Care UK Community Partnerships Ltd

Lennox House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

Lennox House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lennox House is registered to provide personal care and accommodation for up to 87 people. At the time of this inspection there were 37 people in residence. This is because the home was under a voluntary embargo, and so had temporarily stopped admitting new people until improvements were made. The home is divided over four floors. The ground floor was not currently occupied. Residential care for people using the service who did not require nursing care was provided on the first floor. Nursing care was provided on the other two floors.

This unannounced inspection was carried out on the 10, 11, 13 and 20 September 2018.

At the time of the inspection there was a registered manager in place. 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.

Our last inspection of this service was on 30 and 31 August 2017 and we found concerns relating to regulation 11, 12 and 17 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. We found that the provider had not effectively operated systems and processes to monitor and improve the quality and safety of the service. The provider was not following the requirements of the Mental Capacity Act 2005 (MCA). We also found that people at risk of falls were not properly assessed and monitored.

At this inspection, we saw that methods of monitoring the quality of the service had been largely improved. The service had put in place a range of audits to review people's care. There were systems for reviewing and investigating when things went wrong. However, we found the registered manager still required support from the provider to deliver high-quality and sustainable care.

Risks to people had been identified, assessed and reviewed. Each person's care plan had several risk assessments, including the associated hazards and what measures could be taken to reduce risk. The previous inspection had identified unsafe practices in the management of falls. At this inspection we saw that improvements had been made.

The service had continued to operate systems to keep people safe from abuse. The service carried out appropriate staff checks at the time of recruitment and on an ongoing basis. Although there was a high staff turnover, overall, there were sufficient staff deployed to keep people safe.

The service had learned and shared lessons from incidents. There were adequate systems for reviewing and investigating when things went wrong. Equipment within the home had been serviced and maintained on a regular basis. A fire risk assessment was in place and regular in-house fire safety checks had been carried

out. There was an effective system to manage infection prevention and control.

The previous inspection identified that staff had not consistently received supervision and appraisal. At this inspection we found that although there were arrangements for ongoing staff support, they were not effective.

We found staff had the skills, knowledge and experience to carry out their roles. They supported people to have maximum choice and control of their lives. People confirmed they were involved in planning their care. Their care records showed relevant health and social care professionals were involved in their care. The service was working within the principles of the Mental Capacity Act (MCA) 2005. People told us they liked the food offered, they could choose what they wanted to eat.

We found staff to be compassionate and caring. People we spoke with were happy with the care and support they received. Staff showed a concern for people's wellbeing in a caring and meaningful way. People's rooms appeared to be usable in a safe manner. They were clear of trip hazards and clutter. We noted they were personalised with paintings, photographs and matching bedding, curtains and had adjustable tables and armchairs with personal items in reach. Staff understood the need to protect and respect people's human rights. They had received training in equality and diversity.

The service organised and delivered services to meet people's needs. The records we reviewed set out people's preferences and addressed their individual needs and risks. The service ensured people's activities were taken seriously. This was reflected in people's care records we read. We found that people's assessments had taken account of their choices. Activity preferences had been recorded, including how best to support people in their chosen activities. The service organised and delivered services to meet people's needs. The records we reviewed set out people's preferences and addressed their individual needs and risks.

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. Information about how to make a complaint or raise concerns was available.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people had been identified, assessed and reviewed.

Each person's care plan had several risk assessments, including the associated hazards and what measures could be taken to reduce risk.

The service had continued to operate systems to keep people safe from abuse. Appropriate staff checks had been carried out at the time of recruitment and on an ongoing basis.

Although there was a high staff turnover, overall, there were sufficient staff deployed to keep people safe.

A fire risk assessment was in place and regular in-house fire safety checks had been carried out. There was an effective system to manage infection prevention and control.

Is the service effective?

Requires Improvement

The service was not effective.

Arrangements for staff support supervision and appraisal were not effective.

Staff received regular training to help ensure they had up to date information to undertake their roles.

The service worked alongside a range of health and social care professionals.

People's capacity to make choices had been considered in line with the MCA 2005.

Is the service caring?

Good

The service was caring.

People told us staff were caring and compassionate. They

showed a concern for people's wellbeing in a caring and meaningful way.

People told us that staff treated them with respect and maintained their privacy.

Staff respected people's individual preferences. People's care plans contained detailed information so that staff could understand their preferences.

The service treated people's values, beliefs and cultures with respect.

Is the service responsive?

Good

The service was responsive.

People received person centred care. The records we reviewed set out people's preferences and addressed their individual needs and risks.

People's care plans gave a comprehensive account of their needs and actions required to support them.

The service ensured activities for people were taken seriously. This was reflected in people's care records we read.

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager still required support from the provider to deliver high-quality and sustainable care.

The provider did not have an effective process to develop leadership capacity and skills, including succession planning.

There were no effective arrangements in place to ensure that the registered manager received suitable training opportunities and formal supervision.

However, we also saw that methods of monitoring the quality of the service had been largely improved. There was a system for managing accidents and incidents, safeguarding concerns and

complaints.

Although we saw improvements, we found the provider to be more focussed at addressing immediate concerns. There was no clear plan beyond this.

Lennox House

Detailed findings

Background to this inspection

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

The inspection took place on the 10,11, 13 and 20 September 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor, and two Expert by Experience (ex by ex). An ex by ex is a person who had personal experience of using or caring for someone in this type of service. One accompanied us on the first day, and the other phoned relatives from home. The specialist advisor was a social worker who had experience of working with older people living with dementia and/or mental health needs.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to male. We looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to obtain their views.

During the inspection, we spoke with the registered manager, the area director, staff members, 14 people who used the service, 20 relatives and 11 health and care professionals. We reviewed 7 people's care files including care plans and risk assessments. We also reviewed 14 staff recruitment records, training and supervision records. We looked at records relating to how the service was managed including medicines, quality assurance and policies and procedures.

Good

Is the service safe?

Our findings

At our inspection in August 2017 we found the service was not safe and we rated the provider as 'Requires Improvement' in this key question. People at risk of falls were not properly assessed and monitored. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made.

We asked people if they felt safe living at the home. They told us, "I feel safe. I'm not concerned about anything because they look after me and everything is well done here because they are organised", "I feel everything is looked after and they take care of me the best they can", "We are all safe and looked after here", "They do a great job here. I don't have to worry about things" and "I have no doubts that everyone and everything is well cared for in a safe way."

We found the service to be safe. Risks to people had been identified, assessed and reviewed. Staff could describe the risks to people and actions they took to keep people safe. Each person's care plan had several risk assessments, including the associated hazards and what measures could be taken to reduce risk. For example, one person was at risk of developing pressure ulcers and another was identified to present behaviours that challenged the service. In both examples, action had been taken to reduce risks to people. This was typical of all records we read.

At our previous inspection we had identified unsafe practices in the management of falls. At this inspection we saw that improvements had been made. This was typified in a response from a relative we spoke with. The relative told us, "The home has improved a lot in the last year. I don't have any concerns. When my mother had a fall after she got back from the hospital they put a mat down with sensors on it. Previously I would not have recommended the home. I would now." The care records contained a risk assessment for falls and a management plan where this was needed. This was an improvement from the last inspection.

The service had continued to operate systems to keep people safe from abuse. A safeguarding policy and procedure was in place. Staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. The service had taken steps, including working with other agencies, to protect people from abuse. Staff were aware they could notify other agencies such as the local authority, the Commission and the police when needed.

Recruitment was safe and robust. The service carried out appropriate staff checks at the time of recruitment and on an ongoing basis. This included Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. References had also been obtained from previous employers to help ensure staff were suitable and of good character. Checks had also been undertaken to ensure that all the nurses who worked at the home had a current registration with the Nursing and Midwifery Council (NMC).

We spoke with people about staffing levels. They told us, "There are always people around day and night", "Staff are usually friendly and have time for you", "Staff are there for you when you need them" and "Staff help me when I ask and when I don't, they keep an eye on me." Relatives also felt the same. They told us, "The staff do a fantastic job at looking after everyone. There seem to be enough whenever I come" and "Staff do seem to be enough and they come to assist quite quickly."

Generally, staff at the various levels spoke positively about staffing. They told us there was sufficient staff. However, they expressed concerns of high staff turnover since the previous inspection. We could not find evidence to determine how this directly impacted the quality of care. However, there was a risk this could affect continuity of care, among other matters. Overall, there were sufficient staff deployed to keep people safe. We did not see any delays in people being attended to throughout the course of this inspection.

The service had taken action to improve medicines provision. There had been a few medicines errors prior to this inspection. At this inspection we saw that medicines were being managed safely. A policy for medicines management was in place and available on all three floors for staff members to refer to. All staff members had undergone the relevant training for medicines administration as per the service's policy. Medicines, including controlled drugs (CDs) were stored securely and we saw evidence of appropriate stock balance checks. However, we found two boxes of expired medicines which were not in use in one medicines cabinet, which were removed by the staff nurse on notification.

We reviewed 14 medicine administration records (MARs) and their associated care records. Each person had their own profile sheet which contained information to correctly identify the person and to assist staff to administer medicines safely. Staff signed the MAR after administration or recorded to show that medicines were not given. This assured us that medicines were given as prescribed and were available. We were told about the service's ordering process for people's medicines, both regular and mid cycle. We found that the process was robust and that the service had a good relationship with the local pharmacies ensuring medicines were available on time.

Staff had additional guidance to administer medicines prescribed to be given when required (PRN). This assured us that staff could make an informed judgement to appropriately administer these medicines. We saw records of some people who were on medicines which had to be given at specific times of the day to provide them with the most benefit. This was recorded on their individual profiles and there were prompts for the staff in the medicines room. People who were prescribed creams and ointments had a topical MAR chart in place (TMAR) to record time and frequency of application. The TMAR also contained detailed information including a body map to show carers where application was needed.

Accidents and incidents were monitored. There were adequate systems for reviewing and investigating when things went wrong. Staff understood their duty to raise concerns and report incidents and near misses. The service learned and shared lessons, identified themes and took action to improve safety. For example, we saw that improvements were made following a recent medicines incident. There was a discrepancy between the dosage on the MAR chart (which was incorrect) and the label on the medicine bottle. The incorrect dosage had been administered twice before noticed by a member of staff. This was raised in the daily clinical meeting and the weekly clinical meeting. Post incident, all medicines on arrival were checked by two members of staff against the MAR chart to ensure accuracy. Also, since the last inspection, the care home had implemented a weekly medicines audit for each floor demonstrating improvement in their governance processes.

Equipment within the home had been serviced and maintained on a regular basis. A fire risk assessment was in place and regular in-house fire safety checks had been carried out to ensure that the fire alarm,

emergency lighting and fire extinguishers were in good working order and that the fire exits were kept clear.

There was an effective system to manage infection prevention and control. Arrangements were in place for managing waste and clinical specimens to keep people safe. Walking around the home we observed it was clean and well presented, clear of trip hazards and equipment stored away from causing hazards.

Requires Improvement

Is the service effective?

Our findings

At our inspection in August 2017 we found the service was not effective and we rated the provider as 'Requires Improvement' in this key question. This is because the provider was not following the requirements of the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made. However, we found that further improvements were still required to establish an effective supervision and appraisal system.

As stated, in the previous inspection the service had failed to take steps to assist some people to make decisions, and so at this inspection we asked people if they now felt involved in decisions about their care. One person told us, "Staff are very good at explaining what they think would be good and asking what you think. I feel in control of decisions in my life still." A relative of one person said, "We are talked through all his care and any changes that may occur. Our feelings and opinions are considered and we read the plan and ask questions that get answered straight away." This feedback was consistent with our observations.

We found the requirements of the MCA 2005 were being met. The MCA 2005 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. At this inspection we saw that the service obtained consent to care and treatment in line with MCA.

The registered manager and staff understood the requirements of the legislation and guidance when considering consent and decision making. We looked at some care records and found mental capacity assessments had been completed. Details about the specific area for capacity were identified, including the best interests decision. For example, one person was given their medicines disguised in food or drink without their knowledge (covert administration). This was carried out in their best interest under the MCA 2005, with signed agreement from their next of kin and GP. There were clear instructions from the pharmacist on how to give these medicines safely. This was an improvement from the last inspection where we had found inadequate recording for covert administration.

In a second example, we read a best interest decision that had been made for another person. This concerned whether the person could be left to independently administer their medicines. Ultimately, we saw that the assessment took sequential steps to assist the person to take their medicines. Furthermore, where relevant 'do not attempt cardiopulmonary resuscitation' (DNACPR) were in place. DNACPR relates to the emergency treatment given when someone's heart stops or they stop breathing. We found that the documentation was consistently completed to comply with the law.

Less positively, in some files where Lasting Power of Attorney (LPA) was in place, it was not recorded when relevant powers had been activated. In one example, we found that a relative had been appointed as a 'deputy' via their own unsupported assertion. This had not been recorded in the person's file. In other care

records we saw where people's relatives had signed as having a LPA, checks had not been completed by the service to ensure they had authorisation.

The previous inspection identified that staff had not consistently received supervision and appraisal. At this inspection we found although there were arrangements for ongoing staff support, these were not effective. There was an induction programme for new staff, one to one meetings, appraisals, coaching and mentoring. However, the way this was deployed did not help to create a work environment in which staff were enabled to perform to the best of their abilities.

Staff we spoke with felt unsupported. This was reflected in the meetings we had with them during the inspection, at which they aired several concerns. They told us, "The manager needs to support staff more. We are always blamed for mistakes", "The job is not an easy one. At times it is good to be appreciated. A thank you goes so far", "We do not feel appreciated. You could move mountains but that will not make a difference" and "We do not feel happy coming to work."

The supervision and appraisal process was not supportive of staff. Whilst areas of poor performance were always identified, plans for improving performance were not always established. Also, we found that the supervision process was variable in terms of how often it occurred. It was not clear how often supervision occurred. For example, we saw from a supervision tracker that one staff had received 9 supervisions in 8 months. This included three supervisions in February and two in August 2018. No supervisions were provided between March and July 2018. Another staff received five supervisions in February 2018 and one between March and August 2018. Another staff member received eight supervisions between February and August 2018. This included three supervisions in March and three in May 2018.

We recommend that the provider takes advice from a reputable source about appropriate approaches to supervision and appraisal, which engage staff more in the process and drives improvements towards key organisational goals.

Despite this backdrop, we spoke with people receiving care who were unwavering in their praise for staff. We asked people if staff were good at their job and they told us, "They do make me feel safe and they are confident. I feel like they know what they are doing", "Yes, I feel they do. They seem to know what they are talking about with me and know all about the extra assistance I need with certain things which I'm pleased about" and "I'm very happy with the level of expertise. They are very knowledgeable."

Staff had the skills, knowledge and experience to carry out their roles. We were provided with a training tracker and a 2018 training planner. Both documents showed that staff had received regular training which included eLearning in subjects such as dementia care, person centred care, equality and diversity, fire safety, health and safety, medicines awareness, MCA, end of life care, infection prevention control, safeguarding and diabetes, wound care (for nurses) and pressure ulcer management. There were certificates confirming training had been completed within the past 12 months. Up to date records of skills, qualifications and training were maintained.

People were provided with a choice of suitable and nutritious food to ensure their health care needs were met. We observed people having their lunch. There was a comfortable atmosphere and food appeared appetising and plentiful. We asked people if they liked the food offered, including whether they could choose what they wanted to eat. One person told us, "The food here is very good and you have plenty of choice and you can choose other things that are not on the menu." Another person said, "There are lots of good choices and I can eat my own things too. They put Caribbean food on the menu and some of us suggested this at our coffee meeting a while ago." A third person said, "They usually notice if you need a bit

of help and offer to cut for you. They ask first, it doesn't all come cut up already like kid's food would." A fourth person said, "The food is good and caters for culture."

Good

Is the service caring?

Our findings

We found staff to be compassionate and caring. People we spoke with were happy with the care and support they received. We asked if they thought staff were caring. They told us they felt safe and well cared for by kind and caring staff and were happy with a homely setting. One person told us, "They are a good lot and care about me. They help me write letters to my friends and send cards." Another person said, "They have sat with me when I've been worried and helped me to do personal things. They made me feel like just another person they are working with." Relatives had similar thoughts, with one stating, "Staff have lots of time to give when they see something is needed. For example, if my relative is upset or frustrated. They are very calm and make time to talk to you as a relative too."

Staff showed a concern for people's wellbeing in a caring and meaningful way. We took time to observe one person in their room. It was a large single room and easily negotiated with no obstruction or trip hazards. The person's walking frame was in reach of their chair where they were seated with an adjustable table in front of them. The person was reading a newspaper and had personal items on the table, a drink and call bell within reach. The room was personalised with paintings, photographs and ornaments and the television was in view of the bed and chair. The room was tidy and clean and there was a useable lock on the door. The room had a comfortable feel and the person appeared to have all the belongings they needed around them.

We observed that there were themed rooms on all floors. There was a gardening themed room on the ground floor, a music room on the first floor, a sensory room on the second floor and a crafts and reminiscence lounge on the third floor.

People were treated with kindness and compassion. We observed people in the dining room on the first floor. Nine people were using the room. There was music at low levels and people were chatting and eating. They were being asked if they would like refills of drinks and second helpings of food. Staff were chatting with people about their day. We also spent some time in the dining room on the second floor. The room had music playing and a member of staff explained this was played at the request of four people in the room. There were two staff seated and assisting people with their lunch. All people had drinks within reach and could reach cutlery and condiments.

Throughout the inspection we observed courteous interactions between staff and people using the service. People who were being assisted were given time to chew and swallow their food and staff were waiting for this to happen and observing people they were assisting and offering drinks at timely intervals. We could tell people were enjoying the experience.

People were supported to be as independent as possible, and where possible, staff assisted people to increase their independence skills. One person who had finished lunch asked if she could help with clearing up. A staff member gave her napkins and cutlery to get ready for the evening meal. The staff member told us that the person used to work in the hotel industry and liked to help every day.

Staff understood the need to protect and respect people's human rights. They had received training in equality and diversity. The service had a policy and procedure to guide staff around ensuring people were not discriminated against on the grounds of diversity. People's spiritual or cultural wishes were respected. One person told us, " I get a Church service regularly and this is important to me here."

People were treated with privacy, dignity and respect. Staff knocked and waited for a response before they entered people's rooms. We observed staff working well and discreetly sharing information where appropriate and there was a feel of respect for each other and people's individual care needs.

People told us, "Staff always knock on my door and ask if they can come in. I can lock my door at night which, is fine. They are very respectful." Another person said, "I feel they treat me with respect and it's all very dignified. They help me to cover up if I'm getting out of the bath and they turn their back. I asked them not to wake me at night for changes and they respect my wishes." A third person told us, "I have complete privacy. Staff offer to help me with tidying my room but if I say no they don't touch anything, we have a joke together." A relative said, "They respect and listen to him. That makes him happy. He likes a joke and the banter and the unit manager does that with him. He is a fantastic member of staff."

The issue for privacy was extended to their care records, where we saw staff respected people's right to confidentiality. We noted that information was kept confidential. Care records and staff files were stored securely, both in the office and electronically. Records had been updated in line with the General Data Protection Regulation (GDPR). GDPR is Europe's new framework for data protection laws – it replaces the previous 1995 data protection directive.

Good

Is the service responsive?

Our findings

At our inspection in August 2017 we found the service was not responsive and we rated the provider as 'Requires Improvement' in this key question. This is because we found a lack of meaningful activities for people using the service. At this inspection we found the service had made improvements.

The registered manager told us that the service ensured activities for people were taken seriously. This was reflected in people's care records. We found that people's assessments had taken account of their choices. Activity preferences had been recorded, including how best to support people in their chosen activities.

We observed there were themed rooms on all floors. There was a gardening themed room on the ground floor, a music room on the first floor, a sensory room on the second floor and a crafts and reminiscence lounge on the third floor. There was a garden with level access from the ground floor, with large seating areas and raised beds. The pathways were clear and there was a smaller woodland style level walk way. Although we did not see these areas being accessed at the time of the inspection, there was a record of them being used.

Overall, people were appreciative of the support they received from the service. More positively, equipment required for activities was evident throughout the lounges across the three floors of the home. There were games, DVDs, puzzles, musical instruments, sensory items and art materials, all of which were accessible to people. There was an information board next to the dining room. This contained information on activities, including entertainment, music life programme, pet therapy and movie afternoons, some of which we observed taking place during this inspection.

People spoke of activities becoming more regular, including group and one to one activities in the home and on outings. People spoke of upcoming events with excitement. Feedback we heard from people showed that there had been some improvements in activities. They told us, "Staff tell me about activities and I also read it on the board. There are entertainers who visit and people coming to offer other things. If you want quiet time no one makes you join in", "Staff help us to do things like art. I like the entertainers. I love to draw and paint. Visitors can come anytime and I go on the trips to the garden centre or cafes sometimes ", "I go out. I like to go to parks and we've done that but it isn't very often. I'm looking forward to the cinema trip soon" and "You can go out with staff or visitors. I go out for lunch with my friend. I like listening to music and watching sport and I get to do that."

Relatives had also seen improvements. They described examples of how the service was supporting their loved ones. They told us, "They go in the garden more, the activities are better. Previously I would not have recommended the home. I would now", "My relative seems to like the activities. People from the local church come in. She sings along", "My relative doesn't always want to join in. They get lots of volunteers in to sing, do arts and crafts, and gardening", "He goes to the activities sometimes. They always ask him if he wants to join in" and "They come to her room with magazines and they read the papers to her. I can visit anytime"

However, although we acknowledged the improvements, we did not observe as many people engaged in activities as we would have expected. For example, during a 20-minute observation we observed a staff member showing a person using the service how to complete a puzzle. This staff member patiently encouraged the person to find missing pieces. A second person in the same room was observed playing dominoes alone. They explained to us that they had no one to play the game with. A third person was seated, flipping through pages in a book and the fourth person was sleeping in a chair. The home would benefit from further reviewing of people's activities so that the infrastructure and equipment in place could be fully utilised.

The service organised and delivered services to meet people's needs. The records we reviewed set out people's preferences and addressed their individual needs and risks. For example, one person's care plan had been updated following a hyperglycaemic episode (high blood sugar). The new treatment plan was detailed to reflect current diabetes status, expected outcomes and the action that staff needed to take to support the person safely. We looked at other types of risks that had been identified, including risks of falls. Our findings were that the risk assessments and risk managements plans were up to date and were informed by the views of other health care professionals.

Less positively, although we found that people's wishes had been considered, the links between assessment and care planning were not well established in some care records. For example, we saw that an assessment proforma that was used had a set list of categories which were not broad enough to cover all risk areas that had been identified thus seemingly leaving gaps between the assessment and care plan. Even though we found that the additional risks were mentioned in the care plan, this system presented a risk of omission if staff did not access all records. Thus, there was a risk this practice could hinder the provision of person centred care, should omissions occur.

We also saw that the service kept both paper and electronic care records. A unit manager told us the paper folder was for easy access to information, which meant it needed to be aligned to electronic records. However, we found that the system was inconsistent in that where a person's needs changed, the service did not always record their re-assessment or ensure both systems were simultaneously updated as required. For example, the electronic risk assessment of one person had been updated following an incident that had happened two days prior to our inspection. However, the relevant sections of the paper folder had not been updated, meaning it was not reflecting all the current needs of this person.

Staff interviewed had a good understanding of how to support people with behavioural needs and those living with dementia. One person displayed behaviours that challenged the service. A risk assessment for potential need to use physical restrain was in place. There was evidence of behavioural incidents and good use of person centred distraction techniques to prevent the behaviour continuing or escalating. There were no more incidents of the person leaving the building without support. A family member confirmed that there had been no recent concerns around this as they felt that their relative was being engaged more by staff in activities. There were two incidents of aggression recorded in May 2018. In both occasions, no physical restraint was used and the behaviours were successfully addressed via distraction techniques by staff and no one was injured. We saw further good examples of person centred interventions in other areas, including dementia care.

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. Information about how to make a complaint or raise concerns was available. The complaint policy and procedures were in line with recognised guidance. The service had learned lessons from individual concerns and complaints and from analysis of trends. It had acted as a result to improve the quality of care.

People we spoke with, including relatives said they felt able to raise concerns and felt confident that they would be acted upon. One person told us, "I feel any member of staff would take a complaint very seriously and act on it and get back to you quickly. I've never had to complain." Another person said, "They listen to me whatever it is and make time to sit with you to talk. They give me feedback on any queries and if they can't help they find a way to." A relative said, "The staff are very good at dealing with things quickly." Another relative said, "I've never needed to complain but I would if I had to."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2017, we found the home was not well-led and we rated the provider as 'Requires Improvement' in this key question. This is because further improvements were required in the organisation's governance. At this inspection we found that progress had been made. However, we found the registered manager required support from the provider to deliver high-quality and sustainable care.

During the inspection we found that there had been some improvements to quality monitoring. This had been achieved by the service working collaboratively with the local authority and other agencies, as part of Provider Concerns Process (PCP). A PCP is developed as a means of responding to potential business failure (contracts and commissioning responsibilities) and managing large scale safeguarding enquiries. This was also part of the local authority's response to our previous inspections, which had raised concerns about the home. The local authority's role involved co-ordinating action under safeguarding and overall responsibility to ensure that appropriate action was taken, as well as monitoring the quality of the service provided. Overall, we were concerned as to how the service would continue to be effective in these areas when the support from the local authority had ended.

We also found staff were not well supported and motivated. This had resulted in staff low morale and possibly contributed to a high staff turnover. There was also an unstable system of manager rotation and a lack of one to one support for the registered manager.

The provider did not have an effective process to develop leadership capacity and skills, including succession planning. The home has had a few managers in a short period of time. The current registered manager had been in post for just over a year. Prior to this, the previous manager had been in post for less than a year and so was their predecessor. Since this inspection, we have been notified that the current manager's post has been re-advertised. This demonstrates that the service has had a high turnover of managers.

The registered manager told us she felt supported. However, we saw that there were no effective arrangements in place to ensure that she received suitable training opportunities and formal supervision. She had not received supervision since commencing work at the home. She told us that supervision was incorporated in the appraisal process. However, this was contradictory to the Care UK's policy, that stated the need for staff to attend supervision sessions between the appraisal meetings 'in order to supplement the competency reviews that form the basis of the Annual Appraisal Cycle'. This meant the registered manager did not have a structured opportunity to discuss her practice and development to ensure that she continued to deliver safe, effective care and adequately lead staff.

The service had undertaken a staff survey, which showed low staff morale. Staff did not feel supported and valued. They also told us that they did not have confidence that if they raised concerns that these would be addressed. We saw evidence from staff supervision and the 2018 Care UK survey, that some concerns from staff had not been prioritised. Therefore, even though there was an attempt to engage staff, the service still needed to improve how it made use of their feedback.

It was not clear how low staff morale impacted on the service's ability to retain staff. Still, it is worth noting that 75 staff members had left the service since September 2017. This included 12 staff who were on zero hours contract. The service had recruited 47 new staff in the same period, including 12 staff on zero hours contract. Thus, all in all the service had a net loss of 28 staff during that period. This meant staff did not have a stable working environment. This was confirmed by staff who told us they were consistently being moved between units or being assigned to work with agency staff at night time, who were not always familiar with the service.

On the other hand, methods of monitoring the quality of the service had been largely improved. The service had put in place a range of audits to review people's care. This included care based audits, medicines administration, care documentation, infection control, health and safety, and social activity audits. Where audits had identified issues, we saw that action was taken to address this.

There was a system for managing accidents and incidents, safeguarding concerns and complaints. This was reported to the registered manager who logged them centrally and were analysed to identify whether there were any identifiable trends. This provided oversight for matters of concern.
However, although there had been some improvements, it was evident that the provider had not planned nor did they have a long-term plan of continuity when the service had fully met the requirements of their current service improvement plan.

We recommend that the provider takes advice from a reputable source about developing an appropriate and sustainable leadership development strategy.