Acer Healthcare Operations Limited

Appletree Court Care Home

Inspection report

158 Burnt Oak Broadway
Edgware
Middlesex
HA8 0AX

Tel: 02083813843
Website: www.appletreecourtcarehome.co.uk

Date of inspection visit:
22 February 2018
26 February 2018
07 March 2018

Date of publication:
11 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Appletree Court Care Home is registered to provide accommodation for up to 77 people who require nursing or personal care and treatment of disease, disorder or injury. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were 43 people living at the service on the day of the inspection. Most of the people who live there are over 65 years old but the service also supports younger people with disabilities. The inspection took place on 22 February, 26 February and 7 March 2018 and was unannounced.

At the last inspection on the 26 September 2017 we found six breaches of the regulations. We issued three Warning Notices for breaches of regulations in relation to meeting nutritional and hydration needs, governance of the service and staffing levels. The other three breaches related to lack of risk assessments and not always involving health professionals as required, safeguarding people from abuse and treating people with dignity and respect.

At the last inspection the service was rated Inadequate and the service was therefore in 'special measures'. Services in special measures are kept under review. We undertook this comprehensive inspection to check on the progress made by the provider, and to consider whether the service could be removed from special measures, our framework to ensure a timely and coordinated response, where we judge the standard of care to be inadequate.

At this inspection we found progress had been made in meeting nutrition and hydration needs, and dignity and respect. In other areas such as staffing, risk assessments and governance of the service, limited progress had been made. We found additional breaches of the regulations in relation to person centred care and medicines.

At this inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There had been several changes in management personnel at the service since the last inspection. A permanently employed manager had taken up post from the end of November 2017. Whilst the service had worked to make improvements, the impact of numerous changes in personnel meant that outstanding management actions remained and this meant there were still issues with the quality of the care. At the time of the inspection actions were not always taking place following quality audits, and not all quality audits were taking place in keeping with the provider's policy.

Staffing levels had improved since the last inspection, but there remained a period in the early evening when people's needs were not safely met. People and their families told us staff worked hard and were busy.

Whilst the service had undertaken a significant number of risk assessments since the last inspection, there remained areas in which there were gaps in risk assessments. This meant staff were not always provided with guidance in how to meet people's needs safely.

People told us that staff were kind and caring, but the lack of care plans in place meant that the service could not evidence they provided person centred care.

At this inspection we witnessed an unsafe practice in relation to medicines management, and the provider had yet to establish a system for reviewing people who were administered medicines covertly. Medicine administration records were completed in line with best practice, stocks corresponded with records and medicines were stored safely.

The provider had made progress in ensuring people's hydration needs were met and recorded and we found fluid charts were in place and monitored appropriately. Where remedial action was required it was taken. The provider was aware some people found the menu limited.

Recruitment at the service was safe and sufficient checks took place before people were employed to work with vulnerable adults. Staff meetings and group supervision took place to share information and best practice with staff. Individual supervisions and appraisals were not taking place.

People told us they felt safe living at the service and since the last inspection the service were proactive in monitoring how safeguarding incidents occurred and in sharing that learning with staff.

Nursing and clinical tasks were undertaken as required, and recording of this was up to date.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

At this inspection we found that enough progress had been made to address our concerns about people's safety and welfare, and so the service was removed from special measures. However, there were four breaches of regulations, which are listed at the back of the full version of the report.

We have also made recommendations in relation to emergency fire safety procedures, staff training and nutrition arrangements for people on special diets.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were gaps in risk assessments which meant staff were not always given guidance in how best to support people.

There were insufficient numbers of trained staff to meet people's needs.

Medicines administration was not always safe and so potentially placed people at risk of harm.

Checks to ensure the building and equipment safety were not always taking place in line with the provider policy, which placed people at risk.

Whilst the service was clean, there was a malodour at times due to poor continence management.

Staff recruitment was safe.

Is the service effective?

Requires Improvement

The service was not always effective. Documentation did not always accurately evidence how people's health needs were met. There were instances where advice from health professionals was not transferred to care documentation or implemented.

People's hydration needs were met, although the provider was aware there remained areas of improvement for choice of menu for people at the service, and for meeting the needs of people with special diets.

Refresher training had taken place and staff received group supervision but did not receive individual training or appraisal.

The service was following the principles of the Mental Capacity Act 2005. Staff understood the importance of asking for consent prior to providing care.

Is the service caring?

Requires Improvement

The service was not always caring. Care records did not always

set out people's preferences or daily routines, and did not always address people's cultural or religious needs.

We could not always see how staff promoted people's independence.

People told us staff were kind.

Is the service responsive?

Requires Improvement

Is the service responsive?
The service was not always responsive. People did not always have care plans in place and some care plans lacked sufficient detail for staff to provide person centred care.

Although there were some activities taking place at the service these were limited and did not always address the needs of people who spent long periods of time in their rooms.

There was a complaints process in place and the provider dealt with complaints in line with their policy.

Is the service well-led?

Requires Improvement

The service was not always well led. Although we found improvements had taken place in the clinical management of people's needs, there remained areas of concern as not all care plans and risk assessments were in place.

The provider repeatedly underestimated the time and resources required to ensure that actions identified in their plans were implemented. This impacted on people at the service.

The new manager was well regarded by the majority of relatives and people living at the service.

Appletree Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 22 February, 26 February and 7 March 2018 and was unannounced. We visited the service during the day and in the evening to carry out the inspection. The inspection was carried out by five inspectors, a nurse specialist advisor and two experts-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.

Prior to the inspection we looked at information CQC held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We reviewed fluid charts that had been sent to us weekly from November 2017 to the middle of February 2018. We also spoke with external stakeholder organisations who gave their feedback about the service including the local authority and local health commissioners.

As part of the inspection we looked at care documentation for 23 people in their rooms. We also looked at four electronic based transition plans and 11 care records, including ABC behavioural charts and wound dressing records.

We looked at fluid charts for 13 people and checked pressure care management and management of percutaneous endoscopic gastrostomy or PEG feeding. We checked medicines management including 18 medicine administration records, medicines storage and medicines competency assessments.

We checked four recruitment records, staff training for the team, and read minutes for group staff supervision, staff meetings, and management meetings. We checked safeguarding records and accident and incident logs.

We looked at the maintenance of the building and the checks the service undertook to ensure both the building and equipment were safe, including fire safety.

We checked quality monitoring audits in a range of areas including medicines, night time audits and monthly provider audits and observed staff caring for people, and staff handovers. As part of the inspection we spoke with four nurses, six care staff, the activities co-ordinator, the manager, the Regional Director and the Quality Compliance Inspector. The Quality Compliance Inspector worked for the provider to quality assure this service and offered support to the manager in making improvements. We talked with 17 people living at the service and 13 relatives.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found one room with a bed rail in use but without a bumper. This was of concern as it placed people at risk of entrapment and therefore possible harm. We also found there were not always risk assessments in place to provide guidance to staff regarding people's mobility requirements, which also placed them at risk of possible harm.

At this inspection we found that all rooms with bed rails had bumpers in use. There were two rooms that had bed rails fitted but these were not in use. The provider undertook to either remove these or lock them in place to ensure they could not be used by mistake.

At the last inspection we also found there were not always risk assessments in place to provide guidance to staff regarding people's mobility requirements, which placed them at risk of possible harm.

At this inspection the provider had completed a support plan for people which summarised people's care needs and these provided some information for staff, for example, if people should be transferred using a hoist or sliding sheet. We found few detailed risk assessments related to people's moving and handling in place at the time of the inspection.

For one person we saw their 'reviewed assessment of needs' document dated 23 January 2018 stated they were at risk of falls. However, in their care file there was a blank falls risk assessment. Archived records showed the assessment took place monthly until 1 April 2017 but not since. This demonstrated a failure to assess and address the risk of them falling, which was not a safe system of care. There was also blank risk assessments in their care file for nutrition, medicines and oral health, although pressure care risk assessments were updated monthly across the last two months. The nutrition risk assessment was particularly needed as there was a record stating the person's GP was advising a pre-diabetic diet, and as the person had put on almost 10% of their weight in the last four months of 2017. However, even in their archived files there was no nutrition risk assessment. A nurse confirmed that was the case, and told us they were currently reviewing everyone's risk assessments.

We also found a second person who had multiple health conditions including diabetes, schizophrenia and a condition that affected their feet. At the time of the inspection we found a malnutrition universal screening tool, (MUST) calculation, and skin integrity risk assessment completed in the last 12 months, the latter of which was calculated as high but there was no follow on risk assessment. There was no risk assessment for diabetes, or schizophrenia. We noted the support plan indicated this person should not have free access to fluids and the reason why.

At the last inspection we found the service did not always have risk assessments for people with behaviours that challenge. This remained a significant issue meaning that staff were not guided sufficiently in how to care for people.

For example, on the first floor we found two people who had significant issues related to their mental health.

We witnessed two occasions where one person was agitated and verbally abusive to other people, staff and visitors to the service. The reviewed assessment of need for this person dated 19 January 2018 noted they had mood swings and required a lot of attention from staff but lacked specific guidance in managing these verbal outbursts. There was no risk assessment specifically for the management of this person's mental health needs. We asked the staff how they managed this person when they were agitated, and they told us they made this person tea or tried to move them if they were shouting at other people, or move the other person if more appropriate.
ABC behavioural charts can be a useful tool in the management of people's mental health behaviours. They can be used to record when incidents occur and any antecedents to that behaviour, and what staff found to work in dissipating the incident or behaviour. Although there was an ABC behavioural chart in place for this person at the service we found there was insufficient understanding of how to record behaviours, analyse them for the timing or triggers of any behaviours and then to set this out in a risk assessment to provide guidance to staff.

We found whilst a second person on the first floor had their assessment of need reviewed, which noted this person had behaviours that challenged, this did not provide sufficient guidance for staff in how to manage these behaviours. The reviewed assessment of need for this person dated 20 January 2018 noted usually two staff were required to support this person with personal care. There was an ABC chart in place but there was no analysis of the timing or triggers for this person to become agitated which meant there was no obvious learning from these incidents. For this person we found that although they were prescribed a medicine to relax them, as required (PRN), there was no guidance for staff as to when this could be given and consequently it had not been. We saw on one occasion that it had taken three staff to manage personal care for this person. The lack of a co-ordinated risk based approach to managing this person's behaviours meant that staff were not provided with guidance and people were not always supported with care in the most appropriate way.

A third person's ABC chart had been used to record falls and did not always indicate the time of episodes of distress. Despite it being completed on a regular basis there was no evidence that it was analysed to guide future care as it had not been reviewed by the management of the service at the time of the inspection. We found another person's ABC chart stated a person was relaxed and spent time chatting about a TV programme. This showed the staff were not using the paperwork for the purposes for which it was intended, to inform risk assessments and care planning to meet people's needs.

These concerns were evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Subsequent to the inspection the provider confirmed they had completed a number of risk assessments for the second person mentioned above as well as risk assessments for manual handling, falls, choking and nutrition and hydration assessments for a number of people on the ground and first floors. However, there remained gaps in specialised risk assessments for some people.

We checked medicines administration records (MAR) on both the ground and first floors. We found there were no concerns with how MAR were completed, there were no gaps in recording and MAR records tallied with stocks for both routine and controlled drugs. Controlled drugs were stored appropriately and entries in the controlled drugs register were countersigned. Medicines profiles contained a photo of the person, details of allergies and how they liked their medicines administered, for example, "[Person] liked to take her tablets with water after her meals." PRN (medicines taken when required) protocols were in place, the majority of which guided staff on dosage instructions, symptoms of the condition which may require PRN and potential side effects of the medication. Antibiotics were added to the MARs and were administered as

prescribed. Medicines were stored appropriately and storage temperatures checked on a daily basis.

We observed a medicines round and noted that it took approximately two hours as there was only one pestle and mortar to use for medicines that required crushing for covert administration. This needed to be washed in between each usage. We discussed this with the manager who told us they would purchase additional equipment.

There were 17 people being administered medicines covertly. The correct process had been followed, that is to get approval from the GP and pharmacist and by holding a best interests meeting. But we found the service was not always using the same paperwork which meant that information for nursing staff was not always clear and readily available. For example, one person's documentation did not state how to give the medicines covertly and instead stated, refer to the attached report, but there were two reports. Specific medicines can be affected by an interaction with food so it is important that guidance from the pharmacist is clear to staff in how to administer medicines covertly.

There was no process in place to review people having medicines administered covertly. The manager told us they would ensure a system was developed.

Whilst we saw that permanently employed nurses had undergone medicines competency assessments by the service, the manager confirmed this was not a requirement for agency nursing staff. On the first day of the inspection we were made aware by a family member that one person had not been watched taking all their medicines and the family member had found several tablets in a container in this person's room. This placed the person at risk of not getting their medicines. It also potentially placed other people at risk of taking medicines that were not prescribed to them and so was not a safe administration of medicine.

We discussed this incident with the manager who, as a result of this incident, agreed to check the competency of all agency nursing staff. By the end of the inspection period the manager confirmed this had been done.

A risk assessment had been completed for one person in relation to their move from a room on the second floor to a room on the ground floor, which identified a risk of disorientation. Half hourly checks were put in place, however, this person had previously absconded and was known to walk freely up and down the corridor. On the second floor the lift required key pad entry to activate, however on the ground floor it did not. The lack of foresight by the provider to put in a key pad to stop the use of the lift to the second floor placed this and potentially other people at harm as this person was found on the now empty second floor with a minor head injury.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked routine maintenance and found that gas, electricity, including portable testing of equipment and the fire alarm systems had been checked within the appropriate timeframe.

The service had not had a maintenance staff member in post for several months and we could see that certain checks were not routinely taking place. For example, weekly fire checks of the fire safety system and monthly hoist checks were not always taking place. We also found building safety checks including checking window restrictors and automatic door release mechanisms were not being tested in line with the provider policy.

The provider had been utilising the services of maintenance staff from other care homes run by the provider locally to support this service, but this meant all safety checks were not being undertaken in line with the provider policy. This meant that people were potentially placed at risk of using unsafe equipment or the building not being safe for use and which could therefore place people at risk of harm.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the time of the inspection the external organisation responsible for servicing of hoists had visited in January 2018.

At the last inspection we found there were insufficient staff to meet people's needs and keep them safe, and a Warning Notice had been issued to the provider.

At this inspection the number of people at the service had significantly reduced from the previous inspection and we found there to be sufficient staffing levels for the majority of the time. There were 10 carers and two nurses on duty from 8am to 8pm. If additional staff were required to support someone to an appointment they were rostered to work in the day.

From 8pm to 8am there were four carers and 2 nurses in total across both floors. It was during this period, in the early evening in particular, we had concerns that there were not sufficient staff to meet people's needs. For example, on the ground floor one person required continuous supervision to ensure that they did not drink fluid unless under supervision due to a health condition. After 8pm there was one nurse and two carers on each floor. This meant that this person required intensive supervision at a time when the medicine round was being completed by the nurse, and impacted on the care being provided to other people. One relative told us they had been asked to 'keep an eye' on this person when the carers had to leave the living room to attend to another person. We found on the first floor during this period that one person was very agitated and was shouting, swearing and pacing up and down. This meant this person required intensive supervision for over an hour. During this time the nurse was giving medicines and the two carers were trying to supervise this person as well as supervise the lounge and give people tea and biscuits.

We asked the night staff how they managed to meet people's needs given their staffing levels. They told us they could not start any tasks that required two people, such as continence and repositioning care, until the nurse had completed the medicines round and was available to supervise people in the lounge. This meant there had to be a very tight routine of care provided to people. One staff member told us they need more care staff "as two people walk up and down all the time" and they had to supervise them. On the night of our inspection visit a person had been unwell, but as this had occurred prior to the day staff going home a nurse had stayed to support the staff and talk with the ambulance staff called to the service.

We asked people their views of staffing levels. One person told us "The care is good, the staff are very caring but sometimes they are very busy or not sufficient in number." Another said "Staff are very busy. Could do with more. A lot of people want more attention."

Two additional people commented on the time they had to wait for a response to their call bell. "Whenever I press the bell to call someone, I have to wait whilst the staff may be busy with other patients." And "The call bell isn't working all the time. I have to wait for the staff for a long time."

People living at the service were unanimous in their praise of how hard the staff worked. One person pointed to a carer and said "She's a hard worker". Another said "Girls work hard."

We asked relatives their view of staffing levels. One relative told us "Don't think there will ever be enough. Night staff still a problem, not enough. Night staff really stressed. Staff good and doing their best but I worry that if doing something and the bell rings they have to leave that resident and go. But not their fault doing their best only have to have one [carer] off ill and its lots of bells."

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Subsequent to the inspection, the provider told us they will be upgrading the call bell system to monitor response times at the service.

We asked people if they felt safe at the service. One person told us "I never see any trouble." Another said "I am happy here. Feel safe here." A third person told us "I can't say anything against the place." A fourth told us "The staff couldn't treat me better, they're so good."

At the last inspection we found people were not always protected from abuse and neglect as there were a high number of unexplained bruises on people and the provider could not evidence they had investigated if there was a pattern and therefore minimise the risk of further abuse.

Since the last inspection there had been fewer unexplained bruises to people at the service, and where these occurred the service could show they had looked into possible reasons for the bruising. More recently they had developed a spreadsheet to log these and set out if people had health conditions that may contribute to the bruising. This was not fully effective as there were some safeguarding events not on the spreadsheet.

We were concerned that a complaint by a family member in December 2017 had not been clearly identified as a safeguarding when the issues raised met the threshold to be considered so. However, the manager explained there had been a period of upheaval in the management arrangements at the service which explained how this had been overlooked. The local authority had highlighted issues with recording when investigating safeguarding events in the period from the last inspection. We found that the majority of records were up to date which was positive.

Staff were able to tell us about the different types of abuse. They understood what abuse was and the action required if they should encounter it, particularly about reporting it to the management team. One staff member told us "I have to report any bruise, pressure sore or skin break to nurse to take picture. I report to manager, team leader, call head office, call CQC. "

We checked pressure ulcer care. There were positional change charts in place which indicated when people were being turned. Since the last inspection the service had introduced comfort charts which indicated when people had had continence care, and were used to record hourly checks on people who couldn't use the call bell. We found these were, in the main up to date. Despite a number of people routinely spending time in bed due to frailty, there were not high levels of pressure areas which indicated that the service was managing this issue well. The process for updating care plans following input from professionals was not always robust, for example, advice from the tissue viability nurse (TVN). Where we found this as an issue, it had not adversely affected a person, but we discussed this with the manager who agreed they would review the process.

We saw that safe recruitment practices were in place. Records showed that pre-employment checks were

carried out before staff started work. These included two written references, proof of identity as well as their employment history and a criminal records check. This meant staff were considered safe to work with people at the service.

The service was clean and we saw domestic staff working throughout the days of the inspection. Serving kitchens were clean and open food was labelled and sealed. Microwaves and fridges were clean. The shower rooms were clean however we found several occasions when trolleys used to support staff with continence management were placed in the shower rooms on both the ground and first floor, with soiled incontinence pads in a bag hanging off the trolley. We also found one soiled incontinence pad in the sink in the shower room which was not pleasant or hygienic. This meant that at times throughout the inspection period there was a strong malodour which was unpleasant. This had been noted as an issue at the last inspection.

People's rooms were clean. One family member told us "[Name] the head housekeeper very good. Rooms are always lovely. My husband is incontinent and rooms always fresh. They change him, get the odd accident." One person told us "It's clean. Cleaners in here every day, very good." However one person's room had a very strong malodour as the flooring was not suitable for a person who had continence issues but was very reluctant to accept help.

We discussed these issues with the manager who told us they had repeatedly discussed with staff the need to dispose of soiled incontinence pads, and would continue to raise this issue with them. They also confirmed that the flooring for this particular person was not suitable and they planned to change it in the near future.

In summary, although people were not necessarily placed at risk from infection there remained some issues which reflected poor practice at the service and meant that for some of the time there was a strong malodour which was unpleasant for people, staff and visitors to the service.

We checked accident and incident logs and saw that the majority were signed off by the manager who oversaw the action. We could see that the manager brought up relevant issues at the team meetings and so learning was shared across the service.

We saw that regular fire drills were taking place during the day and night. The notes from a fire drill in December 2017 noted that staff required further training and that certain actions could improve the process. The training had taken place in February 2018 but at the time of the inspection there had not been a fire drill to check that the issues raised in December 2017 were no longer an issue when dealing with a fire drill.

We recommend that the provider satisfies itself that emergency fire safety procedures are understood and actioned by all staff.

Requires Improvement

Is the service effective?

Our findings

At the last inspection the provider could not show that they were effectively supporting people to remain hydrated as we found fluid charts were not being routinely completed or in a number of care records the levels of fluid recorded was very low which placed people at risk of dehydration. As a result we issued a Warning Notice in relation to these concerns.

Subsequent to the inspection the service reviewed the records of all the people with fluid charts and identified additional charts with poor recording of fluid intake. They also referred people to the GP as a precaution to ensure people had not been placed at harm through a low intake of fluid. Where relevant the service also referred people to the nutritionist. As part of the provider review of fluid intake charts, people were taken off them where there was no longer a requirement for this level of scrutiny which meant staff were no longer monitoring people's input where there was no clinical need.

At this inspection we found the service was supporting fluid intake effectively. Charts were up to date and staff had received training so understood how to record accurately people's fluid intake. We found chart totals were completed at or around midnight and signed off by nursing staff, and any people with low intake were noted for discussion at handover, for greater encouragement of fluid intake on the next shift, and if this did not improve were referred to the GP.

We found people were offered a range of drinks. We noted for people with lower levels of fluid intake that their preferences for fluid were not always noted on the fluid chart. The manager said this would be included for those who were at risk of low intake. We cross checked people's fluid charts with bowel movements as low hydration is often associated with constipation and found this was not the case. We also saw that people's skin was intact with no sign of dehydration. In a number of people's rooms, where they were at risk of choking, speech and language therapy guidelines were written in large lettering on the walls to ensure staff knew to check how to support this person with eating and drinking.

We checked how the service supported people with tube feeding directly into their stomach, percutaneous endoscopic gastrostomy (PEG) feeding. We saw that nursing staff knew how to use the equipment safely to feed this person including the angle they had to be elevated to whilst feeding and staff had knowledge of how to maintain hygiene in relation to the equipment. We could see the service involved specialist nurses appropriately to support this process.

We asked people and their relatives their views about food. People told us "If you don't like the food you get something else like omelette. If you get hungry between meals you have a sandwich. Always something you can get." Another person said "The food's magic." Other people told us "Food repetitive." And "Don't enjoy the food. Don't know if you have a choice. I go into the dining room when I am up to it."

One relative told us "Soup good. No problem, always a choice. They have supper at 5 pm and at 8 pm there are sandwiches and biscuits and a hot drink. Can have hot drinks late at night. Food's alright." Some relatives told us they thought the food lacked variety and one relative pointed out the evening meal in

particular was virtually always the same, for example, soup and sandwiches, sometimes with chips, rarely with salad. This did not suit their relative so they tended to bring in food for their family member themselves. We looked at the menus and they did lack variety for supper. The provider had been aware of the relative's concerns regarding food and had carried out an audit of people's experience involving some relatives in the autumn of 2017. Helpful suggestions were made and implemented, however, the provider had not repeated this experience in recent months.

We noted on both mornings of the inspection that breakfast started from approximately 9 and finished late, sometimes at 10.30 or 11am. We asked the manager why this was, and were told that this was partly because of people's preferences. However, we were aware that some people required food with their medicines and the medicine round was very lengthy. One person told us they would prefer breakfast earlier "I would prefer breakfast at 9.30 but just have to wait." We were also talking with one person in their bedroom when a carer asked if they could get them up for breakfast, this was at 10.40.

We noted that people were not rushed with their food, and that staff were attentive to people in both the dining and individual rooms. Menus were in pictorial form which was helpful for people with cognitive issues.

We noted that people were provided with food, either sandwiches or biscuits, at suppertime in the lounge, and in their rooms. People who needed pureed food were offered drinks, but were not offered snacks later in the evening. We discussed this with the manager and were told that yoghurts were available for people at suppertime. However, we checked people's records and did not find anyone who had been offered food after 6 pm who required a pureed diet. The manager told us people may be offered fortified drinks and was making yoghurts available. Given how late breakfast was for some people we were concerned that this could be a long period for people to go without food. We were also made aware by a relative that the range of food available for their family member was limited as the service only offered soft food, for example, mashed potato and soup, as opposed to a wide range of food being pureed.

We recommend the provider reviews nutrition options for people who require a soft diet or pureed food.

At the last inspection we were concerned that the service had not referred people with mental health conditions to the appropriate mental health teams. At this inspection we were aware that referrals had been made to review people's mental health. Although we noted that risk assessments and care documents did not offer sufficient advice to staff we saw two occasions when staff dealt well with a person with agitated behaviour.

On one occasion the staff member encouraged the person to sit with her, talked quietly with them, made them tea and told us "I understand [resident] is just not a morning person and I know they are not angry with me." On another occasion the staff member encouraged the person to go for a walk with them which helped to calm them down.

Health information was held in a number of places at the service. For example, there were people's care plans, the red or blue folders in people's rooms and information in files at the nursing stations. We noted one person had a wound on their right leg on 15 January 2018. There was a wound care record for "both legs" with entries from 17 January 2018, backed by a body map dated 15 January 2018 for two swollen legs. However, entries on a wound care record only monitored one leg and did not state which one. Another wound assessment form, for use after each dressing change, showed monitoring of one unnamed wound. It showed that on 31 January 2018, despite identifying a number of new symptoms that could indicate possible infection including heat from the wound, odour and pain, subsequent assessments only took place

on 5 February then 11 February 2018, which did not indicate a robust frequency of monitoring the wounds. We also saw a body map dated 18 February 2018 stating the person's skin was intact, despite there being ongoing wound care records either side of that date that indicated ongoing wounds. The nurse assured us the wounds were healing and the person was not unduly worried or unwell, but this indicated issues with recording. We discussed this with the manger and the provider's Quality Compliance Inspector who told us they were considering holding nursing records for wound management in one place to minimise these issues.

This person had also been seen by the TVN and special slippers had been recommended to be purchased. There was no evidence this had been done.

There was evidence of health care involvement for people. For example, the person referred to above had also been seen for dermatology concerns and swollen legs. An optician wrote up a new prescription for glasses on 26 January 2018. However, when we asked to see the new glasses, only a pair prescribed from 2016 could be found, and there were no records to show action had been taken to follow-up on the optician's advice about their long-sightedness. The manager acknowledged they needed to establish a system for follow up action following input from external health professionals, and said they would address this, and purchase the slippers and the glasses.

One person told us of seeing the GP recently due to stomach pains. Another person told us "Doctor comes here. I say I want to see a doctor and I see a doctor. If you are not well they take them to hospital." The GP had routine and regular contact with the service and was notified if there were concerns following a fall or due to people's food or fluid intake. Relatives told us they were usually notified of any health conditions their family member had or the outcome of hospital appointments. One relative had very high praise for the nursing and care staff in the way they managed their family member's ill health. They told us that their relative went from "dying to being capable and alert to everything around them."

Two relatives had some reservations, one with the health care provided by the service; the other told us of an episode in which they felt communication had been poor and they had not been updated about an imminent procedure their relative was due to have.

For one person we noted they were sat on a pressure cushion in the lounge as per their care plan. The cushion was plugged in and working and we saw staff later checking that remained the case as it had been identified recently as a risk to their skin integrity if there was insufficient support whilst sitting. A walking frame, labelled with their name, was next to their seat. We later saw the person using it to move around independently.

We asked people and their relatives whether they thought the staff had the skills and knowledge to provide appropriate care. People spoke well of the majority of the staff. They told us "The care is good." And "Staff good, facilities good. Always someone here checking like the bed." A third person told us "Staff are very helpful." Two people gave slightly less praise.

One relative told us "Some [staff] are excellent. Another said "Since we last spoke [at the last inspection] there has been a lot of training and it shows." Asked how they said "There is a lot more paperwork. New staff are very good." Other relatives told us the care staff tended to be permanently employed whilst the nursing staff comprised of a number of regularly used agency nurses. Relatives appreciated that carers in particular knew the needs of their family member well. Only one relative told us they did not consider the staff to be effective in their caring role.

We were of the view the majority of staff were effective in their caring role.

We could see that new staff had a role specific induction process. The induction for care assistants covered three days and included provider policies, how to use equipment such as hydraulic baths and call bell systems, health and safety, fire procedures and mandatory training. There was an induction programme booklet with e learning as part of the induction. The care assistant induction booklet was signed off by their mentor when completed and this included being competency assessed at supporting with personal care, taking people to the toilet and use of bed rails.

At the last inspection we made a recommendation that supervision was prioritised as the provider had not been routinely offering staff supervision in line with their policy. At this inspection we found the provider was still not offering individual personal development supervision for staff but instead was undertaking regular staff meetings and group supervision and briefings. The provider acknowledged that this was not ideal but had decided that group supervision and briefings were the most effective method of conveying good practice and implementing changes across the staff team. One staff member told us they "did not get as much support" as they would like.

Once the new manager was in post we could see that carers and nurse focused meetings took place regularly to discuss the issues the service wanted to improve, for example, food and fluid charts, safeguarding, and recording of comfort and positional change charts.

The provider told us new care staff should receive supervision at the end of the first, second and third month, with the overall outcome signed off. However this was not happening at the time of the inspection. The provider gave us information to show they were introducing new personal learning development plans which would include a process for staff to evaluate their own skills and deficits and then discuss with their supervisor how best to meet these.

On the day of the inspection we saw some staff transfer people safely and in a dignified and safe way, and we saw one person transferred in a way that made the person anxious as they were high off the ground and the staff did not talk through the process fully with the person. We discussed this incident with the manager who told us there was further moving and handling training booked for staff the following week.

We saw from records that the majority of staff were trained in the key areas to enable them to complete their role, for example, moving and handling, safeguarding and dementia care. One staff member told us "We have a lot of training. E-learning on the computer. Last week fire and moving and handling. Tomorrow dignity." Following the last inspection staff had undergone training in 'dignity' and through the use of a 'dementia bus' had had the opportunity to consider how some people may experience confusion and what they could do to support people with memory problems.

The provider had also had some training and support for staff with the completion of ABC behaviour charts in the autumn. However we found a number of staff were still confused as to how to complete and use the ABC charts and there was a lack of understanding of how these could assist staff in managing people's behaviours. Although we witnessed some staff managing people's behaviours effectively other staff did not have the skills to do so, and the service did not have a robust framework to support people in this area which included improving staff understanding and skills. Subsequent to the inspection the manager had met with a health professional with expertise in this area who agreed to offer ongoing support in this area.

We recommend the provider sources suitable training to support staff in managing people's behaviours as a priority.

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

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

The provider had previously sent us information regarding the list of people who were on DoLS and showed us they had a system to ensure these were up to date.

Staff understood the importance of gaining consent before providing care to people. One staff member told us they respected anyone who did not consent to care, but of trying to engage them if they believed the care was necessary, coming back a short while later, or seeing if the person consented to a colleague providing the care.

We saw records of an assessment to see if someone had capacity to consent to a decision to move downstairs from a top floor room. There was a best interests review meeting held with the person's family about the decision. We also saw that where people were given medicines covertly appropriate best interest meetings had taken place. It was difficult to see how people's capacity was determined in other key areas as the care records were not always in place.

The service is provided in a building on three floors. Each floor is accessible by a lift, so it is suitable for people with mobility needs. There is an accessible garden for use by people living at the service.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we were concerned that people were not always shown dignity and respect. At this inspection we found improvements in this area.

We saw staff paying attention to people's dignity. This included the use of privacy screens when hoisting people and helping people to adjust their clothing when needed in the lounges. People had also been supported with their appearance before coming into the lounge for the day. One person told us "they always knock on my door and ask if they can come in."

People were largely positive about the care staff including the nurses. They told us "Carers are nice", "the staff are very caring" and "they treat you nice."

We witnessed kind and caring interactions between people using the service and staff. We found that whilst care records did not routinely record people's likes and dislikes, a number of staff had worked with people for some time, and so they knew what people liked and disliked. One staff member was able to tell us in detail how they supported two people they were familiar with. We saw staff interacting kindly and in a friendly manner with people. For example, one staff member checked, "Is that too tight?" when supporting someone to be hoisted. Another said "I love it when you smile" to someone who we saw otherwise appeared disengaged. They smiled as a result of the staff member taking the time to talk with them whilst helping them drink a cup of tea.

A number of relatives also told us that staff were kind and caring to their relatives. One told us of a period of ill-health their family member experienced in the last five months during which the staff "were brilliant for [family member] and brilliant for us" as a family. They also said that during this period the manager took time to talk with them and listen to their worries about their relative's health. They found this very kind and caring.

We witnessed staff talking kindly to people and asking before they carried out any caring role. We observed people having breakfast and lunch. We saw on both occasions the carers serving breakfast and lunch were welcoming when people came in. People were asked what they wanted for breakfast as they came in over the next hour and their meal was served with a smile. At lunch-time we saw carers were talking with people whilst moving them in their wheelchairs from the lounge or bedrooms to the dining room and each was greeted by name by the carer in the dining room. People were not rushed whilst being supported with food. Some people were supported with meals in their rooms.

The service could not evidence they were supporting people to express their views and be actively involved in making decisions about their care as care records were not routinely signed. We asked people if they had a care plan. One person told us "I must do." Another person told us they were "Not aware of care plan." A family member told us "They are working on a new care plan, not got it yet. They are working on it." Another relative told us they had been asked for information before Christmas for their family member's care plan but had not seen the outcome of that discussion.

The provider told us they were implementing the 'key worker system', so staff understood individual people's preferences and routines and staff would then be able to record this information in care records. The provider told us they also planned to involve people and their families in the care planning process. The provider did not have a set date for completion of care records at the time of writing this report.

Existing care documentation did not routinely document people's religious or cultural needs. For example one person spoke English as a second language. We asked staff what language was their first language but they did not know and this was not documented on their care record. We also witnessed one person telling a member of staff she was Jewish as she was talking about a Jewish festival. The member of staff did not know about the festival. However, the staff were aware that some people wished to be visited by their religious leader and so a priest visited the service regularly. The service had offered for a rabbi to be invited for one person but they had declined the offer.

We found that 'Do not attempt resuscitation' (DNAR) forms were on some care records but were not always fully completed. The manager told us they had noted this and were working with the GP to review them all and ensure appropriate people were consulted and they were completed accurately.

We noted that despite us highlighting to the management that seven people on the first floor did not have a name or their picture on their door on the 26 February, no action had been taken by our third visit on 7 March. By the time of writing this report, the manager told us this had been remedied.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found that care records were in various different formats, with some care records containing detail whilst others did not. Few had personalised information that described people's routines. The provider explained at the last inspection that they were planning to introduce a new electronic care system which would standardise care plans across the service.

At this inspection the service still had a variety of care plan formats in place and care records often contained little personalised information regarding people's daily routines and preferences.

The service had started to put information into the electronic care system and at the time of the inspection they had completed eight transitional care records in full and seven records in part. Those completed did contain personalised information regarding people's care needs. For example, in relation to communication needs "We need to speak to X in a calm and clear manner. X talks with staff in short sentences. X is verbally able to make themselves understood." Another person's said "Gain his consent and give him enough time to express himself by pointing at things or sign language." Another part of this person's plan in relation to continence noted "X wears size 6 during the day and size 7 [pads] at night. He also uses a urinal which he likes to be on his side table at all times and the staff will empty it at regular intervals." The transitional plans did not contain background information on people's personal history or information regarding their cultural or religious needs. The provider told us the transitional plans were the initial plans and once these were completed the system prompted staff to complete more detailed care plans for specific care needs.

The provider, realising the delay in rolling out the electronic care recording system, had reverted in January 2018 to putting their attention into paper based records. We found that people now had a folder in their room, that held a reviewed assessment of need document completed in January 2018. This summarised a person's needs and was useful particularly if agency staff were unfamiliar with a person. Examples of detail included "X is doubly incontinent. X requires assistance of two staff and full body hoist for his transfer from bed to armchair." And "X is not able to summon the call bell for assistance. X spends time out of his room at the lounge and dining area with residents. He likes listening to music."

The folders in people's rooms also contained documents which care staff regularly completed. For example, comfort charts, positional change charts, food and fluid charts, and ABC charts were in use. The placing of this information in an accessible way meant staff could routinely record care provided in real time and we found the majority of care records were up to date.

However, these folders only provided limited information. They did not contain personalised information regarding people's backgrounds, and they did not contain detailed information to inform staff how to care for people, particularly if they had specific medical conditions, for example diabetes or a mental health condition.

Of the paper based care records stored outside of people's rooms, we found a variety of formats and lack of structure to the files. Some care plans were word documents, others were card based care records which

were brief. We found some files with numerous care plans covering areas such as mobilising, personal care, skin integrity and falls. These had been completed in the last 12 months, but a number of these files were poorly ordered so information was difficult to find. We asked the provider's Quality Compliance Inspector why the files were not ordered in the same way. They told us they had recently asked the night staff to collate people's information from various folders but had not provided guidance on the filing system desired. This meant that documents were in different places and were not always easy to read. A number of files had no index.

For a number of people we could not find detailed care plan guidance to meet their needs. For example, for one person who had complex mental health needs which manifested in shouting and swearing the care plan noted. "If X is uncooperative please use assistance of two staff members as she has challenging behaviour." This person had a care plan that related to medicine and diabetes and food and fluid intake which outlined what they liked to eat and the care plan in relation to personal care noted her ability to dress and choice of clothes when eating breakfast. However, for this same person we found on documents from the local authority which contained personal information about her life history, however none of that was transferred to the rest of the care plan. We also found information on a hospital transfer form to indicate that this person was Jewish, but this was not documented on care records set out by the service.

This person had a falls risk assessment last updated November 2017 in which the score is high risk and Waterlow assessment updated January 2018 which rated this person as at risk of skin breakdown. There were not care plans for these areas of need.

For another person with behaviours that can challenge we found a care plan that stated "staff should maintain a behavioural chart and record any changes; this will enable management to decide what line of action to take to support resident" and "staff should refer to GP or mental health team in case behaviour becomes unmanageable." This guidance was non-specific and did not give staff guidance in the approach to take as the behaviours were occurring.

In addition to the 'Reviewed assessment of need' document, another person had care plans in place for nutrition, dementia, pressure ulcer risk assessment, falls risk assessment, and stoma care. However they lacked person centred information and detail. For example, "X is unable to manage with her personal hygiene needs. She needs assistance of one or two staff." In relation to eating and drinking this person's care plan stated. "X is not able to eat herself. She needs assistance of two staff." These care plans had recently been reviewed in February 2018.

We discussed the care plan documentation with the provider's Quality Compliance Inspector and the manager in detail on the first day of the inspection and they acknowledged the existing paper based care records were variable and some of them were basic.

At the last inspection the service were unable to evidence that they were offering people showers on a regular basis. At this inspection we found two documents in the showers, one was called 'weekly shower list'. This indicated the day on which people were expected to have a shower and had been set out as Monday Room 1, Tuesday Room 2 through to Sunday Room 7 and so on. This indicated an approach that was not person centred in the planning of people's showers. The lack of a system for monitoring when showers actually took place is covered in the Well-Led section of the report.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they had re-introduced the key worker system and intended for specific staff to meet with people and their relatives to capture person centred information including their background history and likes and dislikes so these were recorded. The provider was also aware they needed to complete care planning records for people but at the time of writing this report there was not a set date for this to happen. Talking with staff we could tell that some staff knew a lot about people and their preferences, for example one staff member said "[Person's name] likes to do her hair weekly and her nails. She likes to be beautiful and wear nice clothes" but these comments were not routinely documented.

At the last inspection there were mixed views from people and their relatives regarding the activities taking place at the service. Following the last inspection the provider told us they would review the level of activities provided as whilst there was a full time activities co-ordinator, their ability to cater for all the people's needs across three floors was limited. At this inspection the service was on two not three floors and this meant the activities co-ordinator was able to be more available to people. A number of people who were frail spent a lot of time in their rooms.

The activities co-ordinator published a monthly newsletter for people at the service, and ran a breakfast club on the first floor. We saw the activities co-ordinator was helpful in managing the need of some people with behaviours that challenge in having breakfast.

On the first day of the inspection we saw six people singing in the lounge with the activities co-ordinator; we also saw exercises taking place. In the afternoon some of the residents were drawing pictures. The activities co-ordinator showed us how they marked special days with celebrations and pictures of the local school visiting at Christmas. We found whilst there were some activities taking place, people did not routinely have personalised information regarding the activities they participated in, although the summarised 'reviewed assessment of need' document stated if people enjoyed TV or music or if they enjoyed sitting in the lounge or in their room. We found one activities record on one care record which said that a person liked their hair and nails to be done, they enjoyed one to one attention, going into the garden, afternoon tea party and family time. However it was not clear whether they had participated in any activities as there were no further records available.

We found the TV on, sometimes at the same time as music which was confusing for people who lived at the service. When we visited in the evening we saw that whilst the TV was on, it was at an angle that not everyone could see it who wanted to.

We asked people and their relatives about the activities. People told us "If the weather is good I go into the garden. A lady called [name] does activities like exercises and quizzes." Another person told us "I like to sit in the lounge. There are enough activities for me."

One person who spent much of the time in their room said "I watch TV a lot. Nothing else to do. I used to read a lot but can't now. Same thing day in and day out but I make the best of it. I can hear activities from here like the choir." We asked if they had anyone come to their room for activities, they said "They don't come in." Another person who was able to articulate their needs told us "Books are not available. I like the radio. I would like to do a lot more. There is not a lot of visitors at weekends."

One relative told us "There aren't many activities for my [family member]." Another family member told us "There's not a lot of activities, not a lot of stimulation" for their relative.

We found the service was still not providing a range of activities for all the people who lived at the service and people's interests in activities were not documented in detail.

At the time of writing this report the provider told us they now had funding to recruit for an additional 20 hours and had successfully recruited a person who was undergoing employment checks. They hoped that when this person was in post, the two activity workers could link up with other services run by the provider to get additional ideas on how to meet people's social needs, including people who were more articulate.

The provider had a complaints policy in place and had systems to respond to complaints. It was not clear how people were facilitated to make a complaint as many had communication needs or memory problems, and relied on their relative to support them. One person told us "I would take it to the manager".

Whilst some relatives were positive that issues raised had been addressed and their complaints had been responded to promptly and to their satisfaction, there remained some relatives who told us whilst the complaint was logged and 'dealt with' their experience of care for their relative still fell short in some areas. The manager told us they were keen to meet with relatives to discuss any concerns they still had.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we had serious concerns regarding how the service was managed at both a provider and service level. We issued a Warning Notice in relation to breaches of Regulation 17 as we found that the provider had identified issues with a range of areas in the months prior to our inspection in September 2017 but had not effectively addressed these issues, and they remained issues of concern. These concerns included low recording on fluid charts and lack of rationale for people remaining for long periods in bed.

We also noted in the previous inspection report there had been a number of changes in management at the service and this had adversely impacted on the care and that supervision and staff meetings were not routinely taking place.

Following the last inspection the provider developed an action plan to address the concerns raised and agreed to work with the local authority staff team who support care homes to improve quality.

Between the last inspection in September 2017 and this inspection there had been a number of changes to management personnel at the service, and this has impacted on the provider's progress towards improving the quality of the service. A new manager was recruited in November 2017.

At this inspection we found that the new manager was working to address the concerns outlined in the previous report and identified in the action plan, with the support of additional staff from the provider. However, there remained a number of areas of concern at this inspection.

For example, following the last inspection the provider decided to follow their plan to implement a new electronic care system which would streamline the care recording process. The provider told us they would offer support with the implementation of this system and although they acknowledged the implementation of a new system was in itself an additional task to achieve, the provider was of the view it would resolve a number of issues. These included streamlining the care recording process so there were no longer different formats of care plans and that it would also provide staff with a chance to review people's care needs and ensure their care records reflected these accurately. The decision to progress with this system meant the provider had determined to focus on electronic as opposed to paper based systems.

At this inspection we found that there was neither a comprehensive electronic care recording system in place nor was there an effective paper based system. Although the provider had persisted with pursuing the electronic care recording system until January 2018, and had employed supernumerary staff to support them in this task, at the time of the inspection they had not made much progress.

The Regional Manager told us the provider had made a decision to revert to paper based care plans in January 2018 and at the time of the inspection we found that staff had been collating existing paper based care plans into folders with mixed results.

We found at the inspection that not all risk assessments were in place despite this being raised at the last

inspection. Although the provider had worked to improve the number of risk assessments in place between this inspection and the time of writing this report, the provider acknowledged that there remained specialist risk assessments outstanding across the service.

Similarly although there are some care plans in place for individuals there were significant gaps where there were no care plans in place, or where the quality of them was poor. We discussed this with the provider who acknowledged the significantly delayed timeframe.

This indicated to us the provider's inability to competently establish systems and processes to ensure compliance with the regulations as care plans are vital to the safe provision of care. The lack of risk assessments to cover all areas of need illustrated the provider's inability to assess, monitor, mitigate and improve the quality of the service in the carrying on of the regulated activity.

Senior management at provider level have repeatedly underestimated the time required to complete these tasks and the personnel required to adequately complete the necessary documentation. This has been evidenced by the continually changed and updated timescales on the provider's action plans.

We found other areas in which the provider had not implemented actions in a timely way. For example, the weekly analysis of ABC behavioural charts was identified as a management action in October 2017 on the provider monthly quality assurance report, with a due date of 1 November 2017. The November and December 2017 provider report shifted this task to a new timescale for completion of 10 January 2018. However, we found that this analysis was not taking place in the period up to, and within the timeframe of the inspection. At the time of writing this report the service had gained the advice from a specialist mental health professional and had started to analyse ABC charts to inform future care for people. Staff were still awaiting further training on this subject to support them in their caring role.

On the first day of this inspection we saw a sheet up in the bathroom for staff to complete to record the water temperature when providing people with a shower. This form had been used by staff to record when people had had a shower. However, this information was not transferred routinely into people's care records to provide a log of personal care. We discussed this with the manager and the provider's Quality Compliance Inspector at the end of the first day of the inspection. By the second day of the inspection we found a number of care records had documentation in place to record when people were supported with personal care. This was evidence that the provider had not set up a system or process which was effective prior to this inspection to record when people were having a shower despite this being raised at the last inspection.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Areas in which the new manager and supporting peripatetic staff had made progress included daily and weekly 'flash' meetings at which heads of department could share information and prioritise remedial action. Recording of comfort charts, fluid charts and positional charts was largely up to date which meant that the provider could be more confident that information captured on records was correct.

Nurses signed off fluid charts daily and the manager audited the fluid charts weekly to ensure people's fluid intake was recorded and remedial action was taken where appropriate. Staff handover information from one shift to the next was more detailed and handover notes usually captured this. People whose fluid charts were of concern were discussed and staff knew to prioritise them in the subsequent shift. This showed there was sharing of important information between staff to help improve the quality of care. A clinical risk register was set up across both floors to capture important nursing information at a glance, for example,

who had a PEG, catheter, and who had bedrails in place. These were evidence of new systems being developed to improve the quality of the care at the service.

Other areas in which we could see improvements were in the number of permanent care staff which contributed to continuity of care and the use where possible of regular nursing staff. Recruitment of permanent nurses remained an issue, although the service were block booking agency staff for long periods to maximise continuity of care.

The provider had a system of quality assurance processes they expected services to undertake. The manager had continued to audit medicines so there were minimal issues with medicines management and recruitment remained safe. At the time of the inspection there were night time audits, medicine audits, limited health and safety audits and infection control audits taking place.

We asked relatives and people using the service their views of the new manager and the management of the service. Most people did not comment on the manager but talked more of the staff and how good they were. One person told us "My son knows everything; I don't need to know about the manager."

One family member told us "[Manager name] seems thorough. Knows what's going on. I have been to two residents meeting since September. Last one was positive. [Manager name] is honest and will say "I don't know rather than make promises." Another relative told us they "couldn't fault the management" and "top marks to [manager's name]." A third relative told us they wanted to "commend the new manager." Two other relatives told us they thought the management of the service was good. Another told us they had not been happy with the service in the autumn but now were largely happy with the service to their relative.

However, some relatives were less enthusiastic about the care offered to their relatives. One said although they were "gaining confidence in the service" they had never been asked how to care for their relative, and they thought this was a lost opportunity.

Three other relatives expressed reservations about the progress of the improvements since September 2017. One told us they thought there was at times a lack of transparency about events at the service which they did not appreciate.

We found the manager to be keen to make improvements and along with additional clinical support from the provider had made some progress since the last inspection, although there were still a number of areas requiring improvement to raise standards across the service.

A staff member told us, "things are actually happening now; if something is on the timetable, the manager makes sure it will happen." Another staff member told us "If I have a problem with a colleague, I would go to the nurse in charge or the manager." Two additional staff members told us, "It's got a lot better; there's now a sound manager who is approachable and directs us." They explained this included making sure staff do what needing doing such as filling in forms which "makes life easier." Therefore there was better teamwork, morale was improving, and, "it's perked us all up."

Through increased staff meetings, staff were able to contribute to the way the service ran. There were relatives' meetings every quarter and one was due to happen over the period of the inspection but was cancelled due to extreme weather conditions. We saw the provider had updated relatives following the last inspection report and told us they planned to hold another meeting soon. The provider had included relatives in the dining room experience audit that took place in November 2017 but there had not been an audit since that date.

It was not clear how people's views of the service were collated. For many people a regular meeting would not necessarily be appropriate due to memory issues and also a number of people spent long periods in bed due to their health condition. The provider told us they hoped that key worker's would be able to get feedback from people about the issues they were not happy with, but this system was not up and running at the time of writing this report.

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 9 HSCA RA Regulations 2014 Person-centred care The provider could not evidence that person centred care was provided at the service. Regulation 9 (1)(2)(3)

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 The provider had not always assessed the risks to service users' health and safety or put in place plans to mitigate risks. Regulation 12(1)(2)(a)(b) The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)(2)(g) The provider did not always ensure the premises and equipment used by the service is safe for such use. Regulation 12 (1)(2)(d)(e)

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 The provider could not evidence that systems and processes were established and operating effectively to ensure the needs of service users were assessed, monitored and the risks mitigated to ensure the service users' health, safety and welfare. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider could not evidence there were sufficient staff to meet the requirements of the service users at the service. Regulation 18 (1)