Barchester Healthcare Homes Limited

Newton House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Newton House is registered to provide accommodation for up to 126 people requiring nursing or personal care, including people living with dementia. The home is purpose built and is divided into four discrete 'communities' or units. The Watergate and Somerby units provide accommodation for people with general nursing and care needs whilst Castlegate and Brownlow are reserved for people living with dementia.

We inspected the home on 12 September 2017. The inspection was unannounced. There were 84 people living in the home at the time of our inspection. This was because, following our last inspection in December 2016, the registered provider had introduced an embargo on new admissions.

The home did not have a registered manager. The registered provider had appointed a new manager in July 2017. At the time of our inspection an application to register this person had been submitted to the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers ('the provider'), 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.

In December 2015 we conducted a first comprehensive inspection of the home. We found the provider was in breach of legal requirements in two areas and rated the home as Requires Improvement in all five key questions and overall. In December 2016 we conducted a focused, follow up inspection to review the provider's progress in addressing the two breaches of legal requirements. We found that the necessary improvement had not been made and the provider was now in breach of legal requirements in three areas. As a result, we reduced the rating in the Safe key question to Inadequate and initiated further action against the provider.

On this inspection we were pleased to find significant improvement had now been made and that the three breaches of regulations had been addressed. Reflecting our findings, the rating of the home is now Good.

There were sufficient staff to keep people safe and meet their care and support needs. Staff worked well together in a mutually supportive way. Training and supervision systems were in place to provide staff with the knowledge and skills they required to meet people's needs effectively.

There was a friendly, relaxed atmosphere and staff supported people in a kind and attentive way. Staff knew and respected people as individuals and provided responsive, person-centred care. People were provided with food and drink of good quality that met their individual needs and preferences. The décor and facilities in the home had been refurbished to reflect the needs of people living with dementia.

People's medicines were managed safely and staff worked closely with local healthcare services to ensure people had access to any specialist support they required. People's individual risk assessments were reviewed and updated to take account of changes in their needs. There had been significant reductions in

the number of falls and violent incidents between people living in the home. Staff knew how to recognise and report any concerns to keep people safe from harm.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection the provider had been granted DoLS authorisations for 45 people living in the home and was waiting for a further 17 applications to be assessed by the local authority. Staff had an understanding of the MCA and demonstrated their awareness of the need to obtain consent before providing care or support to people. Decisions that staff had made as being in people's best interests were correctly documented.

Although she had only been in post for two months, the manager had already won the loyalty and respect of her team. A range of audit systems was in place to monitor the quality and safety of service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise and report any concerns to keep people safe from harm.

People's risk assessments were reviewed and updated to take account of changes in their needs.

Action had been taken to reduce the number of falls and violent incidents.

There were sufficient staff to meet people's care and support needs.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff understood how to support people who lacked the capacity to make some decisions for themselves.

The provider maintained a record of staff training requirements and arranged a variety of courses to meet their needs.

Staff were provided with effective supervision and support.

Staff worked closely with local healthcare services to ensure people had access to any specialist support they needed.

People were provided with food and drink of good quality that met their needs and preferences.

Is the service caring?

Good

The service was caring.

Staff provided person-centred care in a kind and friendly way.

Staff encouraged people to maintain their independence and to

exercise choice and control over their lives.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's individual care plans were well-organised and kept under regular review by senior staff.

Staff knew people as individuals and provided care that was responsive to their personal preferences and needs.

A range of communal activities and events was provided to help stimulate and occupy people.

People knew how to raise concerns or complaints and were confident that the provider would respond effectively.

Is the service well-led?

Good

The service was well-led.

The manager had the respect and loyalty of her team.

Action had been taken to address shortfalls identified at previous inspections.

A range of auditing and monitoring systems was in place to monitor the quality of service provision.

Staff worked together in a friendly and supportive way.

Newton 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. The inspection was planned to check whether the provider was 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.

We visited Newton House on 12 September 2017. The inspection team consisted of an inspector, an inspection manager, two specialist advisors whose specialism was nursing and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the home, what the home does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report. In preparation for our visit we also reviewed information that we held about the home and reports provided by other agencies, including the local authority.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with 13 people who lived in the home, eight visiting family members, the manager, the deputy manager, the provider's regional director, the head chef, eight members of the nursing and care staff team, the occupational therapist and two members of the activities team. We also spoke with one local healthcare professional who visited the home during our inspection.

We looked at a range of documents and written records including people's care files and staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Good

Is the service safe?

Our findings

On our last inspection of the home in December 2016, we found the provider was failing to ensure staffing resources were deployed in a way that ensured people received safe, effective care that met their individual needs and preferences. This was a continuing breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA).

On this inspection, in marked contrast to our previous visit, people told us there were sufficient staff to meet their needs and keep them safe. For example, one person commented, "There seems to be enough [staff] now. More staff and a happier place." Another person said, "I am very safe here. There is always someone around if I need them." Talking of the improved staffing ratio on their unit, one staff member told us, "At the moment we have enough staff, it's working nicely. Last year it was fraught. It's [now] nice and relaxed. Not rushing around." A relative said, "They re-organised the staffing so they work as a team. A big improvement." Reflecting this feedback, throughout our inspection we saw staff had time to meet people's care and support needs without rushing. Staff also had time to sit down and interact with people on a one-to-one basis. For example, on one occasion we saw two members of the care staff team providing a person with a hand massage. They were massaging one hand each, singing together as they did it. Something that was enjoyed and valued by the person.

In the light of our observations and the positive feedback from people and their relatives, it was clear that the provider had taken action to improve the deployment of staffing resources and we were satisfied that the breach of Regulation 18 had been addressed.

The manager said she kept staffing levels under regular review using a tool devised for this purpose by the provider. Discussing the embargo on new admissions the provider had introduced following our last inspection, she acknowledged the importance of ensuring staffing levels remained sufficient to meet people's needs when the embargo was lifted and the number of people living in the home started to increase.

On our last inspection of the home, we also found the provider was failing to protect people from the risk of harm from other people living in the home and from the risk of falling. This was a breach of Regulation 12(2)(a) and (b) of the HSCA.

In preparation for this inspection, we reviewed the notifications (events which happened in the home that the provider is required to tell us about) we had received from the provider. In the nine months since our previous inspection visit we had been notified of two serious injuries sustained by people as a result of a fall, with none since January 2017. This was a very significant reduction from the 12 months preceding our previous inspection, when we had been notified of 15 serious injuries resulting from a fall. Similarly, we looked at the notifications of violent incidents between people living in the home. In the nine months since our previous visit we had been notified of 18 such incidents, with only three since June 17. This compared to 51 such incidents notified in the 12 months preceding our previous inspection.

When we discussed these issues with the manager she told us that monthly 'clinical governance' meetings were now held in each of the four units, rather than one meeting for the whole home. She said this change had improved the monitoring of falls, violent incidents and other risks to people's safety and welfare. We reviewed the notes of one of these clinical governance meetings and saw that a very detailed discussion had taken place about the risks relating to particular individuals and the strategies that had been put in place to reduce them. Talking specifically about falls, the manager told us, "Falls have gone down. I can't say we will never have another serious injury [but all] the falls incident forms are checked by me. If [there is a] trend we review [the person's] equipment, medication [and consider the need for] one to one staffing. Can the occupational therapist help?" Reflecting this focused approach to falls monitoring and prevention, when we reviewed the provider's records, we found there had been a 33% reduction in the total number of witnessed and unwitnessed falls recorded in the three months preceding our inspection. Commenting positively on the provider's approach in this area, one relative told us, "[Name] has a wheeled walker now and walks better with it. Rather than wandering on foot." Another relative said, "He's much safer now and doesn't fall nearly as much, having his escort." A member of staff told us, "I do think the unit is a lot safer. We are a lot more aware of the ones that are a falls risk."

Similarly, when we discussed the issue of violent incidents between people living in the home, the manager told us, "Resident on resident [incidents] have gone down. [We] can't stop them completely [but] residents who shouldn't have been here have been moved on. [We are also] doing a lot of training [on] dealing with residents [with] dementia." Reflecting this approach, when we reviewed the provider's records, we found there had been a 69% reduction in the total number of violent incidents between people recorded in the three months preceding our inspection. Commenting on the positive contribution improved staffing ratios had made in helping to keep people safe from another, one staff member told us, "[At the time of the previous inspection] … we weren't being listened to. We told [the managers] that it was not safe because we couldn't monitor people. We were too stretched." Another staff member said, "There are absolutely less incidents. We have now got a sensory room [which] does relax people that are about to lash out." One person said, "I feel safe staying here … we're well looked after."

Although work was still required to reduce further the number of falls and violent incidents, we were satisfied the provider had taken sufficient action to improve the safety of the people living in the home and address the breach of Regulation 12.

The provider maintained effective systems to ensure other potential risks to people's safety and wellbeing had been considered and assessed. Each person's care record detailed the actions taken to address any risks that had been identified. For example, staff had assessed one person as being at risk of developing skin damage and a range of measures had been put in place to reduce the risk. Senior staff reviewed people's risk assessments on a monthly basis to take account of any changes in their needs.

Staff were aware of how to report any concerns relating to people's welfare, including how to contact the local authority or the Care Quality Commission (CQC), should this ever be necessary. Advice on how to contact these external agencies was provided in the information pack given to people when they first moved into the home.

We checked seven staff personnel files and saw that suitable references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable to work with the people who lived in the home.

We reviewed the arrangements for the storage, administration and disposal of people's medicines and found that these were in line with good practice and national guidance. Expressing their satisfaction with

the support they received from staff in this area, one person said, "They are spot on with my medication as it's very important to get it right." Another person told us, "My medicine comes like clockwork." Staff maintained an accurate record of the medicines they administered, including any creams applied when providing people with personal care. Pre-administration checks such as pulse or blood sugar monitoring were completed correctly. When skin patches were used, a record of the site of application was in place to ensure this was rotated regularly. We observed the administration of people's medicines and saw that staff stayed with the person whilst they took their medicines. However, on one occasion, a member of staff left an unlocked medicine trolley unattended for a short period of time. Although no harm resulted from this error, we alerted the manager who told us she would consider the need for any additional training or supervision for the staff member concerned. The procedures for the use of 'controlled drugs' (medicines which are subject to special storage requirements) were also managed safely, in line with legal requirements.

Good

Is the service effective?

Our findings

People told us that staff had the right knowledge and skills to meet their needs effectively. For example, one person said, "They're good as gold. Very capable." Another person's relative told us, "You won't get much better care elsewhere now."

New members of staff participated in a structured induction programme which included a period of shadowing experienced colleagues before they started to work as a full member of the team. Reflecting positively on their induction, one staff member told us, "I spent a week on induction, learning about dementia and moving and handling. I [also] did some … shadowing. Getting to know people before I was left on my own. [And] if I had any questions, the nurses and [other] staff were very helpful. There was no such thing as a stupid question!"

The provider maintained a record of each staff member's annual training requirements and organised a range of courses to meet their needs. Speaking positively of the provider's approach to training one member of staff told us, "We do the mandatory training every year. [For example] fire safety, moving and handling, safeguarding. [And] we have six monthly catch ups in case anything's changed. It enlightens you to some of the things you need to know." Reflecting on their recent training in dementia awareness, another staff member said, "[It was] very informative. [It has given me] that little bit more knowledge of what's happening [to a person] and how we can help." The provider also encouraged staff to study for nationally recognised qualifications in care. One member of staff said, "I have just got my application form to do NVQ 2. [A senior staff member] printed it out for me [and has] given me a lot of encouragement to do it."

Staff received one-to-one supervision on a regular basis in line with the provider's policy requirements. Staff told us that they found this a safe opportunity to reflect on their work and discuss any issues of concern. For example, one member of staff said, "I have [supervision] once a month [with] the senior nurse. If I have got any problems we can talk. You can ask their advice and they give it." Another staff member said, "If you don't feel comfortable [about something] you can bring it up in supervision. [And] if you have any worries you can request an early supervision."

Staff were aware of the Mental Capacity Act 2005 (MCA) and understood the importance of obtaining consent before providing care or support. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Describing their approach in this area, one staff member said, "If a resident [can't make a decision for themselves] we do it in their best interests. [But we] can't force people to do something that they don't want to do. That's abuse!" Confirming the approach of staff, one person told us, "They will ask me first."

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). At the time of our inspection the provider had been granted DoLS authorisations for 45 people living in the home and was waiting for a further 17 applications to be assessed by the local authority. Senior staff made use of best interests decision-making processes to support people who had lost capacity to make some significant decisions for themselves. For example, some people were receiving prescription medicine 'covertly', without their knowledge. We saw that this decision had been taken as being in the person's best interests following a documented discussion with relevant parties. We noted that the provider had not involved a pharmacist in these discussions and the manager agreed to make sure this was done in future.

People told us they enjoyed the food provided in the home. For example, one person said, "I have a lovely big cooked breakfast. At lunch we get a nice choice. There's always someone in … the kitchen so we can ask for a drink or snack at any time." Another person who liked to eat in their room commented, "I enjoy the meals and I get them nice and hot." At lunchtime, people had a choice of two starters, two mains and three puddings, although kitchen staff told us they were always happy to make an alternative if requested. In confirmation of this approach, at lunchtime we saw one person who had declined both main course options was provided with a favourite alternative.

Kitchen staff understood people's preferences and used this to guide them in their menu planning and meal preparation. For example, the head chef told us she reviewed the menu every three or four months in discussion with people and their relatives to identify any particular dislikes or requests. Staff also had a good understanding of people's nutritional requirements, for example people who needed their food to be pureed to reduce the risk of choking and people who followed particular diets. Kitchen and care staff met together on a monthly basis to review people's individual nutritional needs and to agree any changes that were necessary. Staff were also aware of the importance of encouraging people to drink regularly, to prevent urinary tract infections and other health problems. One person commented, "It's important we drink. A trolley comes round and we have drinks with our meals. You can have a bottle of beer if you ask."

The provider ensured people had the support of local healthcare services whenever this was necessary. From talking to people and looking at their care records, we could see that their healthcare needs were monitored and supported through the involvement of a broad range of professionals including GPs, community psychiatric nurses and speech and language therapists. Talking positively of their experience of working with members of the senior staff team, one local healthcare professional who was visiting the home during our inspection, told us, "The unit manager here does what she says she will. She keeps in touch." Additionally, the provider had recently recruited an occupational therapist to work solely at Newton House. We met this new employee and she told us she was in the process of assessing the needs of everyone living the home and had already ordered new equipment to assist people to eat more independently and to spend more time out of bed.

Most people expressed satisfaction with the provider's approach towards meeting their healthcare needs. For example, one person said, "I see the chiropodist regularly and if I need my eyes testing they take me to Boots." Another person's relative commented, "[Name] had a urinary tract infection and they were pretty quickly on to it with the doctor. She [also] gets her … feet done regularly." However, some people told us they had experienced delays in getting dental care and one member of staff expressed concern that some doctors were prepared to diagnose conditions and prescribe medication over the telephone, without visiting the person first. We discussed these issues with the manager who told us she would follow them up with the relevant agencies.

Good

Is the service caring?

Our findings

People told us that they were happy living in the home and that staff were caring and kind. For example, one person told us, "It's the next best thing to being at home." Commenting on the changes in staff attitude and approach they had noticed since our last inspection, another person said, "We chatter, as they've got more time for us (now). And they're enjoying it more too. The staff smile more now [and] I feel more relaxed."

There was a friendly, relaxed atmosphere and throughout our inspection we saw staff interacting with people in friendly, attentive ways. For example, we observed a member of staff supporting someone to eat in their bedroom. The person asked the staff member to sing to them which they did. On another occasion, we saw a staff member sitting on a window seat with a person who had become agitated, stroking their head and talking softly to them to help reduce their anxiety. Commenting positively on the kind and thoughtful approach of staff, one person said, "Oh good, it's Wednesday tomorrow. The girls will usually get me up early and give me a bath and let me soak a bit. They really look after me well. I get a cake on my birthday which is nice as I don't really have family around." Another person's relative told us, "[Name] has [a particular medical condition]. It's getting more frequent so they have organised an appointment at the hospital. They will sort out transport and send a carer with her. If the appointment is over a lunchtime they will … save her something for when she gets back."

The information booklet that was given to people when they moved into the home stated, 'We believe in a "Person-Centred Care" approach to ensure that every resident is treated as an individual'. This commitment to supporting people in ways that met their personal needs and preferences was clearly understood by staff. For example, one member of staff told us, "Everybody has little quirks. One lady … everything has to be done in a particular way. That's fine. This is their home. So we help them do things as they would have done at home." Commenting positively on the staff team's knowledge of her own personal preferences, one person said, "They know I like to go out in the garden sometimes. So they ask me if I want to go out when it's warm." Observing one staff member engaging with a person who was sitting alone in one of the lounges we heard her say, "Hello [name]. I've got you a nice drink here. Blackcurrant, your favourite. Would you like some? The sun is on you. Can I close the curtain for you? I'll put your music back on for you. There, all comfy?"

People told us that staff supported them to have as much choice and control over their lives as possible. For example, one person said, "I am a bath person. I usually have one (each week) but if I want more I can have them." Another person told us, "You can do as you like. They don't interfere one little bit. My bedtimes are quite up to me [and] I can decide what I do and eat." Describing their approach, one staff member said, "[We] offer choice in everything. What they want to drink, when to get up. It's what they want, it's not our choice."

Staff also understood the importance of promoting people's independence and reflected this in the way they delivered care and support. For example, one staff member said, "We can't take their independence away. It's not fair. If they have the ability to do something, let them do it. There are a lot of people who can stand up and a lot … who can wash themselves." This approach was clearly valued by the people living in

the home. For example, one person told us, "I am able to decide what I do." Another person's relative told us, "[Name] has help [to eat] at times. But they try to let her still feed herself if she will."

The staff team also supported people in ways that helped maintain their privacy and dignity. For example, with one isolated exception, we saw staff knocked on doors to private areas before entering. On one occasion we watched as a member of staff whose hands were full, approached a person's bedroom. Respecting the person's privacy, they called out "knock, knock" and waited to be invited into the person's room. People told us that staff were discreet when supporting them with their personal care needs. For example, one person told us, "No one in looks in on me. They keep me private." Another person's relative said, "They definitely respect him and treat him a dignified way even though he can be difficult to manage." The provider was aware of the need to maintain confidentiality in relation to people's personal information. People's care plans were stored securely and computers were password protected.

Information on local lay advocacy services was available to people and their relatives in the reception area of the home. Lay advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes. The registered manager told us one person had the support of a lay advocate currently and that she would not hesitate to help others secure one, should this be necessary in the future.

Good

Is the service responsive?

Our findings

Following our last inspection in December 2016 the provider introduced an embargo on new admissions, to create an opportunity to focus fully on meeting the needs of the people already living in the home. At the time of our September 2017 inspection this embargo was still in place and the number of people living in the home had reduced to 84 out of a possible maximum of 126. The manager had come into post shortly after the embargo had been put in place and therefore had no direct experience of overseeing any admissions to the home.

Looking ahead, the manager outlined her intended approach to managing new admissions, should the provider decide to lift the embargo. She told us, "My intention would be to go out and do an assessment with my deputy. I [will then] discuss each person involving the team in each unit. Making a decision as a team, making sure that when they come in … we are fully aware of their needs." Speaking candidly about the provider's previous approach to managing admissions to the home, the manager told us, "The previous manager said, '[They are] going on here [one of the units] and that's it'. I need to take on board what [the staff in each unit] are saying."

When we reviewed people's care plans we saw that they were well-organised and provided staff with detailed information on how to respond to each person's individual needs and preferences. For example, one person's plan gave staff clear guidance on how to help him manage his long term health condition. Another plan advised staff to observe the person's facial expressions as a means of establishing her wishes, as the person had lost the ability to speak. Staff told us that they found the care plans helpful to them in their work. For example, one member of staff said, "Anything we need to know tends to be in the care plan. [They are] updated daily." Some people had completed a 'This is Me' document which provided a summary of the their likes, dislikes and key support requirements. Staff told us this was particularly helpful when getting to know someone when they first moved into the home. One staff member said, "[There is a] 'This is Me' [document] in some of … the care plans. [With details of the person's] job, favourite name etc. It helps to have a conversation with new people [who can be] shy having come from their [own] home." Senior staff reviewed each person's plan on a monthly basis to make sure it remained up to date and accurate. In addition to these monthly care plans reviews, every six months the provider organised a further full review of each person's care plan, in discussion with the person and their family, should they wish to be involved. Commenting positively on their involvement in the care planning process, one relative said, "I have seen [name's] care plan. It's all done by the book here and we've no issues." Another relative told us, "I have deputyship for [name] and see the care plan and have had reviews. They ring us about anything."

The provider employed a specialist activities team to take the lead in providing people with stimulation and occupation. Since our last full inspection of the home the provider had doubled the size of this team and people spoke highly of the positive difference this had made to their lives. For example, one person said, "It varies day to day. It used to be predictable. It's better now as there's more surprises." Another person told us, "[A member of the activities team] is brilliant! There have been times when she has had me dancing in my wheelchair and we have a laugh. It certainly has been nicer around here since the new activities people arrived." A relative commented, "My bugbear used to be the lack of activities. But that's taken a giant leap

forward and a lot of activities are going on now." Details of planned daily, weekly and monthly activities were displayed widely throughout the home. For the week beginning 11 September 2017, the planned activities included baking, arts and crafts, bingo, reminiscence sessions, a birthday party for one of the people living in the home and a visit to a local RAF base for a Battle of Britain commemoration event. There were also visits from professional entertainers including a singer and a magician both of whom performed on the day of our inspection, events which were clearly enjoyed by those who attended. Although generally very positive about the range of activities on offer, some people told us they would like more outings. Although the home had its own minibus and some outings did take place, only one member of the activities team could drive the minibus which limited its use.

One member of the activities team took the lead in visiting people who were unable to leave their bedrooms to participate in communal activities. Talking positively about these one-to-one sessions, one person said, "[Name] comes and visits me in my room and we do things together. She's lovely. [Yesterday] they had made biscuits in the kitchen and she brought all the stuff so that I could decorate them." Another person told us, "I just like my TV [but] one of the girls will come and play cards sometimes." Reflecting the improvements to staffing detailed elsewhere in this report, we saw that care staff also had time to spend interacting socially with people on a one to one and small group basis. For example, we saw one member of the care staff team assisting a person to paint and another leading an animated discussion with several people about their favourite foods. Describing the change since our last inspection, one staff member told us, "There's more to do than there used to be. We have an activities team that come round but we [also] have board games and jigsaws [here on the unit]. More things to do with them." Staff told us that people were encouraged to maintain personal hobbies and interests, for as long as they were able. Confirming this approach, one person told us, "I really enjoyed the magician today but I also like knitting. I knit blankets for Mother Theresa or I play dominoes with the lady down the hall." One person had a master key for some of the doors in the home. Staff told us they used to be a security expert and took pleasure in accompanying them to check locks around the home.

Since our last inspection, the provider had invested a considerable sum of money in improving the décor and facilities in the home, to make it more suitable for the needs of people living with dementia. For example, in the communal lounges and corridors there were posters and vintage artefacts to remind people of their younger days. Similarly, in the units for people living with dementia there were sensory items for people to explore, including straw baskets filled with soft toys and a board with locks, bolts and switches. A new relaxation lounge on one of the units had sensory lights and a projector which created a quiet, calm environment which was popular with several people.

Information on how to make a complaint was available in the reception area of the home. People told us they were confident that the manager and other senior staff would respond positively to any concerns or complaints. For example, one relative told us, "I am much happier with it here [now]. There have been big changes with communication with families, from the manager down." Talking about a previous long-standing concern about missing laundry, one person told us, "Nothing has gone missing since the new manager started. It seems to be getting better." The manager told us that formal complaints were now relatively rare as she spent time with people and their relatives and was able to resolve any issues informally. Confirming this approach, one person told us, "I see her walking around … she's easy to chat to." Another person's relative said, "She's there if I want her. We had some chats about doing things in the community with some of the residents. Like going to the senior citizens' group I help run." The provider kept a record of any formal complaints that were received and the manager ensured these were managed correctly in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

People spoke highly of the home and the improvements they had seen since our last inspection. For example, one person said, "Things are looking up here." A relative told us, "It's pretty much spot on!" Another relative said, "The management is 100% better." One staff member told us, "[There have been] a lot of changes, changes for the better. You come in, you know what you're doing. You're not rushed. I think it's … brilliant now!"

Describing her leadership style, the manager told us, "[Since] I have been here I have [tried to] build relationships with staff. Get their confidence. They see me on the floor, they hear me in handover. If I see something [wrong] I want to fix it straightaway, before it escalates. I come in at weekends. I am always on call." Although the manager had only been in post for two months it was clear that her visible, 'hands on' approach had already won the respect and loyalty of her team. For example, one staff member told us, "[The manager] is getting on really well. I feel she genuinely cares. She comes round every day [to] talk to the residents. [She will] sit down and have a chat, not just walk past. It's the little things that are so important." Another member of staff said, "[The manager] is brilliant. We have had more out of [her] than we did out of [the previous registered manager]. Things get done. That's how it should be. I give [her] stick but I do like [her]!" The manager had submitted an application to CQC to become the registered manager for the home and was waiting for this to be assessed.

Staff worked together in a well-coordinated and mutually supportive way. For example one member of staff said, "The team spirit is phenomenal. It's come on leaps and bounds with the new [manager]." Another staff member commented, "The atmosphere in the home has lifted. People want to come to work. I … love it. I'd recommend it to anyone." Team meetings, communication logs and daily 'stand up' handover meetings were used by the provider to facilitate effective communication. Talking positively of their experience of attending staff meetings, one member of staff said, "You can talk openly [and] bring issues up. Communication is 100% better."

On our last inspection of the home in December 2016, we found the provider was failing to implement and maintain effective systems of governance to ensure compliance with legal requirements in the provision of people's care and support. This was a continuing breach of Regulation 17(1) of the HSCA. In particular, we were concerned at shortfalls in the provider's quality monitoring systems and the failure to address breaches of legal requirements and other areas for improvement identified at previous inspections.

At this inspection we were pleased to find the provider's quality monitoring systems had been strengthened and improved. For example, as detailed elsewhere in this report, the new unit-based 'clinical governance' meetings appeared to have been effective in reducing the number of falls and violent incidents. Talking of this new approach, the deputy manager told us, "It's a much better place … with our new risk management … and clinical governance processes. We've got the tools now [to prevent] putting people at risk." A comprehensive range of audits was also in place and operating effectively, including regular medication audits, health and safety audits and care plan reviews. Additionally, the provider's regional director conducted detailed 'quality improvement' reviews on a regular basis. We looked at the report of her most

recent review and saw several issues had identified as requiring attention and were being addressed by the manager and her team.

As a further component of its quality monitoring arrangements, the provider also conducted annual surveys of people and their relatives. The manager told us the 2017 survey was underway and she would review the results carefully to identify any opportunities for further improvement in the service. The provider also organised regular meetings of people and their relatives to discuss any issues and invite feedback on the running of the home. We reviewed the minutes of a recent meeting and saw that this had been well-attended with a wide-ranging discussion of a number of issues including staffing, hairdressing arrangements and the installation of free wi-fi throughout the building.

As detailed elsewhere in this report, the provider had taken action to address the continuing breaches of regulations relating to staffing and risk prevention identified at our December 2016 inspection. Action had also been taken to address the issues identified as requiring improvement in our December 2015 inspection, including medicines management, staff training and supervision, staff attitude and approach, activities provision and complaints management.

In the light of these improvements to quality monitoring and the governance of the home, we were satisfied that the breach of Regulation 17 had been addressed.

The provider was aware of the need to notify CQC or other agencies of any untoward incidents or events within the home. The report and rating from our previous inspection was on the provider's website and on display in the home, as required by the law.