Crown Care VI Limited

Holyrood House

Inspection report

Spawd Bone Lane
Knottingley
West Yorkshire
WF11 0JG

Tel: 01977679219
Website: www.crowncaregroup.couk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 and 24 January 2017 and was unannounced. Holyrood House is a purpose built 85 bed nursing home in Knottingley. There were 58 people living in the home at the time of the inspection.

There was a registered manager in post. This manager had been newly appointed at the time of the previous inspection and had managed the home for 12 months.
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.

The last inspection took place in February 2016 and there were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was in special measures. The provider had sent us an action plan following the previous inspection to show when the regulations would be met. We found at this inspection there were significant improvements, although we identified a breach in the regulations regarding the safe management of medicines.

There was a friendly atmosphere in the home and each unit was welcoming. In particular, the unit for people living with dementia had been vastly improved since the last inspection. People told us they felt safe at Holyrood House and relatives said they had no safety concerns.

Staff had been given regular opportunities for support, learning and development and they had improved knowledge and understanding of mental capacity. 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.

Mealtimes were sociable and staff understood people's dietary needs, with appropriate attention given to ensuring people had enough to eat and drink. Where there were concerns around people's nutrition or ability to eat properly, these were referred to other professionals as necessary.

Staff delivered a kind, caring and compassionate service to people, with good quality interaction which enabled people to feel valued as individuals. Staffing levels had improved, although deployment of staff on the nursing unit meant staff were only able to engage in physical care due to people's dependency needs.

Care records had improved since the last inspection and staff updated these in a timely way and in partnership with other professionals to ensure continuity of care.

Activities were more meaningful and frequent, with staff paying attention to those people who remained in bed.

The culture in the home was open and transparent with effective communication throughout.

Systems and processes to ensure the quality of the service delivery were in place and in most areas were thorough and robust. There was close monitoring by the management team to check and reinforce good practice.

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

We identified a breach of regulation in the safe management of medicines.

Staffing levels had improved since the last inspection, although the deployment of staff in the nursing unit meant staff had little time to spend with people in other ways than physical care.

Systems for recruitment of staff were more robust and there was less reliance on agency staff than at the last inspection.

Staff understood the risks to people and care records were updated as people's needs changed.

Is the service effective?

Good

The service was effective.

Staff had many opportunities for training, development and support to carry out their role in caring for people.

There was improved understanding and documentation around people's mental capacity and clearer assessments were in place.

People's nutritional needs were well met and staff had a good understanding of individual risks, with close monitoring and referral to other professionals where there were concerns.

Is the service caring?

Good

The service was caring.

Staff interacted with kindness and compassion in all communication with people.

People were involved in their care and support and staff gave explanations and reassurance to make sure people were fully included in any discussions affecting them.

People's dignity and privacy were given high regard and staff

encouraged people to retain their independence.

Is the service responsive?

Good

The service was responsive.

Care was person-centred and there were many opportunities for people to be purposefully engaged in activities of their own choice and interests.

Care plans were more detailed and up to date than the previous inspection with information clearly recorded for staff to provide continuity of care for people.

Complaints were recorded with detailed information about the provider's response and the outcome.

Is the service well-led?

Requires Improvement

The service was well led, although the inspection identified a breach in the 'safe' domain.

The registered manager was committed to driving improvement in the home and there had been significant action taken to address the concerns at the previous inspection.

There was an open, transparent and communicative culture which staff understood and there was clear direction and leadership for the staff team.

Systems and processes to monitor and evaluate the quality of the provision had been clearly implemented. Audits were clear and action plans to improve practice as a result were devised and monitored, although there were some weaknesses in the auditing of medicines management.

Holyrood House

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 19 and 24 January 2017 and was unannounced on the first day. There were 58 people living in Holyrood House at the time of the inspection.

There were three adult social care inspectors 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. Their area of expertise was in mental health.

We reviewed information from the provider information return (PIR) and notifications about the service, as well as information from the local authority and partner agencies. A PIR 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 spoke with 16 people who used the service, seven relatives, nine staff, the registered manager and the managing director. We reviewed three staff files staffing rotas and meetings of minutes as well as quality assurance documentation and records to confirm equipment and premises had been checked for safety.

We reviewed five care plans in detail and nine care plans for specific information, such as medicines records, mental capacity assessments and deprivation of liberty safeguards (DoLS) applications.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe living at Holyrood House. One person said: "Yes I am safe, there's no safer place for me". Another person said: "If I didn't feel safe here I wouldn't want to be here". Another person said: "It's very safe here, that's why I put myself in this home. There's always someone here for me". One relative we spoke with said "I can relax knowing my [family member] is safe. I have trust in that" .

One member of staff told us: "I feel people are safe, I would bring my family member here". Another member of staff said: "I do think people get safe care here".

Staff were confident in their understanding of how to identify signs of possible abuse and what to do to make sure concerns were raised appropriately. The registered manager referred any safeguarding notifications through to CQC as required and took any necessary action to ensure safeguarding procedures were followed. Staff understood the whistleblowing procedures to enable them to report poor practice. Staff said they were confident anything they reported would be dealt with. One staff member said, "I am absolutely certain things would be dealt with properly."

Accidents and incidents were responded to, recorded and monitored to ensure people's safety. Where a person had a fall, there were 24 hour observations completed and a universal pain tool with facial illustrations on a scale to show the level of pain a person may be experiencing. Where an increase in falls was noted for a person, there was evidence of action taken such as medicine review, infection check and referral to the GP or falls team if necessary.

Staff reminded people about safety in the routine by talking to them about their equipment, such as walking frames and making sure they had this within their reach. We saw where people were supported with their mobility this was done with care to ensure their safety. When people were hoisted from their chair to a wheelchair, this was done in a safe and caring manner. People were given reassurance and information as staff supported them with moving and handling. We heard staff say 'please keep your elbows in' and 'are you comfortable?' as they assisted people. We saw sling weight safety checks were made and equipment was available on an individual basis according to people's needs.

Staff we spoke with understood how to use equipment safely. Where new equipment was introduced staff worked closely with other professionals to find out how to use it. For example, we saw staff liaised closely with a visiting professional who demonstrated how to use pressure relieving equipment. There was clear discussion with the occupational therapy team and the home staff about a person's mobility and risk.

Premises and equipment safety was well maintained overall, with available documentation to show regular checks were made in line with health and safety legislation. People had personal emergency evacuation plans in place which staff knew and understood, with colour codes to indicate the level of assistance each person would need. We saw this was regularly updated. The provider had addressed concerns from the last inspection in relation to fire safety training and all staff in post had undertaken this.

Recruitment procedures were seen to be more robust than at the last inspection, with evidence of necessary vetting of staff prior to appointment. Staffing numbers were seen to be adequate, although the deployment of staff on the nursing unit meant staff were fully occupied with meeting people's physical care needs. We saw little evidence on the direct impact to people, for example, call bells did not take longer than five minutes to be answered, but moreover upon staff, who were at times stretched to their limits moving from task to task. However, we saw some people in their rooms had to wait to be served their meals in the nursing unit, around 40 minutes after lunch began to be served.

One member of staff on the nursing unit told us: "We do not stop, we are busy. When we have three carers and one nurse we have time to talk to people. If someone buzzes and we are busy they have to wait 10 minutes. We try to be as quick as possible". Another member of staff told us: "We sometimes don't get a break as we are really busy. People can be waiting five to 10 minutes. We sometimes have to rush people so we need to move on to other people to get up". Another member of staff said: "In an ideal world we could do with another staff member. It's difficult, residents do have to wait. We have to prioritise, people have to wait up to 20 minutes. Sometimes they have wet their pads by the time we get to support them". Staff said they had spoken to the registered manager about this who had said when more people came in they would appoint more staff.

We spoke with the dementia unit manager who told us staffing levels were determined by the number of people and their care and support needs. Staff told us they felt there were enough staff to ensure the service was safe. One member of staff in the dementia unit told us, "Staffing has improved majorly since the last inspection; all credit to [name of unit manager] and [name of registered manager], they have really turned things around." We saw there had been a large turnover of staff since the last inspection and a reduction in the number of agency staff required.

We spoke with the registered manager about staffing levels on the nursing unit in light of all 12 people on the unit requiring support from two staff for personal care and nine people needing direct support with meals. The registered manager explained how staff numbers were calculated, based upon dependency information and said statistically the home was operating on higher staffing levels. However, they agreed they would make some closer observations of how people's dependency needs impacted upon staff time in the nursing unit.

People we spoke with expressed no concerns about staffing levels. One person said: "They come if I need them to. I try not to call them, but I find there's no need as someone always pops in to see if I'm alright". Another person said: "It's reassuring to see staff around, there's usually someone to call upon". Relatives told us staff were visible in the service when they came to visit their families.

Systems in place did not always ensure medicines were managed safely. We looked at medication storage. We found the storage cupboards were secure, clean and well organised. Medicine fridge temperatures were taken daily and recorded. The treatment room was locked when not in use. However, on the dementia unit some medicines we looked at were in a foil packet and the dose the person received was half a tablet. The other half of the tablet was stored in the packet for the next administration, wrapped back up in the torn foil. This was not suitable storage for this medication. We advised the registered manager and they made immediate arrangements to discuss this with the pharmacist to ensure safe storage.

Controlled drugs (CDs), which are medicines liable to misuse, were locked securely in a metal cupboard and the controlled drugs log was completed and correct. We saw the log was checked weekly to ensure controlled drugs were managed safely. The unit manager on the nursing unit told us only trained nurses gave medicines on that unit, and where CDs were given, team leaders supported to second-check the

administration.

Medicines for return to the pharmacy were documented in the home. However, there was no system in place to ensure safe receipt of these when they were returned; there were no signatures or receipts to confirm medication had been returned. The medication awaiting return to the pharmacist was not in a tamper proof container and did not meet the National Institute for Health & Care Excellence (NICE) guidance which states 'medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy'.

We observed administration of some medicines and saw medication was given out at key times in a timely way and the process was explained to people and they were appropriately encouraged to take it; this was done in a calm, sensitive and caring way. However, we noted on one occasion in the dementia unit the medication administration record (MAR) was signed before the medication was administered. This did not meet NICE guidance on the management of medicines in care homes.
One person in the dementia unit was prescribed thickeners to make sure they could have drinks whilst minimising the risk of choking. We found staff who prepared and served drinks had written guidance as to how to thicken people's drinks to the correct thickness. The unit manager said they signed the MAR in advance of the prescribed thickener being administered as the person regularly received this in their drinks throughout the day. The MAR was not an accurate record of the number of times the thickener was administered. The registered manager said there was no system in place to record administration of prescribed thickeners but they would look in to ensuring this was put in place. We also noted thickening agent which can be a choking hazard if swallowed without being added to liquid, was left unattended on one occasion.

Some people were prescribed pain relief patches. Records showed these were applied as prescribed and changed every 72 hours. We spoke with the dementia unit manager who was aware of the need to rotate the position of the patch to reduce the risk of skin damage. Body maps were in place to demonstrate the patches were rotated to different parts of the body.

In the dementia unit, we saw one person's medication had been supplied in a dosette box and their MAR was handwritten. The number of tablets received had not been documented and the MAR sheet had not been signed for the last two days prior to our inspection. We therefore could not be sure this person had received their medication as prescribed.

One person was prescribed eye drops. The bottle did not have a record of the date it was opened. The instructions on the bottle advised they should be discarded after four weeks. We could not be certain these eye drops were safe to be administered. The unit manager agreed to obtain a new supply for this person.

We saw one person was prescribed medication which they frequently refused to take. A health practitioner was involved in the management of this. However, we found on two occasions their medication, lansoprazole and loperimide were still in the monitored dose packaging yet the MAR had been signed to say the medication had been administered. We also saw the code 'S' was occasionally used to indicate the person was sleeping when they had actually refused their medication. The unit manager agreed this was an oversight. This person also had some medication prescribed which was supplied in a box, risperidone. We saw on the 15 January 2017, this medication had been refused and we were told it was placed in the monitored dose packaging with other medication. This meant the boxed medication was removed from its original packaging and there was a risk this was not able to be identified. We also saw the box of risperidone tablets should have contained 19 tablets and there were only 10 present which meant this medication could not be properly accounted for. The unit manager explained there may have been an oversight in the

recording of refused medication but agreed the records did not show this.

We also saw another person was prescribed furosemide and the MAR in use at the time of our inspection showed 28 tablets were received in to the home. However, the MAR showed 20 tablets had been administered yet there were 9 tablets left in stock. We could not therefore be sure this person had received their medication as prescribed.

Some people were prescribed medication to be given 'when required' or 'as directed'. We saw there were some protocols in place giving guidance for staff and indicating the reason the medication was given and why. However, we saw two people were prescribed laxido one or two sachets as required. There were no protocols or instructions in place to guide staff as to when one or two sachets were administered. Records we looked at showed there were some occasions when one sachet was administered and other occasions when two were. It was not clear why this dose varied and under what circumstances the dose was varied.

Two people had been identified as needing their medication to be administered covertly. This meant they were not aware that some of their food or drink contained medicines. The unit manager told us they crushed the medication and put it in some water to administer it. The unit manager told us it had been agreed three days before our inspection, with the people's GP to administer medication covertly. The written instructions for this could not be located. They were obtained from the GP during our inspection. The safety of crushing the medication had not been checked with a pharmacist to ensure this was a safe and effective method of administering the medication. The registered manager made arrangements to do this during our inspection and we saw confirmation this had been actioned. By the second day of the inspection there were clear directions obtained from the pharmacist for how to administer each medicine covertly and there was a corresponding care plan and mental capacity assessment in place for each person.

We were told medication audits were completed monthly by unit managers and these were submitted to the registered manager. We saw medication audits were carried out regularly. The registered manager told us they were confident some of the issues we identified at inspection would have been highlighted by their own internal audits, such as the administration of covert medicines.

We saw on the residential unit there was a record which should have been completed daily for staff to sign to account for the keys to the medicines storage. We saw this was only recorded sporadically and therefore it would not be possible to show which staff had been accountable for handing over and receiving the medicine storage keys.

We concluded medicines were not managed safely and people were not protected against the risk of not receiving their medication as prescribed. This was a breach of Regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the home, which included some bedrooms, bathrooms and communal living spaces. We found all areas were very well maintained, clean and tidy. There was evidence of regular cleaning throughout the inspection. Cleaning staff and care staff were knowledgeable about their role in how to prevent the spread of infection.

Good

Is the service effective?

Our findings

People told us staff knew how to do their job properly. One person said: "They know what's what" and another person said: "I've no worries, I trust them". Relatives we spoke with were positive about staff's ability. One relative said: "I have total peace of mind because they know [my family member] very well and how to meet their needs". Another relative said: "I have every confidence in the staff's abilities to look after my [family member].

We saw staff training records which detailed all training undertaken by every member of staff. At the last inspection we had been concerned about the lack of evidence of staff training, but at this inspection it was evident this had been given high priority. The training matrix was colour coded to show training completed and highlight any gaps; we saw the majority of the matrix was coloured green and there were clear reasons where gaps were.

Staff told us they felt well supported and had supervision meetings with the unit manager to discuss issues and training needs. We saw from staff records, supervision was regularly carried out with individuals or in a situational supervision if practice needed to be improved. Staff also told us they felt they received the training they needed to meet people's needs and do their job well. One member of staff said: "We do lots of training, face to face and online; just completed wounds dressing training". Another member of staff said: "We get so much training, there's always something to learn about or to refresh". Staff told us domestic staff had the same training as care staff and they were 'happy with the training'. Staff told us their competency to carry out their role was regularly checked and they said this was done in a supportive way.

Regular meetings with staff were evident and staff we spoke with said they had opportunities to discuss issues together or at any time with the registered manager. Staff told us communication was much better than at the last inspection.

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 registered manager told us two people had authorised DoLS in place and there were a further five requests made. We did not see any evidence the registered manager had queried the progress of DoLS applications with the local authority.

We saw people's care records contained information about making decisions. Care records contained assessments of people's capacity to make decisions and were supported by best interest decisions. However, the decision taken three days before our inspection, to administer medicines covertly to two people who used the service had not been recorded as in their best interest. There was no record in place to show how this had been agreed. The registered manager was aware of this and agreed the records would be

updated as a matter of urgency and we saw this was promptly done. We saw best interest decisions did not always show who, other than staff, had been involved in making the decisions. The unit manager said they always tried wherever possible to involve family members or others who may have known the person well.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw appropriate DoLS authorisations had been made for people the service had identified were likely to have their liberty deprived and conditions were met; for example one person who had a DoLS in place had a condition that they must have regular telephone calls to their partner and staff told us this was adhered to. We saw a DoLS application had been sent for one person but there was no confirmation this had been authorised. We discussed this with the registered manager who promptly chased this up with the relevant authority.

We asked staff about the MCA. They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions. One staff member said, "It's important to do everything possible to help people make choices and decisions; making it as easy as possible for people to understand." Another member of staff said: "Assume everyone can make their own decisions, keep best interest at heart". Staff we spoke with confirmed they had received training on the MCA and they had been given individual booklets about this. The training matrix showed evidence of recent training in MCA.

We saw people's right to give consent and make decisions for themselves was encouraged and staff sought people's consent before providing them with care and support. For example, people were asked if they wished to take their medication, participate in activities or needed any support with mobility and their decisions were respected. Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions.

We observed the lunch time meal in the home. In the dementia unit, people were supported to eat in the main dining room, a small dining room and in their own room if they chose this. They were also able to have their meal in the lounge area if this suited them better. The tables were laid in the dining room to welcome people, the atmosphere was relaxed, music was played and people were singing along, tapping their feet and clearly enjoying the social occasion of the meal time. People were chatting and staff supported people discreetly with their meal. No-one was rushed and staff gave people plenty of opportunity to make choices for their meals and checked their enjoyment of them. Brightly coloured contrasting crockery with large rims and deep insets were available. These can help food recognition, and assist with placing the food onto the cutlery and so aid people's independence.

Mealtimes in the residential unit were sociable and relaxed and there was soft background music creating a pleasant atmosphere. Staff were attentive of people's needs, offering choices of meal, component parts and portion size, with table by table serving. Where people chose to eat in their own rooms, staff made frequent checks to ensure they had what they needed. In the nursing unit, staff worked hard to ensure people's meal delivery was timely and supportive of their needs, although we noted some people waited whilst staff had to attend to others.

Staff we spoke with understood people's dietary needs and how to offer additional support where people needed this, such as where people were at risk of weight loss. We saw staff were observant of people's food and fluid intake and considered ways of ensuring effective support. For example, one member of staff noticed a person struggled to pick up a heavy cup and so they discussed with them having a lighter beaker. Staff told us this would make the difference between the person drinking or not and we saw this was

successful. People's weight was regularly monitored and more frequently if there were concerns.

People and relatives told us they had no concerns with meals and drinks provision. One person said: "I think the food is excellent". Another person said: "They ensure we eat well and snacks are available. If you just want a sandwich instead of lunch they get it for you". One relative said: "There was a concern about the hydration of [my family member] but they were excellent in the way they encouraged [them] to drink. I can't praise them enough".

A number of dementia friendly improvements to the unit's environment had been made since the last inspection. Corridors had good, clear signage and were themed to assist people with their orientation. There were small seating areas for people to rest on the corridors or sit with their friends, family or staff. There were items of interest such as hats, coats, puzzles, books for people to interact with and reminiscence items to evoke memories. We saw some very good hand knitted items were available to stimulate the senses of people who were living with dementia. These included knitted hand muffs with a variety of textures sewn onto them for people to interact with.

Good

Is the service caring?

Our findings

People told us they felt well cared for at Holyrood House. Comments from people included: "I like it here, it's a home from home", "It is like a hotel", "It does not feel like a care home", "It's wonderful, exactly right for me" and "What more could I want, the staff are all lovely, so kind". Relatives comments included: "The kindness of the staff is obvious, they really care", "The staff are never too busy to speak to me. I am totally reassured about the care my [family member] is receiving. They are totally patient and try and get everyone involved" and "I can't praise them enough". Another relative came to seek the inspector out to give praise for the attitude and approach of the staff. One relative whose family member was there on a temporary basis for respite care said, "My [family member] cried when they had to leave and has asked to stay for longer".

We saw positive interaction throughout our visit and the people who used the service appeared relaxed and comfortable with the staff. When one person became disorientated and needed some reassurance we heard staff say: "You won't get lost, we're here with you, you're safe here".

Staff told us they worked to ensure positive relationships were developed between them and the people they supported. They explained it was important for them to get to know people's histories and background. They said this enabled them to provide care and support in a person centred way. One member of ancillary staff said care staff 'go the extra mile' to ensure people were cared for.

We saw staff were smiley and cheerful in their work and this helped to create a happy atmosphere. Staff communicated well with one another to meet people's needs. Staff showed care and compassion when interacting with people. One member of staff took time to ensure a person was comfortable in their clothing, offering them a choice of a short or long sleeved sweater.

Throughout our inspection staff demonstrated to us they knew people well and were aware of their likes and dislikes. We saw staff treated people as equal partners which showed how much they valued people who used the service. People looked well cared for which is achieved through good care standards. People were clean, tidy, dressed with thought for their individual needs and style. One relative we spoke with told us their family member took a great pride in their appearance and always wore make up and jewellery. They told us staff supported their family member in this and knew how much it mattered.

We observed people were treated with dignity and respect. We saw when staff entered a person's room they knocked before entering the bedroom and bathroom and waited to be invited in. We heard one member of staff ask a person if it would be alright to come in to make their bed, or if they would prefer them to come back later. Another member of staff noticed when a person was feeling tired and said, "Let's sit down here and put your feet up, you let me know if you need anything". There was help and support when people requested it and the staff spoke kindly with people and knew them all by name. We observed staff treating people sensitively and with patience; they got down to people's level when helping them and gave explanations of any interactions.

Staff were skilled in their recognition of when people showed they were distressed or anxious. They provided

reassurance when needed and responded well. For example, one person in the dementia unit became particularly upset and confused at tea time and staff swiftly supported them in a quiet seated area, held their hand and offered sensitive reassurance and distraction from what appeared to be troubling them. One person on the residential unit became restless and unsettled. Staff asked them if they would be able to help with the tea trolley and engaged the person with a purposeful task offering snacks and drinks. We saw the person became visibly happier and there was a respectful sense of staff working alongside the person.

Staff were clear about how they supported people to maintain independence and how they promoted privacy and dignity. They spoke of the importance of treating people well and being respectful of people's individual needs. One staff member on the dementia unit said, "It's important to see the person and not the dementia." Another staff member said, "We encourage people to be as active as they can be to maintain what they can do for themselves."

Care records reflected people's individual needs in their life story, although some records we looked at contained basic information and two records we looked at did not contain life story details. The activities staff told us they knew people's diverse social, cultural and spiritual needs and aimed to ensure these were met through activities and events. People's wishes for the end of their life were sometimes, but not consistently recorded. Staff we spoke with said they felt end of life care was done well. One member of staff said, "We excel at palliative care here, we look after all the family, we respect people and their families".

Where people needed an advocate we saw this was detailed on their care record. We saw on one person's record the advocate had given consent to the sharing of information with health care professionals, social work team and the police, but there was no signature or name of the advocate recorded which meant it was not possible to be sure the consent was valid. The registered manager told us they would make sure all consent was duly authorised.

Good

Is the service responsive?

Our findings

People said their needs were met and they had enough to keep them occupied. One person said, "Staff know what I like and how to help me take care of myself" and another person said, "Staff here make getting old feel not so bad. They help me with what I can't do for myself". One person said, "There are lots of things to do. I have a wide choice of things to do. We are encouraged to keep doing our hobbies".

All the staff we spoke with said they thought people who used the service had enough to do and enjoyed the activities on offer. Staff were enthusiastic when describing the activities they were involved in with people and said they were supported to come up with new ideas and make suggestions for future activity. We saw staff were involved throughout the day in providing activity or assisting the activity co-ordinator in provision of activity. One staff member told us of a dementia café in the local community that they took people to. They said, "It's important for people to get out, do things like they used to do."

A number of activities took place throughout our visit and the activities co-ordinator was animated and enthusiastic about engaging people in purposeful ways. On the first day of the inspection there was a volunteer member of staff supporting the activities co-ordinator and they complemented one another with their input. People enjoyed a lively reminiscence quiz. This was well attended and people were engaged throughout with staff on hand to ensure active participation. We heard some lively banter about people's recollection of earth toilets and extreme weather. The activity coordinator organised a singing session in different units. People were provided with song sheets to assist their memories in remembering the songs and encouraged by staff to participate at their own pace. The atmosphere was jovial and people were clearly entertained by this activity. Some people chose activity that took place in small groups such as a game of 'play your cards right' or general chatting.

Where people were in bed, we saw the activities staff made every effort to engage with them and invite them to join in with activities. The activities co-ordinator showed us 'Dolly the trolley' which was a trolley containing resources which were taken to support people's interests in their own rooms such as items for hand massage, nail varnish, a bible and some books. The activities co-ordinator told us people sometimes just wanted a conversation and they recognised the importance of spending time in this way.

Care records were held on the computer and we saw staff regularly updated these with information. Staff invited other professionals to update information as they visited people in the home. Care records showed people's health and care needs were monitored and updated as changes occurred and we saw people and their families had been involved in care planning and reviews. Daily notes were comprehensive and gave a clear picture of how people's needs were met. We saw one person's pressure care assessment had not been added to their care plan since October 2016. We spoke with the unit manager who explained the information was there, but the nurses had to transfer the information within the computer system and this had not been done. The registered manager told us there were plans in the near future to introduce a more user friendly computerised system for recording care.

Relatives and residents meetings were held monthly and were well attended. Discussions were positive and

issues raised were acted upon.
People and their relatives said they knew how to raise a complaint if they were unhappy and they were aware of the complaints policy. They said they would approach the registered manager or any of the staff. One relative said when they had raised minor concerns with staff, prompt action had always been taken. We looked at the record of complaints and saw these were recorded and responded to appropriately. There was one compliment on file which had been made by the advocacy service. This gave praise for the way in which the dementia unit was run, the activities and the environment. Staff told us they were always informed of any important issues that affected the service such as feedback on complaints or concerns. One staff member said, "We are kept informed to make sure we do a good job."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had been newly appointed at the last inspection and who had since been managing the home for around 12 months. People told us they thought the home was well managed. One person said, "We know who the boss is, [they are] always around and about". Another person said, "This place is run well". Relatives told us they had confidence in the management of the home. One relative was aware the previous inspection had highlighted several concerns and they reported significant improvements since. They told us, "They're not perfect, but this is not the place it was when [CQC] last came. There's definitely an improving picture and a culture change". Another relative said they were aware there had been a poor inspection report but they thought the service was good. They told us, "I use my judgement and it's good enough for my [family member]."

Staff told us the registered manager and unit managers were enthusiastic and committed to providing a good standard of care for people who used the service. One staff member said, "It's a very well managed home. [Name of unit manager] is hands on, always involved." One member of staff said: "[Name of registered manager] is brilliant, can talk to [them] about anything. Communication is good". Another member of staff said, "It's a different place now, we have clear leadership and direction. We have a manager who knows what [they're] doing". Another staff member said, "The registered manager is lovely, can ask [them] anything" and "The atmosphere, care, everything is lovely. I would move my family member in if needed, as it's a lovely place".

Staff also told us they enjoyed their role and felt well supported. They said the management team in the home were approachable and they felt any suggestions they made were listened to. Staff told us they regularly attended team meetings and there was improved morale in the team. Staff we spoke with understood the visions and values of the service and they were committed to putting people first. We found evidence of teamwork and cohesive working between staff on each unit, enabling a more joined up feel to the home than at the previous inspection.

We reviewed the provider information return (PIR) before the inspection. This is a form the provider submits which gives us details about the quality of the service and how it is run. We saw there was a detailed analysis of the strengths of the service and a clear illustration of the hard work put into the home since the previous inspection. Areas to improve were acknowledged with an emphasis on openness and transparency, clear expectations and pride in the service.

We spoke with the registered manager and they told us how they had worked with the staff to address the concerns found at the last inspection, with particular focus upon the dementia unit and the care for people who were living with dementia. We found the assurances of good intention which the management team had given at the last inspection, were put into practice and there was a clear oversight of the quality of the provision. The registered manager told us they felt well supported by senior managers and this enabled them to address the challenges they faced when first appointed. The management team felt there had been an improvement in the culture within the home and the registered manager said there was an 'open door policy' for staff to approach them any time.

There were established systems and processes in place to evaluate and monitor the standards of care in the home. For example, regular audits were completed in key areas and close attention had been paid to working with external agencies, such as the infection prevention control team to drive improvement. The audits in place were regularly implemented and robust on the whole, with details of where actions required were addressed through clear action plans. However, the auditing of medicines management was not as rigorous as it could have been and the inspection highlighted some weaknesses in this area.

Documentation was much improved and any information required to demonstrate the running of the home was filed securely and orderly, with good regard for confidentiality.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not managed safely and people were not protected against the risk of not receiving their medication as prescribed.