

Veecare Ltd

# Sevington Mill

## Inspection report

Sevington Lane  
Willesborough  
Ashford

Kent

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Tel: 01233639800

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05 July 2016

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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 4 and 5 July 2016 and was unannounced.

Sevington Mill is registered to provide personal care and accommodation for up to 50 people. There were 33 people using the service during our inspection who were living with a range of care needs. These included diabetes, Parkinson's and mobility support; and some people were living with early stage dementia.

Sevinton Mill is a large, detached premises situated in a residential area just outside Ashford. The service had a large open plan communal lounge available with comfortable seating and a TV for people. There were separate dining areas and a bright conservatory with further comfortable seating.

There was not a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. 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 was however, a manager who had been running the service since January 2016; and who had applied to the CQC to register.

Sevington Mill was last inspected in November 2015, when it was rated as Inadequate. The service was placed into special measures as a result. The provider sent us an action plan to tell us how they would address the breaches in Regulation identified at that inspection. This stated that all remedial actions would be completed by 30 March 2016.

At this inspection we found that much improvement was evident around the service; but some issues highlighted at our last inspection had not been put right.

The management of medicines was significantly better, but there remained issues with creams applications. Some information about medicines interactions and signs of over and under dosing was missing from records; which created risks to people.

Assessments of other risks to people had been carried out and actions to minimise them were generally in place. However, air flow mattresses for people prone to skin wounds had been set at the wrong levels; meaning people did not receive the therapeutic benefits of the equipment.

Recruitment processes were still not sufficiently robust to provide assurance about staffs' backgrounds.

Records of people's food and fluid intake were sometimes scant or were not detailed enough to provide an accurate picture of people's nutrition and hydration. People told us they enjoyed the meals on offer and could choose off-menu alternatives. There were plenty of drinks freely available.

The principles of the Mental Capacity Act had not been followed with regard to obtaining consent, but

Deprivation of Liberty Safeguards (DoLS) had been appropriately sought.

The service was clean and hygienic throughout and laundry was better-managed.

Staffing levels had been increased following our last inspection and competency was checked through practical supervision. Training was up to date and more effective because it took into account the different ways in which staff learned.

People's healthcare had been monitored and they had regular appointments with opticians, chiropodists and dentists. Staff were caring and considerate and went out of their way to make people comfortable. People's privacy and dignity was respected and staff were mindful of people's preferences.

Care plans were person-centred and detailed and were an accurate reflection of the care people received. Information about people's life histories had been compiled to give staff a sense of people's personalities and achievements. People engaged in a variety of group and individual activities depending on their choice.

Complaints had been managed effectively and people and relatives knew how to raise any concerns. However, the service was not consistently well-led. Audits designed to identify shortfalls in the quality and safety of the service had not always been effective and management oversight needed to be improved to make sure that people were safe and had their needs fully met.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

As this service is no longer rated as inadequate, it will be taken out of special measures. Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of Regulations. We will continue to monitor Sevington Mill to check that improvements continue and are sustained.

## 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 had not always been managed appropriately.

Some risks to people had not always been minimised.

Recruitment checks were incomplete.

The premises was clean and sanitary throughout.

There were enough skilled and competent staff on duty to support people.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

People's rights had not consistently been protected by proper use of the Mental Capacity Act (MCA) 2005.

Records about people's care and treatment were not consistently complete.

People's health care needs had been met.

Staff training and supervision had improved and people had confidence in staffs' abilities.

### Is the service caring?

**Good** ●

The service was caring.

Staff delivered support with consideration and kindness.

People were encouraged to be independent when they were able.

Staff acted to protect people's privacy and dignity.

Staff knew people well and remembered what was important to them.

### Is the service responsive?

Good ●

The service was responsive.

An activities coordinator supported people with meaningful activities and reminiscences.

Care planning was person-centred and took account of individual preferences.

There was an effective complaints process in operation.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

Not all concerns raised during the last inspection had been addressed.

Some auditing was ineffective and oversight of the service was sometimes lacking.

Staff said there was a good teamwork and that they could raise concerns if necessary.

Feedback had been sought and acted upon.

# Sevington Mill

## **Detailed findings**

### Background to this inspection

This inspection took place on 4 and 5 July 2016 and was unannounced. The inspection was carried out by three inspectors. Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with ten of the people who lived at Sevington Mill. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support and carried out a Short Observational Framework for Inspections (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 five people's relatives. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with seven of the care workers, kitchen staff, the manager and the provider.

We 'pathway tracked' nine of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

# Is the service safe?

## Our findings

People and relatives said they felt the service had improved and was safe. One person told us, "I feel more secure here now" and a relative commented that, "I'm much happier that Mum's safe and well-cared for".

At our last inspection in November 2015, medicines and creams had not been safely managed. At this inspection improvements had been made overall, but records about applications of topical creams were still incomplete. One person had been prescribed a pain relieving gel for application three times a day but records showed that it had rarely been applied this often; and there were dates when none had been applied at all. Other people's charts included creams which were not listed on medicines administration records (MAR) as prescribed for them. This made it difficult to confirm whether people had received their creams in the way the prescriber had intended.

Individual protocols had been introduced for people who had medicines to be taken as and when required or 'PRN'. These documented the reasons why people needed the medicine and the maximum doses to be given in any 24-hour period. However, they did not include information about known interactions between some medicines; even though this information was provided on dispensing labels and MAR charts. There was a risk that people might be given two medicines simultaneously, against the prescribers' advice; although there was no evidence that this had happened.

Some people took blood-thinning medicines. Information about variable doses had been clearly recorded and people had received the right amounts at the right times. However, there was no information in care plans or MAR charts to highlight the signs and symptoms of under or over dosing of these medicines. Neither was there any guidance to make staff aware of particular risks to people on blood thinners; such as heavy bleeding. Although most staff were knowledgeable about blood thinners, the service was using a lot of agency staff and it was possible that they would not recognise the significance of symptoms and seek urgent assistance.

The failure to safely manage medicines is a continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Creams were now stored safely in people's rooms and the manager had assessed the risks of keeping creams there.

At our last inspection medicines which required safer storage had not been safely managed. At this inspection, administration of these medicines had been witnessed by two staff on every occasion to ensure that doses were correct. Regular auditing had taken place to check the balances of drugs remaining to quickly identify any missed doses. All administrations were signed off on MAR charts by staff when people received their medicines. We observed medicines rounds where staff followed safe practices and reminded people what their medicines were for. The temperature of the medicines fridge and rooms was monitored and recorded daily and liquid medicines were clearly dated when opened to make sure they were used within the manufacturers' recommended timescales.

There had been delays in some people receiving their medicines but the manager explained that she had been in contact with the GP practice to raise concerns about this and to remedy the situation quickly.

At our last inspection, actions to minimise identified risks to people had not been put into practice. This time assessments had been made about individual risks to people such as falls and mobility. These held detailed guidance for staff to follow when delivering people's care; and we observed this happening in practice. However, when some people had been assessed as needing special air mattresses; these had not been set at appropriate levels for them; based on their weight. One person's mattress was set to 100kgs but they weighed 82kgs; and another person's was set towards 'Firm' when they weighed just 36.9kgs. Both people had been assessed as needing the air mattresses to relieve pressure on their skin and prevent sores. Staff were unclear about whose responsibility it was to check or alter the air equipment settings and some people had not received the intended benefits of air mattresses.

The failure to take actions to minimise identified risks is a continued breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, recruitment information was incomplete; which created a risk that the work histories of job applicants could not be fully explored to ensure they were suitable for the roles. At this inspection there were still unexplained gaps in some staffs' employment history. Character references included information about applicants' work performance including time- keeping and their reason for leaving former jobs. These had been provided by people who knew the applicants in a personal capacity and so were not in a position to comment about employment-related matters. One employment reference stated that they would not re-employ the applicant in a similar position to the role being recruited to in the service. Pre-employment checks for another staff member highlighted a historical issue which could affect their suitability for the job. In both cases the manager told us she had assessed the risks of employing these staff and was satisfied that people were not at risk. There were no written records, however, to evidence that risk assessments had been made or that any measures had been put in place to monitor those staff.

The failure to operate a robust recruitment process is a continued breach of schedule 3 of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the service was neither clean nor hygienic. At this inspection all communal areas including toilets and bathrooms were fresh and hygienic and people's bedrooms were clean and dust-free. The laundry was well-organised, and a defined dirty- to- clean process was in place to avoid cross-contamination. Staff confirmed that people no longer shared some items of clothing. Waste had been disposed of properly and all bins were appropriately lined and regularly emptied to ensure there were no odours; and that soiled items were quickly removed.

We had highlighted that care staff walked through the kitchen to access other areas of the home; making it possible for them to transfer dirt or germs into the food preparation area. At this inspection staff no longer used this route. People and relatives told us that the service was, "Much cleaner than before" and rotas showed that cleaning staffs' hours had been increased to ensure levels of cleanliness were maintained.

At our last inspection, there had not been enough staff to meet people's needs. This time people and relatives told us that there had been an improvement in the numbers of staff on duty and their availability to support people. One person told us, "If I need them, staff come quickly" and a relative said, "I can't fault the staff or the service they provide".

The manager showed us how staffing levels were based on people's care needs and a dependency tool; that



was used to work out how many and which skills were required on each shift. Rotas showed that staffing levels had increased and were consistent; although around 40% of staffing was provided by agency carers. The manager said that this was a temporary situation while permanent staff were recruited. Some applicants were being interviewed during the days of our inspection. People and relatives said that agency staff were good, and one person commented, " They use the same ones[ agency staff] each time so we've got to know them and they're just as good as the normal staff. They know what I need and they're cheerful and helpful to me".

At the previous inspection there had been no robust system in place for raising safeguarding alerts with the local authority. At this inspection accidents and incidents were properly documented and staff could accurately describe the process for escalating concerns. The manager had appropriately referred some matters to the local authority for investigation and staff had received training in identifying and reporting suspected abuse.

At our last inspection, maintenance of the premises had not been carried out to an acceptable standard. At this inspection the premises was in good condition and the areas we highlighted in our last report as needing repair, had all been addressed. A new maintenance person had been employed specifically for the service and an audit had been carried out on each room and communal area to identify and remedy any issues. There was a maintenance book for staff to record any tasks that needed attention and entries had been signed and dated when complete. We checked some of these signed -off jobs and found that the repairs had been undertaken.

Equipment and utilities such as gas, water and electricity had been regularly safety-checked. Personalised emergency evacuation plans (PEEPS) had been completed for each person and detailed the number of staff and any equipment needed to assist them. Fire alarms were routinely tested and staff had received training in fire safety. Fire exits were marked and staff could describe escape routes to us. The service had a reciprocal arrangement with another local care home, so that people could be provided with continuity of care in the case of an emergency.

## Is the service effective?

### Our findings

One person told us: "I really enjoy the food; it's so much better since the new cook came". A relative said, "We've no complaints about the food; there always seems to be enough and it looks appetising".

At our last inspection, charts to record people's intake of food and fluids had not been adequately completed. At this inspection there had been little improvement. Although people appeared to be well-hydrated, the amounts that people had drunk each day had not been totalled up to provide a quick reference when reviewing charts to see if people had received enough fluid. One person's care plan documented that they were at risk of urine infections. Fluid charts for this person had been poorly completed. For example; on some days 'Tea' or 'Water' was written with no amounts included. It was not possible from these entries to see whether this person had had sufficient to drink. A GP had advised staff on 2 July 2016 to 'Push fluids' for this person and to document their intake. The fluid chart for 3 July 2016 contained just one entry which read 'Bottle lemonade', with no starting amounts or level of fluid consumed. Care plans did not record target amounts for people to drink and staff were unable to tell us what would be a reasonable fluid intake.

The failure to maintain an accurate and complete record of people's care is a continued breach of Regulation 17 (1) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were offered drinks from a trolley throughout the inspection and large flasks of water flavoured with fresh fruit slices were available in communal areas for people to help themselves freely. The cook maintained a list of people who required special diets and was able to tell us about how they catered for these. Fresh fruit was on offer alongside biscuits during drinks rounds, to give people the option to choose healthier snacks. There was a menu board on display with photos to illustrate the meals on offer, and tables were laid up with attractive cloths and napkins. People could enjoy a cooked breakfast every day if they wished and there was a choice at lunch and dinner. One person told us that they could ask for something else if they did not fancy what was on the menu. They said, "I sometimes ask for a jacket potato and they never mind doing that for me." A relative had responded to a recent survey to say, 'The variety and quality of food is good and there's always a choice'.

At our last inspection the principles of the Mental Capacity Act 2005 (MCA) were not being followed. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At this inspection, capacity assessments and consent continued to be muddled and sometimes contradictory.

Capacity assessments were not based on individual decisions and people's ability to make them. One person's care file contained three different assessments of their capacity; but a general one stated they had capacity for most day to day decisions. However, consent to vaccinations, photographs and medicines had been signed on behalf of the person by care staff. We saw this repeated in another care file of a person who

had been assessed as having capacity to make their own decisions.

This is a continued breach of Regulation 11(1) (2) (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made applications for DoLS and received authorisations from the relevant authority.

People's health care needs had been appropriately met. Records showed that people received regular input from GPs and other professionals to help maintain their health. District nurses visited to support people who needed wounds dressed or to give insulin injections to people with diabetes, for example. Appointments with opticians, dentists and chiropodists had been documented and diarised; so that people had routine health checks on a regular basis.

At our last inspection we reported that training had sometimes been ineffective. At this inspection staff told us that they felt training had improved significantly. Staff had completed mandatory training sessions in subjects such as safeguarding adults, first aid and fire safety. Some staff had passed additional training courses about dementia, behaviours that challenge and diabetes. Since our last inspection, the local Clinical Commissioning Group (CCG) had provided workshops to staff in a range of areas such as; end of life care, signs and symptoms of common illness, care plan writing and preventing skin damage.

All of the staff spoken with said that the new manager had started to introduce a more structured approach to training and refresher sessions. The manager told us that she was trained to deliver training courses and her methods took account of the different ways in which staff learned and absorb information. We heard that the manager had brought in workbooks; which involved staff taking a test to assess their level of understanding at the end. In addition, the manager carried out observations of staff as they worked to check that what they had been taught was being carried out in practice. All staff had been allocated a mentor to help them to develop within their role.

Records of staff supervision were in place and confirmed that staff had been given regular opportunities to discuss any concerns or request extra training. Feedback had been provided about performance and any areas for improvement and these were monitored. New staff underwent detailed inductions and a period of job-shadowing before working alone. Staff told us that they felt supported by the training on offer and people and relatives reported feeling confident in staffs' abilities. One person told us, "The carers are really good and experienced in dealing with the elderly" and another person said, "Staff know what they're doing which helps me relax".

At our last inspection there had been no special adaptations to help people living with dementia to find their way around; such as picture signage. At this inspection, new and clear signs had been introduced to identify communal rooms and bathroom facilities. People had their names and a picture on individual place cards on dining tables. A large wall clock with distinct markings had been purchased from an organisation specialising in aids for people living with dementia. These improvements had made the environment better for supporting people living with dementia to orientate themselves.

# Is the service caring?

## Our findings

People and their relatives told us the service was caring and that staff were kind and patient. One person said, "I need help with my buttons and staff always do that for me with good grace even though I'm really slow-nothing's too much trouble for them". A relative remarked that there had been much investment to improve the service since our last inspection, but that "The staff have always been wonderful here".

At our last inspection, some items of clothing such as socks, tights and incontinence underwear had been shared between people; which was not dignified for them. At this inspection, laundry and care staff confirmed that the incontinence underwear was no longer used and that people only wore their own socks and tights. People and relatives told us that the laundry service had improved significantly and that they no longer had problems with clothing going missing. There had been a large pile of clothing in an upstairs lounge during our last inspection; which was made up of unnamed items which staff could not allocate to people. This had all been cleared and the laundry was now well-organised and tidy; with people's clothing hanging neatly on rails.

At this inspection, people's privacy was respected and staff were discrete when reminding people to use the toilet. Staff knocked on bedroom doors and waited for a response before entering and they ensured that personal care was delivered in private. They routinely asked people for verbal consent saying, for example; "Would you mind if I turned the volume up on the TV for X?" or "Is it ok to wipe your face for you?"

Staff were considerate and thoughtful and made sure people were offered salt, pepper and sauces with their meals. Fruit was peeled for people who needed support to do this. Gentle music was played during the lunch period to provide people with a pleasant atmosphere to eat in. People laughed and chatted with each other and staff throughout mealtimes and there was gentle and relaxed banter between them. One person remarked, "The staff are so happy- go- lucky now, it's wonderful".

People were encouraged to be as independent as possible and care plans contained detailed information about which tasks people could manage alone; and those they needed support with. For example; one person's care plan noted that they could squeeze toothpaste onto their toothbrush themselves but would need prompting from staff to clean their teeth. Staff told us that it was important not to "Take over" and to let people do as much as they could. Another person was able to feed themselves but needed staff to remind them to eat. We saw that this happened at lunchtime. Another person asked staff to cut up their food for them. Staff did so and then discretely monitored the person to make sure they were managing to eat.

Staff knew people well and remembered things that were important to them. For example; one person enjoyed knitting and staff engaged them periodically in chats about this and what they would knit in the future. Staff cleaned people's spectacles, plumped their cushions and generally made efforts to make people as comfortable as possible. There were many occasions during the inspection when we observed caring and kind interactions between staff and people. Staff were patient when supporting people to walk with Zimmer frames. They walked alongside at the same pace and offered encouragement to people. Staff spoke about the people in their care with affection and one staff told us, "I'm so happy things have got better

here. All I've ever wanted is for the residents to feel loved and cared for".

People were involved in decisions about their care on a day to day basis. Staff asked people if they knew what their medicines were for when they administered them; and gently reminded them if they were not able to recall. PRN pain relief was offered regularly for people who had it prescribed to them and staff asked people to consider whether they had any pain anywhere and whether medicine might help them.

Sensitive records had been compiled about people's wishes and preferences about the ends of their lives; where those were known. These included people to be contacted, information about funeral services and any special requests. Do not attempt resuscitation (DNAR) orders were clearly displayed at the very front of care files; and staff handovers between shifts included information about those people to whom an order applied. Staff had received training about supporting people at end of life and was able to tell us what this meant. One staff member said, "It's about giving them the most comfort, dignity and respect at that last time in their life. Making sure they're not in pain and have everything they want and need".

## Is the service responsive?

### Our findings

One person told us, "It's very good here-I choose what I want to do and I choose not to go down to activities". Another person said, "I am a loner but there is plenty to do if you want it". A relative commented, "The new activities girl is really special: she's so good with the residents and she's working hard to find out what people want to do".

At our last inspection there was no activities coordinator in post and there was little happening to stimulate people. At this inspection people's needs for social interaction and stimulation had been addressed. A new coordinator had been employed full-time and had started to introduce a range of different activities for people to enjoy. An activities board showed that scrabble, quizzes, armchair exercises, nail painting and Music For Health were regular features. The coordinator also told us about a visiting entertainer who had played guitar and told wartime stories recently. The coordinator said that people had, "Absolutely loved it" and that she was looking to book a further session in the near future.

A vintage typewriter was brought out and a number of people tried it out and spoke for a considerable time about their memories. We observed that the coordinator made eye contact with each person individually during this reminiscence and we could see that this made people feel involved and a valued part of the conversation. People's life histories had been recorded, and this information was used effectively by staff during the session to promote a meaningful discussion.

One person presented a slide show to others about their travels. Staff supported this person to assemble equipment but they independently delivered the session; while others watched and asked questions. At another time, the coordinator and staff were using a colourful parachute in a ball-passing game. This did not go quite to plan and there were screeches of laughter from people as staff disappeared under the parachute. People clearly enjoyed the session and there was a jovial atmosphere in the lounge during the exercise.

A number of people we spoke with preferred to stay in their rooms and not join in with activities. They said that this was their personal choice and that they did not feel they were missing out in any way. The activities coordinator told us that she visited these people in their rooms to have one-to-one time if they wanted it. Social and leisure assessments had been made for each person; to record the things they liked to do and records were kept to document the activities that people had been involved in.

Care planning was documented in a person-centred way; with records setting out the individual ways in which people liked to receive their care. For example; people chose the times they liked to get up and go to bed. This was shown in care plans and staff knew people's preferences. People we spoke with said that these times were generally observed by staff and it was only occasionally that they were not woken at the time they preferred. One person's care plan had very detailed information about how they liked their hair to look and another person's documented their religious beliefs and the way that they liked to discuss these. In both cases these preferences had been respected by staff and people were supported to receive their care in the way they wished.

At our last inspection, people told us that their complaints had not always been appropriately addressed by the former registered manager. At this inspection, people and relatives told us that they knew how to make a complaint if they needed to. One person said, "I've spoken to the new manager about a couple of things and she has been reasonably receptive". A relative said, "The home has improved an awful lot, but I monitor things and wouldn't hesitate to complain to the manager if anything wasn't right".

The provider's complaints protocol was on display and this clearly detailed the steps to take if making a complaint; and the timescales in which a response would be provided. Contact numbers and addresses for external bodies which might help with unresolved complaints were listed. A complaints report had been publicised on a notice board in the entrance hallway so that people and their families could read the actions taken to remedy previously-raised concerns.

The manager maintained records of all complaints received along with investigations, outcomes and responses made to complainants. These records were thorough and kept in an organised way, which made it easy to track a complaint from initial receipt to final response. Monthly audits of complaints were undertaken by the manager and noted the number and type of complaints. This helped the manager and provider to identify any trends and take action to put things right.

A number of compliments had been received by the service; including letter and cards. One of these read, 'Thank you for making a difference'.

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One person presented a slide show to others about their travels. Staff supported this person to assemble equipment but they independently delivered the session; while others watched and asked questions. At another time, the coordinator and staff were using a colourful parachute in a ball-passing game. This did not go quite to plan and there were screeches of laughter from people as staff disappeared under the parachute. People clearly enjoyed the session and there was a jovial atmosphere in the lounge during the exercise.

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Care planning was documented in a person-centred way; with records setting out the individual ways in which people liked to receive their care. For example; people chose the times they liked to get up and go to bed. This was shown in care plans and staff knew people's preferences. People we spoke with said that these times were generally observed by staff and it was only occasionally that they were not woken at the time they preferred. One person's care plan had very detailed information about how they liked their hair to look and another person's documented their religious beliefs and the way that they liked to discuss these. In both cases these preferences had been respected by staff and people were supported to receive their care in the way they wished.

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A number of compliments had been received by the service; including letter and cards. One of these read, 'Thank you for making a difference'.



## Is the service well-led?

### Our findings

At our last inspection, staff had reported a culture of fear and bullying. At this inspection, all of the staff we spoke with told us there had been "Massive improvements right across the board" and one staff member said that the new manager had "Done wonders for the home". Staff generally said they now felt more valued and an 'Employee of the month' award had been introduced. However, at this inspection the culture of the service was not always described as open or inclusive. Although the majority of staff said that they felt supported by the manager; we did receive feedback from other staff and a relative who said their attempts to make suggestions had been misinterpreted as criticism, and had deterred them from doing so again. This is an area we have identified as requiring improvement.

The manager had been working in the service since January 2016. They had not been registered by the Commission at the time of our inspection, but had completed an application to become so.

Although there had been significant improvements in a number of areas since our last inspection, some of the issues we reported had still not been adequately addressed. This was despite assurances from the provider and manager in their action plan. Resources had been made available by the provider for new furniture, flooring and extra staffing but the areas which continued to need focussed input included; the management of creams, some risk assessments, food and fluid charts and operation of the MCA. The new manager and provider had introduced a range of audits to monitor the quality and safety of the service. While many of these were effective; such as those checking care plan updates, falls and complaints, others had failed to highlight the shortfalls found during this inspection. For example; the manager told us that senior staff were supposed to check that food and fluid charts had been completed appropriately. This had not happened and there was insufficient oversight to ensure that care was consistent and that it was evidenced appropriately.

The lack of a robust auditing process is a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection, feedback about the service had not been sought from people or their relatives. This time there had been a survey to find out what people thought. The manager had analysed survey responses to give her an overview of any areas which needed to be improved. We read the completed surveys and saw that people had been positive overall about the service. Comments included; 'Very good care here-excellent during the night', 'Improved a lot in décor' and 'All staff are very helpful'. Where some people had remarked negatively about activities or food, actions had been taken to make these areas better for people.

People's confidential information had not been kept securely at our last inspection. This time staff were vigilant about private records being left unattended, and ensured they were locked away after use. The staff flat situated on the second floor of the building was no longer occupied and the manager told us this space was being converted into a training suite. There was no longer a risk that visitors to the flat would be walking through the premises and past people's bedrooms.

The new manager was knowledgeable about people's needs and had welcomed input from the local authority and CCG to help improve and develop the service. Staff told us that there was good teamwork and that they now felt more accountable for their actions. Most staff said that they felt able to approach the manager with any concerns or to make suggestions and all of those we spoke with appreciated their responsibility to whistle blow if necessary. Minutes of staff meetings showed leadership by the manager who set out expectations for staff but also invited feedback from them.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent  The principles of the Mental Capacity Act (MCA) 2005 had not been consistently applied.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Medicines were not always managed safely. Assessed risks had not always been minimised appropriately.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed  Recruitment processes were not sufficiently robust to ensure that fit and proper persons were employed.

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Oversight of the service had not been sufficient to ensure people's health, safety and well-being.

### **The enforcement action we took:**

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