Pilgrim Homes

Pilgrim Homes - Evington Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 August 2017and was unannounced. We returned on the 16 August 2017 to complete the inspection.

Pilgrim Homes – Evington Home is a care home that provides residential and nursing care for up to 30 people. The service specialises in caring for older people including those with physical disabilities, people living with dementia and those who require end of life care. Accommodation is over two floors. Bedrooms are all single rooms with an en-suite facility. At the time of our inspection visit there were 25 people in residency.

At our previous inspection in September 2016 we rated the service as requires improvement. We found the provider had made some improvements to how people's medicines were managed and administered. Improvements were found to how risks to people's physical health and wellbeing were managed and care provided was personalised. We also found some improvements had been made to the provider's governance system used to monitor the quality of the service provided. Further action was needed to ensure those improvements were sustained. In addition the service did not have a registered manager in post. A registered manager is a person who has registered with us to manage the service and has the legal responsibility for meeting the legal requirements in the Health and Social Care Act 2008.

At this inspection we found the service remained requires improvement.

This service is required to have a registered manager. A registered manager was not in post. The provider had appointed two managers. We were aware that they had begun the process to become the registered managers for the service. Following our inspection visit they were confirmed as joint registered managers for Pilgrim Homes – Evington Home.

People told us there were not enough staff to meet their needs and to keep them safe and meant that their health and wellbeing had been put at risk or compromised. For example, people were not supported with their personal hygiene needs to then be able to attend the morning religious service which was important to them. A number of other examples were shared indicated that there was an institutionalised practices and regimes of supporting people. Staff acknowledged that there were delays at time but despite this people's needs were met. Our observations during the inspection also supported the feedback we received.

The provider's quality governance and assurance systems was not fully implemented. Audits we looked at were fragmented, lacked attention to detail and no plans to address the shortfalls found. Further action was needed to ensure any shortfalls identified were addressed in order to drive and sustain improvements.

People lived in an environment that was maintained. Further action was needed to ensure the premises and equipment were clean and that staff followed the infection control procedures.

Risks in relation to people's care and support needs were assessed. People were involved in the development of care plans. That helped to ensure staff knew how people wished to be supported. Care plans were reviewed regularly. However, we found some inconsistencies in the records. The manager told us that the care plans were being transferred to an electronic care planning system. This process would enable care plans to be checked for accuracy and used to review people's care to ensure any changes to care needs could be met.

People mostly received their medicines safely. People's dietary and nutritional needs were mostly met. People had access to a range of healthcare services and attended routine health checks.

People's safety was protected because staff were recruited through safe recruitment practices. We found there were sufficient numbers of staff to provide care and support when people needed it. Staff received an appropriate induction, training, supervision and appraisal.

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.

People's privacy and dignity was respected. Staff's approach was caring and they knew people well. People were involved in the review of their care plans which helped to ensure they received personalised care that was responsive to their needs. People maintained contact with family and friends. People's religious needs were met. People's wellbeing could be promoted through more l opportunities to engage in meaningful activities that were of interest to people.

People's views about the service had been sought through a survey and at residents meetings. People and their relatives felt confident to raise concerns with the managers. A complaint process was available and advocacy support was made available to people.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

Improvements were needed to ensure there were enough staff to meet people's needs and to keep them safe. Staff were mostly recruited safely. Further action was needed to ensure that the premises and equipment were clean and safe for people to use and that staff followed the infection control procedures. Risks associated to people's needs were mostly managed and monitored effectively. Staff were trained to recognise abuse and respond to allegations or incidents. People received their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's views about the quality and choice of food and drink were mixed. Further action was needed to ensure people's dietary needs were met and monitored, where required. Staff received appropriate induction, ongoing training and supervision. People's rights were protected under the Mental Capacity Act 2005. People had access to a range of healthcare support to maintain their health.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs but not always in good time. Whilst people religious needs were met, there were limited opportunities for them take part in activities that were of interest to people. Care records were mostly accurate and were reviewed regularly. People knew how to make a complaint and were confident that they would be listened to and action taken to resolve their concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had appointed two managers who had begun the process to be joint registered managers for the service. The provider's quality assurance systems needed should be fully implemented to drive improvements more effectively. People's views as to their ability to share their views on the service were mixed. People's views were sought annually through the provider satisfaction survey. Staff mostly felt supported and were confident to approach the managers.

Pilgrim Homes - Evington 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 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 15 August 2017 and was unannounced. The inspection team consisted of one inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in older people living with dementia. The specialist advisor had experience working and caring for people within health care.

The inspector returned on the 16 August 2017, to complete the inspection.

Prior to our inspection we reviewed information we held about the service. This included the previous inspection reports, the provider's action plan and notifications we had received. A notification is information about important events which the provider is required to send us by law. We received information from Leicester City Council and Leicester City Clinical Commissioning Group fund the care for some people who used the service. This information was used to plan our inspection.

We used a variety of methods to gain people's views about the service. We spoke with eight people who used the service and three relatives. We made direct observations and also used the Short Observational Framework for Inspection (SOFI). A SOFI is where we observe care to help us understand the experience of people who were not able to have conversations with. We observed people being supported in the dining room at lunch time.

We spoke with two managers, two nurses and six members of care staff, a bank staff and the cook. We also

looked at 17 people's care records. We looked at recruitment files three care staff and nurse, and the staff training records. We looked at records relating to all aspects of the service including care, maintenance records for the premises and equipment, complaints and quality audits.

Requires Improvement

Is the service safe?

Our findings

People expressed concerns about the lack of staff available to meet their needs and to keep them safe. They said, "I don't think there can be enough staff as they are always in such a rush and if you are having a wash, it's not always comfortable." And "I don't believe there are enough staff here. There are a lot of people with more needs than most and they get looked after first." A visitor said, "I really don't think there are enough staff here. Some [staff] have left recently and they don't seem to be been replaced."

A person who was still in bed at 11am, said that was not by their choice. They were upset because staff were not available to support them and had missed the morning [religious] service. They told us, "I have to fit in with the system." That meant that they had to wait for two staff to be free long enough so that they could be moved and assisted with their personal hygiene needs. Another person said, "I used the buzzer in the night last week and waited ages for [staff] to come. When they did come, they put their head round the door and told me they would be back. They did come back sometime later and I told them I wanted to use the commode. I was told that I had been given a larger pad so I didn't need to use the commode. They then left the room. I rang again when the day staff came on and a carer helped me to the commode. It was such a relief and had been a very uncomfortable night." These were examples of how inadequate staffing puts people's health and wellbeing at risk.

We observed a number of instances that indicated there were not enough staff available to meet people's needs. Staff with a specific role of 'humming bird' had been trained to engage with people living with dementia. We saw they were sat in the lounge talking with people. However, they were not able to assist people because they had not been trained. That meant when people wanted to use the toilet they had to wait for care staff to assist them.

Meal times were regimented and it was evident there were not enough staff to meet the support needs of people. In the dining room we saw a staff member sat between two people and assisted them to eat alternatively. A staff member placed a meal in front of a person but they did not know what to do. Several staff walked passed this person. A short while later the office staff member had been asked to assist the person to eat. We also saw the manager assisted another person to eat.

Staff expressed concerns about that there were not enough staff to meet people's increasing needs. A staff member who took their break in the lounge with people told us they had to take their breaks in the communal area with people. That meant staff had no time or space to reflect, have a comfort break and something to eat and drink. We saw this staff member assisted people several times during their 15 minute break. This increased the risk of staff being tired and less effective.

The manager explained that they took account of people's dependencies to plan the staffing levels. A staffing tool used to assess the hours and number of staff required to support people showed that there were greater care hours provided that calculated. However, our observations during our inspections showed that clearly showed that people's health, safety and wellbeing was being put at risk because there were not enough staff.

This was a breach of breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were not enough staff to meet people's needs and to support them to stay safe.

At our previous inspection of 26 September 2016 we found some improvements had been made to protected people from avoidable risks. Staff followed the guidance in the care plans to meet people's needs. Improvements had been made to ensure people's medicines were managed and administered in a safe way but these improvements needed to be sustained.

At this inspection we found improvements had been sustained with regards to the how people's medicines were managed and stored. People told us they were supported to take their medicines. A person said, "I get my pills from the night staff – about 6am and then a cup of tea." Another person said, "My tablets come between 6am and 9am depending on how busy they [staff] are. I get them in a little pot and then they come back for it later." When we asked them whether staff watched them take their medicines, they said, "Oh they trust me to take them, although lots of residents have to be watched."

Medicines were stored securely and storage temperatures were monitored daily. Records showed these medicines had been stored within the recommended safe temperature range. Medicines such as eyes drops were kept in the fridge and were dated when opened. Topical creams were stored securely in people's rooms and clearly labelled, dated when opened and were safe to use. This helped to ensure medicines were safe to use.

We saw a nurse washed the medicine pots by hand and had left them to dry. These pots had been used to dispense medicines into. There was a further risk to people's health if staff used these pots which may not be thoroughly disinfected. This supported an issue in a report we were shown from the health commissioner report and had recommended a safer alternative by using disposable paper pots. When we raised this issue with one of the managers' they told us that that a decision had been made to move to the new medicine system which was due to start in September 2017.

Training records showed that the nurses had their competency assessed to administer medicines safely. We observed the nurse administering medicines at lunch time. They explained to people what their medicines were for. They observed that the medicines were taken and completed the medicine administration records (MAR) to confirm this.

We looked a sample of people's MARs and all were completed accurately. All contained photographs of the person to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine they were allergic to. Documentation was available to support staff to give people their medicines according to their preferences. A body map chart highlighted where the prescribed topical creams should be applied. Records we viewed confirmed that people received their medicines at the right time and in a safe way.

People in receipt of 'as required' or PRN medicines had instructions added to the MARs. This provided nurses the guidance as to the correct dose, the maximum dose the person could have within a 24 hour period and the action to take should the person develop any side effects. At the lunch time medicines round we heard people being offered pain relief which was prescribed on an 'as required' basis. That demonstrated the nurse had administered medicines in a safe way.

Records showed that safety checks of the premises and equipment had been carried out at regular intervals to ensure people lived in a safe, well maintained environment. However, we found some areas required

attention. A window on the landing had no restrictor and could be opened fully. There was no mechanism to protect people from falling out or from unwanted intruders. This was raised with the manager who assured us they would make it safe. Following our inspection the manager confirmed in writing that a secure lock had been fitted to the window.

There was a secure system to enter and leave the building. A number of internal fire doors to the stairway were held open by magnetic catches and had to be pushed to be closed. Despite this the doors did close automatically when the fire alarm test was carried out. The garden area was secure and the pond had a mesh cover to prevent the risk of people's fall into it.

Hoists and other moving and handling equipment were stored in a separate room when not being used. There were four hoists but only three were safe to use. We saw a piece of equipment used to help a person to stand up from a wheelchair to an armchair was dirty and stained with dried food and drinks. This was brought to the attention of the manager. When we checked later that day and the following day we noted that it had not been cleaned. That meant people were using equipment that was not cleaned or disinfected regularly.

Individual risk assessments for evacuation of the service in an emergency, also known as PEEP's (personal emergency evacuation plan) were mostly in place. However, five people's PEEP's were missing. We found some PEEP's were overdue a review. That meant staff did not have accurate information about the level of support people needed in the event of an emergency evacuation.

We found the provider's recruitment procedure had been followed which ensured staff were safe to work with the people using the service. A sample of staff recruitment files we checked contained all relevant information and confirmation of checks carried out before staff started work. A further check was undertaken for the nurses with the professional body as to their continued registration, qualifications and suitability.

Volunteers also visited the service regularly and spent time with people using the service. Although the manager told us that volunteers were subject to a Disclosure and Barring Service (DBS) check, no checks were found for the two volunteers in the service that day. A DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This was shared with the manager who told us they would address this. Following our inspection visit the manager confirmed that DBS checks had been applied for the volunteers and that they would work under supervision until the checks were completed.

Risk assessments had been completed to identify risks to people's health and safety. These covered risks such as managing skin conditions, mobility and falls and swallowing difficulties or choking. Records showed people's rights and choices had been considered to avoid undue restrictions. These were reviewed monthly and amended when changes in risks had been identified.

A person who was nursed in bed was at risk of developing a pressure sore and required assistance to move. The care plan stated two staff were required to use the hoist and move the person. The person had pressure relieving equipment in place, and this adjusted for the person's particular weight. A staff member told us that they re-positioned the person at regular intervals and the turn charts confirmed this. This showed staff provided the care and support this person needed to minimise the risk to their health and wellbeing.

We checked the settings on the pressure relieving equipment for four other people. All had been set to 'medium' even though people's weights differed. It is important that the pressure relieving equipment is set

according the people's weights to prevent the risk of development pressure sores. When we asked the nurse how the equipment was sent they told us the maintenance staff had responsibility to set it and confirmed they did not do any checks to ensure it was adjusted appropriately. We found no written advice for staff to follow about how the equipment should be used. That meant staff could not ensure people's treatment was being continued which put their skin integrity at risk. We shared our findings with one of the managers'. They confirmed that it was the responsibility of the nurses to ensure equipment was set correctly.

Records showed accident and incident reports were completed. A person's risk assessments for falls and mobility had been reviewed following a fall and the care plan updated. This explained the person required a walking aid and should be seated on a sensor cushion which would alert staff when they got up, and could then be assisted safely. This demonstrated the plan in place helped to manage the risk without undue restriction being placed on the person. We saw when this person attempted to move, a staff member was prompt to support them. Their walking aid was placed in front of them and the staff member guided the person. That meant the person's safety and independence had been promoted.

Staff we spoke with were aware of the infection control procedures and were observed wearing protective clothing when preparing to support people with personal hygiene needs. Staff wore the brightly coloured waxed aprons which had been hung on a coat stand. However, not all staff disinfected them after use, which we shared with the manager.

The provider's safeguarding procedure and information leaflets about support services were available at the service. These set out how information about any alleged abuse would be handled and included the contact details for external agencies who could be contacted. A person said, "I don't remember being spoken about abuse or harm but I know what it looks like and sounds like, so I should think I would recognise it."

We asked people if they felt safe and why. A person said, "I feel safe here [in my room]. [Staff] do come quickly if I use the buzzer when I do need help." Another said, "I feel safe enough here, although when the doors automatically [close] at night that can be a bit scary when you are not expecting it."

Staff were aware of safeguarding procedures and the signs of abuse. A staff member said, "There's different types of abuse, like physical, financial, verbal like shouting and emotional. I've not seen anything like this but if I did I'd go straight to the manager with it." That showed staff understood their role and people could be assured they would be protected from avoidable harm.

Requires Improvement

Is the service effective?

Our findings

A picture menu displayed in the dining room which enabled people living with dementia to see the meal choices. However, there was only one main meal on offer and a selection of deserts. The meals served did not resemble the picture menu. Staff member told us, "I did tell them [management team] to take a picture of the plated food but was told find the picture that is the closest match. For example, the gammon was not served with an egg or peas as in the picture menu.

Information about people's dietary needs had been given to the cook. They described the types of meals prepared to meet people's dietary requirements. These included a fortified diet using full fat cream, and a fork mashable meal. This ensured people's dietary needs were met.

We asked people about the choices and quality of food and drinks. They said, "We don't get a choice of lunch but there were four choices for pudding today." "Cook ran out of meat the other day. I just had vegetables and extra pudding." "The food used to be lovely here but there have been some big changes recently and it's not quite the same now" and "It would be really nice to have fresh fruit or even a salad sometimes. We get tinned fruit everyday but it's not the same." When we asked a person what they would do if they didn't like the meal, they said, "I would leave it and hopefully they would know not to give it to me again."

At lunch time we saw that staff served the meals individually. Meals looked appetising and portion sizes varied according to people's requests. A person declined the main meal and was offered an alternative, which the cook prepared.

People were provided with suitable cutlery to eat independently. A number of people would have benefited from staff supporting them. We saw a staff member moved from person to person cutting their food up and another staff member encouraged people who were unsure what to do with the meal. The interaction was limited at times and task- led. Two people sat looking at their meal for more than 30 minutes before a member of care staff and an office staff member assisted them. We noted that the meals were not replaced or re-heated. Plates were cleared up and deserts were served before everyone at the table had finished eating the main course. One person clearly felt hurried and left the half eaten meal so they could have the desert. This made it difficult to ensure people had enough to eat and drink. We shared our observations with one of the managers' and they assured us improvements would be made.

On the second day of our inspection visit some improvements had been observed in relation to people's being supported to eat and plates were not being cleared up until everyone at the dining table had finished eating.

Care records we looked at showed that people's nutritional and hydration needs were assessed when they began using the service. Care plans provided information for staff such as people's likes and dislikes, how food choices were made and the level of assistance required at meal times.
People at risk of dehydration had their fluid intake monitored but records were not always accurate. This

meant staff may not be able to monitor whether people had consumed the recommended amount of fluid to maintain their health. One of the managers' told us that the new electronic care plan and recording system would ensure people's health could be monitored effectively.

People told us they were able to see the GP if they became ill. Records confirmed this and showed that people had access to a wide range of health care professionals and attended routine health checks. This supported the information sent to us in the PIR and meant that people received the support needed to maintain their health.

People told us that they felt confident that staff had been trained in their role. A person said, "They [staff] have to hoist me and I'm quite happy with how they help me." A relative said, "I come every day and see the staff do a good job which they are trained for."

Nurses and care staff we spoke with all confirmed that there were systems and processes in place to provide them with the skills and knowledge required to provide safe care. They had a range of training to do their job safely. A staff member told us the induction provided them with an insight to the home's religious principles and values. One of the managers' told us that new staff would be required to complete the care certificate, which is a set of standards that should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

The PIR stated that staff had received training in a range of topics to support the health, safety and wellbeing of people. Training records we viewed confirmed this and showed that staff had attained qualifications in health and social care, and specialist training to meet the needs of people with specific health conditions such as dementia and Parkinson's.

Staff received regular support and supervision from the management team. A nurse told us they had been supported with their ongoing training and professional registration by the management team. Staff meetings took place regularly. These meetings were used to share information about changes to the service, and enable staff to provide an effective service to meet people's needs. This meant people could be assured staff were supported in their role.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. All records containing information about people's care and support were reflective of the principles of the MCA.

People had the opportunity to give their consent about their care and make decisions about their care needs, which staff respected. Care records we looked at for people who were subject to Deprivation of Liberty Safeguards (DoLS) authorisations with conditions to restrict their liberty in their best interests, had been met. Care plans provided clear guidance for staff to follow and appropriate authorisation was in place, for instance to administer medicines disguised in food. The service had in place a system to record and monitor the authorisations to ensure they were renewed as necessary. That meant the principles of the MCA were followed.

Good

Is the service caring?

Our findings

People we spoke with all said staff were kind, caring and supportive. We observed this to be the case when we heard conversations between people and staff. A person told us they had developed a good relationship with staff and said, "The staff are really lovely to me on the whole." Relatives told us staff built positive relationships with people using the service and themselves. One relative said, "I can visit whenever I like, which is nice and if I want to, I can make myself a drink in the kitchenette, although there is not always milk in there."

Staff told they liked working with people using the service. Staff no longer wore uniform but still had a name badge on, so that people could identify them. A staff member said, "I love my job and the residents. You learn so much about people. I take pleasure in knowing that by me sitting having my break here has made [person's name] feel good."

We saw staff showed a caring nature in their approach and supported people in the way they wanted. For example, when someone who was unsteady on their feet wanted to walk a staff member accompanied them. They chatted to the person in a reassuring way whilst promoting their safety and independence to move around.

A person told us that they had been involved in the planning of their care. They said, "I've got a care plan and as my needs have changed so has my care plan. It's important that the staff know how to support me; I rely on them for most things."

Care records showed the decisions people had made about how they wished to be cared for. People's individual choices, preferences and daily routines were being documented in the electronic records and used to develop their care plan. A person said, "I do like to have a bath once a week and they [staff] do let me soak for a bit." A relative told us that they were involved in making complex and long term decisions about their family member. The care records we viewed confirmed this.

People told us that staff respected and promoted their privacy and dignity. A person said, "They [staff] always knock on the door before entering. They use a towel to cover my lower half they wash and dry me, and always speak nicely to me."

People looked well-presented and we noted their nails were clean which showed staff paid attention to people's appearance and cleanliness. When a person was supported to move we saw a staff member adjusted the person's clothing which maintained their dignity. We observed that staff always knocked on people's bedrooms doors and waited for a response before they went in. Staff were always polite and kind when they spoke with people and discreet when people needed assistance with their personal care. This contributed to their dignity.

Staff worked closely with health care professionals to support people towards the end of their lives. People had made an advanced decision about their care with regards to emergency treatment and resuscitation,

which meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. These had been put into place with the involvement of the person, their relative or representative and health care professional. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

Good

Is the service responsive?

Our findings

People told us that staff had a good understanding of their needs but did not always respond promptly. A person told us that they had a cup of tea after taking their medicine at 6am. We asked them whether they liked to be woken up at that time they said: "Well that's the time they do the tea run." At lunch time we observed some people had to wait for their meals to be served. We saw staff move from person to person when supporting people to eat. This meant people did not received continuity of care and support to promote their wellbeing.

Several people told us that staff appeared 'to be rushed of their feet' because people's needs had increased. Staff we spoke with expressed concerns about the changes in how staff worked. An example being communication and changes to the handover meetings. A staff member told us that they were not always able to spend meaningful time with people. They said, "We don't have time to do activities with them. We're not part of the main handover in the morning only a quick handover about 11am, once we've got everyone up." Another staff member told us they were given information about people who are sick or unwell and felt the handovers were not informative. Despite this staff told assured us that people's needs were met albeit with some delay at times and if they were unsure about changes to people's care needs they spoke to the nurse or read the care plan.

We observed a staff handover meeting. Information was discussed in a respectful manner. For example information about a person's deteriorating health was shared. We saw that staff made their own notes on a piece of paper.

We were shown the handover record for previous day. There were comments against some people's names, albeit brief where there had been changes, or concerns about people's health and wellbeing. In some instances, the action staff should take, but this was not consistent. For example, it was noted that a person had not been given a drink the previous night but no instructions as to supporting this person's needs. We would recommend that the provider reviewed the content of information shared within handovers to be assured that people's care needs continued to be managed and monitored effectively.

The PIR described a range of activities held at the service including the daily religious services and celebrating birthdays and special occasions. However, at the time of our inspection visit the manager was in the process of recruiting an activity co-ordinator. We asked people about the opportunities to take part in activities and religious services. A person said, "When [staff's name] was here I used to come and join in the activities more and really enjoyed the craft sessions with the children. But that has stopped now. No budget." Another person said, "I do get bored sometimes but then I just come to my room and read or do colouring." There was an emphasis on meeting people's religious needs in all aspects of their daily lives. For example, at meal times someone would say grace [prayer].

A third person said, "I like the tranquillity of my room and enjoy knitting, which I do for the lord. I also attend the morning service and the Sunday service." We saw a number of people had attended the morning service held in the lounge. This showed that people's religious needs were being met.

Information in the PIR stated that staff had been recruited to a 'humming bird' role. We observed this staff member spent time with people living with dementia having short meaningful conversations and supporting them when they became anxious or distressed. We asked people for their views about the humming bird staff, a person said, "I like talking with the butterfly lady [humming bird]. She actually had time to sit and chat which is lovely."

We were shown as sample of the electronic care records. People's needs had been assessed and care plans were developed with information gathered from the person and their relatives, where appropriate. This helped to ensure people's preferences were known and staff had access to information to provide personalised care that met people's needs.

Care plans provided guidance as to how staff needed to respond to support people and meet any changing needs. For example, to re-position a person nursed in bed to prevent the risk of developing pressure sores. Another person's care plan included the signs that indicated the person's mood changes and how staff should respond to reduce anxiety and the topics of conversation that could improve the person's mood.

People's care plans were reviewed regularly or in response to changes in the person's needs or wishes. Records showed when a person's health had deteriorated, staff sought advice from the GP and had notified the person's relative. This showed staff were responsive and that the person wish for their family member to be informed had been respected. People and their relatives told us they had been involved in the review of their care. A visitor said, "I know [person's relative] gets updates on what is happening but [they] live some distance away, so can't get here." A relative said, "I'm involved in [my relative's] care reviews. They [staff] keep me informed as to any changes and how they plan to support [them] deteriorating health."

People and their relatives told us they felt confident to make a complaint. A relative said, "Any concerns I've raised with the manager have been addressed." They were confident that the management listened and acted on concerns.

The provider's complaints procedure was displayed within the service. The PIR stated the service had received two complaints in the past 12 months. When we reviewed the complaints record the service had received a further three complaints. Records showed that all complaints were responded to appropriately. Whilst there were no trends in complaints the manager had liaised with the relevant healthcare professional in relation to one complaint and the outcome was shared with the complainant. That showed the complaint procedure was followed.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in September 2016 we found some improvements had been made as to how the provider assessed and monitored the quality of service. Further action was needed to ensure the improvements had been sustained. In addition, the service did not have a registered manager. A registered manager is a person who has registered with us to manage the service and has the legal responsibility for meeting the legal requirements in the Health and Social Care Act 2008.

At this inspection we found the provider had appointed two managers. We were aware that they both had begun the process to become the registered manager. Following this inspection visit they were confirmed as joint registered managers for the service.

We saw the current CQC rating was clearly displayed and a copy of the latest inspection report was available in the reception area. The provider had sent most of the statutory notifications to us when required.

The provider had made some changes to the management of the service. A business manager had key non-care related responsibilities supported the managers. People were aware of some of the changes in staff and the management. Some people were concerned that the changes in the management did not take account of people's quality of life. A person said, "There are people who need more care but less staff to help them and even less things [activities] for us." The person added that the residents meetings were informative about the management changes and hoped that the new activity co-ordinator would provide people with more opportunities to take part in activities of interest to them. When we asked the manager about the recruitment of the activity co-ordinator they told us interviews were planned to take place.

The provider had a governance system to monitor the service but it was not fully implemented or used effectively. We looked at some audits and checks that were carried out. These included audits on the premises and equipment, review of people's care records, medicines and the analysis of incidents, accidents and falls. These were fragmented, lacked attention to detail and no plans to address the shortfalls found. The manager told us that an infection control audit was done, but was unable to locate the record.

The only medication audit we found since our last inspection visit was done in June 2017 and did not specify what action had been taken to address the issues found such as missing signatures.

We found personal emergency evacuation plan were not kept up to date and reviewed. That meant staff did not have accurate information about the level of support people needed in the event of an emergency evacuation.

The care file audits showed that where risk assessments were identified as missing, no action had been taken. There was no action plan to demonstrate how and when the shortfalls found would be addressed.

We were shown the provider audits supposedly carried out in May and June 2017. However, these were dated 06/06/2017 and 28/06/2017. There were comments that indicated the shortfall found or further action

was needed. Because no action plan was in place it made it difficult to manage and monitor improvements. That meant the provider's governance system had not been fully implemented and sustained the improvements that were already made. Therefore further action is needed to bring about sustained improvements.

This was a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider's governance system to monitor the quality of service was remained fragmented and not used effectively to drive improvements.

We spoke with local authority and health commissioners who are responsible for funding some of the people using the service. They told us they had recently undertaken a quality assurance visit and found the service to be very welcoming and found some issues. The manager showed us the report from the health commissioner's recent visit. They found people's needs in general were being met however, recommended that record keeping and effective monitoring could be improved, which supported our findings during this inspection visit.

We found the people's care records were mostly transferred to the new electronic care planning system. However, paper records were used to document daily care and support provided. Whilst there was evidence of people and their relatives being involved in the review of care plans, there were some inconsistencies in the recordings. The manager assured that they were reviewing the content and quality of information as people's care plans were being transferred to the electronic records. This process would help ensure the information was accurate and any changes identified to people's needs would be discussed so that they ongoing care needs could be managed. We will continue to monitor this.

The manager confirmed that the views of people who used the service had been sought in May 2017. The report reflected satisfaction in the service people received. These had been shared with people at the residents' meeting in June 2017. Some areas of improvements had been identified in relation to the premises and staffing. As a result the dining room had been refurbished and new staff had been employed to the role of a 'humming bird'. During our inspection visit we saw they spent meaningful time with people living with dementia which had had a positive impact on their wellbeing.

We asked staff about the support they received. Most said they felt supported and were confident to approach the manager that they thought would act on issues raised. Some staff were encouraged that both managers worked alongside the staff team to meet people's needs. This helped the managers to monitor at first hand, the delivery of care as part as well as managing the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance system to monitor the quality of service was remained fragmented and not used effectively to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs and to support them to stay safe.