signs and symptoms that would alert them and said they would discuss concerns with a senior carer or the registered manager. We described a scenario which they correctly identified as a safeguarding issue. The deputy manager knew how to complete relevant documentation and notify the authorities. We saw appropriate safeguarding referrals had been made.

People told us they felt safe. One said, "There is a fire drill every week. I don't lock my bedroom door, don't need to nothing's been nicked." A relative told us "[Person] is absolutely safe, [person] has a falls monitor in their room. [Person's] meds have been amended since they came here." Another relative said, "I feel [person] is safe because of the atmosphere with the carers. I like [Registered manager] and all the carers. I feel there are enough staff and they are all nice kids."

Staff said they had received training to understand, prevent and manage behaviour that could challenge. We discussed two people living at the home who sometimes exhibited behaviour that challenged. All of the staff we spoke with knew the people well and knew how to support them when their behaviour challenged. One person sometimes believed they were in their own home and became distressed objecting to other people being there. Staff described distraction techniques that were effective for the person. Another person had sometimes become agitated and records had been maintained to describe what happened before, the behaviour the person had, what action carers had taken and the consequences or outcome. This ABC charting aligned with best practice and helped care staff understand what triggers could lead to challenging behaviours and the best action to take to prevent or mitigate the effects.

The service's role in relation to medicines was clearly defined and described in relevant policies, procedures and training. Carers were trained and assessed as competent to administer medicines and competency had been assessed by the registered manager. The registered manager told us the comprehensive documentation we saw was new; they said they planned to use the new documentation to repeat staff competency assessments every three months.

A system was in place to ensure medicines were available when people needed them. Monthly repeat prescriptions were requested by the manager or deputy each month and dispensed and delivered by a pharmacy in time for the next month. Carers said these were checked when delivered and if there were discrepancies, they immediately contacted the pharmacy to rectify them. Most medicines were supplied in multi-dose blister packs. Where tablets or liquids were dispensed in original packaging, the number, or volume supplied was recorded on the new MAR. Any remaining medicines were carried forward onto the new MAR.

Medicines were stored securely in a locked trolley and cupboards in a locked, dedicated medicines room. We noted the trolley was always locked between administration of medicines to people. A medicines fridge contained appropriate medicines. Temperatures of the fridge, medicines room and trolley had been recorded each day and checked to ensure all medicines had been stored within safe temperature ranges.

Controlled drugs (CDs) are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. There are legal requirements for the storage, administration, records and disposal of CDs. No one living at the home was currently receiving CDs but we saw the service had a locked cupboard to store them and a ledger to record stock and administration, in line with current legislation.

The MAR file had a list of all staff competent to administer medicines with their signature and initials. This is good practice and helps managers audit practice. MARs included photographs of each person to help staff identify them. Information included their date of birth, allergies, GP and cognitive ability. When MARs stated the person lacked the capacity to make decisions about taking medicines, mental capacity assessment had been made and care plans were in place to help carers support each person safely. MARs had information about how each person preferred to take their medicines, including which drink they preferred.

We observed morning medicines administration in the dining room. The staff member wore a red tabard, designed to reduce interruptions which could increase the risk of errors. They checked the MAR, asked the right person if they were ready for their medicines before preparing them and supported the person to take their medicines in the way they preferred. One person refused one of their tablets, despite encouragement. The staff member recorded the refusal and stored the tablet securely for disposal.

Staff said no one currently received medicines covertly. Covert administration is the term used when medicines are administered in a disguised format, without the knowledge or consent of the person receiving them.

Although routine medicines were signed for at pre-filled times such as breakfast or lunch medicines which needed to be given at specific times, or with specific intervals such as antibiotics and as required analgesia, were given at the right time, which was recorded. Some people were prescribed medicines which needed to be given at eight am, before people received breakfast. A staff member said if people needed antibiotics more than twice a day, they would record the actual time to ensure people received them at the right time.

Some people had been prescribed medicines for use 'when required' (PRN). When medicines had been prescribed PRN, the carer asked people if they wanted the medicine before preparing it. We saw there were detailed protocols in place for most PRN medicines that included why they were needed, what they were for, and person specific details about how people communicated to express pain, for example. Administration was recorded on a separate record with the exact time. Two people were prescribed PRN laxatives. No protocols were in place for these and we drew this to the attention of the registered manager and the deputy manager said these would be in place by the end of the day.

The number of remaining tablets was checked and recorded each time PRN medicines were administered. We checked the count of three medicines and the actual count matched the expected count.

When people received a variable dose medicine such as warfarin, information was available, provided by a nurse based on blood results, to show carers what dose to administer each day. The count of remaining tablets was checked after each dose was given.

Topical preparations such as barrier creams and emollients were applied in people's bedrooms by staff delivering personal care. Protocols were in place, with body maps to indicate where these should be applied but the frequency of application was not always indicated. We saw staff had signed once each day for all topical preparations and the document did not have a space to indicate the time, or to record additional applications.

Medicines audits had been carried out each month and issues had been actioned.

The majority of the home was clean and tidy. However, we saw some examples of staff practice which would not support effective infection control. For example, one bedroom had been left with faeces smeared on the floor and washbasin and in another room the commode had not been emptied and the lid for the commode was on the floor next to the duvet. Dirty laundry had also been left on the floor. The registered manager questioned staff to establish who was responsible for this so that this poor practice could be addressed without delay. The registered manager told us a member of care staff had taken on the role of Infection Control Champion who has attended Infection Control and Prevention meetings. They also told us, the day after the inspection that they had introduced a new checklist for the senior staff to complete before their shift started every morning to ensure that night staff had completed their duties appropriately and in line with their training.

Systems were in place to check environmental safety on a weekly basis and we saw up to date certificates and records to show the provider ensured routine testing and maintenance was kept up to date. This included equipment used to provide care such as hoists, fire systems, and gas and electricity installations.

However, we noticed two people's mattresses were too long for their beds. This had not been identified as a risk and had not been identified in the mattress audit or room checks. The registered manager told us they thought the mattresses must have been changed over the weekend by the cleaning staff. They took immediate action to rectify the issue.

Accidents and incidents were recorded and reported as appropriate and analysed by the registered manager and deputy manager to look for any possible themes and trends where action could be taken to reduce the risk of reoccurrence.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found people's nutritional needs were not being met, the principles of the mental capacity act were not being followed and staff were not working in line with the training they had received. At this inspection we found improvements had been made in all these areas.

The registered manager had completed a number of observations of the mealtime experience and had invited people's relatives to do this as well. They had also researched good practice in mealtime experiences for people living with dementia. We saw the dining room provided a pleasant environment for people to eat. Matching table cloths and napkins were available and condiments were on tables for people to use. Pictorial menus were in place to help people make choices. People were supported to the dining room or to take their meal elsewhere as they chose. We observed a pleasant atmosphere at mealtimes.

People were supported to eat and drink enough to maintain a balanced diet. We observed the breakfast and lunchtime meals and saw staff supported people in a discreet and patient manner. However, we observed one person, after being supported with their porridge at breakfast was left at the table for over half an hour before staff supported them to move. We did not see the person being offered any cooked breakfast. We also observed another person in the lounge area with a bowl of porridge in front of them for over fifteen minutes. The person appeared to be asleep. The registered manager intervened when we brought this to their attention.

We saw the food offered was appetising and nutritious and people were offered more when they had finished.

People said of the food "Is ok" and "I always enjoy my lunch.". Another person told us, "The food is very good we had a roast pork dinner yesterday with proper gravy."

Nutritious snacks and drinks were served at various times throughout the day and we saw treats such as sweets and ice-creams, from the ice-cream machine, served.

We spoke with the cook who told us they had a list of people who required a fortified diet and told us about how they fortified meals with such as butter and condensed milk. However, we saw in one person's care records how sugar was used to increase their calorific intake. This included putting sugar in their drinks despite them not liking this. Using sugar to fortify diet is not a healthy or appropriate way to fortify a diet. We were concerned by the response we received when we asked about how food was adapted for people with diabetes. The cook told us they did not put salt in any food and but would give people with diabetes smaller portions of cake and puddings. No artificial sweetener was available.

We recommend the registered manager reviews the way special diets are catered for to make sure people receive the diet they need in line with their preferences.

The cook told us they had information given to them about which people were on a food and fluid chart but

did not have information about who required their food in an altered state, for example, fork mashable.

Peoples nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST). The registered manager audited people's weights and we saw most people had gained weight since our last inspection. Any losses were minimal and were because of illness.

We were concerned that all people were served their meals and drinks in dementia friendly crockery whether they needed it or not. We discussed this with the registered manager and they agreed this should not be the case. They contacted us after the visit to tell us people were being supported to choose their own mug or cup and saucer from a local shop.

People consented to care and treatment, unless they lacked mental capacity to make their own decisions. We saw people had been asked to sign consent to photography, administration of medicines and to receive personal care support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making particular decisions on behalf of people who may lack the capacity to make those decisions for themselves. These can be small decisions – such as what clothes to wear – or major decisions, such as where to live. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)- part of the MCA. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

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. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'.

We saw mental capacity assessments had been made and where people lacked capacity best interest decisions had been appropriately made. This included use of falls detection equipment, medicines, and flu immunisation. These were of a good standard and clearly showed, if people lacked capacity to make a decision, who helped make decisions on their behalf. When relatives held power of attorney (POA) for health and welfare, this was recorded. However, we noted that one person's relative held POA for finance and affairs but not health and welfare as their mental capacity assessment suggested. We drew this to the attention of the manager.

Some MARs stated people lacked the capacity to make decisions about taking medicines. We checked these people's care files and saw a mental capacity assessment had been made and care plans were in place to help carers support each person safely. DoLS were either in place, or had been applied for as required. The registered manager maintained a matrix of DoLS applications so they could track when renewal applications were needed or chase long-standing applications. The registered manager said they reviewed this every month.

Two people had conditions attached to DoLS. We saw records that confirmed the conditions had been met.

Staff told us they received the training and support they needed and we observed staff worked in line with their training, for example, in moving and handling. The training matrix was up to date and showed staff received training in many areas but did not indicate whether the training was face to face or on-line. The

training matrix also did not reflect specific training we were aware staff had received such as the 'React to Red' and 'Advanced Tulip Pressure care training' for prevention of pressure sores. The registered manager told about planned training which included a 'Virtual dementia tour.' This type of training is very effective in helping staff to understand the experiences of people living with dementia.

A person who lived at the home told us, "I don't think they are trained, but they do the job correctly. They are always tired." A relative said, "You only have to watch them [staff] they all seem adequate."

Staff new to care completed the Care Certificate. This is a set of standards for social care and health workers to equip them with the knowledge and skills they need to provide safe, compassionate care. Staff with previous care experience followed the service's induction programme and were enrolled on the level three QCF (Qualifications and credit framework) programme of training. Records showed staff were supported and assessed in their competencies throughout their induction period. Where staff needed extra support, the induction period was extended to accommodate this.

Staff received one to one supervision sessions with the registered manager every two months.

Prior to people coming to live at Clover House, the registered manager completed an assessment of their needs to make sure they could be met at the home. Other assessment tools were used to make sure people received the care and support they needed. Assessments included falls risk and skin viability assessments.

Records showed people were supported to access healthcare services as needed. We spoke with a visiting district nurse who told us staff were knowledgeable about people's needs and communicated them well. They praised the way staff supported people.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found people's dignity needs were not being met. At this inspection we found improvements had been made in this area.

We saw people were treated with kindness, respect, compassion and were given emotional support. We observed carers interact with people during the day of our visit and they did so in a way that showed they knew people well and cared about their welfare. Staff talked about people in a way that showed they knew them well, and knew people's preferences.

Staff demonstrated a patient approach with people living with dementia and gave explanations and reassurance to help people understand what was happening. For example, when staff were supporting people to move from the dining room, they checked the person wanted to leave and explained how they would help then with walking or with using a wheelchair.

We saw a member of staff giving gentle reminders to a person who was not eating their meal, when the person did not respond to that staff member, another gave similar support which the person responded to. However, we did not see any evidence of people being supported in their independence at mealtimes. For example, one person who was fully independent in this area was not given the option to put their butter and jam on their toast. We also noted a lack of opportunity for people to put their own sugar or milk in their drinks.

One relative told us, "Yes. They are kind I can't fault them." Another said, "They are all lovely kids. I can come when I want and I do on different days and weekend too. I come to reviews I come to everything." A third relative said, "The staff are fantastic and definitely caring."

We saw people had been supported with their personal hygiene and noted gentlemen had been supported to shave, people's hair had been attended to and clothing appeared to have been cared for.

We saw some examples of people's choices being sought and respected. For example, people had been asked how they would like their bedroom decorated and had been given a choice of options for decoration of the home's hallway. However, we saw in one person's care plan that they usually preferred to go to bed after 8pm. When we looked at their daily records we saw the person had been supported to bed before this time on the six evenings prior to our inspection visit.

We saw people's dignity was respected during care interventions. For example, when staff noticed a person's trousers were falling down, they discreetly assisted them to pull them up. Another example was when a person told us they did not feel comfortable in an item of their clothing. We told a member of staff and they immediately supported the person to change. However, when we looked in people's bedrooms we found clothing, including underclothes, belonging to other people in drawers and wardrobes. We saw a laundry audit dated 17 October 2018 which identified a number of items of clothing found in the wrong person's room. The only recorded action from this audit was to carry out a thorough audit the following month. We

also noticed several people did not have any underwear in their drawers. This meant that staff would not be able to efficiently support them to change as the need arose. We noted this issue had previously been raised as a complaint by a person's relative.

We recommend systems are reviewed to make sure people have their own clothing available in their rooms at all times.

Some people have specific needs or preferences arising from the seven protected characteristics of the Equality Act 2010. These are age, disability, gender, marital status, race, religion and sexual orientation. We saw staff used visual aids to help people understand what they were saying. For example, people were shown pictures of the meals on offer to help them to make a choice and when old fashioned sweets were offered to people, these were laid out on a tray so people could clearly see what they had to choose from. The registered manager told us about how staff had learned to sing 'Happy Birthday' in one person's first language ready for their birthday party. They also told us they regularly purchased a specific item of food from this person's culture.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found people were not receiving person centred care. At this inspection we found improvements had been made in this area.

There had not been any new admissions since our last inspection and the registered manager told us they had used this time to build a staff team and to make sure staff received effective training to support them in making sure people received person centred care. The registered manager had completed observations of care practice and used these to inform staff training and support.

The registered manager had also done research into best practice for supporting people living with dementia. The registered manager told us they have introduced a new 'Buddy system' for people moving into the home. This meant each person would have a member of staff acting as their buddy to help them to settle in and provide ongoing support. The registered manager confirmed that people already living at the home would be allocated a 'Buddy' and hoped to match service users with staff they related well with.

Documentation showed the registered manager assessed people's needs before they came to live at Clover House. This was to make sure the home could provide the right environment and that staff had the right skills to provide the support people needed.

Care records we reviewed were detailed and contained a lot of information about people's physical care needs and assessment of risks. They provided guidance for staff on how to support each person with each aspect of their care. There was evidence to show people and their relevant representatives had been consulted and regular documented reviews of people's care and support had taken place. In addition to people's care files there was a smaller file in each person's bedroom for staff to refer to whilst providing personal care. We spoke with a new member of staff who told us they had read people's care plans and where there was something they were not clear about had asked other staff. This demonstrated care plans were being used. We found some records relating to personal care were not kept within people's care plan files. We discussed with the registered manager how keeping all personal records within the care plan file supported the person-centred care approach and encouraged staff to look regularly at care plans. The registered manager agreed with this

We saw an activities programme was in place which included weekly visits from outside entertainers and a weekly tea dance. On the day of our inspection an entertainer was in the home and we saw them encouraging people to join in. People's interests and preferred activities were detailed in their care plans. For example, one person's care plan said they liked to use the rummage boxes. We saw this person engaged with the tool kit rummage box. Other rummage boxes were themed around sewing and jewellery. One person's care plan said for staff to encourage the person with their knitting. However, when we asked staff where the knitting was, they said the person had been winding some wool but there was not any knitting on the go for them.

One person interacted with a baby doll. The reasons for this were known to staff and we saw the person

gained comfort and enhanced wellbeing from their interactions with the doll. All staff knew the doll's name and looked after it for the person whilst they were having their meals.

We saw photographs of trips and events in people's care files. The registered manager told us about how people had chosen to go to Llandudno for a day trip. The day had been well planned with provision to meet people's personal care needs organised through contact with a hotel.

When we asked people about activities one person said, "There are books, chess and draughts, TV entertainers, memory man. Yes, we do go out I went to M&S. The vicar from St Jude's comes, I organise that." Another person told us they didn't have much to do. Relatives told us about outside entertainers and trips and parties held at the home although one said, "Schools could come in and different entertainers." Some people had 'Memory files'. We saw an example of one of these. The file contained photographs of the person from throughout their life, enjoying holidays, times with family following their interests and hobbies. The photographs were accompanied by details of names of people and where the photographs were taken. The registered manager told us staff were working on making sure everybody had a memory file.

A relative gave us an example of how staff responded to people's needs. They told us "You only need to mention something and they act on it." They gave an example where they had noticed a patch of dry skin on their relation. They told the care staff and they referred the person to a district nurse who assessed them and prescribed emollient cream.

A complaints procedure was in place and people told us they would speak with the registered manager if they had any complaints. One person told us, "I would complain to [registered manager], I have complained about missing clothes, she always says they will be in the wash. They eventually come back." We saw an example of how one complaint had been managed in line with the procedure. However, we had received some concerns about how a complaint made had not been managed appropriately or with confidentiality. We spoke with the registered manager about this who confirmed the complaint was being dealt with by solicitors and accepted they had made an error of judgement in their handling of the complaint.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found there was a lack of effective governance within the home. At this inspection we found improvements had been made. However, before we can conclude the service is well-led we need to be assured the registered manager can maintain effective quality assurance systems to ensure improvements will be sustained and developed to make sure people consistently receive high quality care.

At the time of our inspection there was a registered manager in post. They were also the provider of the service. Staff rotas showed the registered manager worked between 8am and 5pm, usually six days each week.

People spoke positively about the registered manager. One staff member said the registered manager had made several improvements in the last year, this had included the appointment of new staff which meant care staff now worked as a team when they had not done so in the past. Another staff member told us the registered manager was quick to tell staff if things were not done, that should be done but said the registered manager, "Can panic if things are not done well." They said the registered manager was approachable, always acknowledged them and listened to what they said. They said improvements had been made in staffing, cleaning and timings of meals, snacks and drinks for people.

One relative told us the registered manager was very creative, very friendly and not "Stuck in the office." They said the manager was enthusiastic to improve the service and make life better for the people living there. Another relative said, "I think it has got better recently, I wouldn't want [name] to go anywhere else, I am content. It has a lovely atmosphere it's the carers that do that. I like the way [registered manager] speaks to the staff."

We saw the registered manager had systems in place to monitor the quality and safety of the service. This included a large number of audits covering areas including mattresses, laundry, staff training and medication. They told us they also completed a check on the environment three or four times each week. We found some of these audits had not been fully effective. For example, a recent laundry audit had identified issues but did not say what immediate action had been taken to resolve them. We also discussed how the timing of the environmental audit may not identify issues we had found such as staff not practising good infection control procedures. The registered manager responded positively to our findings and the day after our inspection sent us examples of more robust audits they were introducing that day.

At our last inspection we found confidential records were not being stored appropriately. Since then the registered manager had completed an audit of how the service managed General Data Protection Regulation (GDPR) in line with the Data Protection Act 2018. As a result, the registered manager had produced an easy read document informing people of how information about them is stored and what their rights are.

Since the last inspection the registered manger had completed a number of observations of practice within the home. This included meal time experiences which included relatives, and observations of staff practice.

They had also completed research into best practice in areas including staffing and activities for people living with dementia. We saw examples of how this research had been used to affect improvements; for example, the introduction of themed rummage boxes for people to engage with.

Staff meetings were held every two months. Staff told us they were able to raise items for discussion at these meetings.

The registered manager told us meetings for people who lived at the home and relatives were held approximately every four months or if there were any planned changes in the home. People told us they were involved in these meetings. We did not see any outcomes of these meetings available for people on the home's notice board.

The registered manager was aware of their legal responsibility to inform the Commission of notifiable events in the home and our records showed these had been made appropriately.