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St Georges Nursing Home

Inspection report

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Date of inspection visit:
25 September 2018

Date of publication:
24 October 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced inspection on 25 September 2018.

At our last inspection on 10 April 2018 we rated this service 'inadequate' and placed the service under special measures. We had found breaches of regulations concerning safeguarding adults, the recruitment of staff, management of medicines, training and supervision, person centred care, good governance and the management of complaints.

At this inspection we found significant improvements had taken place. The service was now meeting regulations. We have changed the rating to 'requires improvement'.

St George's Nursing Home is a care home with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides nursing care to up to 44 older people with some living with dementia or substance misuse issues. The provider was voluntarily not admitting new residents since our last inspection and there were 25 people using the service at the time of this inspection.

Since our last inspection the provider had appointed a senior manager and had worked with the local authority to bring about improvements. They were delivering an action plan which addressed our previous findings. There was a more open and creative culture amongst the staff team. Regular meetings were taking place with staff and the families of people who used the service and there were clearer systems of communication between staff and managers. There were processes to be followed for investigating and responding to complaints.

People had access to more interesting and varied activities designed for people living with dementia and a full-time activities co-ordinator was in place to continue to develop these. We observed positive interaction with people using the service.

The provider had changed their processes for the management of medicines. There were thorough checks carried out which meant people received their medicines safely. Safer recruitment processes were in place to ensure staff were suitable for their roles. The provider's audits had shown that they did not always hold the correct information on staff members and this had not yet been fully addressed. There were suitable assessments of staffing levels and people told us there were enough staff to meet their needs.

Care workers and nurses were now receiving training and supervision, but had not yet received all the training they required. There was further training planned from credible sources to make sure staff continued to develop the right skills to carry out their roles. Managers received training in safeguarding adults to make sure they knew their responsibilities to report suspected abuse.

There were improved processes in place to monitor when incidents and accidents had occurred and how to learn from these. Infection control procedures had improved. Managers carried out detailed audits of all aspects of the service to identify areas for improvement and act upon these. The service was better organised in every respect.

The provider carried out detailed assessments of people's needs, but sometimes these contained minor errors. Care plans met people's needs and were reviewed regularly, but sometimes lacked person-centred details for people's personal care. There was improved life story work and information about people's wishes and preferences. There were measures to offer people choice on what they ate and drank and to protect against malnutrition.

The provider had taken advice on how to make the building more suitable for people living with dementia. We saw examples of how the provider had acted on this advice, such as improved signage, higher contrast toilet seats and staff wearing name badges. Aspects of the building's design did not promote independence and managers told us they intended to develop this. There were processes in place to ensure the building was safe and kept in good repair.

Consent to care was obtained. People's decision-making abilities were assessed in line with the Mental Capacity Act. Potentially restrictive measures were assessed to ensure deprivation of liberty safeguards were being followed. Care plans were in place which met people's needs and were reviewed monthly. The provider was not meeting accessible information standards to provide information in a manner suitable for them. We have made a recommendation about this.

The service is no longer in special measures. We will continue working with the local authority and NHS to monitor this provider to ensure the improvement we observed continues. We will carry out a further comprehensive inspection within 12 months. We will return before this time if we think this improvement has not been 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

Aspects of the service were not safe, but there had been clear improvements in the overall safety of the service.

Staff ensured that people received their medicines safely.

There were effective measures in place to manage risks to people using the service and to safeguard people from abuse.

The service had improved recruitment measures in place and had identified when they did not hold the required information on staff members.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Staff had received some training since the last inspection but had not yet completed mandatory training. There were plans in place to address this. Staff were now receiving suitable supervision.

People received the right support to eat and drink and to stay healthy.

The provider had made changes to develop a more dementia-friendly environment, but aspects of the building's design did not always promote this.

The provider was obtaining consent to care and working in line with the Mental Capacity Act to assess people's decision making abilities.

Is the service caring?

Good

The service was caring.

People told us they were treated with respect by staff.

Plans had information on people's life story work and how to meet people's cultural needs.

We observed positive interaction with staff and people who used the service.

Is the service responsive?

Good

The service was responsive.

Plans were in place to meet people's needs. These were reviewed regularly but did not meet accessible information standards.

There was an improved and developing activities programme taking place.

The provider investigated and responded to complaints about the service.

Is the service well-led?

Requires Improvement

Aspects of the service required further improvement and sustainability needed to be demonstrated for the service to be considered well led and this will be checked at our next inspection.

There had been changes in the culture of the organisation to be more open. There was better communication with staff and a more coherent staff team. Regular team meetings were used to change the culture and encourage staff to speak up.

Managers carried out audits to assess the performance of the service. There had been a credible action plan to bring about vital improvements to the service.

St Georges Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 September 2018 and was unannounced. We carried out this inspection as the service had been rated 'inadequate' at the last inspection on 10 April 2018. You call see full details of our concerns in our previous report.

Since this inspection we had worked with the local authority and Clinical Commissioning Group to monitor the provider's service improvement plan. Prior to carrying out this inspection we reviewed information we held about the service, such as notifications of serious incidents the provider is required to tell us about, and records of complaints we had received about the service. We spoke with the quality assurance team at the local authority and reviewed records of their visits to the service they had shared with us.

The inspection was carried out by three adult social care inspectors, a pharmacy inspector, a specialist professional advisor who worked as a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with six people using the service and one relative. We also spoke with the clinical lead nurse, deputy manager, the administrator, activities co-ordinator, three nurses and two care workers. In carrying out this inspection we reviewed records of medicines administration relating to 25 people, records of care and support for five people and records of recruitment and supervision for five care workers. We looked at records relating to the management of the service such as communication books, incidents and accidents, audits and staff training records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found the provider was not meeting regulations relating to safeguarding adults as serious concerns were not reported to the local authority. At this inspection we found the provider was now meeting this regulation.

The provider now had clearer processes for reporting safeguarding concerns in line with local practice. This included clear information on the reporting of pressure ulcers and the need to consider issues of mental capacity in safeguarding procedures. Where an injury had been caused due to poor moving and handling this had been reported as a safeguarding matter.

The provider was working with the local clinical commissioning group to access online courses in safeguarding adults, and the senior management team had booked to attend training on the role of the provider in safeguarding adults. A senior staff member told us "I've been taken through the whole process so I know what to do when something is raised. We have regular team meetings to take people through the processes we have in place."

People we asked who used the service told us they felt safe. Comments included "It is very safe" and "my goodness, yes". People told us they would speak to staff or the manager if they didn't feel safe.

At the last inspection we found the provider was not meeting regulations with regards to the safe and proper management of medicines. We had serious concerns with all aspects of the provider's medicines processes and found repeated and serious medicines errors were taking place.

At this inspection we found that improvements had been made to all areas of medicines management and that the provider was now meeting this regulation.

New medicines trolleys had been purchased for each floor which were secured to the wall and the main medicines storage had been relocated to allow more space and privacy. Oxygen cylinders had been removed. The previous three month's daily monitoring records from the pharmaceutical fridge showed that medicines had been stored at the correct temperature. Controlled drugs were managed safely and we saw that appropriate arrangements were in place to destroy those no longer required. An emergency supply of antibiotics had been purchased as stock for the home and arrangements made for the safe use of these antibiotics when required by the visiting doctor. We saw prescribed fluid thickeners were stored in people's rooms. However, here were no risk assessments to ensure the safety of this practice.

We recommend the provider carry out risk assessments relating to the storage of fluid thickening powders in line with NHS Patient Safety Alert NHS/PSA/W/2015/002. The deputy manager informed us that this work was completed as soon as this was pointed out by the inspection team.

The process for ordering and checking medicines had been changed which meant that this was now done in time for any discrepancies to be sorted out before the medicines were needed. All medicines were available

for people when they needed them. We saw from the records of medicines incidents that an error had been picked up by the nurses and corrected before the prescribed medicine was given, which showed that the system was used in practice. All medicines with a limited shelf life had been dated when opened.

People's medicines were given to them safely, taking into account their own preferences. For example, we saw that one person who liked to sleep later in the day was offered their medicines at a time that suited them and this was recorded on their medicines administration record (MAR). Medicines that needed to be given after food in the morning were now administered after breakfast. No medicines were currently being crushed as liquids and soluble preparations had been requested.

We looked at a complete month of people's MAR; the records and available medicines showed that people had received their medicines as prescribed. Where medicines were not given the reasons were recorded. Creams and external preparations were recorded on a separate MAR by the care workers. These were generally complete but some gaps in the records were seen. A staff member told us "Before we used to see medication under the bed."

Staff had recently received training in medicines management to update their practice and had access to the relevant policies and procedures. Twice daily handover checks were completed by the nurses and a monthly full audit. This audit included appropriate actions to maintain safe practice. Nurses told us they welcomed the changes in practice and had been fully involved in implementing them.

At our last inspection we found the provider was not meeting regulations relating to staffing. This was because they did not carry out the proper checks on care workers before they started work.

There was now a clear recruitment process with a list of the information the provider needed to obtain about applicants. This included a full work history, obtaining references and carrying out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. There was evidence of DBS checks in all the files. There was confirmation of each nurses' PIN which evidenced registration with the Nursing and Midwifery Council (NMC) and when revalidation was due.

The process was clear that one reference must come from the most recent employer, but did not highlight the need to obtain evidence of satisfactory conduct in health and social care. There were two references in place for staff, six out of ten of the references were personal, from either friends or colleagues and not someone in a line management capacity. Four of these references had not been verified.

A personnel audit was being completed and all staff files had been checked to see what documents were missing. There was an action plan in place to ensure that all documents were on file to demonstrate that staff were safely recruited. A more structured process had also been developed for recruitment to ensure that appropriate staff were employed. There had also been an audit to ensure that the provider had an accurate record of the PIN number and expiry date for nurses employed at the service.

People using the service told us they thought there were enough staff. People said that staff never appeared rushed. Comments included "They always give you time" and "I have plenty of time." We observed that people had call bells to hand and staff responded to these promptly.

The provider had carried out an assessment of staffing levels using a recognised model for care homes. This had determined that at the present occupancy the number of staff was sufficient and the distribution of staffing hours was consistent. As a result of this work the provider had drawn up a model rota for required

staffing levels day and night. Managers had made changes to people's working days and patterns to ensure consistent staffing. There was also a plan in place for required staffing levels in the event of full occupancy.

People were protected against risks to their safety by a series of risk assessments and management plans. These included falls risk assessments and detailed assessments of people's moving and handling needs. Falls assessments included a history of people's falls, and factors which may affect the person's level of risk. Plans were clear about people's ability to mobilise and the support and aids they required, and were reviewed monthly. Staff had sought guidance from Speech and Language Therapy (SALT) when people had difficulty swallowing or were at risk of choking. There were also risk assessments around health conditions which may put people at risk, such as diabetes.

People using the service had been assessed for their risk of developing pressure ulcers. Where people were at high risk there were clear plans in place to monitor this risk. Measures such as using pressure mattresses and maintaining accurate records of repositioning were followed by care workers in line with these plans.

There were measures in place to ensure the premises were safe. A lock had been fitted to the front door which was done in a way which controlled access to the premises but meant that people were not deprived of their liberty. Reception staff were able to monitor people leaving the building and were aware of who could safely do this and when people needed intervention. The provider had obtained a quote for a video door system.

The provider had taken action to address concerns we had about the safety of the premises. For example, where previously hoist batteries were charged in unsuitable areas, and sometimes blocking fire doors, chargers were now mounted to the walls. Unused oxygen cylinders had been removed from the building. Fire exits were clear throughout and fire doors were well maintained. There was an up to date fire risk assessment carried out by a qualified professional which did not identify any high risks. Where actions had been recommended staff had acted on these. There were weekly checks of fire safety and records that showed new staff received a fire safety induction. The deputy manager told us "When I go on duty the first job every day is to do the rounds."

There was also a fire emergency plan. Where necessary, people had personal emergency evacuation plans (PEEP) which recorded the support and equipment they would require to evacuate in the event of an emergency.

The provider had arranged for checks of gas and electrical equipment, and when issues of maintenance or safety were raised these were followed up with appropriate actions taken. There was a clear system for reporting and addressing maintenance issues which were recorded by staff. The administrator identified the highest priority issues and ticked these off when done. Records showed that issues of concern were addressed promptly and jobs were not missed. The administrator told us "It works better this way, things get done." Checks were carried out on the safety of hoists, and electrical equipment. Contractors checked that the water was safe and that water temperature valves were operating correctly.

Where people were at risk from accessing balconies, the provider had carried out a risk assessment and fitted locks to the doors where appropriate. We identified one minor issue of concern as a door to a sluice room was unlocked and contained a glass screen which could be a hazard to people using the service. Staff took prompt action to address this when this was pointed out and fitted a lock on the door.

The provider had carried out an infection control audit across the service, including checking areas such as waste bins, hand wash points and the overall cleanliness of the building. We observed that contaminated

waste was kept in secure waste bins and that hand hygiene points were operational. A staff member told us "We never used to have bins in the bathrooms and people never changed gloves, we have better infection control procedures now."

At our last inspection we found that there were not processes in place for responding to incidents and accidents. At this inspection we found there was now a process for recording when an accident had happened, which included recording the immediate actions and monitoring following a fall, the perceived cause of the incident and any recommended actions. This included reviewing a person's care plan and risk assessment, although we saw one instance where this formed part of the plan but did not take place. There had been fewer falls since the last inspection and no recorded examples of repeated falls affecting a single person.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found that the provider was not meeting regulations for the training and recruitment of staff.

At this inspection we found the provider was meeting this regulation. Staff had not yet received all the training they required to carry out their roles, but there were significant improvements in this area. The provider had assessed what they considered to be mandatory training for all care workers. This included safeguarding adults, fire safety, first aid, infection control, health and safety, moving and handling, food hygiene and dementia awareness. There was now a system in place for recording when training had taken place and identified training providers for mandatory trainings. Staff had started to receive these but this process was not yet completed. A staff member told us "The training has improved so much, we used to pay for our training and it was basic" and another said, "The training was lacking before."

Among the nine nurses, all but two had received training in managing medicines. Four had received training in health and safety, three in fire safety and five in infection control. Amongst the care workers, we saw that the majority had not yet received training in safeguarding adults, although staff now had access to an online course. Seven out of 22 care staff had attended infection control, five had attended manual handling training and just three had received health and safety training. 11 care workers had attended fire safety training, but this now formed part of an induction for new staff.

One staff file stated that they had received mandatory training over eight hours in June 2018 that included consent, MCA, safeguarding, infection control, food safety, fire and moving and handling. It seems unlikely that this wide range of topics would be covered in sufficient detail to equip staff with the required skills and knowledge over such a short period of time.

The deputy manager told us that they recognised it was difficult for a whole staff team to access classroom based sessions, and had worked with the local NHS to access a range of online courses. All staff now had access to e-learning and an additional computer had been installed in a staff office to promote access. The provider had contacted their staffing agency to ensure that agency nurses had up to date medicines training.

The provider had a training agreement in place with a recognised provider in order to provide detailed training relating to the needs of people with dementia, including suitable communication and activities and training on providing end of life care. A staff member had been identified to attend training for the role of dementia trainer and the deputy manager was attending training in leadership and management from the programme My Home Life. My Home Life is a national programme which aims to promote quality of life and positive change in services for older people.

There was now a clear process for carrying out induction of new care workers. This included an introduction to the service, mandatory training and shadowing of experienced staff with goals for the first day, week and month at work. However, this did not follow any current national induction standards. There was a

probationary period of two months to decide if staff were competent and suitable before they were allowed to work alone with people.

There was a process in place for assessing staff knowledge of fire safety, reporting of concerns and how care workers identify and minimise risk. Managers had ordered quick reference cards for care workers on key issues of safeguarding adults and mental capacity.

At our last inspection we found that there was not a system of staff supervision in place. Since this time 12 staff had received supervision and there was a schedule which we were shown to demonstrate that supervision was planned for all staff. The deputy manager was meeting with night staff the day after the inspection to discuss the best time for them to have their supervision sessions. A pre-supervision form had been developed to help staff prepare for supervision and plan what they wanted to discuss. Also, a supervision contract had been developed so that expectations were clear for both the supervisor and supervisee. Appraisals had not yet taken place but that these were due to begin at the end of September.

The provider carried out standardised assessments of people's health needs and risks. This included a Waterlow assessment of people's skin integrity needs and the risks of developing pressure ulcers. People's risk of malnutrition was assessed using a Malnutrition Universal Screening Tool (MUST). These were completed and had been reviewed recently. There were also detailed assessments of people's daily living skills and dependency living. We observed minor discrepancies with how some of these were completed. For example, one person's MUST was reviewed monthly including checking the person's weight, but this did not include the person's body mass index (BMI) which was necessary for a comprehensive assessment of risk, and one dependency profile was incorrectly completed as it did not reflect a person's dysphagia. One Waterlow assessment did not include that a person had dry skin and was prescribed cream to manage this, but this information was available elsewhere.

People we spoke with were positive about the support they received to eat and drink. Comments included, "If necessary, [I get help], I haven't had it but I see it a lot in the dining room" and "they help me with the food." People told us that they liked the food and were supported to make choices. Comments included "They ask us what food we want, plenty, we are well looked after" and "We have a choice."

People received respectful support to eat and drink at meal times. We saw that people had drinks in front of them and staff ensured that people were comfortable and in the right position to eat. We saw examples of people being reassured and encouraged to eat. Accurate records were kept of people's food and fluid intakes where people were assessed as being o high risk of malnutrition and monitoring of people's weight. Gaps in records of people's weights corresponded with when records showed people had refused to be weighed and this was respected by care workers.

There were steps in place to monitor people's health and wellbeing. This included plans in place to monitor and support people's bowel movements and accurate records were maintained of this. Where people were at risk from seizures there was a clear plan in place for how staff should respond to a person having a seizure. Staff kept records of seizures and the actions they had taken in response to these. There were suitable records kept of the management of wounds. There were also plans in place to support people to reduce their intake of alcohol when they tended to misuse this. The service worked together with other health professionals such as Tissue Viability Nurses and the person's GP to monitor and meet people's health needs.

The provider had taken advice from experienced sources on how best to provide a dementia friendly environment. Examples of these included clearer signage with pictures to help people navigate around the

building. The deputy manager told us these were temporary and that they were taking advice on more permanent signage. In response to specialist advice the provider had changed the colour of toilet seats to provide improved contrast. All staff members were wearing name badges which were high contrast and easy to read, and these were also provided to visitors. There was a new noticeboard in the day room which showed the date and time and pictures of what foods were available for lunch. We saw that people's meal choices were now made on a daily, not weekly, basis.

Some areas of the building's design still did not support people to move through the building independently. The day rooms were in the basement, which could be accessed by a single small lift. Most significantly, access to the day room, library and dining room also required people to pass through the classroom area, which had automatically closing fire doors that most people were not able to open for themselves. This meant care workers needed to support people to move through this area. We saw that at times care workers found it hard to support people who used wheelchairs through these doors. The deputy manager showed us evidence that they were consulting on fitting door stops that were fire safe. This was to allow people to keep their doors open safely when they chose to. The service had identified which people would need these. A photo board had been ordered to display pictures of the staff team.

We noted that most toilets in the building still lacked locks, which meant people's privacy was not assured when using them. Care workers told us that this was in the event of people falling or requiring help, but the service had not explored alternatives such as locks which could be overridden from the outside, but clearly indicate that a toilet was occupied.

The service obtained consent to care. When people could do so, they had signed their care plans to show their agreement, although we saw one instance where a member of staff had signed instead of the person even though they had signed their other documents. The provider had assessed people's decision-making capacity in line with the Mental Capacity Act (2005) (MCA). The Act 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). Where people were subject to potentially restrictive practice such as the use of bedrails and bumpers, the provider had assessed whether the person had capacity to consent to these. The provider had applied to the local authority when people were deprived of their liberty and informed the Care Quality Commission of this.

The GP had completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms where it was felt resuscitation was not in people's best interests. These were prominently displayed at the front of people's care files. There was evidence that people's views had been relayed to the GP as part of this process, and where a person had expressed a desire to be resuscitated before they developed dementia this had been communicated and upheld.

Good

Is the service caring?

Our findings

People told us they were treated with respect by staff who promoted their independence. Comments included "Yes, they are very nice people, nothing to complain" and "They encourage you to do things for yourself."

Care workers had carried out assessments of people's needs and preferences. People had documents called "This is me" which included quotes from the person and their family members. This included information about the books and television programmes people enjoyed, people's preferred names and details of their daily routine. These documents also included life story work which contained detailed information on people's work and family backgrounds and information about people's interests. People's plans also included details on their religion, for example which church people had grown up in and whether they still wished to attend services. During coffee mornings with family members the provider had recorded in broad terms that they had discussed people's life stories. It was recorded that everyone enjoyed these discussions, but this information was not recorded and used to inform people's care plans or activity programmes. People had communication care plans which indicated how best to communicate with people and the support they received with sensory needs such as their eyesight or hearing.

Care workers supported people in a respectful manner to move into the dining area ahead of lunch. At our previous inspection we saw that people were left unattended without any interaction from staff whilst other people were supported in the dining area. This time we observed people were not left unattended and there was positive staff interaction whilst people waited for their food. We observed that people were responded to promptly by staff members. When people appeared in need of help care workers were aware and offered assistance. We heard examples of care workers explaining what they were doing with people as they provided personal care. Where a person using the service had entered the building, and appeared confused they were promptly engaged by an administrator and a care worker and offered support to access an activity. People could bring their pets to live with them and there were no formal restrictions placed on this.

We saw examples of caring practice by the provider. On the day of our inspection we saw that the activities co-ordinator was carrying out a series of events for a resident's 100th birthday. This included arranging special treats, consulting with the family to arrange a celebration and provide a card from the Queen. We saw a member of staff had been out to buy a birthday cake. The provider had arranged to pay for the funeral of a person who did not have a family member to arrange this. We spoke with a person who lived in the area and came to the service informally most days for a meal and social activity.

There were improved measures in place to protect people's confidential information. The provider had created a new staff office on the ground floor which was kept locked with a keypad code. People's care files and other personal information was stored securely and we did not see any examples of confidential information left out and accessible.

Good

Is the service responsive?

Our findings

At our last inspection we found the service was not meeting regulations relating to person centred care.

At this inspection we found the service was now meeting these regulations. Care was designed in a way which met people's needs.

People had several care plans in place. These covered areas such as personal care, nutrition, social needs and activities, mobility, tissue viability and symptom control. Plans included people's wishes for their care such as the gender of their care workers and the use of prescribed items such as creams. Personal care plans did not always contain information on preferred items such as perfume or make-up which could help to personalise people's care, but we saw examples elsewhere of people's preference being recorded in communication notes. Plans were comprehensive about people's care needs and were reviewed regularly. People's social needs were recorded, including the support people may require if they become anxious.

There was now a list of named nurses and keyworker allocations. Managers told us that key working was new to the service and was continuing to develop. People's plans were reviewed monthly to ensure they met people's needs.

The provider was not meeting the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with the AIS. Care plans had highlighted people's communication needs but not how these related to accessible information. The provider's action plan had highlighted the need to consult with people about the implementation of AIS but this piece of work was not scheduled to have been completed by the time of the inspection.

We recommend the provider take advice from a reputable source on meeting the AIS.

At our last inspection we observed that activities were only intermittently taking place, and these were repetitive and not always suitable for meeting the needs of people with dementia.

Since our last inspection the provider had appointed a full-time activities co-ordinator and now had an improved programme for people to engage with. This included accessing activities from a local initiative called Ladder to the Moon. Periodically the service would receive a suitcase with resources for an activity, and this was to be opened by the staff with people using the service. We saw an unopened suitcase ready for the next activity, which was to re-create scenes from the movie "The Sound of Music". Staff told us they had a film crew coming in to support this. The activities co-ordinator was able to access peer support as part of this programme and said, "They help us support people with dementia, send us activities each month, last month it was bath bombes, residents chose to do Sound of Music and will do a 15 minutes segment, those that don't want to act and sing can do make-up and directing".

Other planned activities included a coffee afternoon in aid of Macmillan nurses and a vibrant communities

day. People told us they had enough to do and that they could choose what they participated in. We observed a coffee morning activity taking place. We saw good quality interactions between people and their care workers. The activities co-ordinator engaged with people positively based around their interests. For example, one person was carrying a teddy bear, which the member of staff used as a starting point for a conversation about the person's childhood. Another person had served in the military and we saw a member of staff bringing a book about the Second World War and speaking with the person about their service.

The deputy manager and activities co-ordinator told us of their future plans for activities. This included arranging for pet therapy and had identified a family member who was prepared to run a bakery session, and were planning additional music sessions, outings and special occasions. A manager said, "Our relatives are getting slightly more involved with our activities." People's plans contained information on the opportunities they had had to participate in activities. When people chose to stay in their own rooms plans did not always contain detail about the social support they received but the activities co-ordinator explained some of the support people received.

At our last inspection we found that the provider was not meeting regulations concerning the management of complaints. At this inspection we found the provider was now meeting this regulation.

There was now a clear process for addressing complaints. Complaints were recorded on a new style form which identified who was making the complaint and what had gone wrong. Senior staff members or the provider had recorded the actions that they had taken to investigate the concerns, such as speaking to all parties involved and checking records. The provider had then met with the complainant to agree a way forward and had put this in writing. Where standards had fallen below what had expected the provider had apologised.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the provider was not meeting regulations regarding good governance. At this inspection we found the provider was now meeting this regulation.

The provider had compiled a detailed action plan to address the serious concerns we found at our last inspection. There were agreed actions in key areas such as leadership and management, safety and meaningful daily activities. These clearly assigned responsibility to members of the management team with dates for completion and identified any risks to delivery. There were also clearly agreed next steps for managers to take to continue implementation. Areas such as staff training and supervision where improvement plans had not been completed had not been due to complete until the end of October, and the plan highlighted that improvements to the accessibility of care plans may not be completed on time. This agreed with the findings of our inspection in other areas, indicating the plan was realistic and being followed. This improvement plan had resulted in the provider complying with all regulatory requirements.

Since our last inspection the provider had worked closely with the local authority and Clinical Commissioning Group (CCG) to improve practice. During provider concerns meetings all parties involved were satisfied with the way the provider had engaged in the process. A senior manager with the local authority told us "From where we were to where we are there is considerable improvement." Two managers had had the opportunity to visit a local provider who was rated Outstanding and told us of what they had learned from this visit.

The Deputy Manager was enrolled on My Home Life, which was an initiative run by the local authority to promote more person-centred practice in care homes. We saw examples of how this had inspired more creative practice. The deputy manager told us of a music programme for care homes they had heard about through this programme and told us "I was so desperate to have it here, it was one of my biggest achievements". Staff we spoke with were proud of the changes they had brought about at the service. A manager told us "We've worked so hard, but there's a lot to do, we're under no illusions."

Managers had carried out a catering audit, which was used to check that records of food preparation were complete and that menu choices were communicated to people who used the service. There were systems in place for auditing the safety of the premises, and actions were taken because of these. An audit had been carried out on personnel files to ensure that these contained the right information relating to recruitment, training and supervision, and had been effective at identifying actions required.

Previously we had seen poor and outdated practice as the service had very few opportunities to explore new and innovative practice. We saw that the culture of the organisation had shifted to be more open to change and improvement. For example, in the classroom area we saw evidence of sessions which had taken place with staff. This included discussions of the provider's core values and suggestions from staff on how these could be implemented. Care workers had written their priorities for the service on the tiles. A session had explored the concept of "Carpe Diem" and staff members had stuck post it notes on the wall with their ideas of what "Carpe Diem" meant to them.

Team meetings had now been taking place weekly. There was a white board with an agenda for the coming team meeting, and we saw that team members had added their own suggestions to this, such as availability of rubbish bags and wipes and training on recognising symptoms. Minutes of previous meetings for day and night staff were prominently displayed. Team meetings were used to consult with staff on changes and to update people on changes which had taken place. This included changes to the rotas and allocations process, how staff were to engage in key working activities and updates on recruiting new staff. Comments from care workers included "I have seen the change since the new manager, things are better", "The management is listening to staff" and "I feel we can now openly discuss issues."

We saw examples of how previous poor practice had been addressed in team meetings. At our last inspection night care workers had been told that they needed to get a certain number of people ready in the mornings. In the most recent team meeting it had been discussed that there was not to be a target for this, but that care workers were asked to take a person-centred approach based on people's preferences and sleep patterns.

Team meetings were also used to agree principles to promoting a better working relationship, such as raising concerns respectfully and working as one team. Minutes showed that care workers were happy with the improved communication. Care workers completed a handover checklist, including passing on information on people's current conditions and any actions required on the next shift, and verifying that checks had taken place of medicines. There was now a clearer system of allocating duties to care workers based on staffing areas of the building, including allocating one staff member to the day room. A new staff office on the ground floor had been created and used to organise records far more clearly. A whiteboard was used to display allocated tasks and key information such as upcoming appointments and outstanding referrals. Files were tidier and information was better organised. A senior staff member told us "It's a great improvement, I've got more confidence now. [the improvement lead] has come in and shown us the way. People are calmer." The deputy manager told us "I feel we're moving forward, the team is more of a team now…there's lots more we want to do."

The provider told us that the improvement lead would remain in the service without an end date. The clinical lead nurse was in the process of stepping down from the senior role, but the provider was advertising for a replacement.

Relatives were kept updated on changes to the service through regular coffee mornings, which were attended by several relatives. These were used to discuss the issues that the service had faced because of the last inspection and to answer questions about what was being done now. "We had a coffee morning [for relatives]. If you read that horrific report you will want to know more about it. We want to keep that going now."

The provider was displaying their rating from their previous inspection in the lobby. Where people had died, or serious events had taken place, notifications of these were submitted to the Care Quality Commission (CQC) as required.

We did not change the rating in this domain as aspects of the service still required improvement. There had not been enough time to demonstrate the sustainability of improvements to the leadership of the service. We will check this at our next inspection.