Tamaris Care Properties Limited

The Meadows Care Home

Inspection report

New Road
Boldon Colliery
Tyne and Wear
NE35 9DR

Tel: 01915364517
Website: www.fshc.co.uk

Date of inspection visit:
22 August 2016
24 August 2016

Date of publication:
30 November 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 22 August 2016 and was unannounced. This meant the provider and staff did not know we were coming. A second day of inspection took place on 24 August 2016 and was announced.

The Meadows Care Home is registered to provide nursing or personal care for up to 69 people, some of whom may live with dementia. At the time of our inspection there were 46 people living at the home, 19 of whom required nursing care.

A registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the last inspection of the home in March 2016, we asked the provider to take action to make improvements. This was because we found the provider had breached a number of regulations. We found the quality of the service had not been monitored effectively to ensure issues relating to people's care and welfare were identified and investigated in a timely manner. Staffing levels were not sufficient to safely meet the care needs of the people who used the service. Staff did not always have the time for meaningful one to one contact with people. There was a lack of continuity of qualified nursing staff. The registered provider was not following the requirements of the Mental Capacity Act (MCA) 2005 to support people to make decisions about their care. Some decisions had not been made in line with the MCA, such as for the administration of medicines covertly and the use of bedrails to keep people safe. People had been placed at increased risk due to staff not following the advice of health care professionals. Systems and processes to maintain complete and accurate care records were ineffective. Safe recruitment practices had not been followed. People were not supported to ensure their nutrition and hydration needs were met in a dignified manner. The meal time experience lacked co-ordination and was disorganised. People's food and fluid charts were not always completed or accurate.

During this inspection we found the provider had made improvements in some areas. The overall rating for this service is now 'requires improvement' so the service is no longer in special measures. We have made recommendations about the management of some medicines, dining arrangements, the specialist needs of people with dementia, activities and quality monitoring.

People said there was enough staff on duty, but relatives and some staff we spoke with felt more staff were needed. Since the last inspection the provider had recruited more nursing staff so there was now continuity of nursing staff.

Staff did not always have time to spend on a one to one basis with people. During this inspection we found this had not improved. We observed some occasions when staff spent some time on a one to one basis with people, but this happened infrequently as staff were mainly busy elsewhere.

Improvements had been made to the arrangements for people who required specialist diets. People with nutritional needs such as swallowing difficulties had a specific care plan about how they should be supported, which was shared with care and kitchen staff. People who required pureed foods were served these in a more attractive way than previously.

Improvements had been made to the safeguards that were in place for people who did not have capacity to make some significant decisions. People were encouraged to make their own day to day choices. The registered provider was following the requirements of the Mental Capacity Act 2005 (MCA).

People were supported to access health services when they needed these, but not everyone had a health action plan in case of emergency treatment.

People told us they felt safe at The Meadows. One person told us, "I feel as if I'm at home." People spoke positively about the caring nature of staff. One person said they were "very happy" with the care they got and that "The girls couldn't be nicer. They are very helpful and very kind."

A relative told us, "We're really happy with [family member's] care. They're very happy here. The staff treat [family member] like one of their own."

Staff received training, supervisions and appraisals to support them in their job role.

Care records we viewed had been rewritten since the last inspection and showed people's current individual needs. These were reviewed and updated regularly or when people's needs changed.

People, relatives and staff had regular opportunities to provide feedback although it was not always clear what action had been taken as a result.

The provider's quality monitoring processes had led to some improvements since the last inspection, but there were still areas for improvement.

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 always safe.

Medicines were not always managed safely as there was no clear guidance for staff to follow regarding 'when required' medicines.

Relatives and some staff felt more staff were needed.

People felt safe and there were systems in place to safeguard them from harm.

Accidents and incidents were recorded and investigated appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Meals were not served in a timely way and people who needed assistance did not always receive sufficient support with their meal.

The registered provider was following the requirements of the Mental Capacity Act 2005 (MCA).

Staff had sufficient knowledge and skills to meet people's needs.

Guidance from health care professionals was updated in people's care records and followed by staff.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always have time to spend with people on a one to one basis.

People spoke positively about the caring nature of staff.

There were good interactions between staff and people who used the service, particularly those living with dementia.

Relatives told us staff knew people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had limited opportunities to take part in meaningful activities.

There was a complaints system in place, but it was not always effective in resolving concerns.

Care plans were up to date and reflected people's current needs.

Clear guidance was in place about people's individual needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality monitoring processes had led to some improvements since the last inspection, but there were still areas for improvement.

People's feedback was sought regularly but not always acted upon.

Regular staff meetings identified actions to improve the service.

Staff felt the service was better organised since the last inspection.

The Meadows Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 August 2016 and was unannounced. A further visit was carried out on 24 August 2016 which was announced. The inspection team consisted of two adult social care inspectors, a specialist professional adviser with a nursing background and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

Before the inspection we also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 20 people living at the service and 10 relatives. We also spoke with the registered manager, the regional manager, the residents' experience manager, two qualified nurses, one senior care worker, one personal activity leader (PAL), eight care staff, and two members of catering staff.

We reviewed 14 people's care records and records for eight staff. We also reviewed supervision and training information and records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. Some people took medicines 'as and when required', such as painkillers. There were no detailed guidelines for staff to follow which explained when a person may require these medicines. Staff described when they would administer 'when required' medicines but there was no clear guidance for them to refer to. This meant people could be at risk of not receiving medicines when they needed them, particularly those who could not always communicate their needs.

When 'as and when required' medicines were administered complete records were not always kept. For example, we found several occasions when a person's painkiller had been administered and documented on the MAR but the reason for administration had not been recorded. This meant the person's symptoms may not have been monitored appropriately.

Prescribed creams were not recorded as administered on topical medicines application records (TMARs) and body maps to highlight where staff should apply the creams and ointments were not in place. Staff told us where people's creams needed to be applied and how often, but records relating to this were incomplete. This meant we could not be sure prescribed creams had been administered in the right way or at the right frequency, in line with the instructions on people's prescriptions.

We recommend that the service consider current guidance on 'as and when required' medicines and prescribed creams and take action to update their practice accordingly.

Medicines that are liable to misuse, called controlled drugs were recorded and stored appropriately, although the key for the controlled drugs cabinet was kept with other keys for medicines, contrary to current guidance. Records relating to controlled drugs had been completed correctly.

There were several occasions in the last four weeks when the temperature of the treatment rooms, where medicines were kept, had slightly exceeded the recommended safe temperature for storage of 25°C. This was due to the hot temperatures outside as it was summer. The regional manager told us they would monitor the situation and obtain more fans if necessary.

People needed some medicines which required refrigeration. Staff told us the temperature of the medicine fridge was checked daily to make sure these medicines were safe to use and records confirmed this.

The service operated a monitored dosage system (MDS) for administering routinely prescribed medicines, with medicines supplied on a seven day cycle. A MDS is where medicines are pre-packaged for each person, according to the time of day. We saw people received their medicines at the time they needed them. We found no gaps or inaccuracies in relation to routinely prescribed medicines. Up to date photographs and key information was attached to people's medicines records so staff could identify the person and be aware of any special precautions before they administered their medicines. This meant people received their routinely prescribed medicines as directed.

The last legionella risk assessment carried out in September 2014 classed the premises as high risk. A number of remedial actions were recommended and a follow up review was recommended to take place in September 2015. Also, we viewed a fire risk assessment which was dated December 2014. We asked the registered manager whether the recommended actions from the legionella assessment had been completed, if a follow up risk assessment had been conducted and whether the fire risk assessment was up to date. The registered manager said the provider's health and safety team would have dealt with these matters so they passed our request for information to them. We also requested this information after our inspection but to date have received no response. We are following this up outside of the inspection process.

The provider used a specific dependency tool called 'CHESS' to determine staffing levels in the service. People were categorized into low, medium and high dependency based on their individual support needs, and records confirmed the dependency tool was reviewed regularly. Staffing levels reflected those suggested by the provider's dependency tool.

People, relatives and staff had mixed views about staffing levels. One person said, "There seems to be enough staff. They are helpful, they are just there". Another person told us, "They're always there when you want them."

Relatives told us more staff were needed. One relative told us, "There's always a problem with staffing levels". Another relative said, "I've always felt that that they need more staff. Most people need two people to assist them so what happens to the others whilst they are being helped?" A third relative said, "It's disorganised chaos. They all need to work smarter because it's not efficient. There are no contingencies if staff ring in sick. Care staff get put on cleaning or in the kitchen." On the second day of our inspection we found a member of care staff was covering kitchen duties.

Staff had mixed views about staffing levels. One staff member told us, "[Staffing] is enough to keep people safe, although sometimes it's bit chaotic." Another staff member said, "We can manage but if a resident needed to go to hospital it's difficult."

Other staff felt there was enough staff. One staff member told us, "We've got enough staff. Covering for sickness can be an issue but staff rally round and go above and beyond. We've got a good skill mix here." Another staff member said, "I feel there's enough staff. I've been to other homes and they're desperate."

During this inspection we noted call bells were answered in good time so people didn't have to wait too long. People and relatives told us call bells were usually answered as quickly as possible. We did observe several occasions when people were unsupervised in communal areas for periods of time.

When we asked the registered manager about staffing levels they said, "We've got enough staff but we could work more efficiently. We've now got a team leader in post to help with this and we've recruited two permanent nurses." This meant there was now continuity of nursing staff.

People told us they felt safe although most of them were unable to give specifics. One person said, "The general place is nice, there's no roughness". Another said, "I feel as if I'm at home."

Most relatives told us they felt people were safe. One relative commented, "I can go to bed and have peace of mind that he's looked after and that's what I want." Another relative told us, "I know he's safe because he's in good hands here. I can go on holiday and not worry about him at all. It's marvellous."

Staff told us, and records confirmed, they had completed training in safeguarding vulnerable adults and this was updated regularly. Staff understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people who lived there. Staff also understood the provider's whistle blowing procedure. One staff member told us, "I've whistle blown before and I would do it again without any hesitation. Residents are my top priority."

We looked at recruitment records for two staff members who had started to work there since the last inspection. The recruitment practices for new staff members were robust and included an application form and interview, references from previous employers, identification checks and checks with the disclosure and barring service (DBS) before they started to work at the home. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. This meant there were adequate checks in place to ensure staff were suitable to work with vulnerable people.

Accidents and incidents were recorded, dealt with appropriately and analysed monthly. Action following an incident or accident was evident, for example increased observations for people who chose to stay in their rooms who had a history of falls, and referrals to the falls team where appropriate.

Risks to each person's safety and health were assessed, managed and reviewed. These included risks associated with medicines, nutrition, mobility and skin care. Appropriate action was taken to reduce the risk of harm to people. For example, people who were at high risk of falls had equipment such as sensor alarms in their bedrooms to alert staff to their movement.

Each person had a personal emergency evacuation plan (PEEP) which contained details about their individual needs, should they need to be evacuated from the building in an emergency. They contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation.

Regular planned and preventative maintenance checks and repairs were carried out by maintenance staff. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as fire safety, window restrictors and bed rails. External contractors also carried out required inspections and services including electrical and gas safety which were up to date.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in March 2016 we found the dining arrangements and support at meal times were not adequate for the people who lived there. This was because meals were not served in a timely way and people who needed assistance did not receive sufficient support with their meal.

During this inspection we found this had not improved. Some small lounges had been adapted to provide additional dining areas. This meant large dining rooms were not crowded. However it also meant there were occasions when there was a reduced staff presence as staff had to go along to the large dining rooms to collect meals and drinks and bring them back to the smaller dining rooms. When we spoke to the registered manager about this they said they were in the process of sourcing more hot lock trolleys to address this issue. They also said they had only recently begun using additional dining areas, so were trying to improve the practical arrangements around this.

During this inspection we found some people still did not have access to drinks or food until a late breakfast was served. In the small dining room on the ground floor people were seated from 0910 until 0940 before getting their breakfasts or a drink. One person commented, "We always have to wait (for meals and drinks). I don't know why they can't just put a kettle and toaster in here so the staff could make it."

People who needed physical assistance to eat their meals were not always provided with support in a timely manner. At one meal time during our inspection we observed five people needed assistance to eat but only one staff member was available.

At meal times on both days of our inspection some people waited half an hour or more before being given their meal. This caused some people to become anxious. A relative said, "Mealtimes are sometimes a bit disorganised."

We recommend that the service reviews the dining arrangements and makes the necessary improvements.

When staff did support people to eat they were engaged with people and knew how to encourage people to eat enough. One person who did not like to sit down at mealtimes was provided with food that they ate while walking around such as toast. At lunch time people were offered two choices of main meal and dessert. There were now pictorial menus outside each dining room with large pictures of the meal choices to support people's decision-making and communication needs. People were asked if they would like an apron to protect their clothes and their choice was respected.

Most people said the food was "nice" and "very good." People felt there was enough food and that it was good quality. People said they could ask for more food and alternative choices were available. One person told us they didn't like the food and two people said the portions were too big. A relative told us, "[Family member] has put on weight since they've been here and is drinking plenty which had been an issue in the past. They love the food here. It's great to see them with an appetite again."

We found improvements in the arrangements for people who required specialist diets. Where people had nutritional needs such as swallowing difficulties there were care plans about how they should be supported. Diet notification forms were completed for each person. The forms included details of any special dietary and texture requirements, for example whether people were diabetic or needed their food to be soft texture if they had swallowing difficulties. The form also included the likes and dislikes of each person. Copies of the diet notification forms were kept in the kitchen by catering staff and also in each person's care file. People who required pureed foods were served these in a more attractive way, for example each food item was pureed and positioned on the plate separately.

If people were identified as at risk of poor nutrition staff monitored and recorded their daily food and fluid intake. Food and fluid charts we reviewed had been completed accurately.

The registered manager told us, "Our focus has been on nutrition since the last inspection. We have reviewed people's risk of choking and now ensure that meals are individually labelled for those people who require specialist diets." We noted that staff had received group supervisions regarding choking, aspiration and nutrition and completed reflective practice in these areas.

Some people still did not have 'hospital passports' or emergency health care plans in place to guide staff as to people's future care wishes, such as whether or not the person wished to be admitted to hospital. This meant there was a risk of a mistake being made by a member of staff who did not know the person and was unfamiliar as to their preferred course of action.

The home provided care for several people who were living with dementia. However there were few design features in the home to support people who were living with dementia. For example, bathroom and toilet doors were painted green and had large picture signs to help people recognise these rooms. Coloured crockery was used to help people see their food. However bedrooms, offices and storage rooms all had white doors so were difficult for people to distinguish. There were memory boxes outside people's rooms which could be filled with familiar and personal items to help people find their rooms, but this had not yet been done. There were no themed areas to help people find their way around. There were very few objects of sensory or tactile interest for people as they walked around.

We recommend the service finds out more about current best practice in relation to the specialist needs of people living with dementia.

The home had a secure garden area to the side but staff said this was not used. There was also a courtyard garden with seating which could be accessed from a ground floor lounge. However there was no indication that people on the first floor had opportunities to sit outside. During the two sunny days of this inspection no one was supported to use the garden areas.

There was a well-furnished and pleasant reminiscence room on the first floor. This room was well-stocked with books, ornaments and other items that would stimulate the senses and provide useful discussion prompts. However, the room appeared to be used infrequently.

We recommend the service researches current best practice regarding the design of accommodation for the specialist needs of people living with dementia.

At the last inspection in March 2016 we found some decisions had been made that were contrary to the Mental Capacity Act 2005 Code of Practice. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for

themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

At the last inspection some people who lacked capacity were being given medicines without their knowledge (covertly) or had bedrails on their bed without a 'best interest' decision about these restrictions. During this inspection we saw this had improved.

There were now clear assessments about whether people had capacity to make specific decisions. There were records of 'best interest' decisions involving other health services and other appropriate people where people did not have the capacity to consent to such decisions. For example, one person was given their medicines in drinks without their knowledge because they refused their medicines which placed them at risk of poor health. The person had been assessed as lacking capacity to make this decision so a best interest decision had been made that involved the person's GP and the relevant person's representative. Other people had bedrails and lap straps on wheelchairs to keep them safe. There were MCA assessments and best interest meeting records to show how these decisions had been made. This meant people's best interests were now protected without compromising their rights.

Care plans about people's ability to make decisions and choices had been rewritten since the last inspection and were now clearer about how people expressed their consent and choices. For example the care plan about consent for one person who was living with dementia and had no verbal communication stated, "[Name] can make non-complex decisions such as what to eat and shows this by smiling and nodding if she likes what is being offered. Staff are to respect [name's] right to refuse."

People who were able to express their views told us they made their own choices over their own daily lifestyle. We heard staff ask people for permission before carrying out care tasks, such as supporting people to eat and drink and when offering medicines. In this way each person's consent was sought before providing care.

People's care records showed when other health professionals had input into people's care. These included, for example, GPs, dietician, occupational therapist and community nurses. We saw that guidance from health professionals was recorded and updated in people's care plans and followed.

The provider made sure staff had sufficient support with their professional development. Staff told us they had regular supervisions with a supervisor. Supervisions are regular meetings between a staff member and their supervisor, to discuss how their work is progressing and where both parties can raise any issues to do with their role. We saw staff had individual supervision about their performance and group supervisions with learning points for example about food and fluid charts and nutrition. During this inspection we found staff members who had been employed for over one year had taken part in an annual appraisal.

Training records showed staff members received up to date training and this included mandatory subjects such as moving and assisting, fire safety, food hygiene and first aid. Staff told us they felt they had sufficient training to support them in their role. For example one staff member told us, "We get enough training including dementia and safeguarding training. I was really proud to achieve my NVQ2 (national vocational qualification in care)." Another staff member commented, "We get plenty of training. It's good that it's not all

e-learning, for instance the dementia training was in a group which is better."

One person told us, "Staff seem nice and good at their job." A relative said, "Staff know what they are doing and if they're not sure they ask someone else - they work as a team".

Requires Improvement

Is the service caring?

Our findings

At the last inspection in March 2016 staff did not always have time to spend one to one time with people. During this inspection we found this had not improved. During this inspection we observed some occasions when staff spent some time on a one to one basis with people, but this happened infrequently as staff were mainly busy elsewhere. This meant the care provided was task driven rather than having a focus on personalised care.

One staff member said, "We have some time to spend with people to chat." A relative told us, "Care staff work their socks off but there's not enough of them." Another relative commented, "They are really good up here. The carers care and they talk to the residents, but often there's no one in the lounge when residents are sitting there."

At the last inspection in March 2016 information was not always provided in a format appropriate to people's needs to help them make informed choices. During this inspection we found some improvements had been made as pictorial menus were in use.

People spoke positively about the caring nature of staff. One person said they were "very happy" with the care they got and that "The girls couldn't be nicer. They are very helpful and very kind." The same person felt staff had got to know them and they were well cared for. Another person said about staff, "I love them. They're champion, top class."

A relative commented, "The staff here are really pleasant. They are like your friends. [Name of staff member] is particularly good, she's amazing." A second relative said, "The staff seem accommodating and friendly here." A third relative told us, "The staff here are marvellous. They all love my [family member]."

People and relatives told us they had a positive relationship with care staff, and felt staff knew people and their families well. A relative told us, "We're really happy with [family member's] care. They're very happy here. The staff treat [family member] like one of their own."

Staff commented that they felt valued by people and got satisfaction from supporting people. One staff member said, "It makes my day when a resident cuddles me or if their eyes light up when they see me." Another staff member said, "I really enjoy my job."

Some people who used the service were unable to tell us about the care they received, but throughout our visit staff addressed people in a kind and considerate manner, and communicated with people as individuals. For example, by giving people time to respond to questions and keeping sentences short. There were good interactions between staff and people who used the service, particularly those living with dementia. For example, we saw one staff member comforting and reassuring a person who was anxious by stroking their arm and speaking to them softly.

The service had received several written compliments from family members of people who used the service.

One relative wrote, 'Staff are always very attentive and make us feel welcome.' Another relative wrote, 'I would definitely recommend this home to family and friends.'

Each person who used the service was given a residents' guide (an information booklet that people received on admission) which contained information about all aspects of the service. This included the service's statement of purpose, how to make a complaint, and how to access independent advice and assistance such as an advocate.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in March 2016 we found that people had limited opportunities to take part in meaningful activities. This had not improved.

People and relatives told us that on admission they were asked about a person's life history, preferences and choices. However nobody we spoke with could provide examples of how that information was used to provide meaningful activities for people who lived there.

People and relatives said there was not much to do and no opportunities to go out. One person told us, "I feel fastened in. I never go out. If I won the lottery I would buy a bus for them to take us for a run out. I can't see the telly, so I just sit in my room all day." A relative told us, "There's not much to do in the way of activities and the activity staff is not very encouraging with people." Another relative said, "There's a lack of variety when it comes to activities. There is some one to one time which largely revolves around chatting." A third relative commented, "There's not enough for people to do. There was a quiz this morning but people never go out."

The home employed two personal activities leaders who worked alternate shifts. A list of available activities was displayed on a poster in the main reception area, but this was not displayed in other areas. The poster advertised general activities such as 'indoor activity' or 'games'. There was not much variation of activities throughout the week. Daily living tasks such as dusting or tidying did not feature in the home as part of supporting meaningful activity.

Group activities included games, bingo, indoor zoo and entertainers. The home had recently had a 'looking back in time' activity where headsets were worn to give people a visual reminiscence experience.

People did not go out in the community as a regular part of the activity programme. There were no regular outings or shopping trips. When asked about outings for people one staff member said "I've never known them go out anywhere."

We recommend the service seeks advice from a reputable source about the activities provided.

One staff member told us, "Care staff do activities with people such as pampering for the ladies and showing DVDs of old football matches for the men as people seem to like this. We're planning on turning one room into a pub."

People we spoke with were unable to tell us if they knew how to complain or not. One person said, "I'm not sure who to complain to." They added they didn't have any complaints at the time. Relatives we spoke with said they knew how to complain and some of them had done so. Three relatives said they felt listened to when they had complained but that not much had changed as a result.

The registered manager kept a log of informal complaints which was good practice, but it was not always

clear what action had been taken. Five informal complaints and three formal complaints had been raised since the last inspection in March 2016. These had been dealt with in a timely manner but had not always been resolved to relatives' satisfaction. For example, one relative commented, "I raised issues about staffing levels but it's still the same." Another relative said, "There were a few teething issues when [family member] moved in, but there was nothing major and this was dealt with straight away."

Two relatives felt they were not included in care planning and reviews and that there were problems with communication. This relative told us, "You have to ask for information rather than it being given to you." Another relative told us they were not informed when their family member was referred to a health care professional. They said, "They didn't tell me they were referring [family member] to this team. I wasn't very happy. Communication in here leaves a lot to be desired."

At the last inspection we found that care plans did not always reflect people's current needs as care plan evaluations were not up to date. During this inspection we found improvements in this area.

The care records we viewed had been rewritten since the last inspection and showed people's current needs. These included care plans that set out people's individual needs and how they required assistance. For example people had plans of care for daily needs such as mobility, personal hygiene, nutrition and health needs.

Care plans guided staff to provide the right support to meet people's individual needs. For example, one person who was living with dementia could become agitated so had a care plan in place that described their specific behaviours and difficulty communicating the reasons they were upset. The care plan guided staff to use positive behaviour practices, for example eliminating the possible cause of the person's agitation such as pain, hunger, or continence needs. The care plan directed staff to use positive body language to reassure the person using a low, calm voice. Another person's care plan about medicines described how the person may on occasion refuse their medicines. The care plan advised staff to return a few minutes later and keep trying as they were likely to take it.

Care plans were reviewed on a monthly basis or more often if people's needs changed. People had been included in their own care planning, where capabilities allowed. Some people had limited involvement in their care planning because they could not always communicate their needs fully.

Most relatives we spoke with felt they were involved in their family member's care. One relative said, "They always inform me if anything happens." Another relative told us how one staff member had tried different approaches to reduce their family member's anxiety. This relative told us, "All the way she's told me everything that's going on. I felt reassured."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in March 2016 we found the provider's systems had not been effective in assessing, managing or improving the safety or quality of the care service provided to people who lived there. At that time the home had been accommodating a number of people from another home operated by the provider which had closed due to an emergency. The provider did not have a plan to manage the integration of the two groups of people or staff teams. The provider had not made sure that people received personalised, safe care.

During this inspection we found some improvements had been made, specifically to people's safety and care documentation. The provider and registered manager acknowledged there were still improvements to be made in the areas we identified during this inspection. Staff felt the service was "better organised" and staff said they were "not as stressed" as previously.

After the last inspection the provider identified in excess of 300 actions required to bring people's records up to date and to reflect people's current needs. This meant processes prior to the last inspection had failed to effectively identify issues and manage them in a timely way. During this inspection we found improvements to the way care documentation was being monitored. Care records were being regularly checked and audited to ensure the required care components were in place, such as assessments relating to mobility and skin integrity to guide staff in people's specific needs. The provider's audits showed that the quality of care plans records had improved from 47% to 90% in the past four months.

Since the last inspection the provider and registered manager had compiled a detailed service improvement plan. The provider submitted regular updates on the progress of this plan to the CQC and the local authority. The registered manager acknowledged that whilst improvements had been made in some areas since the last inspection, improvements in other areas were still needed.

We recommend the service continues to assess the quality of the service provided.

The manager's application to become the registered manager was approved shortly after the last inspection, so they are now the registered manager for this service. They carried out daily walk rounds and weekly 'flash meetings' with heads of department within the home to discuss the safety of the service and give instructions that could be cascaded to all staff. A regional manager carried out monthly audits of whether internal checks had been carried out for example, staff views, care records, medicines audits, dining experience and incidents. Although the provider's own quality monitoring system indicated that there had been improvements it was too early to tell if this would be maintained.

Staff stated they had opportunities to use the quality of life iPad system to give their views anonymously. They also had staff meetings where they received direction about expected standards of service. The service held a number of senior, clinical and health and safety meetings with key staff where actions and improvement were identified and set out in an action plan. Actions included nursing staff now carrying out visual checks of pureed or softened foods with the catering staff before these left the kitchen to ensure they

were the right consistency. At this time the nurse and cook signed a record to show they had viewed the food but the record did not identify the type of food consistency or who it was for so was limited in its value.

The registered provider used a real time electronic system for gathering feedback from people, family members and visitors using iPads located in the reception areas. This meant feedback could be given anonymously at any time and be analysed immediately by the provider. People and relatives also had some opportunities to attend meetings with the provider and registered manager. However there was not much evidence of feedback to people about their comments and what actions had been taken. There was a 'you said, we did' notice in the hallway but this was dated March 2016 and people had given more recent views since then.

At a residents and relatives' meeting in June 2016, relatives had suggested more trips out and making better use of community resources such as performing arts students but there was no evidence that this had been acted upon. One relative commented, "I feel I can talk to the registered manager and he listens, but not much changes." Another relative said, "The manager here is excellent."

The provider had held consultation meetings with people and relatives about proposed changes to the ownership of the service. The meetings had included representatives from the proposed new provider and from the local authority.

The service provided two units for people who were living with dementia, including a nursing unit. However at the time of this inspection there was no dementia strategy for the home and no connections or contact with local or national dementia groups. The home had no visions and values about how the home would support and enrich the lives of people who were living with dementia.