Bondcare (London) Limited

Derwent Lodge Care Centre

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

The inspection took place on 12 June 2018 and was unannounced.

The last inspection of the service took place on 21 November 2017 when we rated the service Requires Improvement in all key questions and overall. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all key questions to at least 'Good'. The provider supplied us with an action plan stating they would make the required improvements by 28 February 2018.

At this inspection on 12 June 2018 we found that improvements had been made in all areas and the provider had met four of the five breaches of Regulation we had identified at the previous inspection. However, we found that further improvements were needed in order for the service to be rated Good in the key questions of 'Is the service Safe?', 'Is the service Effective?' and 'Is the service Well-led?' We found that sufficient improvements had been made in response to the key questions, 'Is the service Caring?' and 'Is the service Responsive?' and we have rated these Good. The overall rating for this service remains Requires Improvement.

Derwent Lodge Care Centre is a care home with nursing for up to 62 people. The service offers support to older and younger people with nursing needs, including people with physical disabilities. Some people were living with the experience of dementia. At the time of our inspection 32 people were living at the service. There are three floors where accommodation can be provided. However, at the time of our inspection only the ground and first floor were being used.

There was a manager in post who had worked at the home since November 2017. They had started the process of applying for registration with the Care Quality Commission. 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 and associated Regulations about how the service is run.

The systems operated by the provider were not always effective at mitigating risks or improving the quality to required standards.

We have made a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Good Governance. You can see what action we told the provider to take at the back of the full version of the report.

Not all risks to people's safety and well being had been mitigated. For example, we identified some environmental hazards, which the provider rectified at the time of our inspection. The provider had not fully met the requirements of the London Fire Brigade to make sure the service was safe in event of a fire, although they were working to do this.

There were enough staff to meet people's needs but sometimes people had to wait for care. In addition, the staff were concerned that the staffing levels at night did not allow for any contingency. For example, they spoke with us about how some people became agitated at night. They said that when this happened there were not enough staff to care for these people and others safely.

Information about people's mental capacity had not always been recorded consistently or clearly. This resulted in some people's care plans giving contradictory information. Furthermore, the provider had not followed (or not recorded that they had) guidance on involving people's representatives in best interest decisions about the administration of covert (without the person's knowledge) medicines. We have made a recommendation in respect of this.

The environment met people's needs to some extent, although improvements in line with best practice guidance for services catering for people with dementia were needed.

The information in people's care records had not always been recorded in a consistent way. This was partly due to the fact the provider was in the process of updating care records to a new system. The staff on duty demonstrated a good knowledge of people's needs, but there was a risk that new or temporary staff did not have the written information they would need to care for people.

The provider was aware of most areas where improvements were needed and had created an action plan which outlined how they were going to address these concerns. They undertook regular checks and audits on the service. Additionally, there was evidence of significant improvements to the service and the care people received since the provider took over ownership and since the last inspection. There was a positive and open culture at the service. The manager and provider worked closely with others, such as the local authority, to make sure people's needs were being met.

People were happy living at the service. They felt their needs were being met and they liked the staff who cared for them. People felt improvements had taken place and they were able to give their views about the service to the manager, therefore being involved in these improvements. People felt able to raise concerns and told us they were listened to. People's healthcare needs were monitored and they had access to external healthcare services. People had enough to eat and drink.

The staff told us they felt supported. They had the training they needed to meet people's needs and opportunities to discuss the service with each other so that people could be cared for.

People received their medicines in a safe way. There were procedures designed to safeguard them from abuse. Risks associated with their planned care had been assessed and planned for.

People were cared for by kind and compassionate staff. Whilst some interactions we observed indicated the staff were focussing on tasks, these were limited and the provider was taking action to improve person centred care at 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

Some aspects of the service were not safe.

In most cases, risks to people's safety and wellbeing had been assessed and mitigated but this was not always the case and there were examples where people would be placed at risk of harm.

There were enough staff to support people and keep them safe, but there was a risk to people's safety and wellbeing because there was not enough staff to mitigate risks if things went wrong.

Medicines were being safely managed.

There were procedures designed to safeguard people from the risks of abuse.

People were protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had acted in accordance with the Mental Capacity Act 2005, however, they had not ensured that information about people's mental capacity was always clearly or consistently recorded. In addition, they had not always ensured that decisions were being made in people's best interests because they had not consulted their representatives when making some decisions.

The environment met people's needs to some extent, although improvements in line with best practice guidance for services catering for people with dementia were needed.

People were cared for by staff who were appropriately trained, supported and supervised.

People were supported to access healthcare services.

People were supported to eat and drink enough to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People were cared for by kind and compassionate staff. Whilst some interactions we observed indicated the staff were focussing on tasks, these were limited and the provider was taking action to improve person centred care at the service.

People's privacy, dignity and independence were respected and promoted.

People were able to express their views and be actively involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care which reflected their needs.

People knew how to make a complaint and felt concerns were appropriately responded to.

People supported at the end of their lives had appropriate care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had not always mitigated risks.

Some records needed updating and improving to make sure they were accurate, in particular around how the provider recorded people's mental capacity.

However, there was evidence that the provider had made improvements at the service.

There was a positive culture which was open and inclusive.

There were systems for monitoring and improving the quality of the service.

The provider worked in partnership with others to improve the

care and services for people.

Derwent Lodge Care Centre

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 12 June 2018.

The inspection team included two inspectors, a member of the medicines inspection team, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at all the information we held about the service. This included notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We spoke with representatives of the local authority who closely monitored the service for their feedback. We looked at the provider's own website and care home review websites where members of the public could leave reviews. We also looked at the last inspection report and the provider's action plan. Since the last inspection the London Fire Brigade had carried out a regulatory visit so we viewed their report, which included a number of actions that the service needed to take, and requested an action plan from the provider to show us what they were doing in respect of these issues.

During the inspection visit we spoke with 13 people who used the service and four visiting relatives and friends. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We spoke with the registered manager and other staff on duty, who included catering staff, domestic staff, the administrator, the actives coordinator, care assistants, nurses and the deputy manager. We also met and spoke with two external professionals from the local authority safeguarding team.

We examined records used by the provider which included, the complete care records for seven people and

part of the care records for a further 15 people, the records of staff training, support and recruitment, audits and records of meetings. We looked at the environment and equipment being used. We also inspected how medicines were being managed, which included looking at storage, records and administration.

At the end of the inspection visit we gave feedback to the manager and deputy manager.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 21 November 2017, we found that the provider had failed to identify, monitor and mitigate risks of people receiving unsafe and inappropriate care.

At the inspection of 12 June 2018, we found that improvements had been made. However, we also identified some areas of risk during our visit. These included call bells being tied up out of people's reach in some of the toilets and bathrooms. This meant that if a person fell in these rooms they would not be able to use the bell for assistance. We discussed this with the manager who agreed to carry out a check of the environment to make sure all call bells were accessible. There were also some areas where repairs were being carried out but the area had not been properly secured to minimise the risks of injury. For example, the drain cover in one bathroom had broken and the plaster board and tiles in another bathroom had been removed from the wall. The manager agreed to make safe any hazards associated with these.

The risks to people's safety in event of a fire had not always been mitigated. We found a hoist had been left in a way which partially blocked a fire exit. This was relocated when discussed with the staff. There was only one working fire extinguisher situated on the ground floor meaning that the staff would not always have access to these in event of a fire. Furthermore, the London Fire Brigade had raised concerns about fire safety arrangements when they visited earlier in 2018. The manager explained that they had started to take action to address these concerns and was able to show evidence relating to this. The provider's action plan for meeting the London Fire Brigades requirements was within the agreed timescales, although had not been completed at the time of our inspection. The manager explained that fire safety training and information had been organised for the staff to make sure they understood how to respond in event of an emergency. In addition, the provider had arranged for a new fire risk assessment, which had been carried out by an independent external company. The staff had created individual emergency evacuation plans for each person explaining how they should be supported in event of a fire.

The provider carried out regular checks on the environment and equipment being used. Equipment had been serviced and was in good working order. The staff received training so they knew how to use equipment such as hoists, pressure mattresses and specialist beds and baths. The deputy manager was a qualified moving and handling trainer and made sure the staff knew how to support people to move safely.

Individual risk assessments were carried out for the risks to people's safety and wellbeing. These included risks associated with their physical and mental health, skin integrity, assisted moving, nutrition and hydration, choking risks and risk of falls. The assessments had been regularly reviewed and updated. They had also been adjusted to reflect changes in people's needs and following a hospital admission. We saw that the staff were careful and followed plans to support people safety. For example, people being supported at mealtimes were positioned correctly and the staff used thickeners to adjust the consistency of food and drink when people had been assessed as needing this. The staff supporting people to move did this in a safe way, for example checking the equipment was safe to use, explaining what they were doing to the person they were supporting and making sure the person was safe and comfortable.

There was evidence of consultation with other professionals within the plans for managing risks. For example, where people were at risk of falls, the staff had consulted with the falls clinic to make sure the plan was appropriate for each person. There was evidence of consultation with others regarding the consistency of food and drink for those at risk of choking.

At the inspection of 21 November 2017, we found that some of the practices staff followed when administering medicines created a risk that things could go wrong. For example, the staff administering medicines did not dedicate time for this and carried on with other tasks at the same time. We also found that some staff had not followed the procedures for recording when they had administered medicines.

At the inspection of 12 June 2018, we found that improvements had been made. We looked at storage, administration, care plans, record keeping and systems in place for the management of medicines. We found medicines were being managed safely at the home.

Medicines were stored securely at appropriate temperatures. Staff members maintained accurate records of Controlled Drugs (CD) held in stock to meet requirements (CD's are medicines which are liable to misuse and therefore need close monitoring). Staff disposed of unwanted waste medicines using appropriate bins.

At the previous inspection we had found the morning medicine round took three hours to complete. Also, a staff member did not sign for each medicine after they gave it to people but signed the Medicines Administration Record (MAR) at the end of the medicine round. During this inspection we observed staff giving medicines to people in the morning on the ground and first floor of the home. Staff members were polite, gained permission and encouraged people to take their medicines. After giving people their medicines, the staff signed the MAR for each person. The medicine round was completed in a timely manner. This provided assurance that the gap between medicine doses was consistent and safe.

We looked at MARs for 11 people. We found no gaps in MARs, which provided assurance that people received their medicines as prescribed. Some people were prescribed creams to be applied to their body. These were stored in people's own rooms, applied by care staff and recorded when applied.

The home had a medicines management policy in place. The supplying pharmacy provider had carried out medicines audits at the home. We saw records to show staff received regular medicines management training and were competency assessed to handle medicines safely. The home had a process to receive medicine alerts and acted upon them if required. There was a system in place to report and investigate medicine errors and incidents.

At the inspection of 21 November 2017, the staff indicated that some practices were not in line with procedures for the prevention and control of infection.

At the inspection of 12 June 2018, we found that improvements had been made. The provider had suitable procedures for the prevention and control of infection. The staff were aware of these and were following them. The service was clean throughout on the day of our inspection and people confirmed this was always the case. The staff wore gloves and aprons when delivering care, serving food and cleaning. These were appropriately disposed of. The staff undertook training around infection control and had a god knowledge of this. There was evidence of regular infection control audits and action taken when concerns had been identified.

People using the service told us they felt safe living there. One person said, ''I feel safe enough, I have nothing to worry about.'' Relatives confirmed this, telling us that they felt people were well looked after. One

relative told us, ''[My relative] is comfortable and secure here.''

People living at the service and their relatives had mixed views on whether there were enough staff. One person said, ''I don't think there is enough staff at night. Sometimes there is only one and it is not safe.'' A second person explained, ''The staff are run off their feet.'' However, most people felt there were enough staff and told us they did not have to wait for care. Their comments included, ''It is alright, it depends how busy they are'', ''I feel there is the right amount of staff, there is nothing wrong'', ''There are enough staff at the moment but will there be when there are more people living here? I do not know and it worries me'' and ''There are actually more staff than I expected.'' People went on to say that if they needed to call for assistance they received this in good time. For example, one person said, ''My call bell is right here next to me and the staff always come if I use it.'' Another person told us, ''I know how to use the call bell and it is always available; when the staff are busy they can take a while to answer it, otherwise they are here in about 20 seconds.''

During the inspection visit we observed that people sometimes had to wait a long time for care. For example, during lunch on the first floor, two people waited for over half an hour for lunch because the staff were not available to support them and they both needed assistance. There were other instances, where people were left without staff interaction or anything to do because the staff were busy helping other people, for example in the morning and again after lunch.

Some of the staff explained that the staffing levels were adequate during the day as long as nothing out of the ordinary happened, but they did not feel there were enough staff at night time. During night time one nurse and one care assistant worked on the first floor where 13 people were living. The manager explained that staffing levels were allocated based on assessed needs. However, the staff working on this floor told us that, at times, a large number of people were awake at night and needed supervision or support. They said that if both staff were supporting a person this meant there was a risk of other people's needs not being met. We discussed this with the manager who told us that staffing levels were being reviewed and that if an increase in accidents or incidents indicated more staff were needed at night, then this would be arranged.

There were appropriate procedures for recruiting staff which included checks on their suitability, including checks on their identity, references from previous employers, checks on their eligibility to work in the United Kingdom and checks from the Disclosure and Barring Service regarding any criminal records.

The provider had a procedure for safeguarding adults from abuse. There was information about this and how to whistle blow on display around the home. The staff received training in this and were able to tell us what they would do if they suspected someone was being abused. One staff member told us, "If I was worried about abuse I would inform the manager." Another staff member explained, "I would tell the nurse in charge or the manager or CQC if I thought there was any abuse happening." The manager had worked closely with the local authority safeguarding team to investigate allegations of abuse and take action to keep people safe. The safeguarding team's representatives confirmed this, telling us that the manager had worked well with them.

There was evidence of learning from incidents, accidents and complaints. The staff recorded all accidents and incidents and the manager reviewed and analysed these for any trends. People's risk assessments had been reviewed and updated following accidents. There had been an incident earlier in the year when a community professional wrongly administered medicines to one person. As a result of this incident, the provider had reviewed their procedures to make sure that communication with community professionals was improved to prevent this happening again.

Requires Improvement

Is the service effective?

Our findings

At the inspection of 21 November 2017, we found that the provider was not always acting according to the principles of the Mental Capacity Act 2005.

At the inspection of 12 June 2018, we found improvements had been made. However, we found information about people's capacity and how decisions had been made was not always recorded in a consistent way, making it difficult to see how some decisions had been made. For example, two of the 12 people's care records we looked at in respect of mental capacity assessments, contained contradictory information about their capacity. In one case, this meant that a decision whether or not to resuscitate them if needed was not clear because the document relating to this stated the person had the mental capacity but they had not been asked for their agreement to this. Other records in the person's care plan stated they lacked the mental capacity to make this decision. Similarly, another person's care records contained some information to state they had the mental capacity to make decisions and some records stated they did not. We discussed this with the nurse in charge of the care of these two people. They demonstrated a good knowledge of each person and their mental capacity to make different decisions. In both cases, we found that the care plans were being updated to a new paperwork system and the issue appeared to be a record keeping one rather than indication that unlawful decisions were being made. The manager agreed to review all people's records in relation to mental capacity.

Some people at the home were given their medicines covertly. Covert medicine is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge of the person receiving them. The provider had involved the GP, pharmacist and carried out assessment to ascertain if the person lacked capacity to make an informed decision and should be given medicine covertly in their best interests. However, the provider did not involve family members when making the decision. This does not meet guidance issued by National Institute for Health and Care Excellence which outlines; ''Best interest meeting should be held involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the person knowing (covertly) is in the person's best interests.''

Recommendation: The provider should review its policy on covert administration of medicines to meet national guidance.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that in general they were.

The staff had assessed people's mental capacity. Whilst there were some issues around the recording of this for some people, we found that ten of the 12 people's records we looked at were clearly recorded. There was evidence of thorough assessment and the reason decisions had been made. In most cases, there was evidence that people's representatives had been consulted regarding how to provide care in their best interests, although this had not been the case with the administration of covert medicines to some people. The provider had made applications for DoLS authorisations where needed and had a record to show when these expired and they would need to apply for new authorisations.

At the inspection of 21 November 2017, we found that the provider did not make sure all the staff had the appropriate skills to deliver effective care because some staff did not have good English language skills.

At the inspection of 12 June 2018, we found improvements had been made. The staff who we witnessed lacking these skills at the last inspection no longer worked at the service. In addition, the provider included tests of the staff understanding and communication in English as part of their recruitment. We observed that all the staff on duty could communicate appropriately with the people they were supporting, as well as understanding written and spoken English instructions.

New staff undertook training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Experienced staff received regular training updates, both on line training and classroom based training. The staff were able to tell us about how they had applied their learning to the work they did and that the training had been useful.

New staff also shadowed experienced staff as part of their induction, completing a series of assessments before they were able to work unsupervised. They confirmed that this had been useful. The staff told us that they had the information they needed to undertake their roles. They said they had daily handovers of information and also regularly met with each other to discuss their work. Staff found the manager approachable and a good source of informal support. However, many of them said they had not had formal individual meetings or appraisals to discuss their work and any needs they had. The manager told us that arranging these had been set back by changes in the senior staff team, but now that the new deputy manager was at the service, they hoped to make sure all staff had opportunities for formal individual meetings.

Since the last inspection, all of the staff had undertaken specialist training to support them to understand how to work with people who were living with dementia. The staff explained that this had been helpful, with the manager telling us that they had noticed improved practice in the support of people since the staff had undertaken this training.

Each day the heads of all units within the service met to discuss any urgent issues and people's particular needs. The manager also spent time on each unit meeting with people living there and staff to make sure they were aware of anything that needed action.

The layout and design of the environment did not always enable orientation, meet best practice guidance or provide the information people needed. For example, people on the first floor were living with the experience of dementia. Whilst there were some labels, such as on bedroom and bathroom doors, there was limited other elements of dementia friendly environments, and some signs did not contain pictures, making it difficult for people to identify rooms unless they could read. There were some pictures and display notice boards but these were limited and the clock in the first floor lounge showed the wrong time, which could be confusing. The manager told us that they were in the process of refurbishing the service.

We saw that improvements had been made to the general décor and furniture. These improvements included new chairs and new flooring, as well as improvements to the garden. The corridors were light and rooms were appropriately ventilated. There was a sensory room, which included equipment such as lights and music, but people told us that this was not regularly used. There was a large activities notice board, although this was situated on the ground floor and not replicated on the first floor. There was a range of leaflets and information available for visitors and menus were available on dining tables.

The provider undertook assessments of people's needs before they moved to the service. These included meeting with the person and their representatives to find out about their needs and preferences.

People's healthcare needs were assessed, monitored and met. Care plans included information about people's health and any conditions they were diagnosed with. There was additional information for the staff to help them understand common medical conditions, such as diabetes and Parkinson's disease. There was evidence of regular consultation with healthcare professionals. The GP visited the service regularly for a surgery and other professionals such as the palliative care team, tissue viability nurses and community mental health team visited to see individuals when needed. The provider employed a physiotherapist to work at the service three days a week to support people. The staff had good systems for communicating with other professionals. We saw that referrals were made in a timely manner when people became unwell. The guidance from other professionals had been incorporated into care plans.

Where people had developed wounds and pressure sores, the staff had taken appropriate action to monitor these wounds and record the action taken to treat them. The provider employed nursing staff who monitored people's healthcare needs and liaised with other healthcare professionals. The nurses working on the day of our inspection had a good knowledge of people's needs and were able to explain how they were caring for each person to meet a range of complex medical conditions.

People using the service told us they liked the food and that they always had enough to eat. Their comments included, ''I like the food, I do not go hungry'', ''It is lovely, too good actually and there is always plenty of it'', ''The food is fine, there is enough of it. I have [special dietary requirements] and the staff sat down and talked with me about what I should and should not be eating'', "I love the food, it's marvellous. They always ask you if you want fruit, I had two bowls this morning'' and ''The food is amazing.'' One visitor explained that the service had catered for the cultural dietary needs of their relative. They told us, ''Initially [my relative] did not really like the food, so I spoke with the chef and they have started providing more Caribbean food and [they] enjoy this so much more.''

The staff completed assessments of people's nutritional and hydration needs. We saw that care plans were in place regarding these. The assessments were reviewed monthly, or more often if needed. People were regularly weighed and action had been taken where people had lost weight. There was clear guidance for the staff on how to support people with different specialist diets and those with a Percutaneous Endoscopic Gastrostomy (PEG) feeding system. In addition to care plans, there was guidance for staff in people's rooms where specialist assistance was needed. We saw that people were given the support they needed. The staff recorded food and fluid intake where this was an identified risk and the nurses monitored these records.

The kitchen staff had information about individual dietary needs and visited the units to speak with people about their enjoyment of the food. There were a variety of options available at each meal and snacks between meals and at night. People had access to fresh drinks throughout our visit.

Good

Is the service caring?

Our findings

At the inspection of 21 November 2017, we found that the provider did not ensure that people were always treated with kindness, respect and compassion, and that they are given emotional support when needed.

At the inspection of 12 June 2018, we found that improvements had been made and for the majority of the time people were treated with kindness and respect. However, we saw a small number of examples where the staff focused on the tasks they were performing without always thinking about the people who they were caring for. For instance, during lunch some people were left waiting for a long time whilst others sitting around them ate. The staff did not offer explanations for this or check on their wellbeing. Also during lunch time, some staff supported people to eat their meals without speaking with them or again, checking on their wellbeing. We discussed these examples with the manager. They explained that they had undertaken work supporting the staff to have a better understanding of the people they were supporting's perspective; and for the most part this is what we observed. The manager told us they would look at ways of providing additional training and support for the staff around mealtime experiences.

Everyone we spoke with told us that the staff were kind, caring and respectful. Their comments included, ''They [staff] absolutely treat me with dignity and respect'', ''We are treated as people, the staff make a point of getting to know us'', ''The staff ask what you like to be called – like a nickname – and they always use this'', ''The carers are all nice people'', ''The best thing about the home is the staff, they are amazing and so nice'', ''They are nice and friendly but I feel they don't have the time'', ''The staff are wonderful, they really look after me and treat me like I am royalty'', ''The care staff are lovely and they are like my friends'' and ''They are lovely and very respectful.'' Two people went on to comment about the positive relationships at the home with other people living there. One person said, ''It is like being part of a big family here.'' Whilst another person told us, ''People living here respect one another and listen to each other.''

We observed kind and caring interactions throughout the inspection visit. The staff offered people choices and supported them in a calm and unhurried manner. People were supported to do things for themselves where they were able and the staff did not rush them or interfere. Staff interactions indicated that they knew the people they were caring for well, anticipating their needs, such as offering portion sizes which reflected their known need, and also talking with people about subjects the person was interested in. When people became upset, the staff comforted them in a gentle and thoughtful way.

People told us they had been asked for any preferences they had with the gender of the staff who supported them with personal care. One person explained, ''I think I was asked if I wanted male or female carers, I prefer female and this is what I have.'' Another person told us, ''They asked me whether minded having male carers and they respect my wishes.'' People also told us that their privacy was respected when they were being cared for.

People explained that they were asked about their care and were involved in making decisions. Families of people told us that they were consulted and felt able to contribute their ideas and explain how the person wished to be cared for. There was some evidence of this in care records, although recording in general

needed some improvement, and this included evidence of people's involvement in care planning. However, the provider had set up a system of ''resident of the day'' where they reviewed each person's care involving the person. The person had opportunities to feedback about their experiences with different aspects of the service, such as mealtimes, activities and housekeeping as well as how they felt about their care and support.

The manager told us that all staff stopped non-essential work at 3.30pm each day to share afternoon tea with the people living at the service. This included managers and visiting senior managers. They used the opportunity to speak with people and find out more about them. The manager told us that they had received positive feedback about this from people using the service, and also that the staff had found it useful and enjoyable.

People using the service told us that they were supported to be independent where they could do things for themselves. One person said, ''The staff support me to stay independent, for example they ask me whether I want to do things for myself.'' Another person told us, ''I am pretty independent now, there are some things I can't do but that is ok they help me with them.'' A relative commented, ''I would say they have got the balance just right – offering help when it is needed and stepping back when [person] can do things for [themselves].''

People's cultural needs were recorded in their care plans. Some staff spoke the same first language as some people living at the service and were able to speak with them in this. A number of religious groups visited the service to support people to worship. The chef provided special diets which reflected lifestyle choices and cultural needs.

Good

Is the service responsive?

Our findings

At the inspection of 21 November 2017, we found that people did not always receive personalised care that was responsive to their needs.

At the inspection of 12 June 2018, we found that improvements had been made. People using the service told us that they were cared for in a way which met their needs and reflected their preferences. Their comments included, ''The staff help me however I want and need, all I have to do is say and the staff do it'' and ''They meet my needs and I have everything I want.'' Two people were able to explain how the support they had received at the service had helped improve their health and wellbeing with one person telling us, ''I was bed bound for a few years but the staff have got me up and about walking around'' and the other person explaining, ''I came here to die but instead they saved my life.'' The relatives of people using the service confirmed people's needs were being met, with one person commenting, ''[My relative] gets all the help they need, they encourage [person] and always offer [them] a shower in the mornings.''

People's care needs were recorded in care plans. The provider was in the process of introducing new paperwork and templates. At the time of the inspection, some information was recorded using a variety of older templates and some on the newer paperwork. In some cases, people's care needs were clearly and consistently recorded, but this was not always the case. Some people's care records included a combination of different styles of records and the most recent information was not always clear. However, the staff working with people demonstrated a good knowledge of their needs and how to support them. The manager told us that they hoped the information would be more clearly recorded once it had all been transferred onto the new system.

People's daily care was recorded in another record. This showed whether they had been offered baths, showers or other personal care, how much they had eaten and drunk, whether they had been repositioned and other activities which had taken place, both care needs and social activities. The recording in these was also inconsistent and would benefit from improvements. However, we could see that care had been provided as planned and that specific needs, such as repositioning, had been met.

Each file also had a 'My Choices' booklet for care staff to complete with the person and their family members. Care staff had completed the preferences and routines section for people and they had done this in a person-centred way. Entries used 'I' statements to indicate they reflected the views and choices of the person concerned. For example, "I sleep on my left side," "I enjoy eating finger food," "I prefer wearing tee shirt and trousers," "I prefer to have a shower every day," "I like to talk about my family" and "When I wake up, I want to be washed and get myself ready with the carer's help."

People told us that the staff spent time talking with them if they wanted company. Their comments included, ''The staff chat to me and we have a little laugh'', ''I speak with them when I want to, I don't like being around other people much but the staff come and talk to me every now and then'' and ''There are friends here and people to talk to.''

People using the service told us their visitors were made welcome. Their comments included, ''My [family] is made welcome and they can visit me anytime'' and ''[My family] visits all the time.'' The visitors we spoke with confirmed this, explaining that they felt able to visit when they wanted and needed. We saw the staff making them welcome and giving them opportunities to speak with their relative in private. They also spent time discussing anything the families wanted to talk about regarding the needs of their relative.

Two people who we spoke with said that they did not feel social activities were designed to meet everybody's needs and interests. They commented, ''There are lots of activities but they aren't really my style'' and ''I do not join in much with the activities because they are not what I am interested in, I just do my own thing.'' One person told us, ''I think people spend too much time stuck in front of the TV, it feels like anything else costs [the provider] too much money and they just don't want to spend it.'' Other people were more positive about the organised activities although a number of people said they would like opportunities to use the garden more and to go on trips outside of the service. We talked with the activities coordinator, who had been in post for a few weeks. They told us they had plans to extend the activities programme and were meeting with people using the service to discuss what they would like.

The majority of people we spoke with told us they enjoyed attending group social activities. Some of their comments included, ''The activities are getting better, we have a new activities leader now and she is very encouraging, I enjoy some things but look forward to going out one day'', ''[My relative] seems to have a special connection with the activities leader, who encourages [them] to get involved – [person] has been up dancing, we are very happy'' and ''They provide some fun things for us to do.''

Planned group activities took place seven days a week and were advertised on a notice board. The activities coordinator told us that they also provided support for individual activities. They explained one person liked to play board games so they did this with them. They also visited people who remained in bed to chat, provide hand massages and other individual activities. The activities coordinator said that three people had taken responsibility for work in the garden with one person (who lived at the service) being assigned as head gardener. They each had a patch where they had grown plants of their choosing. The manager told us, that following a recent meeting for people who lived at the service, they had introduced a ''bucket list.'' People were able to tell the staff what they would like to achieve and the manager said they would try to arrange this if possible.

People using the service and their relatives told us they knew how to make a complaint and who to speak with if they had any concerns. People felt confident that their concerns would be heard and acted on. One person told us, ''A long time ago I made a complaint and it was dealt with. Another person said, ''I made a complaint about the breakfasts but they have really improved since.'' Copies of the complaints procedure were available in people's bedrooms. The manager spent time walking around the building speaking with people and their office was situated in an area close to bedrooms and one lounge where people had easy access to them. They held meetings with people using the service and relatives, during which people were asked for their views. There had been no formal complaints since the provider took over the management of the service.

Some people were being cared for at the end of their lives. There were care plans in place and there was evidence that the staff worked closely with the palliative care team to make sure these plans reflected individual needs. The staff had received training regarding end of life care. For others, care plans included information about their wishes for future and any special needs (such as cultural and religious needs) in event of their death.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 21 November 2017, we found that the provider had failed to identify, monitor and mitigate risks of people receiving unsafe and inappropriate care.

At the inspection of 12 June 2018, we found improvements had been made. However, further improvements were needed. For example, the provider had not always taken action to assess or mitigate risks. During the inspection we found risks within the environment. People had not been harmed, but without further action, there was a risk that they would be. Similarly, we found improvements were needed with record keeping. There were examples where care records did not always include accurate information, such as information about people's mental capacity or evidence that decisions had been made in consultation with their representatives when they lacked mental capacity.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that four of the five breaches of Regulation identified at the last inspection had been met. We also saw evidence of the provider's action plans so that there would be further improvements in the future.

People using the service and their relatives told us they felt it was a good service. Their comments included, ''I am very impressed with this home'', ''There is a relaxing atmosphere''. ''It is very friendly and they seem caring, attentive and tender'', ''It is a good home, maybe other places are better bit I wouldn't know, this place is good'', "It's lovely here. It's not my home but it's like home, if you know what I mean" and ''I am very pleased with the decision we made to come here.''

Furthermore, the staff we spoke with told us they enjoyed working at the service. They explained that they had seen improvements there and were happy with the work of the manager and the provider to make changes. One member of staff told us, "I really enjoy my job, It's hard work but very satisfying." Another member of staff commented, "It's a very happy home, I love working here." All of the staff told us that there was a good atmosphere where they were able to speak with the manager and they felt valued and listened to.

The manager had been in post since November 2017. They had started the process of applying to be registered with the Care Quality Commission because they had made an application with the Disclosure and Barring Service to show they had not criminal convictions. They were waiting for the results of this in order to make the registered manager application.

People told us they knew who the manager was and that they were available to speak with. Their comments included, ''I have spoken to the manager, he is very pleasant, they are all pleasant here'', ''We spoke about things at the resident's meeting, they asked about our opinions'', ''He is a good man'' and ''He is fine, very pleasant.'' The visiting social care professionals who we met told us they had found the manager responsive

and willing to learn from mistakes and improve practice. They told us they had found the manager very 'open' and honest.

The staff also spoke positively about the manager with one commenting, "We have a good manager. He is interested in what we think and how we could do things better." Another member of staff said, "The manager is very good. He comes around every morning and speaks to staff and the residents."

The manager had experience managing other residential care homes. They had a previous qualification as a registered manager. They were also undertaking another leadership course. They told us this was very useful and also provided an opportunity to liaise with managers working for other providers.

The manager explained that the provider's senior managers regularly visited and were supportive. Since the last inspection a deputy manager had been recruited. They were a qualified occupational therapist and nurse. They provided clinical support to the nursing staff and worked two days a week providing care and support.

The provider, manager and staff undertook a number of audits and checks, including checks on the environment, on care and records. These were recorded and there were comprehensive action plans to show where improvements were needed and the action being taken in respect of these.

People using the service, their visitors and staff were invited to regular meetings so they could give their feedback on the service. We saw that ideas they had suggested had been implemented. People had also been asked to recommend staff they felt had provided exceptional care so that this could be shared and they could be commended for their work.

The local authority had worked closely with the provider since they took over the ownership of the service. Representatives of the local authority gave feedback that they felt the service was improving and had listened to their suggestions. The manager also met with other care home managers at local authority run forums where they shared good practice with each other.

There was evidence of joint working with healthcare professionals as the manager regularly met with the GP, palliative care team, community nurses and other healthcare services to discuss some of the people with complex needs and how they were being supported to have joined up services.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems and processes to assess, monitor and mitigate risks or assess, monitor and improve the quality of the service. Regulation 17(1) and (2)(a) and (b)