

Mr A Agarwal

Leiston Old Abbey Residential Home

Inspection report

Leiston
Leiston
Suffolk
IP16 4RF

Tel: 01728830944

Date of inspection visit:
13 June 2016

Date of publication:
09 September 2016

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

Leiston Old Abbey Residential Home provides personal care for up to 40 older people; some people are living with dementia. There were 11 people living in the service when we inspected on 13 June 2016. This was an unannounced inspection.

We carried out an unannounced comprehensive inspection of this service on 29 September 2015 and rated the service as Inadequate. Breaches of legal requirements were found. These related to the safety and cleanliness of the environment, staffing levels, staff training, ensuring people's privacy and dignity, how the service met the care and welfare needs of people and governance. We undertook a further unannounced focused inspection on 18 and 22 January 2016 in response to concerns raised with us around staffing and management. We found no improvements have been made to the overall quality of the service and this had resulted in a continued poor quality of service which placed people at risk. The oversight of management was still failing.

As a result of these two inspections we placed conditions on the registration of this provider, to restrict any admissions without prior written permission from CQC and requiring information and monthly reports from the provider on their governance and oversight.

You can read the report from our comprehensive inspection of 29 September 2015, and focused inspection on 18 and 22 January 2016 by selecting the 'all reports' link for 'Leiston Old Abbey Residential Home' on our website at www.cqc.org.uk

This inspection of 13 June 2016 was to check that improvements had been made to provide a safe good quality service for the people living there. During our inspection we found two continued 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.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager in post who had started working in the service on 4 April 2016, who was in the process of submitting their registered manager application with the CQC.

The quality assurance systems were not robust enough to independently identify and address shortfalls. The new manager has started to make some significant changes to the way the service was being run. It was not possible for them to fully demonstrate the impact of these changes because of the short time they had been implemented for. Further work was needed to ensure that they were fully embedded and sustained. Feedback received regarding the new manager was positive. They had recognised the areas that needed improvements; this showed us that their appointment had led to a more proactive approach, independently

identifying shortfalls and in the process of addressing them. In addition the provider was using the service of an external consultant to support the management team to make improvements.

Improvements had been made in the safe management of medicines. However, the service needs to more proactive in supporting people who refuse their medicines, to ensure their health and wellbeing.

New systems were in place to ensure the safety of people, and the management were listening and acting on the advice of external agencies to provide safe care. Further work was required to ensure people were consistency provided with a clean environment and signage, and any required adaptations to the environment met the needs of people to promote their independence. The manager told us their priority had been to ensure people were provided with safe care, and further work would be undertaken to address these issues.

There had been improvements in the staffing levels which were being monitored to ensure they met the needs of people using the service. Improvements had been made to ensure that all staff received training, achieved qualifications in care and were regularly supervised to improve their practice. This was an on-going process with staff starting to receive more support to enable them to complete their roles more effectively.

People and their visitors were complementary about the relaxed atmosphere of the service and welcoming, friendly staff. Staff had good relationships with people who used the service and their relatives. The majority of staff's interactions with people were caring, respectful, supported people's dignity and carried out in a respectful manner. Improvements were required to ensure all actions by staff put the needs of the person, not of the service first.

The service was aware of the changes to the law regarding the Deprivation of Liberty Safeguards (DoLS). Where needed appropriate referrals were made to external professionals. Further work was required to ensure best interests decisions were followed through in a timelier manner.

People were complementary about the quality of food which met their dietary needs and preferences. Improvements were needed to support people of low appetite to promote their wellbeing. We have made a recommendation on promoting nutritious snacks to support people's individual needs and preferences.

People felt their concerns and suggestions were listened to and acted on to drive improvements in the quality of the service they received. A complaints procedure was in place to ensure people's comments, concerns and complaints were listened to and addressed in a timely manner and used to improve the service.

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.

There were enough staff to meet people's needs. However, improvements were needed to the service's recruitment procedures to obtain more detailed information about the skills and experience of applicants.

Staff understood their responsibilities to safeguard people from the risk of abuse.

There were systems in place to manage people's medicines safely. Improvements were required to support people in a timelier manner, where they lacked the capacity to identify how refusal of their medicines could put their health at risk.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Structured training programme had recently been put in place. Therefore they required further time to enable the learning to be undertaken and embedded in practice.

People had access to appropriate health services which ensured they received ongoing health care support.

People made choices about what they wanted to eat and drink. However, improvements were needed in the use of nutritious snacks, to support people of low appetite, to increase / maintain their weight.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Staff interacted with people in caring and compassionate manner. However, improvements were required to ensure all interactions were person-centred, and caring to support people's wellbeing.

People were being encouraged to express their views about the

care and support they received.

Is the service responsive?

The service was not consistently responsive.

People's wellbeing was assessed, planned and delivered to meet people's needs. Improvements were on-going with the activities that people could participate in.

Complaints were addressed and acted on.

Improvements were on going and for this rating to become good requires consistent good practice over time.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Improvements had been made in the quality assurance system. However further improvements were needed to ensure they were robust enough to independently identify and address shortfalls, and embedded to drive continual improvements.

Requires Improvement ●

Leiston Old Abbey Residential 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.

We undertook an unannounced focused inspection on the 18 and 22 January 2016. This inspection checked that improvements planned by the provider after our comprehensive inspection of 29 September 2015 had been made. This unannounced inspection on 13 June 2016 was to check that the service was meeting legal requirements and improvements made. The concerns raised at this visit led to us imposing conditions on the registration to restrict admissions to the service until improvements were made and sustained. In addition we made requirements for the provider to submit regular reports as to the progress, oversight and management of the service.

The inspection team consisted of three inspectors, which included a pharmacist inspector. Prior to the inspection, concerns were raised with the Care Quality Commission (CQC) that people were not being given a choice as to when they got up in the morning. Therefore we timed our arrival so we could observe the early morning routines.

Before our inspection we reviewed the information we held about the service, this included the provider's improvement plan. We spoke with the local authority safeguarding team and social care professionals. We also reviewed all other information sent to us from other stakeholders such as commissioners, environmental health and feedback received through the CQC website. The local authority has also kept us updated with the support they had provided to the service to assist them to improve the care and support people received.

We spoke with nine people who use the service and one person's relatives. We spoke with seven members of

staff, including the manager, deputy manager, senior care staff, catering staff, maintenance person, and the provider. We looked at records relating to four people's care, management of medicines, staff training and systems for monitoring the quality and safety of the service.

Is the service safe?

Our findings

Our inspection of 29 September 2015 found that improvements were needed to ensure that there were sufficient staff numbers to meet people's needs safely. That people's medicines were given as prescribed, and people were supported in a clean, safe environment. The provider wrote and told us what actions they had taken to address this. However, concerns raised with the Care Quality Commission about the staffing levels resulted in us carrying out a 'Focused' inspection on 18 and 22 January 2016. The concerns were substantiated as there were not sufficient numbers of trained staff to meet people's needs.

At this inspection of 13 June 2016, we checked that these improvements had been made, embedded and sustained over time to ensure people were provided with a consistently safe service. We found the manager, in post since 4 April 2016, had been proactive in driving improvements. They acknowledged that due to all the changes being made, the work carried out had addressed any initial risks to people and they were still working to ensure it was embedded in staff's practice. This reflected our own observations and that whilst it had improved there were still improvements to be made.

Staff authorised to handle and give people their medicines had received training and had been assessed as competent to undertake medicine related tasks. Medicines were stored safely for the protection of people who used the service and at the correct temperatures. Records showed people were receiving their oral medicines as prescribed. There were records of medicines prescribed for external application, such as topical creams. There were internal audits in place to enable staff to monitor and account for medicines. These were overseen regularly; however, records of them did not always indicate actions to be taken when medicine related issues were identified. This is important to support effective monitoring and learning to improve practice.

When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines including pain relief strategies. Staff were not always consistent in their approach to this. For example we saw a person ask a member of staff for some pain relief, and their request was acted on straight away. However, where a person living with dementia was heard to call out whilst being supported with their personal care, their pain relief medicine was not offered to them until after the care had been given. This was not in line with the person's written pain relief strategy. On visiting the person we saw that they looked settled. Therefore we could not be assured if the person calling out had been linked to their anxiety or discomfort. For people who were unable to talk to staff about their pain, assessment tools were not in use. These would support staff in identifying verbal and non-verbal indicators that a person was showing signs of discomfort, so they could give them their painkillers.

Where people were regularly refusing to take their medicines; prompt action had not been taken to address this. For one person with limited mental capacity records showed 16 days earlier staff had consulted with their GP, to make a best interest decision to administer their medicines covertly by crushing it in food. However, this practice had not started and the person was not always being administered their medicines. No GP referral had been made for another person who regularly refused their medicines. On reading their daily notes, we could not be assured that some of the observations made by staff re swollen lower limbs,

were linked to the person not consistently receiving their medicines as prescribed. We raised these concerns with the manager who took action during the inspection to put in place the best interest decision to support the people's health and welfare.

This is a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations

People told us that their medicines were given to them as prescribed and that they were satisfied with the way they were provided. One person told us that they, "Had no problems," with receiving their medicines as prescribed.

People we spoke with told us that they felt safe living in the service. One person said, "I feel safe." A person's relative commented that the staff, "Definitely," provided a safe service.

People were supported by staff who knew what action to take if they had concerns about their welfare. To ensure staff had the same level of awareness of issues that could impact on a person's safety and human rights, the manager had arranged for all staff to attend safeguarding training. Staff were able to relate their training to practice by providing examples of situations that would raise concerns about a person's safety and welfare. They were aware who to report safeguarding concerns to within the service, and the role of external agencies.

There had been shortfalls in monitoring people who were at high risk of falls to ensure their welfare and safety. This included a lack of effective falls assessments in place and taking proactive action to monitor a person's welfare following a fall. Records showed that advice had now been sought from professionals to address these issues which the manager had acted on to drive improvements. For example 'flow charts' were accessible in key areas of the service, which provided guidance for staff on the action they should be taking when a person had fallen to ensure their safety and welfare.

Improvements had been made to the safety and cleanliness of the environment. A stair gate had been fitted to prevent people gaining access to unused / unsafe areas of the premises. Vacant bedrooms used as storage were locked; preventing people accessing rooms where there were trip hazards. Unstable wardrobes had been fixed to the wall to prevent the risk of them falling on a person. There was no sign of the 'cluster' flies which had been previously present in the service. However no action had been taken to address our concerns over the potential risk of a false cupboard door falling onto staff in the kitchen. Also the environmental risk assessments did not take into account the toilet and bathroom facilities, to ensure they met people's needs. For example we noted that the level of the toilet seat was not suitable for a taller person who struggled with their mobility. Both these issues were addressed during the inspection by the manager. A raised toilet seat was made available to use, if applicable, and confirmation given from the manager that individual assessments would be carried out. The maintenance person confirmed that they had been asked to secure the cupboard door.

The manager told us about the work they had undertaken to ensure people were provided with a safe environment. This included taking action when they had identified that staff were, "Bolting," the fire doors, linked to previous concerns over intruders. The unsafe practice had been stopped and external fire exits had been fitted with alarms. This ensured there were no delays in using the fire exits, but staff would be alerted to the potential risk of someone trying to leave / enter the building. This showed that the service was becoming more proactive in identifying risks and taking appropriate action to address them.

The manager checked to ensure all fire signage was correct and relevant. This was linked to concerns where

interlinking doors marked as fire exits, were locked or blocked by furniture. The water sprinkler system fitted in the service meant that they were no longer required as the main routes. The manager told us they were in the process of removing any signage which was no longer applicable.

People's records included risk assessments which identified how risks in their daily lives were minimised. For example where a person was at high risk of falling out of bed, they had been assessed as requiring bed rails, which had been put in place. Advice had been sought from occupational therapist to support a person's mobility needs. We saw the advice had been acted on to ensure the correct equipment was used. One staff member told us about the equipment now available in the service which included a new mobility aid to support people when standing and transferring, also, "A couple of hoist slings for everyone and handling sheets in [bed] rooms." This provision also supported good infection control, by people having their own, and not sharing hoist slings and 'sliding' sheets, used when re-positioning people in bed.

Cleaning schedules had been put in place to ensure people's bedrooms and communal areas were kept clean and hygienic. Improvement was still needed where cleaning was not as robust as it should have been. For example where staff had signed to say that they had 'hoovered' a carpet, they had missed the food debris under the bed. Build-up of lime scale around taps in the sluice, a wet mop not being air dried, and stained commode pots were all potential areas for breeding bacteria. The manager acknowledged our findings and disposed of the stained commode pots. Where shortfalls had been identified in cleaning people's bedrooms, the manager said it would be brought to staff's attention. It demonstrated that although systems were in place, further work was required to ensure they were embedded in staff practice. To assist this, the manager, which was confirmed by staff, were all receiving training in infection control.

Improvements had been made to ensure there were enough staff deployed across the service to meet people's current needs. One person told us, "Got enough staff during the day, have two come on at night," which they felt was also sufficient.

At the time of our inspection there were 11 people living in the service. The manager told us, confirmed by records, the care staffing levels had been set at one senior carer and two carers during the day, and two carers at night. They said they would be keeping the staffing levels under review to ensure they met people's needs. A cook was working a split shift that day, therefore providing cover during breakfast, lunch and tea. This addressed a previous issue we had raised where care staff were being taken away from their care duties to prepare / serve the evening meal. One staff member confirmed that a member of the kitchen staff, "Normally," came back at tea time. Staff confirmed that the staffing levels enabled them to have a greater visible presence in the lounge, monitoring people's safety, reducing the risk of people falling, and ensuring needs were met more promptly.

The service was following safe recruitment by carrying out Disclosure and Barring Service (DBS) checks to prevent unsuitable staff supporting people using the service. However the recruitment systems in place needed to be more robust. This was to ensure they had sufficient information about the applicant's employment history to ensure they demonstrated the values and skills to support people safely.

Is the service effective?

Our findings

Our inspection of 29 September 2015 found that improvements were needed in staff training, supervision, and monitoring to ensure people were given enough to eat and drink. Improvements were also needed in the provider's and staff understanding and implementation relating to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The provider had written to us to tell us the improvements they were making and kept us updated on a monthly basis how these were progressing. During this inspection of 13 June 2016, we found improvements had been made, with further improvements planned in the provision of staff training. These improvements needed to be embedded and sustained over time to ensure people were provided with a consistently effective service.

The manager told us how they had identified training as one of the key issues in driving improvements. To ensure staff were working from the same base line of knowledge, they had arranged three day training sessions covering mandatory key elements of their role. This included fire safety awareness, first aid, moving and assisting people, infection control, health and safety.

One staff member who had attended the training programme told us, "Just been on three days training, very good...I was impressed with the training and the trainers." They felt the quality of the moving and handling training was much better than the training they had received during their induction. They said, "Moving and handling was practical, they worked through the assessments with us, if any problems we could ask questions. Opened my eyes to procedures." Another staff member also described how the training had been more in-depth, as the trainers had checked, "My understanding and was informative about policies and procedures," which raised their awareness of their legal responsibilities.

The service had also signed up for 18 certified training modules which reflected the range of people's and staff's individual needs / roles. This included supporting people with behaviours that staff may find challenging, malnutrition, stroke awareness, dementia, and pressure ulcer prevention and awareness. The local authority were providing support and training for staff in areas of care planning and writing in daily notes. Staff told us they were also completing care certificate workbooks as part of their preparation for staff working towards the care certificate. This is a recognised set of standards that staff should be working to. Catering staff were also being supported with training relevant to their role. From discussion with management, staff and records viewed we could see that there was now a more structured approach to developing staff. Although at the early stages, it showed that systems are now in place. This will ensure staff have the required skills and knowledge to carry out their role effectively to meet people's care and support needs.

The manager was able to monitor the impact of this learning because there were systems in place to ensure staff received supervision and feedback on their practice. This was helping to drive improvement in the quality of service people received. This was confirmed by staff we spoke with and records which we reviewed.

People told us that the staff sought their consent and acted in accordance with their wishes. This was

confirmed in our observations. We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meal and with their personal care needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that the manager had made applications under DoLS to the relevant supervisory body. They understood when an application should be made and the requirements relating to MCA and DoLS. Where an application had been authorised, they liaised with the person's advocate to ensure recommendations were being followed.

A member of staff confirmed they had received training in the MCA and DoLS, and to keep their knowledge updated was booked to attend further training in July 2016. They provided examples of how they promoted choice and supported people to live the way they wanted to. This included a person getting up during the night, as they thought it was morning, and asking for something to eat. The carer said on offering them toast, the person had replied that they were, "Thinking of bacon and eggs," which they cooked for them. It demonstrated how the staff member had taken the lead from the person, providing what they had wanted at the time.

People told us they were supported to eat and drink enough and offered a choice of food. One person said that there was, "Always a choice." Another person told us that they enjoyed their food, and staff offered alternatives to the menu if they didn't like what was being offered. They commented, "I know what I can eat, what I don't like." A person's visitor told us, "The food is very good, we were just talking about what [the person] had for lunch."

We saw staff sitting and eating with people making lunch time a more relaxed and social experience. We heard laughter from one table where three people and a staff member were sharing a joke. Where people needed assistance with their meals this was done by staff in a caring manner. This included supporting a person in their bedroom, who required assistance and monitoring of their welfare whilst they ate. To enable them to share the same positive dining experience, the staff member had taken in their lunch to eat with them. We heard them gently encouraging the person to eat.

Systems were in place to monitor what people had to eat and drink, and advice sought from health professionals where people were over or under weight. This included dieticians, and speech and language therapist to assess their ability to swallow food safely.

The cook showed us the meal monitoring forms that had been put in place, as part of the provider's checks to ensure people were being given enough to eat and drink. Where people had been identified as low weight and were under the care of a dietician, they told us how they were increasing their calorie intake through giving them high calorie foods and drinks. This included 'fortified' milkshakes made with cream, which we saw a person drinking.

There had been improvements in monitoring people who were underweight to ensure they were provided with enough nourishment to support their wellbeing. However, not all the systems had been embedded in

staff practice. For example, where care records provided staff with guidance on how to support a person to maintain / put on weight. It included information about a person's likes and dislikes, their eating routines and level of support they required. When read in conjunction with what staff had recorded in the person's daily care records and meal monitoring sheets, these showed an inconsistent approach to staff acting on the information. Further improvements were required as snacks were being offered as part of the normal routines, mid-morning and afternoon, but not in a planned response to the person having declined a meal. By offering / leaving a nutritious snacks outside of the service's set times, would prevent the risk of the person feeling hungry and support their wellbeing.

We recommend that the service uses a reputable source and latest guidance to support them in identifying and providing suitable nutritious snacks, linked to people's individual needs. That they take action to embed it in practice.

People said that their health needs were met and where they required the support of healthcare professionals, this was provided. Records showed that people were supported to maintain good health, have access to healthcare services and receive on-going healthcare support.

Is the service caring?

Our findings

Our inspection of 29 September 2015 found that improvements were needed to ensure people's privacy and dignity was always promoted and respected. The provider had written to us to tell us the improvements they were making and kept us updated on a monthly basis how these were progressing.

During this inspection of 13 June 2016, we found improvements had been made but there were still inconsistencies with concerns being reported to us about the routines of the service and their approach to some people's care not being as caring or centred on the person as it could be. The manager told us they were actively working to remove these inconsistencies by working with people, staff, relatives and others to ensure care was always provided in the right way.

We arrived at 5.40am and found all people were settled and in bed. Where required, staff assisted people with their continence needs and repositioning in an unrushed manner, leaving them to go back to sleep. Where people did get up, it was the person's choice. However, we did identify there was an expectation from some staff that night staff should have started getting people up before their shift finished at 8am, and people's personal care should only take 15 minutes. This reflected concerns raised with the CQC, about the culture within the service and lack of consistent understanding of person centred care rather than being routine and task based. The manager confirmed that they were doing 'spot' checks to monitor routines and would take disciplinary action where required to ensure that unacceptable practices were addressed.

Changes had been made to ensure the furniture and fittings supplied by the service ensured people's privacy and dignity. A lock had been fitted to the shared toilet, and a privacy screen to a person's en-suite toilet. Staff were also receiving training to support them in recording information in a respectful manner.

People told us that staff treated them with kindness and compassion. One person said, "Staff very kind." Another person said, "We would all rather be at home, but this is comfortable." A visitor remarked, "Its lovely here...[staff] are always smiling, very helpful."

A thank you letter from a person's family offered a, "Sincere thank you for all the wonderful care and kindness shown to our [person's name] we were impressed by the genuine warmth and unstinting devotion given not just our [relative] but to all," the people living in the service.

People had built up caring relationships with staff, asking after their welfare and how they spent their time off. The staff reciprocated, enquiring after people's family, visitors or activities they had been involved in. Staff had an awareness and interest of people's individual circumstances and those people important in their lives.

We observed some good caring interactions. For example where a person and a member of staff were playing a game, we heard the staff member say they had 'broken' a part and asked the person if they could fix it. They said, "I don't know what I have done to it; maybe you can have a look." We saw how this person centred approach, made the person feel valued and had a positive impact on the person's wellbeing, as they

intently tried to fix it.

We saw the provider set up their computer in the office so a person could select their favourite music, which they had tea and listened to together. The person showed signs of wellbeing, laughing, chatting, and they were very lucid as they reminisced about their life and love of music. Staff told us that these types of interaction were natural, regular occurrences, and provided examples of other meaningful interactions they had seen. This included taking a person out to their favourite restaurant.

People were supported to express their views about the service, which had been listened to and acted on. This included monthly 'residents' meetings. Records of the May 2016 meeting showed that six people had attended, and actions from the previous meeting had been addressed. This included a trip to the sea-side and supporting people's religious needs. We saw that the meetings were used as a forum to plan future trips out to the community and activities people would like to see happening in the service, and their suggestions acted on. This included arranging the recent cheese and wine supper, which people and their relatives had enjoyed.

A relative told us that they could visit when they wanted and were always made to feel welcome. They told us there was plenty of space, so they could speak in private. The service had areas where people could go apart from their individual bedrooms, to spend time alone, or with their visitors.

Is the service responsive?

Our findings

Our inspection of 29 September 2015 found care plans did not provide staff with enough information on how to meet people's needs, people were at risk of social isolation and the service were not always listening, acting on, and learning from complaints to drive improvements in the service. The provider had written to us to tell us the improvements they were making and kept us updated on a monthly basis how these were progressing. During this inspection of 13 June 2016, we found improvements had been made. These were yet to be fully embedded into practice and sustained. The service has had a history of implementing changes in the structure and contents of care plans, the most recent in April 2016 and still ongoing.

Staff spoke about the improvements they had noted in the latest care plans. One staff member commented that they had been, "In a mess, [manager] has been updating them and they are much better." People told us that they felt they received care which was responsive to their needs. One person told us, "We get well looked after."

Records provided staff with information about how to meet people's needs. We saw improvements had been made in the format and quality of information held. They provided staff with more detailed guidance on supporting people with their individual needs, taking into account their preferences and wishes. This included their physical, mental, religious, cultural, and social and health needs. The 'A day in my life' section provided an insight into how the person's physical and mental health impacted on their abilities. This included how living with dementia could impact on the person's fluctuating memory, orientation and independence; and how to support them. For example by using gentle prompting to support a person to retain their independence, by offering the person a flannel to see if they were able to wash their face.

The manager told us when making the changes to the care plan format they had used their previous knowledge and experience, as well as acting on advice from social care professionals to make the required improvements. They were aware that there was still some work to be done to ensure they were 'tailored' to the person, but felt that they were going in the right direction. Care records we looked at and feedback from social care professionals confirmed this position.

People told us that there were social events that they could participate in. The service had a new activities person, which had led to an increase in planned activities and organised social events. A weekly programme was displayed so people could choose if they wanted to join in. This included trips out to the local community, baking and armchair exercise. One person said that they, "Will come down if any entertainment, I don't get bored." Another person told us, "They do put a quiz on and a few games, throw a ball around, skittles...might have a quiz here today." They said they liked to go in the garden, or go for a walk with staff, "It's good for you." We observed one person being supported by the activities person in a meaningful activity; the person was absorbed in the task, which supported their wellbeing.

Improvements had been made to reduce the risk of people living with dementia from becoming socially isolated. Care records were more informative about the person's likes and dislikes, including which social interactions were noted to have enhanced the person's well-being. This included more awareness of how

supporting a person's senses could provide reassurance and comfort. For example, for one person reassurance was provided through listening to music, hand massages, and being given comforting items to hold. Sensory pillows and hand muffs, which had items attached which people could touch and fiddle with to stimulate their senses had been placed on armchairs.

People told us that they could have visitors when they wanted them; this was confirmed by people's relatives and our observations. People were supported to maintain relationships with the people who were important to them and to minimise isolation.

People told us that they knew who to speak with if they needed to make a complaint. They felt confident that their comments would be listened to.

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. Since our last inspection of 22 January 2016, the service had received one complaint. Records showed that the concern had been investigated, and responded to in a timely manner. The manager said although the complaint had not been upheld, if they had identified any shortfalls they would have been addressed, and learnt from the experience, as part of driving on-going improvements.

Is the service well-led?

Our findings

Our inspection of 29 September 2015 found the service overall to be Inadequate. Quality assurance and leadership within the service was not robust enough to independently pick up shortfalls and act on them effectively to keep people safe. Feedback was not being used to improve the service and the quality of care was poor with people's needs not being met. The provider was required to send us monthly updates to tell us how they were monitoring and driving improvements within the service. Due to further concerns being raised we inspected again on 18 and 22 January 2016. We were so concerned about the safety of people using the service we took enforcement action to restrict admitting anyone further without our permission. This gave the provider a further opportunity to improve the service without placing anyone else at risk. We shared this information with the local authority who continued to support the service. In doing so they mitigated some of the risks to people who remained at the home. We met with the provider in October 2015 and March 2016 to discuss our ongoing concerns, our enforcement processes and expectations for services rated as Inadequate and placed into Special Measures.

During these meetings the provider demonstrated and acknowledged a lack of understanding about what their responsibilities were to ensure that people received high quality care. The provider has had eight managers over a period of six years. They had relied on them to run the service but had not always recognised the experience, skills and values a manager needed, provided the right support and resources, or understood the regulatory requirements expected of them as a registered provider. This resulted in a service which had not been able to sustain any improvements between inspections because they had not provided a consistently acceptable quality of care.

At this inspection we checked to see what action the provider was taking to address this poor history and move the service forward. A new manager started in April 2016. They had introduced significant changes to the running of the service. This included structured training, regular supervision for all staff, environmental risk assessments, medicine procedures, cleanliness of the premises, staffing levels, and care planning. It was not possible for them to fully demonstrate the impact of these changes because of the short time they had been implemented for.

Audits and governance systems, although improved, required further work to ensure they were fit for purpose in continually monitoring, driving and sustaining improvements. For example where the provider's report to CQC completed on the 6 June 2016, identified that consent was being sought to give a person their medicines covertly, no further monitoring had been put in place to ensure this happened in a timely manner. In another case the provider had overseen the recruitment of new staff, but their checks of personnel records had not been effective enough to ensure all the required information had been obtained. During our visit the provider could not locate recruitment records they said they had to demonstrate their practice was robust.

New systems had been put in place to support staff in monitoring people's welfare to ensure they were eating and drinking enough, but checks and action were still not robust enough to ensure effective oversight. The provider's monthly reports, and phases such as, 'unfortunately the daily notes do not reflect

the care provided,' and 'staff are not completing,' further demonstrated this. Incomplete records are not supportive of enabling effective monitoring to be assured that people are receiving the right level of support.

This is a continued breach of regulation 17: Good governance of the Health and Social Care Act 2018 (Regulated Activities)

One person told us following all the changes within the service they felt, "That things were better, very good."

The provider and manager spoke about their commitment to take the service out of 'special measures' and further work they would be doing to achieve this. The provider acknowledged that the new manager had been instrumental in driving the majority of the improvements made. They recognised how important it was for the future of the service, that they needed to retain, and provide effective support for the manager. To undertake this, they were aware that they would need to gain a greater understanding of what was expected of them as a provider, and to address their shortfall in their regulatory knowledge. To support the provider in developing their skills and knowledge, they were accessing a leadership course, and had employed a consultancy service, to support and provide mentorship. The provider felt the extra training, mentorship, and experience working with the new manager would support them in this.

The local authority assessment of the service had risen steadily between 19 April 2016 and 9 June 2016. They had developed a good working relationship with the new manager. This included providing constructive support in the development of care planning, and providing training for staff. Their confidence in the management of the service had resulted in them no longer undertaking daily checks to ensure people were safe, to that of a planned supportive role.

People were now being involved in developing the service and were provided with the opportunity to share their views which were being listened to, and acted on. This was being done through quality surveys, resident meetings, care reviews and informally with the provider sitting and chatting to people during their visits. For example the suggestions made by people on the outing and activities they wanted had been acted on. Feedback from relatives regarding garden furniture and condition of the car park, had been taken into account during further refurbishment. One person showed us the garden and pointed out the new tables and umbrellas, "When it is nice we go out and sit under the umbrella."

The manager was working to promote a culture where management and staff were accountable for their own practice and responsibilities to drive improvement. For example, where audits identified repeated failing in completion of people's medicines records, it resulted in action being taken up with the individual staff, through supervision, training and where applicable disciplinary procedures. They had started to set clear expectations so staff understood their responsibilities.

Staff told us how the new manager's leadership had a positive impact on driving improvement which included staff morale. One staff member spoke about the, "Massive," improvements, in which had resulted in a brighter, happier atmosphere for people living in the service. They said that they preferred the more structured management approach. The manager informed staff of what, how, why something needed doing, which made them feel more involved in any changes. This included the new 'duty of candour' policy and procedure, which brought to attention staff's responsibility in informing the person and / or advocate of any incident that had occurred that impacted on the person's safety and wellbeing.

Records showed how staff meetings had been used by the provider and manager as a forum to discuss the

provider's vision and values and keep staff updated on the oversight of the service. This included discussing the outcomes following Care Quality Commission (CQC) inspections and what needed to be done to make the required improvements. Discussions with the manager, and records seen showed that the manager was proactive in addressing any shortfalls in the staff's practice which impacted on people's safety and the quality of service they received. Where disciplinary procedures had been used, the manager felt it had alerted others to the seriousness of their actions. An example of this was where disciplinary action had led to improvements in ensuring that staff turned up for their rostered shift.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving their medicines as prescribed. Regulation 12 (1) (2) (g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not robust enough to independently identify shortfalls and take action to improve the service. Regulation 17 (1) (2) (a) (b) (c)