Ranc Care Homes Limited

Park View 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 12 and 13 September 2016 and was unannounced. Park View Care Centre provides accommodation, personal and nursing care for up to 88 older people. There are two units in the home which accommodate people with nursing needs; and two which accommodate people living with dementia. There were 65 people at the service at the time of our inspection. People were living with a range of care and health needs, including diabetes and Parkinson's. Many people needed support with all of their personal care, and some with eating, drinking and mobility needs. Other people were more physically independent and needed less support from staff.

The service did not have a registered manager in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was, however a manager in place; who was applying to become registered.

Park View Care Centre was last inspected on 2 and 4 February 2016 and was rated as inadequate overall. The service was placed into special measures and the provider sent us action plans to tell us what they would do to improve.

At this inspection, we found that there had been much improvement overall; however, some of the issues we raised last time had not been fully addressed.

Risks to people's safety and welfare had been appropriately assessed but actions to reduce those risks were not always taken. There were not enough staff deployed to meet people's needs, but more staff were brought in immediately we highlighted this.

Medicines were well-managed and recruitment processes helped ensure that the right applicants were employed to work in the service. Incidents and accidents were properly documented and raised with the local safeguarding authority when necessary. The CQC were made aware of any events which required statutory notification.

Equipment was regularly serviced and the risks of fire had been assessed and minimised by routine fire alarm testing, personal evacuation plans and proper maintenance of fire equipment. The premises were well-maintained and improvements to décor were seen. There was appropriate picture signage and equipment such as coloured toilet seats to help people orientate themselves.

The principles of the Mental Capacity Act (MCA) 2005 were not consistently followed in practice; to ensure people's rights were considered; but the use of stair gates on people's doors had ceased and assessments of people's capacity had been made appropriately.

Records about people's food and fluid intake were not always being completed accurately or with enough information to monitor if people were receiving enough to keep them well. However, dietician input had been sought promptly when needed and people's weights were monitored. There were choices of meals available and dining tables were laid with cloths, flowers and condiments.

Staff training had improved and supervision and appraisal were being carried out regularly. People's healthcare needs had been met and were monitored for changes. Staff were consistently kind and caring and protected people's dignity. They encouraged people to remain as independent as possible. There was a range of activities on offer and people were observed enjoying group crafts and one to one interaction.

Complaints had been actioned by the manager but records and communication about what had been done were sometimes lacking. Care plans had been reviewed and updated but this area required further work to ensure consistent records were kept.

Feedback had been sought from people, relatives and staff and there was evidence that it had been acted upon. Staff said they felt supported by the manager and her deputy and that they were led by example.

Quality monitoring had not been sufficient to highlight the problems we found during this inspection. More work was needed to fully address the areas which we raised in our last report.

As this service is no longer rated as inadequate, it will be taken out of special measures. Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of Regulations. We will continue to monitor Park View Care Centre to check that improvements continue and are sustained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks had not always been appropriately mitigated to ensure people's health and safety.

There were not enough staff to meet people's needs promptly; but more were deployed during our inspection.

Incidents of harm or potential harm had been appropriately reported to the local authority and/or CQC.

Medicines were well-managed.

Recruitment processes were robust and ensured suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not consistently working within the principles of the Mental Capacity Act 2005 (MCA); although there had been improvements in this area.

Records about people's food and fluid intake had not been consistently completed.

People's healthcare needs were appropriately met.

Staff received adequate training, supervision and appraisal to help them in their roles.

Is the service caring?

Good

The service was caring.

People's dignity was considered and protected.

Staff were kind and gentle and interacted positively with people.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints had not been recorded appropriately or managed in line with the provider's policy.

Staff delivered person-centred care but more work was needed on records to ensure they reflected this.

There was a range of activities available to people; so that they could enjoy social stimulation in groups or one to one.

Is the service well-led?

Requires Improvement

The service had not been consistently well-led.

There had been no registered manager running the service for around seven months.

Not all of the issues highlighted in our last report had been successfully addressed; but others had been put right.

There was evidence that feedback had been sought and acted upon.

There had been a positive change in the culture at the service.

Park View 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 13 September 2016 and was unannounced. The inspection was carried out by three inspectors and a specialist nursing advisor. A specialist advisor is someone who has clinical experience and knowledge of working with older people and those who live with dementia.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met twenty people who lived at Park View Care Centre. Not everyone was able to verbally share with us their experiences of life at the home. This was because they were living with dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with seven people's relatives. We inspected the environment including bathrooms and some people's bedrooms. We spoke with eight care staff including nurses, the deputy manager, the manager and the chief operating officer for the provider organisation.

We 'pathway tracked' fifteen of the people living at the home. This is when we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe, and what happened to make them feel secure .One person said "Staff know me well and really look after me" and another told us "They [staff] keep an eye on me and I know they're there if I need anything. What more could you ask for?"

At our last inspection, risks to individual people had been assessed but not always minimised. At this inspection assessments and actions had generally improved, but not in every case. For example; we observed one person stand up from their armchair and begin to walk in the corridor. They were extremely unsteady on their feet and activity staff had to rush to support them to prevent them from falling down. This person's mobility had been risk assessed; and recorded that they had a sensor cushion on their chair to alert staff when they moved; so that they could ensure the person was given support to stand and walk. The person had a history of falls, but there was no sensor cushion in place and they had almost fallen. A known risk had not been effectively minimised to keep this person safe.

Most people had call bells placed in their reach; but two people did not when we visited them in their rooms. We made senior staff aware of this and the call bells were given to people immediately. A relative told us "X's call bell isn't always where they can get it; and that concerns me". People were checked at least hourly to ensure they had drinks and were comfortable; and this was recorded onto charts. The deputy manager told us that staff were instructed to check that call bells were within people's reach every time they attended to them in their rooms. However this had not consistently happened and the risks to people of being unable to summon staff if they needed them in between routine checks had not been properly addressed. The deputy manager told us that checks of call bells would be included on the room charts in future to prompt staff to ensure bells were always in reach.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risk assessments about supporting people who showed behaviour that challenged had been improved; and we observed staff following guidance about distracting people and using a calm and reassuring voice to do so. The risk of people becoming more distressed had been reduced by staff acting in this way. At our last inspection special air mattresses designed to help protect people's skin, had not been set at the correct levels. At this inspection, regular checks had been made of mattress settings to ensure they took into account people's weight. Nursing staff told us that the district nurse had also given them advice about how to make sure the mattresses were pumped to suitable levels, so that people would be comfortable and the risk of pressure wounds reduced.

At our last inspection, there were not enough staff to meet people's needs. At this inspection, although numbers had been increased overall; we continued to have concerns at times about staffing levels and deployment. There was a head of care, two seniors and six care staff allocated to cover the two ground floor units for 27 people living with dementia. Our observations in these units highlighted a number of situations where there had been no staff available to promptly meet people's needs. For example; one person was

becoming distressed in a communal area because they needed to use the toilet. We tried to find care staff to assist but there were none visible in the unit. Activity staff eventually took the person back to their room because they too had been unable to find care staff who were available. Activity staff was observed helping one person to transfer from their wheelchair to an armchair. This person was at risk of falls and this task should have been carried out by trained care staff. Similarly, the activity staff had to intervene to prevent another person from falling because there were no care staff in the vicinity at the time.

People and relatives told us that there were not always enough staff to provide support when it was needed. One person said "Sometimes it can take a while for staff to come if you need help or use your call bell". Another person told us "It's the staffing that's the problem here. There just aren't enough of them at times". A relative told us "Staffing levels seem unstable and sometimes there are delays in X being seen" and another relative commented "They do seem understaffed. Sometimes you come in and you have to wait for staff to get people up and ready".

We spoke at length with the managers and the chief operating officer about staffing. A dependency tool had been used to determine staff numbers; but this was complex and it was not clear how information about people's needs translated into numbers of staff on duty. However, the manager told us there were two nurses and12 care staff during the day on the nursing floor. There were 38 people receiving nursing care on the first floor and 36 of those people needed two staff to support them with personal care, repositioning and transfers. Most people needed some support with meals. The nursing staff were responsible for medicines rounds and any nursing duties which meant the 12 care staff had to work in teams of two to assist 36 people to get up and dressed; so each pair of staff had six people to support. Some staff told us that they only had time to deal with people's basic needs and none to chat with people. One staff member said "We really do need more staff; but we do our level best for people". The chief operating officer sanctioned two extra staff to be brought in; one on each floor, on the second day of our inspection and going forward. These staff would be allocated to communal areas. They told us that a full review of the dependency tool and staffing levels would be carried out immediately and that any further increases in staffing found to be necessary, would be made.

The failure to ensure there were enough skilled and trained staff deployed to meet people's needs is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Medicines had been managed safely. Medicine administration records (MAR) had been properly completed and showed that people had received their medicines as prescribed to them. Medicines storage was well-organised and tidy; which helped to reduce the likelihood of errors. Liquid medicines had been dated on opening so that they would be disposed of within suitable timeframes. The temperature of medicines fridges had been recorded on a daily basis to make sure that items stored there were kept sufficiently cool. We observed nursing staff administering medicines and saw that they carefully checked all the details on the MAR before giving people their medicines. They waited with people to see that they had swallowed tablets before signing the MAR; which meant they could be assured that people had not spat them out or forgotten to take them. Creams had been safely stored; and charts confirmed that they had been applied regularly and to the correct places. Where people had medicines in patch form, body charts were completed to show the site where they were applied. This ensured that patches were placed in a different spot each time to prevent skin irritation. Medicines for which there are special legal requirements were kept securely and frequent auditing had taken place to check stock and that people had received their medicines consistently.

At our last inspection there was not a robust system in place for protecting people from abuse or harm. At this inspection incident and accident reports had been appropriately completed by staff and when

necessary, referrals had been made to the local authority safeguarding team for independent investigation. Actions were recorded following accidents and incidents to prevent recurrences. For example; staff documented and reported redness to a person's skin. Actions recorded were to change pads more frequently and to apply cream several times per day. The redness was tracked by the manager and was documented as completely healed within two days. These actions and the monitoring of outcomes helped to keep people safe.

Staff were confident about the process for documenting any injuries to people and knew the signs of potential abuse that they should be looking out for. They understood their responsibility to 'Whistle blow' if they ever believed people to be at risk of harm. One staff member told us "We just want to keep everyone safe and well and we are reminded all the time at meetings and from the manager, about our duty to do this well". Statutory notifications had been made in a timely way by the manager; which meant that the CQC was kept informed about any incidents or events which affected people or the service.

At our last inspection recruitment systems were not sufficiently robust to provide assurance about staffs' suitability to work with people living in the service. At this inspection all staff files contained appropriate information about applicants' backgrounds and eligibility to work in the UK. References had been obtained from past employers and records of interviews were retained; which showed that suitability for the roles had been assessed on the answers given by applicants. This was evidence that the provider had taken steps to ensure the right staff were recruited to work in the service.

At our last inspection equipment for use in people's care and treatment was not always clean and in some cases had not been recalibrated in line with the manufacturer's guidelines. At this inspection, all the equipment seen was in a clean and sanitary condition and had been regularly serviced to ensure correct calibration. The manager had audited equipment and this had highlighted that suction equipment needed to be regularly monitored. We saw that this was now happening and management oversight of this area had resulted in safer practice.

Hoists and special bath equipment had all been serviced regularly; and most recently within the previous six months. Scales and slings for use with hoists had also been serviced and there was documentation to show that this happened routinely. Safety testing on the water supply, electric and other utilities; including the passenger lift had been regularly carried out to ensure that people were safe within the service.

The service employed designated maintenance staff and there had been improvements since our last inspection. The first floor dining room had been fully redecorated and curtains re-hung; so that people were no longer sitting in direct sunlight to have their meals. Other areas of the service had been decorated; including a ground floor communal area which had a painted mural and garden-type seating. Maintenance and redecoration had helped to create a more pleasant environment and experience for people.

There was a fire plan on display in communal areas; detailing fire exits. Fire alarms had been tested weekly and records were kept of any issues arising from the checks. For example; on one occasion an automatic door release had not worked satisfactorily. Action in response to this was documented as 'Dor guard adjusted'. Fire drills were also conducted and response times to these were recorded; with comments about how they could be improved. Fire fighting equipment such as extinguishers and fire blankets were checked annually and we noted that one blanket had been replaced when necessary. People had individual emergency evacuation plans which gave guidance about how they could be quickly and appropriately supported to leave the premises if urgent or immediate need arose to do so. The provider had systems and checks in place to ensure people were safe in case of fire.

Requires Improvement

Is the service effective?

Our findings

At our last inspection the principles of the Mental Capacity Act 2005 (MCA) were not always being followed. The 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.

At this inspection, some people had bed rails in use. Some of these people lacked the mental capacity to be able to agree to them. While there were appropriate assessments in place about people's capacity to make specific choices; there had been no best interest decisions documented about bed rails. Best interest decisions would have recorded whether any less restrictive options had been considered, and involved other professionals and interested parties, such as relatives. This would have ensured that people's rights were protected, but had not happened.

The failure to follow the principles of the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection some people had stair gates across their bedroom doors to stop other people going into them uninvited. Other people had been prevented from standing up by lap trays placed across their chairs. At this inspection, there were no stair gates in use and people who were mobile were able to come out of their bedrooms whenever they wished. The use of lap trays to prevent people from standing up was no longer in practice and staff understood that this was inappropriate; and could be deemed a form of restraint.

At the last inspection there had been no MCA assessment about a person who was receiving their medicines covertly or without their knowledge. At this inspection all the necessary documentation was in place to evidence that this person's treatment was being provided in line with MCA requirements. Staff were able to tell us that the MCA required people to be supported to make decisions wherever possible and we observed that they offered people simple choices about what they wore, where they would like to sit and what they wanted to eat and drink.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At our last inspection, the DoLS authorisation for one person had expired. However, at this inspection, the manager talked us through the systems in place to ensure that any reapplications were made within acceptable timescales.

Some people's food and fluid intake was recorded on daily charts. At our last inspection we reported that these charts did not always contain enough information about people's intake to ensure that any concerns were highlighted quickly. At this inspection, there had been some improvement in this area; but this was not consistent across the charts we reviewed. For example; some staff did not record the starting amount of

food offered or itemise the contents of the meal; while others did. For example; one chart showed 'Lunch 70% eaten' or 'Dessert ½'. This was not helpful in establishing whether people had eaten enough or the nutritional content of their intake. However, we saw that people were automatically referred to a dietician if they lost more than 2kgs in a month; so the impact of the poor recording was minimal.

There had been an investigation by the deputy manager during July 2016 about one person's fluid intake and mouth care. Recommendations were made by them following this; that fluids should be recorded every hour or a note made when they were declined. Mouth care should also be documented when given. However, we found that not all fluid charts had been completed hourly despite this direction and in some cases two separate charts were used; creating confusion about people's intake. Following our inspection, the manager sent us details of newly introduced audits of fluid charts; which helped to check that these were being consistently completed .Records about mouth care were scant in some cases, but better in others so it was difficult to tell whether people had received consistent support with cleaning their mouth, teeth or dentures. The manager said that they had sourced refresher training for staff about mouth care and was waiting to hear the date that this would be delivered.

The lack of complete and accurate records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were regularly offered a variety of hot and cold drinks throughout the inspection and supported to drink if necessary. The weather was particularly hot on one day and staff were reminded to encourage people to drink plenty, during handovers and on blackboards at the nurse stations. Dietician advice had been sought about some people who did not drink enough, and jellies, blancmanges and yoghurts had been introduced as a way of ensuring that they did not become dehydrated.

Menu choices were displayed on chalkboards and on dining tables. An autumn menu had been introduced at the time of our inspection and there were different options available at each meal. Picture menus were in use for people living with dementia. Tables were laid with coloured cloths, flowers and condiments; which made an occasion of mealtimes. Background music played which created a pleasant atmosphere while people ate. One person told us: "The food is smashing and I can choose from a list" while another said "The meals are ok but nothing special". A relative remarked "The food has got better since the last inspection".

At our last inspection people were not consistently supported to eat. At this inspection we observed staff engaging patiently with people as they assisted them with their meals. There was good interaction as staff described the food, made eye contact with the person they were supporting and gave gentle encouragement when needed. People who required special diets, such as pureed food, received these and meals were presented in an appetising way. Where people had food supplements; these were now recorded on food and fluid charts; so that a full picture of people's intake was maintained. People had been referred to the speech and language therapist (SALT) or dieticians if there were any concerns about swallowing or weight loss. The manager told us that people were seen by a dietician if they lost 2kgs or more in any month; and we read records to evidence this had happened. This system ensured that people were assessed promptly by nutrition professionals if the need arose.

People's health care needs had been managed appropriately. Any skin wounds or pressure areas had been noticed quickly and treatment plans put in place. These included input and advice from a special tissue viability nurse (TVN), and documented the types of dressing to be used and frequency of changing. Wounds were tracked to monitor their progress and records showed that they healed well. Individual care plans and risk assessments documented how pressure areas would be prevented; including the use of pressure-relieving equipment and frequent repositioning. We saw that that special cushions and mattresses were in

place for those people who needed them and that charts to show when people had been helped to reposition were up to date. There were clear protocols for managing any skin breakdowns, which had been followed in practice to keep people comfortable.

Some people had catheters or received their nutrition through a special feeding system. Care plans about managing, operating and cleaning the equipment were in place, and staff showed a good understanding of caring for people with these needs. Some people had complex nursing needs, such as Parkinson's and there was evidence of specialist involvement to monitor people's health on a regular basis. People had access to dentists, opticians, chiropodists and other professional treatments to help maintain their health. Regular and routine health checks had been carried out and included weight measurements, blood tests and visits from GPs and mental health teams. This helped to ensure that people received appropriate care and treatment in line with any changes to their needs.

At our last inspection training had not always been effective in supporting staff to carry out their roles. At this inspection, staff were able to speak with us in detail about the knowledge they had received through training. At our last inspection we had been particularly concerned about lack of understanding around keeping people safe from abuse, and reporting incidents. At this inspection, staff were clear about their responsibility to protect people from harm and could describe the way in which any incidents or suspicions would be documented and escalated. There was evidence of incidents being fully recorded by staff and reported to the manager. In some cases these had been appropriately referred to the local authority safeguarding team, so that they could be independently investigated.

There was a training schedule in place which set out dates that training was due and had been planned. Seven different courses had taken place in the weeks prior to our inspection and included; continence awareness, end of life care, dementia awareness and MCA and DoLs sessions. The manager told us that there had been some concerns about moving and handling practices prior to our inspection. They had responded by booking staff onto face to face refresher training to ensure that knowledge and understanding had been updated. We observed safe techniques in use when some people were supported to move with a hoist. Two staff carried out the maneouvre; there was constant communication and reassurance given to the person, and good teamwork between the staff involved. One person told us "Staff are amazing here. They know what they're doing and I have no worries about them at all". A relative said "Dad is properly looked after; staff know what he likes and they're very professional in the way they work".

We read detailed records of staff supervision sessions; which demonstrated that staff had been encouraged to be open and honest about how they felt about their roles; and what could be done to support them. Actions were identified following supervision; which included providing further training and more individual support. Staff told us that they found supervision helpful and that they felt listened to by managers. Annual appraisals had been carried out and were documented within staff files. Supervision and appraisal had been used to give staff feedback about their performance and to highlight any areas which needed input or improvement; so that people would receive a better experience of living in the service.

The service had been adapted in ways to make it easier for people living with dementia or memory loss, to orientate themselves. There was clear pictorial signage to direct people to communal areas and toilet seats were red to provide a visual reminder to people. Walls had been painted in bright and cheerful colours and there were textured patches and other tactile stations in the corridors. An area of one dining room had been designed to look like a garden; with an arbour and potted plants. This created a peaceful and attractive place for people to sit in addition to the lounge.

Good

Is the service caring?

Our findings

We spoke with people and relatives where possible; about their experiences of the service. One person said "They are kind to me here you know" and a relative told us "Staff have good manners and they're always friendly". Many people were living with dementia however, and were less able to tell us about their care and treatment. We read thank you cards; one of which said 'All the staff are very kind, caring and attentive to X's needs. We would have no hesitation in placing X at this home in future'.

At our last inspection, staff had not always acted to protect people's dignity. At this inspection, we observed staff quickly and discreetly supporting people to ensure that their dignity was maintained. For example; one person lifted their clothing, exposing their bare skin. Staff noticed this immediately and distracted the person with a question about their day; while gently putting the clothing back in place for them. This was carried out in such a way that attention was not drawn to the person; so they were not embarrassed by the situation.

Another person who was living with dementia sometimes used language which might offend others. Again staff provided distraction and changed the subject; the person became engaged in a more pleasant conversation and their language changed positively. This prevented others from becoming agitated or upset and gave the person an opportunity to calm down.

At our last inspection, not all staff consistently treated people with respect, but at this inspection we observed only positive, caring interactions between staff and people. For example; staff comforted one person who was looking for reassurance when the emergency call bell sounded. Staff used their knowledge about this person's family to divert their thoughts to happy times; by talking about their great-grandchild. The person's face lit up and they settled quickly because staff had offered appropriate support in a gentle and compassionate manner. Another person awoke from a deep sleep and was confused about where they were. Staff explained clearly where they were and the reasons why they had come to live in the service. They spoke quietly, calmly and waited with the person, holding their hand, to ensure that they had come round from their sleep and were orientated again. Comments about staff made in the July 2016 survey included 'Everyone tries their best here' and 'I feel very positive about the care provided'.

People told us that their families and visitors were always made welcome by staff and managers. Relatives we spoke with said that they felt involved in their loved ones' care. One relative told us "I'm always updated with any issues about X's care; so I know what to expect day to day". Another relative remarked "Transparency is good; they keep you informed". Staff involved people as much as possible when they were carrying out tasks. For example; they gave people choices of clothing to wear or drinks to have; and explained which medicines they were given. We read minutes of a residents' meeting in July 2016 and saw that people had been invited to take part in a survey to choose the paint colours for an upcoming redecoration of three lounges. This gave people the opportunity to influence their surroundings and be involved in day to day decisions affecting their home.

Staff told us how they encouraged people to be as independent as possible, by giving them the opportunity

to complete some tasks on their own; while being on hand to offer support if needed. One person ate their tea with their fingers and staff gently asked whether they would like any help to eat their meal. The person declined assistance, finished the whole meal and was clearly happy to be able to eat in the way which suited them. Care plans for other people recorded which tasks they needed support with, and those which they could manage themselves; such as washing their face and hands. This meant people could retain their independence in some aspects of their care; in the knowledge that staff would assist them if necessary.

Although no one was receiving end of life care during our inspection, staff had received training in this area and were able to speak confidently about it. One staff member told us "It's about giving people the best end to their life they can have; with dignity and no pain-really what we would all wish for ourselves". There were records about people's wishes and arrangements surrounding their end of life plans; including any religious or spiritual preferences. Nursing staff were knowledgeable about medicines that were held in case people had any pain or discomfort which needed addressing in their final days. The manager had made links with a local hospice; for on-going support around end of life care. She was also booked onto training about broaching end of life wishes entitled 'Having the big conversation'; with the aim of improving communication around this sensitive subject.

Do Not Attempt Resuscitation Orders (DNAR) were prominently placed in some people's care files and were highlighted during staff handovers. This helped to ensure that people's wishes and rights were protected in an emergency situation. We read correspondence from families of people who had been cared for at the end of their lives. One said 'I'm really grateful for the wonderful care you gave X. You showed great kindness and patience' and another read 'You could not have been kinder to X and we thank you for everything you did".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, complaints had not always been managed effectively, and records about them were inconsistently maintained. At this inspection we saw that actions had been taken in response to complaints, but that the proper recording of them; and communication with some complainants had been lacking. For example; we read a complaint made on 3 August 2016 that a person's meals had not been smooth enough to prevent the risk of choking. The manager had sourced meals from an external contractor that would provide a consistently smooth texture; and the care plan reflected the risks to this person around eating and drinking. However, a formal response had not been provided to the complainant by the manager. The provider's complaints policy said that a response should be provided within 28 working days; but this had not happened.

Another complaint was made on 15 August 2016 about a person overheating in their room. There was no evidence that an acknowledgement had been sent within three working days; in accordance with the provider's complaints policy. The manager had provided a wall-mounted fan and had been making checks herself that staff were turning the fan on when the weather was warmer. However, the manager had made notes about her actions about this, and other complaints, in a notepad, but had not always transposed these into formal responses to complainants. We received feedback during and after the inspection from a relative who said they had not received a formal reply to a complaint. They were unclear about how their concerns were being addressed and felt more could be done to satisfy their grievance. This meant there was no clear resolution to some issues and the provider could not be sure that complainants were happy with outcomes.

The failure to operate an effective system for managing complaints is a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A comment made in the recent staff survey from another relative, however, read 'When I wrote a complaint it was dealt with quickly and professionally'.

At the last inspection, care plans lacked detail about the care and support people needed. At this inspection care plans had been reviewed and updated. The service had trialled a number of different formats to ensure they were keeping clear records; and this process was still on-going. This sometimes made it difficult to check that all relevant information had been included in care plans. However, most of those we read contained sufficient detail about people's life histories, and set out how their care should be delivered in an individual way. We found that people were given support that was considerate of their wishes and preferences; but some records needed further work to make sure that they reflected this. Our observations showed that people's choices were taken into account in practice. For example; one person told us that they were not ready to get up and staff said that this person often chose to remain in bed until later in the mornings; and that they would see if they would like to get up in a while. At lunchtime, staff were able to tell us that one person did not like some of the meals on the menu and that they always chose an alternative on those occasions.

Many people had personalised their bedrooms with photos, pictures and keepsakes. One person told us "It reminds me of home like this". Another person told us that staff knew them very well and this meant they responded to them in a way which took account of the person's personality. The person said "I've lived here quite a while. The staff know what I like and they go out of their way to make sure I've got everything I need". Staff told us about different people's characters and how they adapted their approach to suit individuals. For example; one person did not like to drink liquids but had been encouraged to stay hydrated by eating jellies and blancmanges. This person's needs had been met in a way which they found acceptable and which kept them well.

At our last inspection there had been a lack of activities for people to engage in. At this inspection people's needs for social interaction had been assessed and met. We found there was more on offer and people received individual contact and stimulation. An activities programme for the month was displayed at various points around the service; together with a whiteboard which listed those events on offer that week. These included; drawing and sketching, card games, puzzles and visits from external entertainers such as a guitarist and a saxophonist. There were photo montages on the walls, showing people involved in various activities, such as the 'Monday craft class'. Regular afternoon tea events were held and were popular with people we spoke with, a Summer Fayre had recently been staged and people had enjoyed being involved.

We observed the activities coordinator spending one to one time with people who were living with dementia. They chatted with people and played dominoes or helped with knitting; and people appeared relaxed and engaged during these times. There were other group activities; such as flower-arranging which gave people an opportunity to interact with others and produce crafts that they could show visitors. One person pointed to colourful handmade decorations that were hanging in the lounge area and told us proudly "I did that-clever aren't I?" People who were able to speak with us said they felt there was enough to keep them occupied if they wanted to be involved. One relative told us "X does more activities here than they ever did in their last care home. X loves [activities coordinator] and they always try to encourage people to join in". Another relative told us that they had seen positive change in their loved one; who was now enjoying some activities. They said "X used to stay in their room all the time, but they come out a lot more now".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, appropriate and robust quality assurance systems had not been put in place by the provider. This had resulted in people being exposed to risk of harm. At this inspection, there had been many improvements to these processes; but they had not successfully addressed all of the issues that were raised in our last report.

For example: although risks to people had been assessed, actions designed to reduce the likelihood that people would experience harm had not always been carried out. More could have been done to ensure the safety and well-being of every person; such as checking that a person at risk of falls had the appropriate equipment to help prevent further occurrences. Effective systems had not been devised to regularly check that all people had call bells in reach; which meant they might not be able to raise the alarm if they needed help.

Staffing levels and deployment required a thorough review to work out when and where more staff would be beneficial. Although more staff were brought in when we highlighted the impact of shortfalls, this should have been picked up by the manager and provider. Operation of the MCA had improved, but not all areas had been covered; meaning that people's rights had not always been properly considered and documented.

Record-keeping was inconsistent around food and fluids and had not been adequately audited until we raised concerns about it. The manager acted to introduce a new system immediately following the inspection, but checks should have been carried out routinely; to monitor people's health and well-being. Complaints had not been well-managed because complainants were not kept informed about progress, even though actions had been taken.

The failure to operate effective systems to assess the quality and safety of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider and manager had implemented other positive changes within the service, however. These included; robust systems for recording incidents and raising them with the local safeguarding authority; which helped to protect people from the risk of abuse. Recruitment processes had improved and this ensured that the right applicants were employed by the provider. Medicines had been well-managed and audited so that any problems would be identified and put right quickly; and staff training and supervision had improved. All of these actions helped to keep people safe. Comments made in the July 2016 relative survey included 'Since the home was last visited by CQC, improvements can be seen' and 'We have no concerns, very satisfied'.

The manager had been in post for less than three months at the time of our inspection. The service is required to have a registered manager as part of its conditions of registration with the CQC. There had been no registered manager in post for around seven months; but the manager had applied to become registered.

At our last inspection, we reported that feedback sought from people and their relatives had not always been acted upon. At this inspection we saw evidence of an improving picture. We read minutes of a staff meeting in which feedback from a resident and relative survey in July 2016 was discussed. Some survey responses had indicated that people did not feel sufficiently involved or informed about their care. As a result, monthly keyworker meetings were being introduced. These would provide the opportunity for people (and their relatives if they wished) to sit down with an individually-allocated keyworker to talk about any concerns or simply to provide information about the previous month.

A residents' association was in place and chaired by a person living in the service. They told us how people were given the chance to express their views and ask for change. We heard that some people had asked for a greater choice of breakfast menu and that this had been provided. We read comments left in a suggestion box and reviewed by the manager. One of these remarked that it was disappointing that there had been no management presence at the recent Summer Fayre. The manager explained that the Fayre had been arranged before either herself or her deputy had been employed and that both had other appointments which could not be changed on the day. She had responded that any future events would have a visible management input because they would be scheduled for dates when managers were available to attend. People and relatives told us that they found the manager approachable and that she had an 'Open door'. Feedback had been proactively sought and was used to make change for the better.

Staff had also been encouraged to make comments and leave them in a suggestion box. We read some of these; which had all been signed by the staff making them; even though they could have been left anonymously. This showed that staff felt able to voice their opinions openly and was a sign of a better culture developing. Staff told us that they felt supported by the manager and particularly welcomed the new deputy manager who they said, was very 'Hands on'. Staff confirmed that they were able to be frank with management about any concerns or issues and that they felt listened to. Several staff mentioned that supervisions were now more in-depth and provided a platform for them to talk freely about their experiences of working in the service.

Our observations during the inspection found that staff were more caring. The areas for improvement that we had highlighted in our last report had been addressed and staff showed consistent respect and compassion. Staff told us that things had improved since our last inspection and that "We're trying our very best to be better". Two staff told us that improvements were down to the manager and deputy and that they "Lead us by example". Both the manager and deputy spoke with people kindly and took time with them to chat about things that were important to them; such as family visits. Comments from the July 2016 relative survey included 'The staff are all marvellous and '1st class home, credit to staff'.

At our last inspection, the CQC had not been notified about significant events; which is a statutory requirement. At this inspection we found that we had been informed promptly about any matters requiring notification. This meant that the CQC had been made aware of incidents and could assess any risks based on this information.

The manager had begun to forge links with the local community for the purposes of improving people's experiences of living in the service. Church services were held weekly on site; so that people's religious and spiritual needs could be met. Local schools had been contacted with a view to children visiting occasionally; and the manager had spoken with the Women's Institute and Age UK about opportunities to work together.

The manager is a registered nurse and kept herself and staff abreast of developments within nursing and social care through a number of different sources. These included: subscriptions to the Royal College of Nursing, (RCN) Nursing and Midwifery Council (NMC) and the National Institute for Health and Clinical

Excellence (NICE) for professional updates. In addition, she attended care home forums run by the local Clinical Commissioning Group (CCG) for guidance and information. These contacts helped the service to develop care delivery and provided a professional support network.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act (MCA) 2005 had not been consistently applied.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints had not been managed effectively nor in line with the Provider's own policy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of staff had been deployed to appropriately meet service users' needs.