AJ & Co.(Devon) Ltd

Meadowside and St. Francis

Inspection report

5 Plymbridge Road
Plympton
Plymouth
Devon
PL7 4LE

Tel: 01752347774

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 01, 02 and 07 February 2018.

Meadowside and St Francis is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home is registered to provide care for up to 69 older people. On the days of the inspection, 40 people lived in the home. The provider also operates another nursing home in the same locality.
In June and July 2017, the service was rated Inadequate and was placed into special measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

We told the provider to make improvements to ensure people were kept safe from abuse, that people's medicines were managed safely and risks associated with their care were known by staff and risks mitigated. We also asked the provider to ensure they followed infection control practices to help reduce the risk of the unnecessary spread of infection, and to make sure there were enough suitably trained staff to meet people's needs, and that staff were recruited safely. In addition, people's nutritional needs were not always known and met safely by staff, people's human rights were also not being protected, and people's privacy, dignity and independence was not always respected. Action was also required to ensure people's changing healthcare needs were monitored so responsive action could be taken, that people's care records were created in line with people's wishes and preferences, and that they were an accurate reflection of how their care and support needs should be carried out. Improvements were also required to the leadership and culture of the service. People's confidential information was not always held securely, the provider did not use valuable feedback to help improve the service, staff did not always feel management were approachable, and there were ineffective quality monitoring systems in place to help identify when improvements were required.

Immediately after our inspection, the provider told us they would voluntarily stop new admissions to the service, in order for them to put things right. They also employed a health and social care consultant to help advise them about how they could make improvements, and a robust action plan was submitted to the Commission. We also contacted the local authority safeguarding team who took prompt action to ensure people's health, safety and wellbeing.

During this inspection the service demonstrated to us that improvements had been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. However, whilst action had been taken, some improvements were still needed and ongoing, and where improvements had been made, more time was required to demonstrate they had been embedded in practice and could be sustained.

Since our last inspection the manager had now registered with the Commission and was now the registered manager of the service. 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.

A new management structure had been put into place to help drive improvement and to support staff. This included a new clinical lead, a clinical manager, and a quality manager. The provider spoke proudly of the staff he had employed into these roles, and it was obvious from their interactions with us, that they were a cohesive team, who were passionate and fully committed to improving the service. The service unlike before, no longer felt like two different care homes, but was now more joined up, with staff engaging and leaning from each other across both the residential care home and nursing home.

The registered manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service, for example care plan, medicine and environmental checks. However, these had not always been effective in identifying where improvements were required, such as with the risk management of peoples care, accuracy of people's care records, making sure people's human rights were promoted, and that people's privacy and dignity was respected. The provider had continued to trust the registered manager and staff team, without having effective systems and processes in place to check what was actually occurring within the service. By the end of our inspection, a new provider monthly audit had been created by the registered manager and provider, and would be used.

Changes to clinical management and governance, was in its infancy, and were still being developed. The introduction of a new clinical lead and clinical manger would help ensure clinical practices were monitored.

People had chosen what they wanted the ethos and culture of the service to be, placing them at the heart of the service. People and staff's views were obtained to help with the ongoing development of the service. People and families told us that staff, were kind and caring, and since our last inspection, they had visibly seen the change in the atmosphere and culture of the service. Telling us, "I am staggered at the turnaround in the culture and atmosphere since your last inspection, and importantly I am confident it's not just for effect".

The provider had introduced the voices forum which was a new meeting that took place each week, with people and their relatives. The ethos of the forum was to ensure people's voices were heard. People spoke positively of this new approach.

Staff told us they now enjoyed coming to work, and expressed how well they felt supported. Staff recognised the service was undergoing continued development and ongoing improvement, but were committed to be part of the process, with one member of staff telling us, "Everyone has signed up to improve the service".

People lived in a service whereby the registered manager, provider and management team were continually learning, which helped to adapt and improve the service. Partnership working with other providers was important to the registered manager to help keep on top of ongoing developments and changes in the sector.

Following our last inspection, the provider and registered manager had met with people, relatives and staff to share the findings of the inspection and rating given. Relatives had told us, how they had appreciated this, and the honesty shown at a difficult and challenging time. This open and transparent approach

demonstrated the providers understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong.

Whilst there had been improvements relating to the management of risks associated with people's care, by implementing risk assessments to help guide staff about how to mitigate risks and by holding more detailed staff handovers. Risk assessments continued to not always be in place when a person had a specific healthcare.

Overall, the arrangements for managing medicines had improved, with one relative telling us, "The medication regime has improved immensely". However, people's medicine administration record (MARs) charts were not always accurate or legible. This meant it was not possible to be sure whether people received their medicines in the way prescribed for them.

People and their relatives told us they felt safe commenting, "I feel that I am safe living here", and I am happy that my relative is safe and well cared for here". People were now protected from abuse and improper treatment, and staff acted to keep people safe. Safeguarding had become a topic which was now being openly discussed with people and their families, helping to empower them to share with staff if they felt vulnerable, so immediate action could be taken to protect people.

People lived in a service whereby staff, were now recruited safely to ensure they were suitable to work with vulnerable people. To help improve recruitment practices there had been a change in the management of this area.

People were now supported by suitable numbers of staff to help ensure their needs were met. The registered manager had taken into consideration the Commission's recommendation made at the last inspection, and would be implementing a staffing tool to help assure that staffing levels met with the needs of people. The provider had also installed a new call bell system, which meant the response time to staff answering call bells was now being monitored, helping to identify trends so necessary action could be taken, such as increasing staffing levels at particular times of the day.

People lived in a clean and odour free environment. Staff had been trained in infection control and put their knowledge into practice. People lived in an environment which was now being assessed for safely. People's accidents and incidents were now being monitored to help establish if themes were emerging so practice could be changed. The provider was responsive when things went wrong and used their learning to help improve the service.

Overall, people's healthcare was now being monitored and action was being taken to promptly contact the relevant health as social care professionals. However, people's care plans were not always updated to help ensure the effective management of a healthcare condition. People's health and social care needs were now being assessed in an organised way, however ongoing proactive approaches to people's nursing care, were not always identified or discussed amongst the nursing team, to help ensure people's care and support needs were met in line with best practice.

Overall, people now had care plans in place for their health and social care needs, but these continued to be developed. However, people with nursing care needs, did not always have care plans in place to help guide staff about how to meet people's needs. People's confidential information was now stored securely.

People who had nursing care needs, did not always have their human rights protected because, despite staff

and management undertaking training, there was a limited understanding of the legislative frameworks relating to the Mental Capacity Act 2005 (MCA). People's consent to care had now been obtained. Staff, were observed to ask people for their permission prior to supporting them.

People's individual communication needs were known by staff, however they were not always recorded in people's care plans to help ensure a consistent approach to care. The provider had also not considered whether care plans were in a suitable format for people to read. People were now supported effectively with their nutrition, and had care plans in place to help guide staff to deliver the correct support.

Overall, people now received care from staff who had undertaken training to help meet their individual needs. However, training specific to people's needs had not been completed, for example in skin care and epilepsy. One to one supervision of staffs practice and appraisals of performance, were now being undertaken with staff telling us they felt "supported". The new quality manager worked with staff on a one to one basis, helping to role model outstanding practice.

Clinical competency was now being assessed in areas such as medicine management and tracheostomy care, and robust training records were now being held. This meant there was now a comprehensive overview of nurse training, to help demonstrate that they were practising safely and effectively.

People lived in a service which was adapted to meet their needs. The entrance to the service had wheelchair access, and bathrooms and toilets had assisted equipment to help people with mobility difficulties.

Overall, people's privacy and dignity was now being respected. The management team led by example and were role models amongst the staff team. However, many bedrooms doors were open and when we spoke with staff about the reason for this, we were told it was to ensure people's safety. This meant this decision had been made without considering the impact on people's privacy. People's individual equality and diversity needs were known, for example people's religious and cultural needs were known and respected.

People's independence was now being promoted. Staff told us how they encouraged people to do as much for themselves as possible. People and their families had started to be consulted about the content of their care plans to help ensure they met with their needs.

Overall, people told us the laundry service had improved and that items of clothing did not get lost as much, commenting "The laundry system works much better now". However, one person told us they still asked their family to take their laundry home, because they were not satisfied with how it operated.

Overall, people were supported respectfully at the end of their life. However, care plans were not always individualised to help ensure staff knew what people may specifically want. Such as, people who they may want to be present and music they may like played in their final days and hours.

People's opportunity for social engagement was developing and improving. The 'one more time' project had been created, to capture and recreate what people had previously loved to do, and to relive fond memories from their past.

People's comments and complaints were respectfully listened to, and used to help improve the service, with one person telling us "Things have improved since (the registered manager and quality manager) have arrived. Now I feel that if I raise a problem, it will be addressed". The provider's complaints policy was given to people when they moved into the service, and was displayed within the service. However, the policy may not have been in a suitable format for everyone to understand. The manager told us, they would take action

to review this.

We recommend that the provider takes account of the Accessible Information Standard (AIS) to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

You can see what action we told the provider to take at the back of the full version of the report.

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

We found that action had been taken to improve the safety of the service, but improvements were still required and ongoing.

People's risks associated with their care were known by staff, but these continued to not always be documented to help ensure they received safe and consistent care.

Overall, people's medicines were managed safely. However, records were not always legible which meant it was not always clear if people had received their medicines or not.

People were protected from abuse.

People were supported by suitable numbers of staff to ensure their needs were met.

People lived in a clean and odour free environment.

The provider was responsive when things went wrong and used their learning to help improve the service.

Is the service effective?

Requires Improvement

We found that action had been taken to improve the effectiveness of the service, but further improvements were still required and ongoing.

People's human rights were not always protected.

People's individual communication needs were known by staff, however this was not always recorded in people's care plans to help ensure a consistent approach to care.

People had access to a range of healthcare professionals when required.

People received care and support from staff who had undertaken relevant training to meet their needs.

People were supported with their nutrition, and had care plans in place to help guide staff to deliver the correct support.

People lived in a service which was adapted to meet their needs.

Is the service caring?

Good

The service was now caring.

Overall, people's privacy and dignity was protected.

People and their families told us staff were kind and caring, and that there had been an obvious change to the atmosphere of the service.

People's individual equality and diversity needs were known, and respected.

People were being actively involved in making decisions about their own care and support.

Is the service responsive?

Requires Improvement

We found that action had been taken to improve the responsiveness of the service, but further improvements were still required and ongoing.

People's care plans did not always include sufficient information to ensure care was delivered consistently, and in a way people chose and preferred.

People's comments and complaints were respectfully listened to, and used to help improve the service.

People were supported respectfully at the end of their life. People's care plans continued to be developed.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve the leadership of the service, but further improvements were still required and ongoing.

The registered manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service. However, these had not always been robust in identifying areas requiring improvement.

A new management structure had been put into place to help drive improvement and to support staff.

People had chosen what they wanted the ethos and culture of

the service to be, placing them at the heart of the service.

People and staff's views were obtained to help with the ongoing development of the service.

People lived in a service whereby the registered manager, provider and management team were continually learning, which helped to adapt and improve the service.

Partnership working with other providers was important to the registered manager to help keep on top of ongoing developments and changes in the sector.

Meadowside and St. Francis

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.

We visited the care home unannounced on 01, 02 and 07 February 2018. The inspection team consisted of two adult social care inspectors, a specialist advisor for older people's nursing care, and an expert by experience - this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We also contacted Healthwatch Cornwall, the clinical commissioning group and the local authority quality and service improvement team to ask if they had any feedback about the service. Where feedback was provided, it can be found through-out the inspection report.

During our inspection, we spoke and met with 17 people living at the service, 11 relatives, 21 members of staff, the residential care manager, the clinical lead, the clinical manager, the quality manager, the registered manager and the provider. We also spoke with a visiting healthcare professional to obtain their views about the service.

We observed care and support in shared areas. We spoke with people in private and looked at 14 care plans and associated care documentation. We assessed the environment for safety and looked at training records and catering records. We also looked at medicine administration records, training records, policy and procedures and quality assurance checks.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June and July 2017, we rated this key question as Inadequate because, people were not always kept safe from abuse and improper treatment, people's medicines were not being managed safely, and risks associated with people's care were not known by staff therefore risks were not always mitigated. Infection control practices did not always help to reduce the risk of the unnecessary spread of infection, there were not enough staff to meet people's needs, and staff, were not always recruited safely. During this inspection we looked to see if improvements had been made, and found action had been taken to address all areas, but improvements were still needed. Where improvements had been made more time was required to demonstrate they had been embedded in practice and could be sustained.

Whilst there had been some improvements relating to the management of risks because risk assessments were now in place to help guide staff about how to mitigate risks associated with people's care, they continued to not always be in place when a person had a risk relating to their health and well-being. For example, two people were at risk of choking. Whilst, the risk was known to staff, there were no risk assessments in place to help ensure people received consistent and safe care, by all staff. Another person had a bladder condition, and it had been detailed in the person's daily notes that a GP had asked it to be monitored. However, there was no risk assessment in place relating to the monitoring of blood clot formation and hydration. We asked the provider to immediately take action, and by day two of our inspection these were in place.

Overall, the risks associated with people's skin were now being managed safely. An assessment of people's individual care needs was now carried out, and documentation was in place for staff to record when they carried out care interventions, such as repositioning people. However, we reviewed the records for one person with a wound, and found they did not detail when the wound had been reviewed and measured, to help determine whether it was improving or not.

Overall, the arrangements for managing medicines had improved, with one relative telling us, "The medication regime has improved immensely". People were given their medicines in a safe and caring way. Action had been taken to improve how 'as required' medicines were given, and to ensure medicines were now being stored safely. In addition, policies and procedures had been updated to reflect the National Institute for Clinical Excellence (NICE) guidelines, and staff competency was being assessed to help ensure medicines were being administered safely, and staff told us that they had received updated medicines training.

Staff recorded when medicines were given on medicine administration record (MARs) charts, but when we reviewed the MARs across the service, two out of the three nursing MARs had gaps in the records. This meant it was not possible to tell if people's medicine doses had been given. The stock balances for one person also did not match the number of doses that should have remained in accordance with the running totals, or the number of doses signed for. MARs within the nursing area of the service were also sometimes illegible making it difficult to establish who had received what and when. This meant it was not possible to be sure whether people received their medicines in the way prescribed for them.

A new monthly audit was now in place and these had identified some issues with previous MARs, and actions taken as a result had been discussed and recorded. The current MARs were not yet due to be audited, therefore the issues we found had not yet been identified by the registered manager.

The provider had not ensured some risks associated with people's care were effectively mitigated. People's medicines were not always managed safely because documentation was not always accurate. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and their relatives told us they felt safe commenting, "I suppose I feel safe enough, though I'd sooner be living at home", "I feel that I am safe living here", and I am happy that my relative is safe and well cared for here". The registered manager had also carried out surveys asking people and their relatives about their feeling of safety. Responses included, "My family have put their trust in the staff to keep her safe and well looked after, and after five years they have fulfilled this commitment", and "I feel I am safe in the care home, staff are very good to me".

People were now protected from abuse and improper treatment, and staff acted to keep people safe, because staff knew what action to take if they suspected someone was being abused mistreated or neglected. Safeguarding had become a topic which was now being openly discussed with people and their families, helping to empower them to share with staff if they felt vulnerable, so immediate action could be taken to protect people. There was a formal process starting to be put into place, to help monitor clinical nursing practices, to ensure nursing care was being carried out safely and in line with associated best practice guidelines.

People lived in a service whereby staff, were now recruited safely to ensure they were suitable to work with vulnerable people. Disclosure and baring checks (DBS) were carried out and employment histories reviewed. To help improve recruitment practices there had been a change in the management of this area. This meant nursing staff applications were now being assessed in a more robust way.

People were now supported by suitable numbers of staff to help ensure their needs were met. Since our last inspection, the provider's occupancy level had reduced. However, despite this, they decided to retain the same numbers staff, and used the additional staffing resource as an opportunity to assess the staffing skill mix across the service, and to update staff on subjects such as moving and handling and fire safety. Since our last inspection, the provider had also installed a new call bell system. This meant the response time to staff answering call bells was now being monitored, helping to identify trends so necessary action could be taken, such as increasing staffing levels at particular times of the day. The registered manager had taken into consideration the Commission's recommendation made at the last inspection, and said they would be implementing a staffing tool to help assure that staffing levels continued to meet people's needs and keep them safe.

People's accidents and incidents were now being monitored to help establish if themes were emerging so practice could be changed. For example, one person who had been falling frequently had received a medicine review and had been referred to a falls clinic.

People lived in an environment which was now being assessed for safety. The management team walked around the service each day, taking note of where action was required and making improvements. People had up to date personal emergency evacuation plans (PEEPs) in place. This meant emergency services would know how to safely support people in an event, such as a fire.
People lived in a clean and odour free environment. Staff had been trained in infection control and put their

knowledge into practice. For example, people's tracheostomy equipment was now being cleaned as required and staff wore personal protective equipment (PPE) suitably. An infection control audit was carried out to help identify where improvements were required, and the registered manager was in the process of introducing an infection control champion. This member of staff would have infection control as an area of interest, and use their knowledge and enthusiasm to maintain and improve ongoing standards within the service.

The provider was responsive when things went wrong and used their learning to help improve the service. For example, the provider demonstrated they had positively used the outcome of their last inspection, to help drive improvement within the service. They had also listened to external feedback from health and social care professionals, about how to improve people's documentation, helping to keep people safe. One relative told us, "Since the last inspection there have been a lot of improvements. The home have taken the previous judgements seriously".

Requires Improvement

Is the service effective?

Our findings

At our last inspection in June and July 2017 we rated this key question as Inadequate because, people's nutritional needs were not always known and met safely by staff and people's healthcare was not always monitored to help ensure action was taken promptly to reduce deterioration. In addition, people's human rights were not being protected. During this inspection we looked to see if improvements had been made, and found action had been taken to address all areas, but improvements were still needed. Where improvements had been made more time was required to demonstrate they had been embedded in practice and could be sustained.

Overall, people's healthcare was now being monitored and action was being taken to promptly contact the relevant health as social care professionals. However, people's care plans had not in all cases been updated to reflect changes in their healthcare and to help ensure the effective management of a healthcare condition. For example, one person was suffering from severe constipation. Action had been taken to seek medical advice and to change medicines, and care delivery accordingly. An external healthcare professional told us staff implemented advice immediately. However, whilst responsive action had been taken to seek healthcare support and their care had been discussed within a staff handover, the person's care plan had not been updated to include the advice and guidance provided. The person's care plan also, did not contain any further information to help guide and assist staff in the support and treatment of the ongoing condition.

People's records were not always an accurate reflection of the care they required. This a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health and social care needs were now being assessed in an organised way, however ongoing proactive approaches to people's nursing care, were not always identified or discussed amongst the nursing team, to help ensure people's care and support needs were met in line with best practice. For example, the nursing team had not taken time to reflect and discuss new ways in which they could support one person who was now feeling better after a severe episode of constipation. This meant there had been a missed opportunity to review the person's care plan to help reduce reoccurrence.

We checked to see whether the service was now working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who had nursing care needs, did not always have their human rights protected because, despite staff and management undertaking training, there was a limited understanding of the legislative frameworks. Whilst the registered manager had tried to make improvements, people's care plans contained generalised statements about their mental capacity such as, "I have got full capacity", "I have capacity", and "lacks

capacity". This meant the assessment of people's capacity was an overall judgement, rather than it being decision specific.

Systems and practices did not always ensure people's human rights were understood and protected. 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). When a DoLS application had been made, the outcome of it had not always been accurately detailed within people's care plans to help ensure staff knew how people should be supported to ensure their human rights were protected. For example, one person's care plan detailed the wrong information for the reason their DoLS application had been approved. Their care plan detailed that it was because the person was now living at the service, however the actual authorised application, stated it was in place to support a restrictive practice. In addition, DoLS applications had not always been made appropriately. For example the DoLS team had reported back to the registered manager, that they had received an application for one person who had mental capacity. We asked staff about their understanding of why DoLS applications were in place, comments included, "I don't know what DoLs means" and "For the things we do to help the individual, like personal care".

People's human rights were not always protected because there was a limited understanding about the legislative frameworks. This a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent to care had now been obtained and was being recorded within their care plans. Staff, were observed to ask people for their permission prior to supporting them.

People's individual communication needs were known by staff, however they were not always recorded in people's care plans to help ensure a consistent approach to care. Whilst one person's care plan detailed they communicated with staff by blinking to answer "Yes", people who were profoundly deaf, did not have care plans to explain how staff should interact and support them. Another person needed staff to touch them on their arm, prior to being supported, because they could not hear or see. However, this was not explicit in the person's care plan therefore their relative told us staff did not deliver a consistent approach. The provider had also not considered whether care plans were in a suitable format for people to read.

We recommend that the provider takes account of the Accessible Information Standard (AIS) to help make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Overall, people now received care from staff who had undertaken training to help meet their individual needs. The registered manager had ensured staff undertook training they had deemed as 'mandatory'. Some of which included, moving and handling, dementia and equality and diversity. However, training specific to people's needs had not been completed, for example in skin care and epilepsy, but would be implemented. The provider had devised a new training record so they could easily see what training staff had completed and what was outstanding. An external healthcare professional told us, they thought staff, were knowledgeable. One to one supervision of staffs practice and appraisals of performance, were now being undertaken with staff telling us they felt "supported". The new quality manager worked with staff on a one to one basis, helping to be a role model, whilst displaying good practice.

New staff undertook an induction, and when necessary it incorporated the care certificate. The care certificate is a national induction, and aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

Clinical competency was now being assessed in areas such as medicine management and tracheostomy care, and robust training records were now being held. This meant there was now a comprehensive overview of nurse training, and a system in place to assist with the revalidation process of nursing staff. Revalidation is process that all nurses in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC), to help demonstrate that they are practising safely and effectively.

People were now supported effectively with their nutrition, and had care plans in place to help guide staff to deliver the correct support. There was a new board in the kitchen which detailed people's special dietary requirements, and was updated by care or nursing staff, when changes occurred. The kitchen staff spoke positively about the changes which had been made to help ensure people received the correct diet, commenting "There is a lot more communication now between staff". A new handover form had also been created to support with the effective management of people's nutrition, staff spoke positively about this new form, and told us how it helped them to remind themselves about people's individual nutritional support.

People had access to meals and drinks at all times and told us the food was nice, commenting, "The food here is good, I have mine here in bed" and "The food here is first class. I often eat with my relative and can't fault the choice or quality of the food". However, one relative commented, "More than once I've had to re-make my relative's afternoon tea. The trolley comes round in a set way, and those who receive their drinks first have them hot, but those who are towards the end of the round end up with tepid or even cold tea. I don't mind using the kitchenette to make fresh tea, but surely these arrangements could be changed?". We were told by the registered manager that recent action had been taken to review the process.

The registered manager had listened to people's feedback about the catering arrangements as some people had said they wanted plainer food, and simplified menus, by adding pictures and changing terminology. So action had been taken to review the catering provision, change the terminology and a visual menu was in the process of being created.

People lived in a service which was adapted to meet their needs. The entrance to the service had wheelchair access, and bathrooms and toilets had assisted equipment to help people with mobility difficulties. The provider's new call bell system meant that when people wanted to walk around the grounds they were able to take a call bell pendent, which linked into the system so people could call for assistance when they needed it. People were empowered to use the provider's voices forum (a weekly meeting) to share their views about the environment. One person had commented about the inapproprte height of the dining room chairs, so they were now being reviewed.

Good

Is the service caring?

Our findings

At our last inspection in June and July 2017 we rated this key question as Inadequate because, privacy, dignity and independence was not always promoted, confidential information was not always held securely and people were not always involved in decisions relating to their own care. During this inspection we looked to see if improvements had been made, and found action had been taken to address all areas, but improvements were still needed. Where improvements had been made more time was required to demonstrate they had been embedded in practice and could be sustained.

Overall, people's privacy and dignity was now being respected. The management team led by example and were role models amongst the staff team. People and their families told us, "Respect is good and dignity is good", and "My father has received the care and respect that he should get", "All the staff, always treat us with the greatest of respect". However, many bedrooms doors were open and when we spoke with staff about the reason for this, we were told it was to ensure people's safety. People's care records also did not detail that their consent. This meant this decision had been made without considering the impact on people's privacy. People's individual support needs, such as tracheostomy care or nutritional care were sometimes displayed on the person's bedroom wall. Whilst, this helped to remind staff, it did not promote people's privacy or dignity. The registered manager told us they would take action to review this across the service.

The provider had introduced the 'voices forum' which was a new meeting that took place each week, with people and their relatives. The mission statement of the forum was as follows: "Your voices will be heard, making things better with your help, come and join us". People spoke positively of this new approach, and people were seen to attend the meeting on the day of our inspection. One relative commented, "The Voices Forum has been a good idea. It allows the residents to feel as though they can speak up". For people who were not able to attend, or preferred to speak on a one to one basis, staff visited them in their bedrooms, to ensure "their voices" were also heard.

People's independence was now being promoted. Staff told us how they encouraged people to do as much for themselves as possible. For example, involving them in their own personal care and one member of staff told us how one person enjoyed folding up the washing, and setting the tables for lunch.

People and their families had started to be consulted about the content of their care plans to help ensure they met with their needs. Care plans had been re-designed and were now on an electronic system, which meant families could access their loved ones care plan from their own home, therefore helping them to feel continually involved in their loved ones care and support. On relative told us, "I have been impressed with how much more I am now involved in my relative's care".

People and their families told us staff were kind and caring, and that there had been an obvious change to the atmosphere of the service. Comments included, "The most heartening thing is that the carers now care as I wished they would have done back in 2017. I know this has improved because my relative now smiles again, and that had stopped" and, They (the staff) go about supporting people with a smile and caring way".

People's confidential information was now stored securely. Staff, were more vigilant at not leaving people's records out on display in public areas, and the providers decision to move to electronic records reduced the likelihood of breaches of confidentiality.

Overall, people told us the laundry service had improved and that items of clothing did not get lost as much, commenting "The laundry system works much better now". However, one person told us "My relative takes the laundry home to do as we neither of us is happy with how the laundry works here".

People's individual equality and diversity needs were known, for example people's religious and cultural needs were known and respected. Some people attended church services that took place within the service, and staff explained if people wanted to attend church on a Sunday transport and support was arranged. People's care plans continued to be updated to ensure people's needs and wishes were fully detailed.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June and July 2017 we rated this key question as Inadequate because, people's changing healthcare needs were not always monitored so responsive action could be taken, people's care records were not always created in line with people's wishes and preferences, and people's care records were not an accurate reflection of how their care and support needs should be carried out. During this inspection we looked to see if improvements had been made, and found action had been taken to address all areas, but improvements were still needed. Where improvements had been made more time was required to demonstrate they had been embedded in practice and could be sustained.

Overall, people now had care plans in place for their health and social care needs, but these were still in the process of being developed and improved. One relative told us, "The staff, are now very much more proactive than they used to be. Instead of me having to ask for my relative to be taken out of bed, and down to the lounge the staff now do this without having to be asked". The provider had introduced an electronic care planning system, which helped staff to be more vigilant at updating records following care delivery. Staff told us they liked the new way of working and were embracing the changes.

People's care plans did not in all cases include information about how they chose and preferred to be supported, therefore contributing to people's care not always being delivered consistently and in the way people wanted. For example, one person told us they liked to get up at a certain time. However, they explained some staff supported them at the right time, whereas others did not. When we looked at this person's care plan, the specific time had not been detailed.

People with nursing care needs, did not always have care plans in place to help guide staff about how to meet people's needs. For example, one person's daily records referenced their catheter care, however they had no catheter care plan in place. When a risk associated with a person's care had been identified, a care plan was not always put in place to support any additional needs. For example, one person had epilepsy, and whilst the care plan mentioned it, it gave no details of the support regarding their epilepsy, or about the possible types of seizures that could occur and how the person should be supported.

People's records were not always up to date and reflective of their individual needs. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall people's changing healthcare needs were monitored so responsive action could be taken. For example, staff had identified changes to one person's skin. Staff had been responsive in taking action and contacting a GP, which meant treatment, took place promptly so the person was not in unnecessary pain. Staff had also been quick to recognise the symptoms of sepsis, which resulted in one person receiving urgent treatment. However, one relative told us "Mum was out of sorts a couple of weeks ago. I suspected another urinary tract infection (UTI) and I asked the staff to check. They said they would, but Mum was still not right. I had to chase it up again and ask for the results of the urine dip, only to be told it hadn't been done. I insisted this happen. It did, and I was right. Mum had another UTI, which was then treated".

Staff told us handover meetings, which were used to share important information about people's changing needs, had improved since our last inspection, and they now felt their contribution at these meetings was valued. A new handover sheet had been created to help ensure accurate information about people's care was effectively shared amongst the staff team.

Overall, people were supported respectfully at the end of their life. Relatives had written to thank the staff, telling them "I would like to thank you all for all that you did for Mum to make her happy and loved in her few months with you all". "Your palliative care was amazing for Mum. We could not have asked for any better". The staff team had a good relationship with the community nurses and the GP practice to help ensure, when necessary a co-ordinated approach was taken. People had end of life care plans in place. However, care plans were not always individualised to help ensure staff knew what people may specifically want. Such as, people who they may want to be present and music they may like played in their final days and hours. The registered manager told us they would take action to gather this information, and create individualised care plans for people.

People's opportunity for social engagement was developing and improving. The activities co-ordinators had been finding out what activities and hobbies people liked, so they could tailor group and individual activities, to help ensure people's preferences were catered for. The 'one more time' project had been created, to capture and recreate what people had previously loved to do, and to relive fond memories from their past. One person used to be a performer and singer, so this was being recreated by hosting a Cabaret afternoon, so the person could have the opportunity to sing in front of those living at the service, visitors and staff. The person loved Dolly Parton, so staff had been in contact with Dolly Parton's PR team to try and get a signed autograph. Another person used to enjoy going to the opera with her husband. So an afternoon had been arranged for them both with special drinks and nibbles, as they watched their favourite opera on DVD. One relative told us, "The best example of how care has improved is that my relative is now regularly helped to get out of bed, get dressed and involved in the daily activities. These too have improved recently. This never used to happen, and my relative was almost always confined to her room".

People's comments and complaints were respectfully listened to, and used to help improve the service. One person told us, "I had a problem with my bed, and another with my wheelchair. The staff here listened and fixed both". Other comments included, "The staff here used to be quite complacent. If you raised a problem, the answer never felt meaningful, it was all about lip service. It's very different now". "Things have improved since (the registered manager and quality manager) have arrived. Now I feel that if I raise a problem, it will be addressed". The new voices forum also gave people, on a weekly basis, an opportunity to raise any concerns that they may. Since our last inspection the registered manager had devised a new complaints log to record when a complaint was received, which would assist in identifying themes which maybe emerging within the service. The provider's complaints policy was given to people when they moved into the service, and was displayed within the service. However, the policy may not have been in a suitable format for everyone to understand. The manager told us, they would take action to review this.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in June and July 2017 we rated this key question as Inadequate because, the provider did not use valuable feedback to help improve the service, staff did not always feel management were approachable, and there were ineffective quality monitoring systems in place to help identify when improvements were required. During this inspection we looked to see if improvements had been made, and found action had been taken to address all areas, but improvements were still needed. Where improvements had been made more time was required to demonstrate they had been embedded in practice and could be sustained.

The registered manager and provider had devised some new systems and processes to help monitor the ongoing safety and quality of the service, for example care plan, medicine and environmental checks. However, these had not always been effective in identifying where improvements were required, such as with the risk management of peoples care, accuracy of people's care records, making sure people's human rights were promoted, and that people's privacy and dignity was respected. The registered manager told us they recognised the audits were not yet, fully effective as they had been proactively altering them in response to external feedback. They told us they wanted to ensure they got it right and that the audits were useful tools, in identifying where action was needed, to help drive continuous improvement.

The provider visited the service four to five times a week, and had access to the electronic care planning system. There was now a registered manager's weekly report, which was sent to the provider, for their review. However, whilst the reports detailed information such as recruitment, accidents and incidents and complaints, the provider's review and response to the reports were not detailed, and did not show the information provided by the registered manager, had been scrutinized by the provider to ensure its accuracy. For example, one response was as follows "having looked at the feedback forums to the homes values survey and found them very interesting. I have signed and read the residents forum file". This meant, like before, the provider continued to trust the registered manager and staff team, without having effective systems and processes in place to check what was actually occurring within the service. By the end of our inspection, a new provider monthly audit had been created by the registered manager and provider, and would be used. The audit had been designed to help enable the provider to look more robustly at the day to day management of the service, helping to analyse themes and trends which maybe emerging.

Changes to clinical management and governance, was in its infancy and was still being developed. The introduction of a new clinical lead and clinical manger would help ensure clinical practices were monitored. However, whilst new processes were being put into practice, the current arrangements had failed to highlight that a nurse had made an error, and as a result of this, it had not been robustly followed up. At the end of our inspection, action had been taken to develop a new clinical governance framework. A new policy had been created, which involved the registered manager from the provider's other service, visiting and carrying out monitoring checks.

The provider's governance framework and quality assurance systems, had failed to effectively and consistently identify where improvements were required. This is a continued breach of Regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new management structure had been put into place to help drive improvement and to support staff. This included a new clinical lead, a clinical manager, and a quality manager. The provider spoke proudly of the staff he had employed into these roles, and it was obvious from their interactions with us, that they were a cohesive team, who were passionate and fully committed to improving the service. The management team all told us they felt supported by the provider.

People had chosen what they wanted the ethos and culture of the service to be, placing them at the heart of the service. This had been achieved by the management team, spending time and consulting with people, staff and relatives about what they wanted the core values to be, helping eventually to underpin staff practice, and the care they received. The values chosen were, trust, respect, compassion, dignity and person centred planning.

During our inspection, the management team displayed the values, which were observed to help staff to feel engaged in the inspection process and not to fear the inspection team. The service unlike before, no longer felt like two different care homes, but was now more joined up, with staff engaging and learning from each other across both the residential care home and nursing home.

People and families told us that since our last inspection, they had visibly seen the change in the atmosphere and culture of the service. Telling us, "The improvements here since (the registered manager) took over have been overwhelming. The old blame culture has gone, staff no longer seem frightened of being criticised and things are now quickly addressed when you raise them". Other comments included, "I am staggered at the turnaround in the culture and atmosphere since your last inspection, and importantly I am confident it's not just for effect" and "Things have improved since (the registered manager and quality manager) were appointed. There used to be an atmosphere of complacency here". The introduction of the provider's new management team had clearly helped to create an improved positive and, empowering culture.

Staff told us they now enjoyed coming to work, and expressed how well they felt supported. Staff told us, that unlike before, they would feel confident about whistleblowing if they were concerned about poor staff conduct. They told us this was because of the positive changes in management and the trust they now had in the management team, to do the right thing. Staff recognised the service was undergoing continued development and ongoing improvement, but were committed to be part of the process, with one member of staff telling us, "Everyone has signed up to improve the service". A poster displayed in the service stated, "We aim to be better today than yesterday". A new employee of the month scheme had been introduced, so people, relatives and staff were able to nominate their favourite member of staff, in recognition of their contribution.

People and staff's views were obtained to help with the ongoing development of the service, by completing questionnaires relating to the Commissions Key Lines of Enquiries (KLOEs), and by attending the voices forum. A newsletter which had been sent to people in January 2018 demonstrated how people's views had been used to improve the service, in an article entitled, "What you said" and "What we did". Responses had included, "More information about flu jabs…Information, as received was then communicated" and "A second shower chair on St Francis…Additional shower chairs have been ordered".

People lived in a service whereby the registered manager, provider and management team were continually learning, which helped to adapt and improve the service. For example, the management team met on a weekly basis to review the service, and used these meetings to reflect on their own understanding and

competence and took action to address this when necessary. For example, by contacting external health and social care professionals for advice or guidance.

Partnership working with other providers was important to the registered manager to help keep on top of ongoing developments and changes in the sector. For example, the registered manager kept their ongoing practice and learning up to date. The registered manager told us they enjoyed attending events such as the dignity in care forum and the local manager's network. These helped to share best practice, experiences and to learn from each other. The registered manager told us it was useful meeting other registered managers, who were also managing services in 'special measures' to seek ideas and advice.

Following our last inspection, the provider and registered manager had met with people, relatives and staff to share the findings of the inspection and rating given. Relatives had told us, how they had appreciated this, and the honesty shown at a difficult and challenging time. This open and transparent approach demonstrated the providers understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. Throughout our inspection, the registered manager was also honest about what they had identified themselves as needing improvement. The provider had displayed their latest rating in line with legislation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service user's human rights were not always protected because there was a limited understanding about the legislative frameworks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The provider had not ensured some risks associated with service users care were effectively mitigated. Service users medicines were not always managed safely because documentation was not always accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2 (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Service users records were not always an accurate reflection of the care they required.

Service users records were not always up to date and reflective of their individual needs. The provider's governance framework and quality assurance systems, had failed to effectively and consistently identify where improvements were required.