Reside Care Homes Limited

Reside at Stour Road

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 16, 20 and 22 October 2015. The home is a residential care home and provides support and personal care for up to 20 older people, some of whom had dementia. At the time of our inspection there were 18 people using the service. The home has a ground floor communal area and a first floor which is served by stairs and a lift. There was a garden at the back of the home for people to use.

The home was last inspected on the 2 and 3 of June 2014 and found not to be meeting the standards in the care and welfare of people, requirements relating to workers, assessing and monitoring the quality of the service and records. People's needs were not assessed properly and care plans did not provide sufficient guidance on how to safely meet people's needs. Staff recruitment checks did not include a full employment history for some staff who worked at the home. Although the provider had systems in place to monitor the quality of the service, action was not taken promptly to make improvements. Records were not maintained accurately or effectively.

At this inspection improvements had been made to the care and welfare of people, how people's needs were assessed and how their records were maintained. There was improvement in how information was gathered on applicants' employment history and the range of activities offered. The home had also recruited an activity

Summary of findings

organiser to review activities and arrange more variety and choice. While there were improvements in monitoring and assessing the quality of the service, we found that from previous inspections some actions had not been completed including concerns raised about furniture and the lounge carpet and no action had been taken following an internal quality check of the kitchen area by the provider.

The manager who was not a registered manager had recently started work at the service from June 2015. 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. The manager was aware of the requirement to have a registered manager at the service and at the time of the inspection they were in discussions with the provider about this. The manager and the senior staff had started to identify the improvement and development needs at the home, including changes to how people's needs were assessed and their involvement in the process and greater emphasis on recording and monitoring checks.

There was sufficient staff to care for people, however the manager acknowledged that two staff available after 8pm meant that some people could be put at greater risk of falling if left alone in the lounge when staff attended to other people.

We saw there was enough staff to help people with their activities and the support they needed during the day. On one of the days we visited, there were six staff, the deputy and the manager working at the home. The manager had also been recruiting new staff to the service.

People were at reduced risk of abuse and kept safe because staff were aware of how to report abuse and protect people from harm. For example, staff used body maps to record marks and how they would be alert to changes in the person's reactions. Staff also explained measures to keep people safe from harm. One said, "We always have two staff to move people when using the hoist and we prepare the environment first and protect their feet from injury".

People were assisted and cared for by staff that were aware of the individual risks to the people they supported. Individual risk assessments were used to keep people safe and included making sure staff had up to date information and guidance about the moving and handling needs of each person.

Medicines were managed safely and people received them on time. Medicines including controlled medicines and topical medicines were administered appropriately and according to the home's medicine and infection prevention policy. Staff made the necessary safety checks and explained to people how their medicines would help them.

Staff did not receive consistent annual appraisals. While some staff had been involved in an annual review of their work others had not. New staff received induction and initial training to support their role and were expected to begin working towards their Care Certificate. These certificates have replaced the social care induction programmes. New staff were supported by senior staff with reviews at four, eight and twelve weeks to help them settle within their roles. One staff member explained that apprentices were offered the Diploma level two and three following a twelve week successful induction and received support to achieve this. One person said, "Staff are well trained and have the knowledge and experience".

Newly recruited staff explained their experience of the recruitment process. They confirmed they had been asked to complete an application and had attended an interview and were asked about their work experience.

People were offered nutritious and varied main meals, deserts, seasoning and drinks of people's choice. Some people requested alternatives like sandwiches and one person wanted yoghurt instead of the main desert. One person said, "The food is hot, good and you can have what you like".

Some people living at the home did not have the mental capacity to make some decisions about their care and where they lived. The manager told us that soon after starting work at the home she had checked where people had a Deprivation of Liberty Safeguard (DoLS) authorisation and found these to be out of date. The manager explained that they contacted the local authority to identify people where the arrangements for their care may deprive them of their liberty and to request new DoLS authorisations. The manager was

Summary of findings

informed by the local authority that there was a delay in assessing DoLS authorisations. One person told us that staff approached them first to ask consent before they started caring for them.

People were cared for by staff who demonstrated compassion and kindness as they delivered care. People's relatives were welcomed to visit when convenient to their needs and were encouraged to get involved in their relative's care, for example, by assisting them with their meals.

People received personalised care and staff received hand overs when changes were made. For example, one staff member told us that someone preferred their personal care later in the day and this was shared between staff at shift changes.

The management team were in the process of developing improvements to care planning and assessments. They acknowledged that they were working through this process to bring everyone's assessments in line with person centred practice.

There were no complaints at the time of our inspection but staff showed us letters of thanks from relatives of people that had lived at the home.

While quality and safety checks had been carried out at the home, actions we had asked the provider to take at the previous inspection had not been fully completed. This included addressing a stained carpet and stained soft furnishings. We saw an internal quality check which had found the kitchen to be in need of attention but repairs had not been followed up. Findings from a Public Health Officer's visit in 2014 had not been addressed.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to governance at the service. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe because although there was sufficient staff to meet people's needs during the day the manager acknowledged that two staff available after 8pm meant that some people could be put at greater risk of falling if left alone in the lounge when staff attended to other people.

Staff knew how to identify and report abuse appropriately.

Staff assessed risks to people and took action to address these once they were identified.

People received their medicines on time and according to their prescriptions.

Requires improvement

Is the service effective?

The service was not effective because although staff received training and support to carry out their roles and responsibilities they did not have consistent annual appraisals.

People's consent to care was sought in line with the Mental Capacity Act (MCA) 2005 and staff asked people's permission before they carried out care, treatment and support.

People received regular support from healthcare professionals to meet their changing health needs.

A variety of hot and cold food and drinks were made available to people at meals times and people received the support they needed to manage their food.

Requires improvement

Is the service caring?

The service was caring because staff showed kindness and appropriate attention to people and made them feel valued.

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

Staff protected people's privacy and treated them with dignity and respect. Staff knocked on people's doors and pulled their curtains before providing personal care.

Good

Is the service responsive?

The service was responsive. Staff understood how to deliver individualised care to people and encouraged them to contribute to their assessments. These had recently been reviewed and amended where changes had taken place.

Good

Summary of findings

People were listened to and staff responded to people's questions, suggestions and ideas. No complaints had been received in the time that new management had taken up their posts.

Is the service well-led?

The service was not well led. The new management team had worked hard to make changes since starting their posts but internal quality checks showing action was required and some actions from the previous inspection had not been fully addressed by the provider.

People, relatives and staff spoke about the positive atmosphere at the home. Staff felt that the new management team at the home had made a significant difference to people's experiences.

Requires improvement

Reside at Stour Road

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 unannounced inspection was completed by one inspector and took place on the 16, 20 and 22 October 2015.

Before the inspection we reviewed information we held about the service including notifications, safeguarding concerns, accidents and changes the provider had informed the Care Quality Commission (CQC) about. A 'notification' is information that services have to provide to the Care Quality Commission about serious incidents and events and other changes to the service. We did not request a Provider Information Return (PIR) from the service before the inspection. A PIR is a form that asks the provider to give key information about the service, what it does well and the improvements they plan to make. During the inspection we asked the provider to tell us what they did well and the improvements they planned to make.

We spoke with six people living at the home and four relatives. We spoke with the manager and deputy manager, the administrator, the catering and housekeeping staff and seven members of the care team. We had contact with five health and social care professionals for their views and who worked in partnership with the service and provided support to people living at the home.

We observed care and looked around the communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) at meal times and during activities. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed three people's care records, risk assessments and five Medicine Administration Records (MAR). We also looked at documents related to the care people received and experienced. These included compliments and complaints, accidents and incidents and monitoring documents. We reviewed records relating to the management of the service such as health, safety and fire and a medicine and kitchen check and records from staff meetings, and other service quality reports.

Requires improvement

Is the service safe?

Our findings

There was sufficient numbers of suitable staff to keep people safe and meet their needs during the day, however, there were two staff working between 8pm and 8am to support 18 people. We were told that four staff worked in the morning and four staff worked in the afternoon. One relative showed concern about whether there were sufficient staff at weekends and at night time and said that on one occasion they had noticed that only two staff were working at 8pm and during this time eight people were left alone in the lounge unsupported for up to fifteen minutes while two staff provided essential care to someone. No other relatives or staff shared any concerns about staffing levels with us during the inspection. We spoke with the manager. They told us that arrangements were in place to ensure that the activity organiser was planning a wider choice of activities at weekends and this would make a difference in how weekend staff were deployed.

We looked at the accident and incident reporting records and found that there was a pattern of falls and injuries noted during the evening and night shifts and when specific staff was working. We drew this to the attention of the manager because although the night staff numbers had been maintained and there were no gaps in the number of staff working, the pattern of accidents was much higher when two specific staff members were on duty. The manager acknowledged the pattern and confirmed that night checks had been carried out but that entrance to the building at night would mean that staff would be aware of the check taking place. The manager agreed to monitor the pattern and review this. One staff member told us that there always had to be at least one person in the communal lounge at all times to maintain people's safety.

While staff had been informed that people were not to be left alone in the lounge this was difficult to achieve after 8pm and there was no specific environmental risk assessment to cover this. The manager was aware of this and outlined their concerns including the risk of un-witnessed falls. Three people were at risk of falls from poor mobility and or a lack of awareness of their surroundings. We looked at the staff rota and spoke with the manager but there was no information available on how staff numbers had been calculated or decided in relation to people's needs. The manager told us that staffing levels at night would be reviewed and discussed with the provider as part of their management meetings and to maintain people's safety. This meant that with two staff working between 8pm and 8am there were occasions when the communal lounge could not be covered and people could be at risk of harm.

We saw there was enough staff to help people during the day with their activities and the support they needed. On one of the days we visited, there were six staff, the deputy and the manager working at the home. The manager told us that recent recruitment had yielded good results with 10 staff having been recruited in three months and this was continuing. One relative said, "There is always a good number of staff about when I visit during the week". One person said, "There's much better staffing levels recently and now they are more regular so we get to know them better".

At the previous inspection in June 2014 we found that employment checks and procedures had not been followed when staff were recruited. Some staff had been recruited but their full employment history had not been provided. At this inspection improvements had been made. Three records showed that when recruiting new staff, in particular when checking staff's previous employment history, the correct procedures had been followed. Staff had been checked to ensure they had not been barred from working with adults and children. Newly recruited staff explained their experience of the recruitment process. They confirmed they had been asked to complete an application and had attended an interview and were asked about their work experience. The manager confirmed that employment checks had been used when recruiting staff.

People were at a reduced risk of abuse because staff were aware of how to report abuse. Care staff explained the risk of abuse and described what action they would take to record and report abuse. They told us about the use of body maps to record marks and how they would be alert to changes in the person's reactions. Staff also explained measures to keep people safe from harm. One said, "We always have two staff to move people when using the hoist and we prepare the environment first and protect their feet from injury". This meant staff were aware of risks to people and how to manage these. People and their relatives told us they felt safe and secure at the home. One person said, "I feel very safe here, there is nothing to be worried about

Requires improvement

Is the service safe?

living here". One relative said, "It is very safe here, the staff check the rooms frequently". Information was made available in the home about how to recognise signs of adult abuse and what action to take to report abuse.

People were assisted and cared for by staff that were aware of the individual risks to the people they supported. Care plans included details about how to help people in a way that balanced their right to be independent whilst reducing the risk of an accident. Assessments included how one person was protected from developing pressure wounds by carrying out checks on their skin and monitoring the controls of their pressure-relieving mattress. This included a request to the company supplying the mattress to review the settings and provide guidance to staff on the correct use and maintenance of the product. Staff carried out mattress checks to make sure that people's equipment was safe and working effectively. Individual risk assessments were used to keep people safe and included making sure staff had up to date information and guidance about the moving and handling needs of each person. The manager had arranged for safety checks on walking equipment to make sure that the rubber ends (known as ferrules) of walking frames were sufficiently safe to use. Worn ferrules were replaced following these safety checks.

Action had been taken to make sure the home was safe and secure. The manager described the security system at the entrance to the home and all visitors were asked to sign themselves in and out of the building. Important information was stored at the front of people's notes for accessibility and for staff to use in an emergency. Each person had an evacuation plan to show staff what support each person needed in the event of a fire. Assessments were used to measure individual and wider risks at the home and these had been updated. These included fire risk assessments, equipment use and moving and handling assessments.

Medicines were managed safely and people received them on time. Medicines were administered appropriately and according to the home's medicine and infection prevention policy. Staff made the necessary safety checks and explained to people how their medicines would help them. They asked people if they needed medicines for their pain and assisted people to take them when they needed help. Where people were able to manage their medicines staff provided encouragement but remained with them until they had taken their dose.

People told us they received their medicines regularly and one person told us that staff checked whether they needed medicines to control and manage pain. One relative said, "They get their medicines regularly at breakfast and evening. Staff wear the tabard when giving the medicines and stay with her". This was confirmed by a person living at the home and when we observed medicine administration.

There were detailed policies on controlled drugs, self-administration and non-prescription based medicines which staff understood, clearly explained, and applied when carrying out their responsibilities. Fridge temperatures and the room used to store medicines were regularly checked and records showed they aligned to the expected readings. One staff member gave details about how medicines were ordered, checked, stored, recorded and collected and told us they had completed training to carry out the task. They explained that controlled medicines had to be signed by two staff for safety. An external organisation had provided partnership support, advice and quality checks on medicines and staff understood what actions to take in the event of a medicine error.

Requires improvement

Is the service effective?

Our findings

The service was not effective because some staff did not receive an annual appraisal and where some had, this was sporadic. Records showed that while some staff had been involved in appraisals others did not have consistent annual development plans. The manager told us that this process had begun but they acknowledged there was more work to be done. The manager explained that they had completed approximately 10 per cent of the total staff appraisals. They explained that having been in their post for only a short period of time, the priority was making sure that people received safe and effective care and addressing more urgent and pressing matters but that staff needs were being addressed. This was confirmed by several staff but staff did not report that this had affected the care people received. Four staff members told us they could discuss their development needs at any time with the manager or the deputy manager.

Supervision records showed that staff received regular support and supervision through formal and informal meetings. Reports showed that and these were used to help new staff settle into their roles at four and eight weekly formal reviews.

Staff received support, training and development to carry out their duties. New staff received induction and initial training to support their role. New staff were expected to begin working towards their Care Certificate. These certificates have replaced the social care induction programmes. One staff member explained that apprentices were offered the Diploma level two and three following a 12 week successful induction and received support to achieve this. Staff received training from different sources to update their skills and knowledge although this was not consistent but they were provided with general guidance on a daily basis through management advice and an open door approach.

People received care from staff that had the skills and experience to support people's needs. The administrator had just begun a piece of work on harmonising the staff training matrix and while further work was still required staff were being informed of when their training was due. One person told us that staff understood their roles and said "Staff are well trained and have the knowledge and experience". The manager explained that extra training for staff to attend Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) updates had been requested as part of the team's professional's development. On the staff and community notice board there was educational materials including details about training events and information about the early signs of Lewy body dementia, a particular form of dementia and how to recognise the signs of a urine infection in older people. Staff used the notice board to help them identify and request further training opportunities.

People were offered enough food, drinks and other refreshments frequently and when they requested. One person said, "The food is hot, good and you can have what you like". Staff wore blue aprons as part of infection control procedures when serving food. They offered nutritious and varied main meals, deserts, seasoning and drinks of people's choice. Some people requested alternatives like sandwiches and one person wanted yoghurt instead of the main desert. Several people needed assistance to enjoy their meal and staff used the opportunity to talk with people and create a relaxed yet social experience. A staff member outlined the variable assistance people needed and described how one person preferred not to use their dentures at meal times and pointed out two people who used plate guards to manage their meal without assistance. This showed that staff were aware of how to appropriately support people with their meals.

One relative said, "The food is appetising and they have clear pictures for people to help them decide. I see the staff help people by chopping their food". In the kitchen, the chef spoke with us about each person's dietary needs and what their preferences were. There were clear dietary instructions available to the catering staff on the consistency of people's food and their choices. There was sufficient stock of food and drinks available in the refrigerator and kitchen cupboards. Fresh produce was used besides packaged and tinned food where appropriate.

Staff acted in accordance with the Mental Capacity Act 2005 (MCA). Some people living at the home did not have the mental capacity to make some decisions about their care and where they lived. 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

Is the service effective?

made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. The manager told us that they had assessed the mental capacity of new people joining the home and was in the process of reviewing the mental capacity of people already living at the home by reviewing each person's needs along with their records.

We contacted the authority responsible for the Deprivation of Liberty Safeguard authorisations before and after the inspection. They told us that they had received recent requests for a review of DoLS authorisations for several people living at the home. They confirmed that these people were waiting to be assessed by staff in their authorisation department. We asked the manager whether any conditions on authorisations to deprive a person of their liberty were being met. The manager confirmed that soon after starting work at the home she had checked people's Deprivation of Liberty Safeguards (DoLS) authorisations and found some to be out of date. The manager had contacted the local authority to inform them and to have this addressed and showed us the action they had taken. These were reviewed and new applications for DoLS authorisations and best interest decisions were submitted where these applied.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People were consulted and asked about their care needs and verbal consent was requested before staff carried out care. For example, one staff member asked whether someone needed assistance with cutting up their food, another staff member approached someone and discussed their needs before providing assistance to help them stand and visit the toilet. During a medicine administration the staff member asked the person questions about how they felt, gave clear explanations about the medicine and asked whether people could take their medicines independently or needed help. Where people declined direct assistance this was respected by staff. One person told us that staff approached them first to ask consent before they started caring for them.

Records that had been updated showed that some people had been able to sign their consent to receive care, support and treatment. For some people who lacked mental capacity to make informed decisions about their care, families were approached for greater involvement in best interest decisions and the appropriate services and social care professionals were contacted for support and guidance. Some families had a lasting power of attorney arrangement for their relatives and were involved in decisions about their care and welfare needs.

A staff member told us they asked for people's consent before beginning care activities and for those people who had communication difficulties extra time and attention was given to help people process information. The manager explained that they were developing a consent form designed for use when people were taken out on visits, information sharing and for when people had their photographs taken. This showed that the manager and staff were aware of involving people in seeking their consent about different aspects of their care.

People had their health needs met by health care professionals who visited the home on a regular basis. We met two healthcare professionals who gave examples of when staff from the home had requested support from their teams. People and their relatives confirmed they received support from visiting occupational therapists, district nurses and podiatrists.

Good

Is the service caring?

Our findings

People were cared for by staff who demonstrated compassion and kindness as they delivered care. Relatives spoke of the high standards at the home and how staff had a genuine desire to work with older people. Several relatives told us that staff carried out their roles with care, dignity and respect for people's privacy. One relative said, "I'm delighted, staff are really caring and attentive they listen… it's a bright and lovely atmosphere here" and "People are very well looked after here, if we need anything, it happens straight away. I'm confident that staff treat my relative well; they are respectful to us both. They treat her like she is their own mum, fantastic and lots of empathy for people". Another relative told us that people and their relatives were treated with consideration and respect, commenting, "Staff are thoughtful and informed us within minutes when my relative had to go to hospital."

People's relatives were welcomed to visit when convenient to their needs and were encouraged to get involved in their relative's care, for example, by assisting them with their meals. Relatives described the home as having, "a jolly atmosphere" and staff had "a sense of humour". One relative said, "I have every confidence in the staff who work here, you only have to ask and everyone is helpful and supportive". We saw staff fully engaged with people and their families. People appeared happy and humour was used appropriately by staff to foster a friendly environment where people seemed relaxed and at ease. Relatives commented that they did not hear call alarms left to ring and that staff were responsive to people's needs. One relative said, "Staff are very kind here, (person's name) talks slowly and gets frustrated but (staff name) is so patient and listens without hurrying". Staff told us about how they protected people's information in line with the confidentiality policy which was updated in August 2014. This was made available on the communication notice board.

Some people had their own preferred names different from their recorded name and staff were all aware of this as they communicated with people. One person said, "The manager and the deputy look after us all very well; they are wonderful and so efficient they just want the best for the residents". One person living at the home said, "The staff make me feel very comfortable, they are lovely people".

People and their relatives told us they were involved in their initial assessments and that staff reviewed their needs as these changed. One relative told us they had been involved in identifying their family member's mobility and personal care needs. This was confirmed by staff and the management team. People were encouraged to make their rooms personalised. For example one person had chosen their own bed linen instead of using the linen provided by the home. This showed that staff were receptive to meeting people's expressed choices.

Two people told us that staff communicated regularly with them about their care and changes to their support needs. For example, one person told us that staff approached them soon after they had been visited by a visiting healthcare professional and had discussed their changing needs. The person told us they felt staff respected their view and encouraged them to share their thoughts about the care they received. Someone else said, "Staff are often interested in what I think, we often have a chat about how things are going and if anything needs to change". Relatives of two people described how staff spoke with them and their family members to keep them involved. The manager commented on how care plans had changed and were written to be person centred to demonstrate a greater level of involvement. Records for several people confirmed this. We saw and heard several staff involving people in how they received their care. Staff provided clear explanations to people. For example, people were asked whether they wanted to use their walking appliances or a wheelchair when they were assisted to move from one part of the home to another and staff discussed the reasons for people's medicines and sought their views on the medicines they had been prescribed. One staff member spent time explaining to someone following a visit from their community nurse.

Staff were seen providing encouragement and support to people with their walking, when taking their medicines and at meal times. Staff spoke respectfully to people and demonstrated kindness and understanding in a sensitive way. For example, staff checked what level of help people needed before providing assistance and offered explanations to people. Staff were attentive, aware and remained alert to people's needs when carrying out care, anticipating some aspects of their care to make sure people remained comfortable. For example, some people needed reminding to use the toilet and others with small appetites were prompted or reminded about their meals.

Good

Is the service caring?

Two people experienced pain from their joints and staff checked with these people whether they were comfortable, needed to move, required extra support or wanted to be re-positioned. Although the home was warm and comfortable, some people felt the cold more than others and staff provided blankets for their knees. Some people had their own blankets and extra pillows and these were used to provide support with their posture. The home had been fitted with wall rails to assist people to freely move about and feel safe as well as maintain their independence.

Staff told us they enjoyed their work and one member of staff said, “This doesn’t feel like work, I really enjoy being here and supporting people”. Staff spoke positively about their role with pride and enthusiasm. They told us that it felt more like a family home than a care home.

People were encouraged to join in with activities to avoid feeling isolated although some people preferred time on their own. Community events were arranged including a local faith group who visited the home to offer singing and a piano event and a musical entertainer. The choir group used hymns and music to celebrate the harvest festival. The deputy manager arranged a Halloween flower display to help people focus on the event and generate conversation between people. One staff member described the communication needs of several people commenting that one person relied on facial expressions and body cues to communicate with staff.

Written information about the equipment people needed in an emergency evacuation was written in a way that did not always reflect dignity. The term ‘Zimmer frame’ had been used to describe someone’s walking aid and we heard the term ‘feeding’ to describe someone’s meal experience. We drew this to the attention of the manager who acknowledged this and told us that the use of language and other terminology would be reviewed.

Good

Is the service responsive?

Our findings

People received personalised and appropriate care. At the previous inspection in June 2014 we found that some people's needs were not assessed properly and they did not receive the individual and appropriate care to meet their needs. At this inspection we found improvements had been made.

The management team were in the process of making improvements to care planning and assessments. They acknowledged that they were working through this process to bring everyone's assessments in line with person centred practice. The management team advised us that 60 per cent of care plans had been completed while others had been checked and reviewed. The manager told us that this was in line with the development of revised documentation – a suggestion made soon after the management team took up their respective roles. We looked at samples from assessments, reviews and care plans which indicated that this process had begun but required on-going work until fully complete. There was a plan in action for this piece of work and the management team had received input from other agencies about the improvements required in assessments and care plans.

Staff were seen involved in one to one activities with people including board and word games and small groups of people enjoyed floor activities including skittles. One healthcare professional described how they had regularly seen staff sitting engaged with people in communication and involving people in maintaining the garden during the summer months. An activity organiser was responsible for planned events and trips for people to participate in. At the previous inspection a lack of varied activities was noted and while there had been some improvements this remained an area of concern for some people and their families. One person told us that they would prefer more activities at the weekends and a relative told us that they could not be sure that activities took place at weekends as there was less staff about. The manager told us that the activity coordinator, who covered care hours as well as activities, would arrange for more activities at weekends and these would increase once the full care team had been recruited. An example of weekend activities included a cinema afternoon.

Staff understood the care and support needs of people and demonstrated this as they carried out their roles. People were given the time they needed to move about freely and safely or with the level of assistance they needed. One relative told us that all the staff knew their relative's needs, preferences and choice. Another relative told us that when their family member had experienced a fall and needed the doctor, they were contacted straight away and kept informed. They said "It was reassuring to know that staff thought about the relatives as well".

People received personalised care and staff received hand overs when changes were made. For example, one staff member told us that someone preferred their personal care later in the day and this was shared between staff at shift changes. People's needs were assessed and their care provided in line with their care plans. For example, staff gave explanations of several people's care needs and their individual choices about food, the time they chose to get up, clothing, makeup, care and mobility. They described the individual preferences of several people at the home including two people who preferred to rest on their bed in the afternoon. A person had requested changes to their room layout and this had been addressed.

One staff member described how someone had needed support from the district nurse and another person required pressure relieving equipment and creams applied to reduce the risk of sores. Another staff member described how one person was at risk of falls and required support from one staff member to keep them safe. This was seen in care records used to inform staff of people's needs. People and their relatives told us they were involved in their initial assessments and that staff reviewed their needs as these changed. One relative told us they had been involved in identifying their family member's mobility and personal care needs. This was confirmed by staff and the management team.

Three healthcare professionals described the service and gave positive accounts of good care for people. One told us, "One person has really improved since they first arrived. Staff have worked closely with our team to tailor the care and get it right".

The manager told us that each person had received an Occupational Therapy (OT) assessment of their walking equipment to ensure that these were height and design appropriate. We saw that these were labelled to ensure

Good

Is the service responsive?

that people used only the correct equipment to meet their assessed needs. People received individual resources according to their support needs which included individual seating to prevent the risk of pressure wounds developing.

Several relatives told us they had been invited to attend two relative's meetings and felt encouraged that the new manager and staff team were engaging with people and their families.

One relative said, "There are relatives meetings once a month – there's an open exchange and I'm confident that if I raised any concerns the staff would listen to me". One example included changes to the management of laundry which had significantly improved because dedicated staff had been assigned the responsibility. One person said, "We have meetings here and the manager and deputy get involved. You can talk to staff; if there is a problem I'm happy to raise any concerns they're all approachable".

There had been no complaints since the new management team had been employed and this was confirmed by people and relatives we met throughout the inspection. Records of how complaints prior to the management team had been employed were not readily available. This meant it was not clear how complaints about the service had been previously logged and addressed. Senior staff could not be sure whether there had been a written record of complaints maintained before they started working at the home but had started to collect feedback provided by people and their relatives. We looked at a sample of 'thank you' cards and correspondence from people's relatives. These contained positive comments and individual accounts of the care people had received.

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Our findings

The service was not well-led. Although assessment and monitoring of the home took place, improvements to the quality of the service people received did not always take place. At the previous two inspections in October 2013 and June 2014 we found that improvements were needed to the home environment including the lounge carpet and some soft furnishings. At the inspection of the home in October 2013, the registered manager told us that the home was due to be redecorated and carpets would be replaced in the main communal areas including the lounge. However, at the inspection in June 2014 the work had not been completed. Carpets were stained and the arms of some chairs in the lounge showed signs of wear and soiling.

At this inspection in October 2015, sufficient improvements had not been made. The carpet in the main communal lounge area remained the same and some chairs had stains and had an unpleasant odour of urine. We made contact with the provider and spoke with them on the 1 December 2015. The provider informed us that new vinyl flooring had been fitted in the conservatory but they had decided not to change the carpet in the lounge as they did not feel this was necessary. The provider told us that some furnishings had been replaced since the previous inspection but they were unable give specific details. We pointed out the stained condition of the lounge carpet and that several chairs remained stained and had malodours.

The provider had carried out safety, quality and monitoring checks on systems and areas of the home. However, these did not always result in prompt action being taken to improve findings. For example, a quality check on the catering area showed that the kitchen was in need of repair. While this had been noted and reported through the internal quality check over a year ago, no action had been taken. We saw that cupboard doors did not fit correctly, internal cupboard space and cupboard flooring was damaged and door hinges were not secure. Chips on surfaces of food preparation areas and for food storage cupboards presented a health and food hygiene hazard. We reported our concerns to the Public Health Office for food standards. Requirements made by the Public Health Office, Food Standards Agency of 2014 in relation to the kitchen environment had not been acted on by the provider. The Food Standards Agency had issued a three star rating. These ratings range from one star to five star, with five stars being the highest quality rating. The Public Health Officer was aware of the situation and had provided detailed information of their most recent findings to the manager. The manager had previously carried out an audit of the kitchen area, health safety and hygiene and recorded that actions were to be completed across November, December 2015 and January 2016. We were later informed by staff at the home that a new kitchen would be fitted in December 2015.

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

Records were maintained, managed and stored securely. At our previous inspection in June 2014 we found that records did not contain enough information about people's needs and how they were met. There was a lack of information about where, how or when creams should be applied on people's skin. At this inspection improvements had been made. Although some records including care plans required updating senior staff had begun to use new and less complicated documentation to achieve this with a plan to address 10 per month. Other improvements to records included an amended hospital transfer form and this along with other changes was to be discussed at the next team meeting. One recent development included the use of a Care Summary at the front of care plans to assist new and agency staff to quickly access important information about people. People had body charts and skin ointment records which showed when they had received topical creams to treat skin conditions. These were accurately completed. Staff and people's records were securely filed in a locked cabinet in the office when not in use. However, staff had access to the daily records they required to help them deliver the care people needed.

The management team were new and in the process of agreeing dates for meetings to discuss day to day management topics and future governance of the home with the provider. We asked to see records of what regular support the new management team, including the manager and deputy were receiving from the provider to address the previous inspection shortfalls and to address day to day responsibilities. There were no records of meetings between the provider and the management team to discuss or address the governance needs of the service. However, the manager told us that Keep In Touch (KIT) contacts took place. We asked how these were used to

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make changes but were told that these were informal and unplanned and therefore there were no records of actions discussed or agreed. The manager explained however, that further management meetings had been arranged with the provider in November 2015 and beyond to discuss service progress and home improvements and these meetings would form the basis of future developments.

Checks were carried out on the quality of the care provided by staff and actions were taken accordingly. For example, medicine checks were carried out by the manager and an external agency and improvements were made and sustained.

Relatives explained how the new management team had improved the atmosphere and the running of the service. This was also confirmed by staff that made positive comments about working at the home and the improvements they had seen. Although people at the home had not been asked for their views through a survey, people felt that ideas and feedback were welcomed by staff. The manager told us that surveys would be carried out once the initial and important developments were addressed as there were priorities identified by the new management team.

One person we spoke with said, "What a lovely atmosphere and now that the new management has started it is even better". One relative said, "This place has improved a 100 per cent in the last three months since the senior managers have been here". Someone else told us that the new manager, deputy and administrator had made positive changes to the home. These included improved domestic and housekeeping skills, and a greater choice of food. Staff were seen working well together to meet people's needs. A relative said, "Much friendlier, approachable and very efficient; we've all seen quite a change for the better" and "If something needs attention or you need to speak with the manager, they make time and are pleased to help".

At the recent meeting with people and their families, the manager explained that new bed linen and more sheets and towels had been ordered and a wet room was in the process of being developed. The first meeting was used to introduce the new manager to people and their families. In the meeting, points about staff recruitment, activities, person centred care plans and new documentation were discussed and explained. People were told about future plans to request people's GP's attend the home to carry out regular medicine reviews.

The manager described future improvement plans to develop a dedicated space for peaceful and quiet reflection in the garden area. Discussions also included a newly placed bed linen order and requests for moving and handling resources like a new sliding sheet. The manager told us that although the service did not have an identified set of values for staff to follow; thought had been given to the term LIFE (Living in a Friendly Environment). The manager explained that this was felt to be a description of the values of the service and what people could expect. The manager told us this would be discussed with the provider and staff at the next management and team meeting.

The manager and staff told us they encouraged an 'open door policy' and used team meetings to discuss ideas and look at ways to improve the service. Staff contribution was welcomed and recent discussions included improving activities for people. Recent service improvements included a full review of laundry care and housekeeping, health and safety and infection control resources. Staff had discussed and requested more waste bins and disposable gloves and improved soap dispensing units. These had been ordered and received.

Senior staff commented, "We bounce ideas off of each other, we know how things should be done and we have experience". Staff told us they were much happier with the new management team and had noticed significant differences in the overall efficiency, support and atmosphere. All staff felt that the team worked well together and were supportive of each other, particularly since the new manager, deputy and administrator had been employed. Staff told us they were asked for feedback and felt involved in developing the service. Comments used by care staff to describe their recent experiences in the home were, "Lovely environment now that new managers are here; a breath of fresh air", "confident to make suggestions and contributions", "I've learnt a lot from my colleagues" "relaxed, never hurried" and "very supportive team". One comment included, "Very friendly team, the manager is hands-on and visible, likes to know what is happening". Healthcare professionals described an organised home, one said, "It's improved massively since the new management started, communication particularly and it's more relaxed".

As part of effective governance we asked to see records of how the service was maintaining its equipment and

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resources including gas and electrical safety checks. Although records could not be found for previous checks the new management team had requested immediate safety checks on these systems and other equipment like the lift and weighing scales. These had been carried out and completed and the certificates were made available to us. We checked fire equipment including extinguishers and these were maintained within their specified check dates. Senior staff had arranged for quality checks to be carried out on people's call bells to ensure these were working and well maintained.

The manager explained that a meeting had been booked for early November 2015 to discuss and review the home's policies and procedures to reflect the necessary changes required at the home to bring about effective governance.

The home was required to have a registered manager in post as part of their condition of registration. There was no registered manager in post at the time of the inspection. The manager had recently taken up employment at the service in June 2015 and was in discussions with the provider about the registered manager's role and how this requirement would be met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had systems and processes in place to assess and monitor the service but did not take prompt action to improve some findings. Regulation 17(1)(2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.