

Ideal Carehomes (Number One) Limited

Ebor Court

Inspection report

Great North Way
York Business Park, Nether Poppleton
York
North Yorkshire
YO26 6RB

Tel: 01904606242

Website: www.idealcarehomes.co.uk

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Ratings

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|---------------------------------|------------------------|
| Overall rating for this service | Good ● |
| Is the service safe? | Good ● |
| Is the service effective? | Good ● |
| Is the service caring? | Good ● |
| Is the service responsive? | Good ● |
| Is the service well-led? | Requires Improvement ● |

Summary of findings

Overall summary

This inspection took place on 7 and 15 February 2018 and was unannounced.

The home had been inspected four times between November 2015 and July 2017 and on each occasion was rated Requires Improvement. At our last inspection in July 2017 there were breaches of Regulation 12, 17 and 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because of concerns in relation to the management of medicines and because robust recruitment procedures had not been followed. We issued a warning notice in respect of Regulation 17, Good Governance, because the quality assurance systems in place were not being used effectively to assess, monitor and improve the quality and safety of the service provided. The systems had been ineffective in driving sufficient improvement to demonstrate sustained progress and achieve a rating of Good. At this inspection we found improvements had been made and the home was now meeting all legal requirements.

Ebor Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ebor Court does not provide nursing care.

The service is registered to provide support for up to 64 older people and people living with dementia. The home is spread across three floors. The Guy Fawkes area is on the ground floor, the Dame Judy area on the first floor and the George Hudson area on the second floor. At the time of our inspection 54 people were using the service.

The registered provider is required to have a registered manager and there was a registered manager in post, who had been working at the service for about five months. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Improvements had been made in relation to the management of medicines. Medicines were now safely stored, administered and recorded and the provider was working with their pharmacy suppliers to maximise the effectiveness of the systems in place.

Recruitment records showed that staff only commenced working with people on their own once all appropriate safety checks had been made. This included previous employment references and a check with the disclosure and barring service (DBS).

At our last inspection in July 2017 the provider had failed to ensure that Deprivation of Liberty Safeguards authorisation applications had been submitted for all people who needed one. At this inspection we found that action had been taken to address this and the provider had submitted appropriate applications for all those who required them. Staff worked within the principles of the Mental Capacity Act 2005.

Staff knew how to identify and respond to any signs of abuse, to protect people using the service from harm. There were mixed views about staffing levels at the service, but the majority of people and relatives we spoke with felt there were sufficient staff to meet people's needs. We found that the provider had recruited new staff, and agency staff were used where required, in order to maintain staffing levels.

There were systems in place to identify and minimise risks to people's safety. The provider was taking action to try and reduce the number of falls at the service and staff had worked with the local clinical commissioning group to access pressure ulcer prevention training. People received appropriate support with their nutrition and hydration needs.

People told us that staff were caring and we observed staff treated people with respect. People's privacy and dignity was upheld. People's diverse needs were catered for.

Staff had access to end of life care training and we received positive feedback from a visiting healthcare professional in relation to the support people received at this stage of their lives.

Care plans were in place to guide staff on how to meet people's needs and preferences. The provider had recently introduced a new electronic care monitoring system. The system enabled the registered manager to monitor the care that was delivered. We noted some errors recorded on the new computer system in relation to people's care requirements, but the provider addressed this by the second day of our inspection to ensure that staff had the information they needed.

Activities were available to people who used the service and the provider had recently appointed a new activity coordinator to develop the opportunities on offer.

There was a system in place to investigate and respond to complaints. Resident and relatives' meetings were held, and surveys conducted, to give people opportunity to comment on the quality of service provided.

Staff received induction, training and support. There was a plan in place to ensure all staff supervisions were up to date.

Infection control measures were in place, but greater vigilance was required to ensure bathrooms were maintained in a clean and hygienic state at all times.

Quality assurance systems were in place. The provider had made sufficient improvement to achieve an overall rating of Good at this inspection. However, some of the improvements made were still relatively recent and further time was required to fully imbed these systems and demonstrate consistent, sustained progress. There were also a number of minor issues that the registered manager was continuing to address, such as ensuring all supervisions were up to date, consistency of record keeping and improvements to cleaning and laundry arrangements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Medicines were stored, administered and recorded safely.

There were sufficient staff to meet people's needs and recruitment processes were robust.

Staff knew how to report any safeguarding concerns and there were systems in place to identify and manage risk.

Environment checks were completed. Greater attention was required to ensure all areas of the home were clean at all times.

Is the service effective?

Good ●

The service was effective.

The service worked in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff received an induction and on-going refresher training to give them the skills they needed. Work was on-going to ensure all staff supervisions were up to date.

People were supported to access healthcare support where required. People received appropriate support with their nutrition and hydration needs.

Is the service caring?

Good ●

The service was caring.

People's privacy and dignity was upheld.

People were involved in decisions about their care and their choices were respected.

We observed staff spoke with people warmly and with respect. People told us staff were kind and helpful.

Is the service responsive?

Good ●

The service was responsive.

People had access to activities and there were plans in place to increase the opportunities on offer.

Care plans were in place to guide staff on how to meet people's needs and preferences. The provider had recently introduced a new electronic care monitoring system, to assist them in ensuring that people received timely and responsive care.

People received compassionate end of life care.

The provider had a system in place to manage and respond to complaints and concerns.

Is the service well-led?

The service was well-led, but further improvement was required.

Many of the improvements made since our last inspection were relatively recent, and further time was required to demonstrate consistent and sustained progress.

There was a registered manager, who had been in post approximately five months. The registered manager worked in partnership with other organisations.

There was a quality assurance system in place, including a range of audits to monitor the quality of the service provided.

Requires Improvement ●

Ebor Court

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 registered 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 7 and 15 February 2018 and was unannounced.

The inspection was carried out by three Adult Social Care Inspectors, a Specialist Advisor (with specialism in dementia care), and two Experts by Experience on the first day of our inspection. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of care service. The second day of the inspection was conducted by one Adult Social Care Inspector.

At the last four inspections the home was rated Requires Improvement. We conducted a full comprehensive rated inspection to check all aspects of the service again. Before the inspection we reviewed the information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also sought feedback from City of York Council's contracts and commissioning team.

As part of this inspection we spoke with ten people who used the service, five care staff, the registered manager, the administrator and the nominated individual for the provider. We also spoke with four relatives of people who used the service, four visitors and two visiting healthcare professionals. We looked at 11 people's care records, four care staff recruitment and induction files, training records and a selection of records used to monitor the quality of the service. We also spent time in the communal areas of the home and made observations throughout our visits of how people were being supported. We carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves.

Is the service safe?

Our findings

We asked people if they felt safe living at Ebor Court and people told us, "Oh yes, definitely. It is a nice place to be" and "Yes I do. They are very nice people." Others told us, "I get a nice feeling. I feel I am safe" and "My room makes me feel safe, I can shut the door." One visitor said they had had concerns about another person going into their relative's room. They told us that after raising the issue they were given a key to enable them to lock the room when their relative wasn't in it. Another relative expressed satisfaction in relation to safety at the home and told us they felt their relative was in "Safe hands."

At a previous inspection in May and June 2016 we found that the provider was in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to concerns about medicines management. At an inspection in December 2016 we found that some improvements had been made and the provider was meeting legal requirements. However, at our next inspection in July 2017, the provider was in breach of the same regulation again. We found hand written amendments on medication administration records had not always been countersigned, there were some gaps on topical administration records and stock had not always been ordered in a timely way, resulting in one person not receiving their medicine for three days.

At this inspection we found improvements had been made in relation to medicine practices and the provider was no longer in breach of legal requirements. Since our last inspection, the provider had designated one person with specific responsibility for ensuring oversight of medicines practices to ensure compliance. Staff had completed additional training and the registered manager had recently met with their pharmacy supplier and the two GP practices they used, in order to review current systems and identify ways to make these more efficient. All required medicines were in stock when we visited and medication administration records (MARs) were appropriately completed to show that people had received their medicines as prescribed. MARs were checked every shift by senior staff, and any gaps highlighted, to enable prompt identification of any potential medication errors or omissions. Medicines were stored securely and at the correct temperature. Stock balances we checked were consistent with the MARs.

We observed a staff member supporting people with their medicines. This was done appropriately and the staff member demonstrated knowledge of good practice and an understanding of people's individual needs and preferences. We noted occasions where the staff member was disturbed by other staff whilst supporting people with their medicines. We discussed this with the registered manager, who agreed to monitor and address this, to reduce the potential risk of medication errors occurring due to distractions.

After the inspection the provider notified us of a medication incident that had occurred. They gave us detail of the responsive action they had taken to prevent recurrence.

At our last inspection in July 2017, we found the provider was in breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed. This was because some staff had commenced their training and shadowing of experienced staff prior to the return of

their full Disclosure and Barring Service (DBS) check and this had not been appropriately risk assessed. The DBS checks whether applicants have a criminal record or are barred from working with vulnerable people. These new staff had also shadowed night shifts, and because routine staffing levels on a night were lower than in the day, this presented a greater risk that staff may need to be left unattended. There was also a lack of evidence to show issues identified in references had been explored.

At this inspection we checked the recruitment records for four care staff who had been employed since our last inspection and found that safe recruitment practices had been followed. These included the completion of application forms, interviews and reference checks. DBS checks were conducted prior to them working with people. The provider was no longer in breach of Regulation 19 (2).

The provider had notified us of a comparatively high number of falls resulting in injuries in the year prior to our inspection, when compared against the average number of potential injuries occurring in other homes of this size. We found that falls and mobility risk assessments and care plans were in place and these were generally appropriately completed and regularly reviewed. Staff had awareness of falls prevention measures and we saw that a range of measures and equipment were used, such as sensor cushions and movement sensors.

Accidents and incidents were recorded on a monitoring log and the registered manager completed a monthly falls audit to ensure appropriate action had been taken. A root cause analysis was used to identify any causative factors. Lessons learned were discussed with staff. The provider had taken action to try and reduce falls and accidents and to take a more proactive response to the changing needs of people using the service. In the provider information return, we were told how this was being achieved through a research project and reviewing the falls risk assessment tool. The provider told us that a positive impact had been made and we found that in the three months prior to our inspection the number of accidents had reduced by approximately 30 per cent, compared to the previous average monthly figures.

As well as falls risk assessments, assessments were also completed in a range of other risk areas, such as skin integrity and nutrition. These were reviewed regularly and we saw examples to show that staff took appropriate action in response to identified risk. We observed staff were attentive and responded promptly when people needed assistance.

Staff had a good knowledge of the safeguarding vulnerable adult's procedure and were able to explain the different types of abuse that could occur and how to respond and report them. The provider maintained records of safeguarding referrals made to the local authority safeguarding team, and these showed that concerns were reported appropriately to enable them to be investigated.

During our inspection we observed that there were sufficient staff available to meet people's needs. People we spoke with all felt there were enough staff, although one commented that there was still some staffing inconsistency and staff who didn't know people's needs as well. Most relatives felt there were enough staff but one felt there were not enough because their loved one sometimes had to wait for assistance. There continued to be some staff turnover but the provider had recruited new staff and we saw from rotas that agency staff were used to maintain safe staffing levels where required. Staff told us that staffing levels were safe, but the use of agency staff sometimes impacted on them and people using the service, due to agency staff not knowing people as well. One commented, "We are not fully staffed yet, but we are almost there. The manager is good at looking ahead and recruiting before we need the staff."

The provider had infection control policies, procedures and cleaning schedules in place and staff used personal protective equipment (PPE) such as gloves and aprons. The home was generally clean and free

from malodours. However, on the first day of our inspection we found that the toilet in one bathroom on the first floor was dirty for most of the morning and we had to draw staff attention to this. Greater vigilance was required to ensure all bathrooms were maintained in a clean and hygienic state. The registered manager advised us they were already reviewing the amount of domestic staff hours required for the home. They anticipated this would also help with plans they had to make improvements to the efficiency of the laundry service.

Environment and equipment checks were undertaken, including checks of gas and electrical safety, hoisting equipment and lifts. The service had received a rating of five at its most recent food hygiene inspection undertaken by the local authority Environmental Health Department in August 2016. Five is the highest score available.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application processes for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we found that the provider had not always submitted DoLS applications in a timely manner. We made a recommendation that the provider took action to ensure they were working within the principles of the MCA at all times and that DoLS applications were consistently submitted.

At this inspection we found improvements had been made and DoLS applications were appropriately submitted for people who required them. The provider was working within the principles of the MCA. Care files contained mental health and capacity assessments and where people lacked capacity to make decisions for themselves, those made on their behalf were done so in their best interests. We observed staff seeking people's consent and waiting for verbal agreement or non-verbal cues before providing care to people. Staff received training about the MCA and a manager from one of the provider's other services had been providing additional guidance to staff in this area and support to ensure DoLS application were up to date.

We asked people who used the service whether they thought staff had the right skills to care for them well and people told us, "I am sure they do" and "I think they are very good."

The nominated individual for the provider told us that since the last inspection they had changed the induction for new staff and instead of completing all training in a two week block when commencing in post, staff now completed their induction training over a 12 week period, with a different training course each week. This was to give staff more chance to practice what they had learned and help consolidate their learning in between the courses. Staff completed vision and values training, moving and handling and first aid at the start of their induction, followed by training such as dementia awareness, infection control, food hygiene, health and safety, first aid and communication.

The provider maintained a training matrix (record), to enable them to monitor when staff training updates were due. We saw that the majority of training was up to date. The provider had taken action since our last inspection to increase the frequency and consistency of staff supervision, and this work was on-going to ensure all supervisions were up to date. We saw records to show that routine supervisions took place, as well as themed supervisions on topics such as medication and infection control. There was also opportunity for staff to raise any issues or concerns. Handover meetings were held twice a day to exchange information between staff. The registered manager told us the handover system had recently changed in order to try and improve communication at the home; there was now a separate handover session for each floor of the

home.

The provider used a range of assessments based on nationally recognised assessment tools, for areas such as nutritional risk and skin integrity. The registered manager demonstrated knowledge of best practice in relation to dementia care.

The environment was suitable for people's needs; the home was purpose built, with wide corridors and room for people to navigate. There was some consideration of dementia friendly design features, such as colour contrasting doors and toilet seats. There was a cinema room, library and various other quiet rooms, although we noted these were not always well used because most people tended to stay in the main communal living and dining area on each floor. Most people were happy with the environment, but one person told us they were worried about bumping into the low coffee tables on one floor because they could not distinguish them from the carpet, due to the lack of colour contrast. We shared this feedback with the registered manager, who said it would not be a problem to change the tables. They agreed to look into alternative options.

Visiting healthcare professionals we spoke with confirmed that staff contacted them if they had any concerns about people. One told us they felt there had been improvements at the home recently, due to more leadership since the new registered manager had started. They felt there was still some inconsistency with staff communication in the home, such as meeting requests for information in relation to continence. However, they felt the registered manager was approachable and they would be able to work with them to address any issues. Another healthcare professional we spoke with confirmed they visited regularly and staff were always prepared for their visits. They said, "Staff know what they are doing. They take the advice we give and act on it."

Care files contained information in relation to people's healthcare needs and their contact with healthcare professionals. This showed us that people were supported to access healthcare services in order to maintain their health.

People were satisfied with the meals available at the home. Their comments included, "The food is nice," "It's fine," "It is very good" and "Suits me." We observed two mealtimes and the food served looked and smelled appetising and was of good portion size. People were offered a choice of meals and drinks. There were also fruit bowls, snacks and hot and cold drinks available throughout the day.

Care plans contained information about people's dietary needs and an assessment of any risks in relation to their nutrition and hydration. Staff regularly monitored people's weight and sought advice from dieticians or speech and language therapists where required. The home had recently introduced a new electronic care monitoring system, and staff recorded people's food and fluid intake on hand-held electronic tablets. This enabled staff to easily monitor if people had had enough to eat and drink.

Is the service caring?

Our findings

We asked people about staff at the home and they told us, "The staff are helpful and quite pleasant," "Most of the staff are caring," "Lovely staff" and "They don't come and chat but they ask how I am." Others told us, "You see the same faces most of the time, so you get to know them," "They speak to me in a nice way" and "Staff are very kind." Relatives and visitors we spoke with agreed staff were caring.

We observed staff were respectful and friendly towards people throughout our inspection, and spoke to people in an affectionate manner. Staff chatted with people about topics of interest to the person. Staff were patient and referred to people by name. We noted two occasions where a staff member used terminology which was patronising; referring to things a person had done as "Naughty." The registered manager agreed to monitor this and provide additional guidance to staff. Most staff appeared to know people well and tailored their approach to people's needs. We saw occasions where staff intervened discreetly and offered support and advice to other newer staff about how to support someone with a particular activity. For instance, support for one person to eat their lunch. The advice offered worked very successfully, and the change of staff approach meant that the person responded and ate more of their lunch. This showed staff were attentive and worked together to ensure people got the care and support they needed.

The service had a dignity champion, whose role was to promote and champion dignity issues at the home. The provider had a privacy and dignity policy and we saw staff promoting people's privacy and dignity during the inspection. For instance, by closing doors when supporting people in their bedroom or bathrooms and speaking to people discreetly about personal matters. People told us staff were respectful of their privacy and knocked on their bedroom door before entering. One person said, "They knock and say 'Can we come in?' and 'Do you need any help?'" Another told us, "I need help bathing and they are always respectful."

Most people and relatives told us staff promoted people's independence and encouraged people to do things for themselves. One person said, "They encourage us by saying 'Come on, you can do it'." A relative told us, "When my [relative] first came they liked to dance, but their dementia has deteriorated fast and now they don't want to, but staff still encourage them, even though they always say no." However, one relative was frustrated that their relative had not regained their mobility since moving to the service and felt staff could do more to support this.

We observed staff involving people in decisions, offering choices and responding to people's requests. There were relative and residents meetings which people could join if they wished, to discuss issues in relation to the service. Not all the people we spoke with were aware of the meetings, but we saw minutes of the meetings which showed that some people had attended. A relative told us that dates for forthcoming meetings had recently been put on display in the home, and we saw planned meeting dates were displayed in the lift and on notice boards. Various other information and notices were also posted on the boards, including some in pictorial form. Information about local advocacy services was available, for people who may require independent support to help them express their views. One person had an independent mental

capacity advocate, and others had representatives to support them with their finances. This showed people could access independent support with decision making where required.

People were supported to maintain relationships with those important to them and visitors were welcomed. Some relatives visited the home very regularly. One person told us they had a volunteer befriender and looked forward to their visits and chatting with them.

The provider had an equality and diversity policy and staff completed equality and diversity training. People were able to practice their faith where they wished to and there was a regular church service held at the home.

Is the service responsive?

Our findings

The provider conducted an assessment prior to people moving to Ebor Court, to ensure the service could meet the person's needs. A care plan was then developed, involving the person and their family where appropriate. The care plan included information about people's needs and preferences in a range of areas, along with instructions to staff on how to meet these needs. This included skin and pressure care, health and wellbeing, mobility and falls, continence, communication and nutrition. Care plans were reviewed monthly. This helped to ensure that staff had the up to date information they needed to be responsive to people's needs and preferences.

The provider had recently introduced a new electronic care planning system, and at the time of our inspection they had commenced the first phase of the implementation of this system. Staff had hand-held electronic tablets, which provided prompts to them about tasks they needed to complete. Staff also used the tablets to record the care they had delivered to people, including the checks they conducted, such as checks on people's well-being in the night. When staff were conducting checks, they were required to scan the tablet on a sensor in the person's room, which meant they could accurately note the time each check was conducted. Staff also recorded information such as what people had to eat and drink. The registered manager was able to view on the computer all the monitoring information recorded for each person each day, including relevant detail such as when they had been repositioned, if necessary, and any personal care provided. Staff were generally enthusiastic about the new system and felt that it would help save time and improve the accuracy of recording.

The registered manager told us the next phase of the implementation of the new system was to transfer the whole care plan for each person onto the computer system, but they intended to do this later once staff had got used to using the tablets. The nominated individual for the provider told us they had learned from the experience of implementing the system in their other services, and believed taking this phased approach was the safest and most effective way to implement it.

We found that care was delivered in line with the requirements recorded on the system for each person. We noted however, that the requirements recorded for one person had not been accurately transferred on to the computer. For instance, the person's care plan stated they required hourly night checks, but the computer system was set to prompt staff to complete two hourly checks. This meant there was a risk the person may not be checked as frequently as required. We asked the registered manager to re-check the requirements set up for each person on the computer, to ensure they were all consistent with the information in the person's care plan. When we returned for the second day of our inspection we were advised that the provider had completed this task and had made a small number of minor amendments where these were required.

The provider had a policy on the provision of care to people at the end of their lives, and staff received training in end of life care. We received positive feedback from a visiting healthcare professional about the care the staff had provided at this stage of people's lives. They told us about two situations recently which they felt had been managed well and commented, "People were comfortable here, where they wanted to

be."

People had access to some activities and entertainment at the service. On the first day of our inspection we saw some people taking part in games and exercise, such as soft ball (catching and throwing), bat and ball and table tennis. This was facilitated by three university student volunteers, who were regular visitors to the home. We also saw staff sat with people colouring pictures and painting people's nails. On the second day of our inspection we observed the end of a music session which had been taking place with a visiting entertainer. Approximately 20 people had come to watch the singer and people were joining in with the songs. Some people also got up to dance. People enjoyed the session. Art classes and Thai Chi took place weekly.

We did note though there were some periods of the day when there was limited stimulation, other than television and radio. People who used the service told us about activities they took part in, including one person who said, "There is singing and that is good." Several people told us they liked quizzes and one said, "We used to have quizzes and we love them, but they don't happen as often now. I wish they did." The registered manager and staff told us they hoped the range and amount of activities on offer would increase further now that they had just employed a full time activities co-ordinator for the home. We spoke to the new activities co-ordinator who told us about the types of activities and trips they planned to organise, taking account of people's individual preferences.

The provider had a complaints policy and procedure. We looked at records of complaints and compliments, and saw that there had been six concerns and complaints received since our last inspection. These had been appropriately investigated and a response given to the complainant. Where appropriate, responsive action had been taken and relevant learning shared. Three compliments and thank you cards had also been received since our last inspection.

Not all people and relatives we spoke with were aware who they should speak to if they had a complaint, but they confirmed they would feel comfortable raising any concerns with staff if they had any. One relative told us some concerns they had raised, such as staff brushing people's hair in the communal living area, had recurred. The complaints policy on display did not specifically name who to raise a complaint with, but it provided assurance of the policy in place and how people could expect their complaint to be handled. There was also a suggestions box in the entrance of the home.

Is the service well-led?

Our findings

At our last inspection in July 2017 the service was rated Inadequate in the key question: Is the service well led? This was because it was the fourth successive inspection where we had identified areas of concern, which showed the provider had failed to mitigate risks and implement effective systems to make necessary improvements. Some areas, such as medication, recruitment practices and DoLS requirements had also deteriorated, and the quality assurances in place had not been effective in identifying and addressing these concerns. This was a breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made improvements throughout and was no longer in breach of any regulations. Furthermore, they had made sufficient improvement to achieve an overall rating of Good. However, some of the improvements made were still relatively recent and further time was required to fully embed these systems and be able to evidence the consistent sustained improvement needed to demonstrate a Good rating in the key question: Is the service well led? There were also a number of minor issues that the registered manager was continuing to address, such as ensuring all supervisions were up to date, consistency of record keeping, developing pictorial menus and improvements to cleaning and laundry arrangements. On-going improvements were being addressed via an action plan, which was being monitored by the regional director. The provider also acknowledged that the full implementation of the new electronic care monitoring system would require further work and attention to ensure it was successfully embedded into daily practice.

The provider is required to have a registered manager for the service, as a condition of their registration. There was a registered manager in place, who had been in post for approximately five months. Prior to the registered manager starting in post there had been a period of about 18 months of management changes and inconsistency, but the service was now benefitting from having a consistent manager in post. The registered manager was also supported by a manager from one of the provider's other services, in order to help make all the improvements which were required from our last inspection. There were also two deputy managers and a care manager, who spent time working directly with people as part of the care rota, so were able to direct and guide staff on a day to day basis.

As well as support to staff, we found the registered manager was working to build relationships with external professionals and services, in order to improve multi-agency working and access staff skills and development opportunities. This included working with the local Clinical Commissioning Group to access 'React to Red' pressure ulcer prevention training, and working with pharmacy providers to improve medicine systems.

One staff member we spoke with felt the management team could show more appreciation for the work staff did, but others we spoke with felt more supported. Their comments included, "We are well supported. The management come round and talk to us. They tell us 'well done' when things have gone well. I had a recent supervision with [Name] – it was helpful" and "I can always ask the manager anything. She is really good." Another staff member told us, "[Registered manager] is really good." A relative told us, "You can tell

there's a new manager; things have changed for the better."

The registered manager completed monthly quality assurance audits to monitor the quality of care provided. This included audits in relation to infection control systems, medication, care plans, pressure sores, bed rails, accidents and falls and a weight loss action plan. There were also quarterly catering, health and safety and mattress audits and mealtime spot checks. There was an improvement in the consistency of audits being completed since our last inspection. They were generally appropriately completed, and there was evidence of action taken as a result of findings. However, there were still some minor examples identified where it was not clear from audit records if particular actions had been completed, such as a medication audit we viewed, but in the main the checks demonstrated that audits were being more effective in driving improvement and the provider was now meeting legal requirements in this regard. The provider also conducted staff, service user and relative surveys to seek feedback on the quality of the service provided.

The registered manager was aware of their responsibilities and legal requirements, and notifications had been appropriately submitted to CQC.