Silverdale Care Homes Limited

Silverdale Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 8 February 2017 and was unannounced.

At our inspection in February 2016 we had serious concerns that people who used the service were not safe and the service was not well led. We had rated the service as 'Inadequate' and placed it into special measures.

At our last inspection in July 2016 we judged the service was still not meeting the required fundamental standards of care. We had continuing concerns regarding the safety of people who used the service. The service remained in special measures as we judged the overall rating of the service as Inadequate.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We worked closely with the provider, local authority safeguarding team and the commissioning department at the local authority to ensure people were provided with an improved service and their safety and welfare was ensured.

During this inspection 7 and 8 February 2017 we saw improvements had been made to ensure people were provided with a safe, effective, caring, responsive and well led service. The provider had reviewed the internal management team and changes had been made. We judged sufficient improvements had been made; no areas now had an inadequate rating so the service will no longer be in special measures. However, we will continue to closely monitor and review the service to ensure further improvements are made and people are provided with a safe service.

Silverdale Nursing Home provides support and care for up to 27 people, some of whom may be living with dementia. At the time of this inspection 14 people used the service.

The service did not have a registered manager. 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.

Improvements were needed to ensure that medicines were managed safely and effectively.

People were supported with their daily nutritional requirements, however one person's specific nutritional requirements was not always provided.

Staff were aware of the action they should take where they had concerns regarding the safety of people. Appropriate action was taken when allegations of abuse and concerns with people's safety were identified.

Sufficient staff were available to keep people safe and meet people's care needs in a timely manner. Staff had training opportunities to acquire the knowledge and skills necessary to meet people's individual care and support needs. Recruitment and vetting procedures were in place that ensured appropriate people were employed.

Risks to people's health and wellbeing were identified, assessed and reviewed to ensure the actions needed to mitigate the risks were recorded and the risks were minimised.

The provider followed the requirements of the Mental Capacity Act 2005 (MCA) where people lacked the capacity to make certain decisions about their care. Staff understood their responsibilities and followed the requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) when they provided support.

People were supported to access other healthcare professionals to maintain and improve their health and wellbeing.

Staff showed care and kindness towards people who used the service. Improvements had been made to ensure people's rights to privacy and dignity were upheld.

There was a range of daily activities arranged for people to enjoy. People were offered the choice of whether they wished to participate or not and staff respected their choices.

The provider had a complaints procedure and people knew how and who to complain to.

Systems were in place to monitor the quality and safety of the service had improved but further improvements were needed. Changes had been made to the internal management structure of the service, which provided leadership and guidance for staff to deliver an improved service for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Medicines were not managed in a safe way. People's risks had been assessed, managed and reviewed, action had been taken to mitigate and reduce risks. People felt safe, staff knew how to protect people from avoidable harm and abuse. Enough staff were available to keep people safe and the provider had effective recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not consistently effective. One person did not always receive the correct diet to fully meet their nutritional needs. The principles of the MCA and DoLS were followed to ensure that people's rights were respected and upheld. Staff had been provided with appropriate training to fully meet people's needs and promote people's safety, health and wellbeing. People's healthcare needs were met.

Is the service caring?

Good

The service was caring. People received the care and support they required in a person centred and individualised way. People's dignity and privacy was upheld.

Is the service responsive?

Good

The service was responsive. Care plans were reflective of people's current care and support needs, which meant staff had the information to support people with their needs. People told us they enjoyed the activities that were available. The provider had a complaints procedure in place and people knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led. There was no registered manager. Quality assurance systems were in place to monitor the service. Improvements had been made in regard to providing people with a well led service; however the provider must ensure the improvements continue to provide stability and good leadership and for the benefit of people who used the service.

Silverdale Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 7 and 8 February 2017 and was unannounced.

The inspection team consisted of two inspectors, a pharmacist specialist 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 care service.

We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We used a range of different methods to help us understand people's experiences. We spoke with two people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. 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.

We spoke with two relatives of people who used the service to gain feedback about the quality of care. We spoke with the provider, the manager, the nominated person, three registered nurses, three care staff, and a member of the ancillary and catering team. We looked at 10 people's care records, staff rosters, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2016 we found the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe or consistent way. People's medicines were not stored safely or securely.
At this inspection we found improvements had been made to ensuring people's level of risk was managed in a safe way. Further improvements were need in relation to the safe management of medicines.

A member of the CQC medicines team reviewed the management of medicines, including the Medicine Administration Record (MAR) charts for six people. There was personal identification and information about known allergies/medicine sensitivities available to staff with the MAR charts.

We saw that records of medicines administration were not always accurate. For example, we saw three medicines that had not been given but had been recorded on the MAR chart as having been given. We also saw a record that showed medicines had not been given as prescribed and a signature on the MAR chart had been completed for a date in the future to indicate a dose had been given. Another person had a 5ml dose of a prescribed medicine administered instead of the prescribed 40ml but the record had been signed to say a full dose had been given.

Some people that take medicine only when required had protocols in place to provide staff with enough information to know when the medicine was to be given. However, we saw that this information was not specific for each person, which meant people might not always be given their medicine consistently, and at the times they needed them.

We looked at the records for people who were using medicinal skin patches. Staff did not always make a record to show where the patches were applied to the body. This increases the risk of patches not being applied and removed in line with the manufacturer's guidance, which could result in unnecessary side effects.

Carers applied prescribed creams to people's skin. Body maps were available to staff to show where the creams should be applied. However, carers had received no training to carry out this task.

Medicines that needed cold storage were kept in a fridge and daily records showing temperature monitoring were completed. However, records showed that the fridge temperature had been out of the recommended range and staff told us they had not reported it and were unable to demonstrate how to take accurate temperature readings.

We saw one person had been given their last dose of medicine. Staff had not made any attempt to ensure more medicine was in stock for when the person would need their next dose.

Where people were prescribed a variable dose of their medicine, a record of how much they had taken was

not kept. This would mean that, in the event of further treatment being needed, there would be no way of knowing the total dose already given to the person.

During an observed medicine round, we saw one person was chewing their medicine instead of swallowing them whole. When we asked the nurse if the GP was aware as this is not how the medicines are intended to be take, the nurse told us: "He has always done that. I don't know if the GP knows". This meant that important information was not being shared with the GP in order to ensure appropriate medicines were available to people.

We saw another person being given their liquid medicine in a cup whilst they were reclined. Some of the medicine spilt on the person and the person was unable to take a full dose. Staff did not ensure the medicine was given in a more suitable way such as an oral syringe or a spoon.

Some people were being given their medicine by disguising them in food or drink. We saw that there was not enough information available to inform staff how to prepare and administer these medicines safely and the correct people had not been involved in the decision making process.

Tablets and capsules, that were no longer needed, were disposed of appropriately. However, there was no arrangement in place for the disposal of liquid medicines. Staff described how they would dispose of liquid and this was not in line with current waste regulations.

The provider was not able to demonstrate they had a system in place for recording medicine errors. This meant that there was no evidence of learning from past mistakes and there was an increased likelihood that the same error could happen again and people were not protected against these risks.

These issues constitute a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of the proper and safe management of medicines.

Some people were resistive when care and support was needed in regard to their personal care needs. We spoke with two care staff who offered a different explanation of the care and support they provided to people in such circumstances. One staff member said they would leave the person, (ensuring their safety first), and then return shortly after. However the other staff member told us they would continue with the intervention. We did not see that the staffs' different approaches caused the person any harm or ill being during the interventions. The management plan for supporting people when they became anxious during these interventions were not sufficiently detailed to ensure people were provided with consistent and reliable support. The internal management team told us they would review these management plans to ensure there was sufficient information recorded so that staff had the information to provide a safe and consistent service.

People's risks had been assessed, managed and reviewed. Action had been taken to protect people from the risk of harm. For example, we saw one person had poor mobility and was at high risk of falling. We saw staff were aware of the whereabouts of this person and were quick to offer support when the person wished to move around the service. This ensured the person's risk of falling was reduced and ensured they were able to safely move around the service when they wished to do so. A relative said: "[My relative] is definitely safe now. Arrangements are in place to make sure he is safe; staff keep a close eye on him. We have no worries at all as he is really settled and happy". They went on to say: "He isn't good at walking these days but they [staff] always try to give him a walk to help him. They [staff] encourage him to stay mobile". We saw this person's risk assessments had been completed with a full review of the actions needed to reduce their risk of falling but still maintaining and supporting the person to retain a level of independence. A referral had

been made to the falls specialists for additional advice and the doctor had completed a medication review. These actions ensured that all possible reasons for the person falling had been investigated.

Some people were very frail, had reduced mobility and were at risk of developing sore skin. Staff told us about the care and support they provided to people to reduce their risk of developing sore skin. This included supporting people with regular repositioning and the provision of specialist equipment. For example, air flow mattresses and pressure relieving cushions. We saw mattresses and cushions in use to support people with reducing the risk of them developing sore skin. We saw the mattress settings were calculated for each person and recorded on the monitoring documents so that staff had a clear indication of each setting on their daily checks. This meant action had been taken to mitigate the risks of harm for people.

People were supported to move in a safe way. Some people were unable to weight bear and so required staff to support them with the use of a mechanical hoist. We saw people being hoisted safely, in a calm and measured way, consideration was given to their comfort and their dignity. Staff consulted with the person and then informed them that the hoist was to be used. People were put at ease and reassured during this manoeuvre. People had been assessed for the appropriate size and type of sling that was to be used with the hoist. We saw that the person's moving and handling details were recorded in the care plans and risk assessments for that person. This meant people's safety was assured as the techniques and equipment used were used in a safe way.

At the last inspection in July 2016 we found the provider was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014. People who used the service were not always safeguarded from abuse as staff were unsure of what to do if they suspected someone had been abused. During this inspection we saw improvements had been made.

People who were able to tell us their experiences told us they felt safe. One person who used the service said: "I like it here; they [the staff] always come to you". Staff we spoke with knew the signs of abuse and who they needed to report it to if they suspected someone had been abused. One staff member said they would report any concerns straight away to the nurse in charge. The manager was aware of their responsibility to act on any allegations of abuse or concern. We saw referrals for investigation into allegations of abuse had been made.

We observed two people who became agitated and upset when they were in the close company of each other. Staff were in the vicinity, were quick to intervene, and the distraction and diversion techniques used were effective to resolve the situation. Staff took their time to discuss this incident with both people and offered some solutions to prevent a similar situation occurring again. Both people very quickly became less upset because of the actions taken by the staff. The manager ensured the details of the incident were recorded and confirmed it would be referred to the local authority for their consideration. This meant that staff were able to identify and report abuse and take the necessary action so that people's risk of harm was reduced and their safety upheld.

At the last inspection in July 2016 we found the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014. There were not always enough available nurses or care staff to keep people safe and meet people's care needs. Staff did not receive suitable adequate training, induction or supervision.

At this inspection staff told us and we saw there were sufficient numbers of staff to support people in a timely, safe and effective way. A relative commented on the staffing levels and said: "There has been a

turnover of staff, lots have left, but we now have a lot of new staff. There are enough staff now and there is always someone around". There was a strong staff presence in the communal areas, where the majority of people spent their day. Staff were visible and able to provide support to people in a timely way when people needed help. The staffing levels allowed for continuous, individual care and interaction to be given to the people who currently used the service.

We saw that some people needed the support and supervision of staff at all times for them to remain safe. Staff were allocated to provide this level of support. Previously some people had been at extreme risk of harm and injury due to poor mobility and frailty. We saw this level of risk had significantly reduced since the introduction of this close level of supervision.

At the last inspection in July 2016 we found the provider was in breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) 2014. Recruitment procedures were ineffective.

The manager told us of the recent turnover of staff and that some staff had left. The manager told us and we saw that agency workers were used to fill the shortages until sufficient regular staff were employed. We saw that some profiles on the agency workers had been provided by the agencies. The managers explained their continuing problems with obtaining sufficient information regarding the suitability and competencies of the workers. They confirmed that further discussions would be made with the supplying agencies to ensure they received the required information prior to agency workers working at the service. This would mean that the provider would be sufficiently assured that the agency workers were fully suitable to work at the service.

The recruitment for staff and nurses was on-going and we saw recent people employed were subject to checks to ensure they were suitable to work at the service. These checks included references of the staffs' characters, police checks and their suitability to work with the people who used the service. We spoke with one member of staff who had recently started working in the service. They told us the provider had received references and a police check had been carried out to ensure they were suitable to work with people before they started work.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in July 2016 we found the provider was in breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The requirements of the MCA 2005 were not always followed. At this inspection we saw some improvements had been made.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw that some mental capacity assessments had been completed when people did not have capacity to make some decisions for themselves. Some specific decisions had been made by the person's nominated representative, family and professionals involved in the care of the person. For example, we saw end of life decisions had been made on behalf of people, and these decisions had been deemed to be in their best interests. However, we saw some best interest decisions had been made without consultation with other people and in isolation by one staff member. For example where a person should be accommodated and how they were to receive their care and treatment. The managers had identified this through an audit of the care plans and told us these best interest decisions would be discussed again within a multi-agency meeting.

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). We saw that some people had authorised restrictions to their liberty such as rails on their bed, were under close supervision and control and not free to leave the building unsupervised. Some authorisations in place had conditions attached; we saw the conditions were being adhered to. For example one person required close observation at all times, we saw a member of staff was allocated to provide this level of support. This meant the provider followed the principles of the MCA which ensured people were not being unlawfully restricted of their liberty.

At the last inspection in July 2016 we found the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014. Care staff said they received training however this was not always reflected in their care practices. People's nursing care needs were not met due to the lack of training for the nurses. At this inspection we saw some improvements had been made.

Staff told us they received an induction when they were first employed at the service. One staff member said: "The induction was good, I had training and I shadowed another member of staff for a week before I felt confident to provide support on my own". Staff also told us that the training was available and they could suggest topic areas where they felt this would be beneficial. One staff member told us about the recent dysphasia training they had completed. They told us this was very useful as they learnt about the different types of food which could be provided to people when they were at risk of choking due to

swallowing difficulties. We saw records and staff confirmed they had received training to help them carry out their role effectively. Staff received supervision from the manager on a regular basis. This offered staff the opportunity to meet with their line managers to discuss work related issues and their performance and development needs.

Most people were unable to tell us their views and opinions of the food provided but we saw the menu was well-balanced and alternatives were readily available. A relative told us: "They [the staff] help [the person] to eat now which helps their confidence. [The person] is regaining weight here and loves to have tea and biscuits in the afternoon. [The person] is often awake at night and can have drinks and snacks if they want any". Another relative said: "An alternative meal is offered if they don't like what is on the menu. We only have to ask". We observed breakfast and lunch were served at a relaxed pace and catered for the individual needs of people. We saw one person became upset and agitated and refused food. Staff sat quietly with the person until their agitation lessened. The person continued to refuse the alternatives which were offered, staff told us this was a regular occurrence. We saw a short while afterwards the person enjoyed a hot drink and sandwich. We observed those people who required assistance had the full attention given to them throughout their meal by staff.

Some people required special diets, for example fortified, pureed and lactose free. We saw people were mostly provided with the diets they had been assessed as requiring. However, we observed that one person did not fully have the diet they needed and this may have had a negative impact on their general health and well being. Although some aspects of their diet were well catered for not all elements of the diet were provided. This meant the person's specialist diet was not fully provided and the guidance for this diet was not followed. The managers took immediate action and had discussions with the catering staff to ensure the person received all elements of the specific diet they required.

Relatives commented about the healthcare arrangements at the service. One person said: "The GP visits the home regularly and they have recently reviewed my relative's medication". Another relative told us: "When [person's name] was unwell they arranged a GP visit the same day as well as a review the following day". We saw that the GP visited the service each week to review the healthcare needs of people and referred people to other external health professionals when needed For example, we saw one person had been referred to the dietetic services due to concerns with their weight and reduced appetite. People's care records were updated following each GP consultation to ensure staff had the information regarding people's current health care needs.

The provider and managers told us and we saw improvements had been made and were on-going to improve the environment. Some bedrooms had been redecorated and refurbished to provide people with more comfortable accommodation. Some communal areas had been provided with dementia friendly signage to support people with finding their way around the service. The provider told us of the plans to further improve the service, this included new lighting and flooring in the main lounge, refurbishment of the garden and upgrading the remaining bedrooms. We saw the provider had a plan of action for the work to be carried out.

Good

Is the service caring?

Our findings

At the last inspection in July 2016 we found the provider was in breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The low staffing levels impacted on the quality of the care and support provided. Institutional routines did not afford people the person centred care they required. This resulted in people's privacy and dignity continued being compromised. At this inspection, we found improvements had been made.

During this inspection we observed many positive, kind interactions between staff and people. One person who used the service told us: "They are lovely people just like me and you". A relative said: "The staff are so friendly and they include us, the family, I really couldn't fault them. They always treat my relative with dignity and respect; they understand my relative's moods and feelings. For example, my relative has a book which is a security blanket; they always make sure it is to hand. They know that the book needs to be near". Another relative told us: "My relative always seems happy and in general is well looked after. The whole time they have been here, I have never had any worries or concerns". We saw a person had been assisted with their personal hygiene and told us they had enjoyed a shower. This person was smiling; attention had been given to their appearance and they were happy that other people commented on how well they looked. This meant staff acted in such a way as to promote the comfort and well-being of people.

One person was anxious and wasn't quite sure where they were. We saw a staff member sat with the person for 20 minutes, stroking the person's hands and talking softly with them. It was a compassionate interaction and was clearly very soothing for the person. Staff were consistently kind and caring in their approach to people and displayed respect, warmth and gentleness.

We saw staff offered people individual choices and respected people's wishes. For example, we overheard a conversation between two care staff where one person was still in bed. The person had told the care staff they wanted to stay in bed for a while. This was respected and staff later returned to the person to offer support when they were ready to get up.

Staff had a good knowledge of people's individual care and support needs. For example, we observed a person was trying to place an item around their neck. The care staff intervened, we saw the care staff knew that the person liked to wear a scarf; they asked the person if they needed their neck scarf. The person said: "Yes, I do please". The carer then supported the person with wearing their scarf. We saw the person was happy, comfortable and relaxed following the support provided by the care staff.

Good

Is the service responsive?

Our findings

At the last inspection in July 2016 we found the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. People did not always receive care that reflected their needs and respected their preferences.

During this inspection we saw improvements had been made to ensure people received the care they needed in a personalised way that was responsive to their needs. A relative told us: "We are always involved in reviews and discussions about my relative's care. We have to look after my relative as they have dementia and unable to speak for themselves". The records we viewed showed that people's plans of care were detailed and contained what was important to them and how they liked to be supported. We saw that people's life histories had been recorded, to enable staff to have discussions about peoples' past lives before they used the service. We saw one person was provided with care and support from male carers. This specific care requirement had been assessed and was appropriate for the person's needs and to their preferences. Staff told us and we saw that male carers supported the person. This meant that staff were responsive to this person's specific care need, and their preferences had been taken into account.

At the last inspection in July 2016 we found the provider was in breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) 2014. People knew how to make a complaint but action was not taken to rectify the concerns.

Relatives told us they knew how to complain if they needed to and they were comfortable raising concerns. One person said: "I have never needed to complain. If I ever have any small issues I just go to the office and they always resolve them". The manager told us they had successfully resolved a complaint, which had been raised by a relative, regarding environmental concerns. They had met with the complainant, discussed the issues and made the necessary improvements. They told us the complainant was satisfied with the way the complaint was dealt with and handled. This meant that the manager acted on complaints received to improve the quality of the service provided.

The manager held regular open days where people could visit and speak with them if they had concerns or any suggestions that could improve the service. We saw notices of the times and dates were displayed in areas around the service. The manager told us no one had attended but it was their intention to continue to offer these additional times when they were available.

An activities coordinator was at the service on both days of this inspection, and engaged people in a variety of different activities throughout the day. We observed a session where two people helped to make scones. They had short attention spans and became easily distracted; however they enjoyed the end result when the scones were cooked.

People told us and we saw various activities had been arranged and facilitated for people to engage in and enjoy. A relative told us: "[Name of person] doesn't join in activities too much but they went recently to a garden centre which they thoroughly enjoyed as they used to love gardening". Another relative said: "They

are always busy with residents and activities but my husband chooses not to join in. We had a wonderful fireworks party and also the dignity day was good. We joined in with those and enjoyed them".

Most activities were organised on a one to one basis and were facilitated to suit the needs of the individual person. The activities within the service were delivered in a low key way and for short periods. Throughout the building there were wall displays of old photographs, cupboards with games, jigsaws, CDs, DVDs and videos. There was a piano, an aquarium and books and newspapers which were within the reach of people. Baskets with tactile objects were provided and we saw one person engaged independently for a short time with one of those items. The music was playing in the lounge and people were clearly enjoying it and were singing along. The manager told us that the activities coordinator had a good knowledge of peoples' likes and dislikes in regard to recreational pastimes and activities.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in July 2016 we found the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014. Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm from occurring.

There had been a change in the management arrangements. A registered nurse had been recruited and was working as the home's manager. They had begun the process for applying to be the registered manager with us (CQC).

An external care business consultant had been employed by the provider to support the manager to make the improvements required as a result of our last inspection. Their role was to support the manager and the staff with effecting and managing the changes that were needed to improve the service. The external care business consultant told us they had agreed with the provider that they would take a permanent position within the service which would support the registered manager's role. We have received the notification of this intention.

Staff told us the new management arrangements were 'working well' and commented on how supportive and approachable both people were. A relative commented: "The manager is approachable and has been very good with arranging the one to one care and support for my relative. The previous manager said it would be dealt with but it never got done. This new manager always seems to be around". Another relative said: "I know who the manager is and she is very approachable. I am very happy with the home to be honest. There have been a lot of improvements". The provider must now ensure this level of management support is maintained to provide guidance and leadership to benefit and support the people who used the service and the staff.

Quality monitoring and auditing systems were in place, where each month regular checks were made to ensure a safe, effective, responsive and well led service was provided. Any issues or themes, trends or patterns that affected the safety of people or the service were identified quickly. For example, concerns with the use of a specific item had been identified which was not conducive to the comfort of some people. We saw that staff had been informed of the concerns and the recorded action directed staff which ensured people's comfort was maintained. This meant people were now supported with this item in a more appropriate way so their comfort and wellbeing was upheld.

We saw audits of the care plans and risk assessments were completed each month to ensure the information in both the records corresponded and gave an accurate overview of people's current care and support needs. Checks were made on the incidents which occurred monthly, these include information regarding slips, trips and falls. People who were at risk of weight loss were identified and monitored through these monthly checks. The action taken to reduce further weight loss was made by referral to the doctor and dieticians in addition to providing fortified diets and prescribed food supplements. We saw some audits around medicines where some of the issues found on the day of the inspection had been identified but had not improved. On the second day of this inspection we saw the provider had arranged for the supplying

pharmacist to visit the service to update some documents in relation to the administration of medicines. However, this was in response to our findings and feedback and not through the service's auditing processes. We saw systems were in place to identify any themes, issues or risks associated with the service provision and were identified and action was taken promptly in response to areas of concern being identified. However, these systems were not yet fully effective, for example, one person did not have their dietary needs fully met, the medicines audit did not identify any areas of concerns. The provider must now ensure the quality and safety audit processes are further developed to ensure an effective, safe service is provided.

Staffing levels were at a level where people were provided with a safe, effective, responsive service in a timely way. A visitor told us: "There are enough staff now", and went on to say how this had improved the safety of their relative. We saw this person had been assessed as being at 'extreme risk of falling'. Staff told us, and we saw records which indicated, the frequency of this person falling and coming to harm had drastically reduced since the staffing levels had been reviewed. The person's The manager told us and we saw the staffing levels were determined and based on the dependency needs of the people who used the service and they were reviewed monthly. This meant that staffing levels were assessed as being in sufficient numbers to provide care and support to people who used the service in a safe and timely way.

The manager told us they arranged regular relative's meetings but these were not well attended. We saw the dates and times of these meetings were displayed on the notice boards so that visitors were aware of them. One relative told us: "There are regular relative's meetings and I have also given feedback on a questionnaire. The only improvement for me would be maybe a keypad for access to the building when reception is closed". The manager told us that arrangements were being made to facilitate this suggestion.

Regular staff meetings were arranged for the various staffing disciplines. This gave staff the opportunity to discuss the care and welfare of people, any changes or improvements that were needed or had been implemented and any issues or concerns that had been identified. Staff told us they felt well supported and they worked well as a team.

At the last inspection in July 2016 we found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider was not notifying us of safety incidents that occurred at the service.

It is a legal requirement of the registered person's registration that they must notify the Commission without delay of any incidents which affect the health and well-being of people who used the service. Since the last inspection we have received these statutory notifications which enabled us to monitor the service.

We previously had concerns with the management and leadership of the service, and the inability to provide people with a safe, effective, caring, responsive and well led service. The service was subject to the local authorities large scale investigation procedures because of the level of concern. Changes and improvements have been made to all aspects of the service; however the provider must now make sure the changes are effective, sustained and continue to ensure stability and continuity of the service so that people who use the service are safe and their well-being preserved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.