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Lyndhurst Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Lyndhurst Residential Home took place on 16 and 19 January 2017 and was unannounced. The location had been previously inspected during July 2016 and was found to be 'Inadequate' at that time, with multiple breaches of regulations in relation to staffing, safe care and treatment, good governance, person centred care and dignity and respect, and the service was placed into special measures. During this inspection, we checked to see whether improvements had been made. Whilst we found improvements in many areas, we found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulations 12 Safe care and treatment, 18 Staffing and 17 Good governance. We also found a breach of Regulation 11 Consent.

Lyndhurst Residential Home is registered to provide care for up to a maximum of 15 people, some of whom are living with dementia. Accommodation is provided over two floors, which can be accessed using a stair lift. Eleven rooms are single occupancy and two rooms are shared, accommodating two people in each room. There were 12 people living at the home at the time of our inspection.

The previous registered manager had left the organisation and had not been managing the service since December 2013. The current manager had been in post since then but was not registered with the Care Quality Commission. The current manager was on leave and not available during our inspection. The return to work date for the manager was unclear.

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 registered provider had a safeguarding policy in place and the staff we spoke with understood the signs to look for which may indicate potential abuse and staff were clear about who they would report concerns to. However, not all staff had received safeguarding training.

Staff were not always recruited safely. A member of staff had commenced work prior to their employments checks being returned.

Although some risks had been assessed and measures had been introduced to reduce risk, some, such as those related to diabetes or moving and handling, had not been adequately assessed.

Improved plans had been implemented since the last inspection in relation to emergencies and evacuating the building. New evacuation equipment had been provided and staff had been trained how to use this effectively. A policy was in place which outlined the procedures to follow in an emergency.

Building and equipment safety and maintenance had improved since the previous inspection. Regular

safety checks took place and fire, gas and electrical systems had been tested.

A dependency tool was used to help determine staff numbers and we found the numbers of staff deployed were able to effectively meet people's needs.

Medicines were managed, stored and administered effectively and in a safe way.

Although staff observations had increased and improved since the last inspection, not all staff had received appropriate training and supervision.

Consent to care was not always sought in line with legislation. No staff had received training in relation to the Mental Capacity Act 2005. This was also highlighted as a concern at the previous inspection.

People received appropriate support in order to have their nutrition and hydration needs met. Mealtimes were a pleasant experience and people enjoyed the food.

All of our observations indicated staff treated people with kindness and compassion. People told us staff were caring and we observed people's privacy and dignity being respected. There was a pleasant atmosphere in the home.

Care plans had been recently updated and contained person centred information, including people's personal histories, likes and dislikes. However, some essential information such as safe moving and handling plans was lacking.

Audits and quality assurance systems had improved since the last inspection and these had begun to identify areas for improvement, although further development was required, for example to ensure care plans were effectively audited.

There were two newly appointed team leaders who were temporarily managing the day to day running of the home. They were supported by the registered manager of a domiciliary care agency who was associated with the registered provider, a consultancy company whom the registered provider had commissioned to work with the home to improve standards and the registered provider. However, we found a lack of structured support mechanisms in place and there was a lack of management presence at the home.

Policies and procedures were out of date and related to obsolete legislation and organisations.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.
Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

People told us they felt safe.

Risks to people had not always been adequately assessed.

Safe recruitment practices had not always been followed.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they felt staff were well trained.

Not all staff had received appropriate training and supervision and no staff had received training in relation to the Mental Capacity Act 2005, despite making decisions on behalf of people who lacked capacity.

People received appropriate support to have their nutrition and hydration needs met and people liked the food.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring.

People's privacy and dignity was respected and personal information was kept confidential.

Positive interactions were observed between staff and people who lived at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives told us they were involved in activities.

Care plans had been re-written and included information relating to people's likes and dislikes as well as their care needs. However, some essential information, such as moving and handling plans, was missing.

People were encouraged and enabled to maintain contact with those important to them.

People and their relatives felt able to complain if the need arose. However, the complaints procedure was in need of updating to include current procedures.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post.

In the absence of a manager, two team leaders were managing the day to day running of the home. Although support was being provided, this lacked structure and there was a lack of management presence at the home.

Many policies and procedures related to out of date legislation and were in need of updating.

Lyndhurst Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 16 and 19 January 2017 and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience on the first day and an adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority contracts, commissioning and safeguarding teams as well as information we received through statutory notifications.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with seven people who lived at the home, two relatives, two team leaders, four care staff and a cook.

We looked at six people's care records, five staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

We spoke with six people who lived at Lyndhurst Residential Home and they all told us they felt safe. One person, who had previously lived in another home, told us their confidence was returning on a daily basis because of the level of personal interest shown to them by staff. Another person, who had previously lived in another home, said, "It's like moving from the Salvation Army hostel to The Ritz." Other comments included, "Staff look after me well," and, "It's so peaceful here and everyone seems so relaxed, nobody's getting agitated and they still get things done."

People told us their call bells were effective and one person told us staff tell them to, "Press it if I need anything during the night." A relative told us they felt their loved one was safe living at the home because, "They [staff] put safety measures in place." Another relative said, "Yes, certainly," when we asked whether they felt safe care was provided.

The previous inspection found a lack of risk assessments in place to reduce risk to people. We saw some assessments of risk had been undertaken, such as in relation to potential hazards associated with fire and more personal risk assessments regarding a person's medication. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised. The person's medicines risk assessment considered risks in relation to the medicines the person was prescribed, any physical condition that could interfere with the administration of medicines, whether the person understood their medicines, whether they were administered covertly and how the person liked to take their medicines.

However, we found a lack of risk assessment relating to diabetes, in order to guide staff as to the potential complications and signs that staff should look for which may indicate action would be required. This meant people were placed at risk because staff were not advised of the risks associated with diabetes and how to minimise them. Furthermore, although we did not observe any poor moving and handling techniques, we also found assessments relating to the safe use of moving and handling equipment, such as the stair lift or bath hoist, were lacking. This meant there was increased risk of harm to people. The team leader was receptive to our findings and agreed to address both of these issues as a priority. However, this demonstrated a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks to people had not always been appropriately assessed.

We observed staff assist people, giving appropriate support. For example, there was a stair lift in use and we observed staff assist people using the stair lift. Staff ensured the lap belt was in place to reduce the risk of harm. A relative we spoke with said, "I've seen them [staff] assist [name] to move and they always seem to do it in a calm, gentle manner."

The registered provider had a safeguarding policy in place, which had recently been developed. Not all staff had received safeguarding training. However, all of the staff and team leaders we spoke with were clear about what constituted potential abuse and they were able to describe the signs to look for in a person which may indicate they were at risk of abuse. Staff were clear they would report any abuse to senior staff

and the team leaders explained they would report to the local authority safeguarding team and notify the Care Quality Commission, in line with their duty. We saw evidence advice had been sought from the local authority safeguarding team where appropriate.

Concerns were raised at the previous inspection in relation to the safety of the building and equipment. During this inspection we found improvements had been made. Fire evacuation procedures had been developed, which included emergency contact numbers and a safe place for temporary shelter. The automatic detection system had been recently tested and the fire alarm and call bells had been checked and tested. Fire equipment was serviced and this was valid until June 2017. Weighing scales had been calibrated. We saw evidence of weekly fire tests and faults had been recorded and actioned, such as when batteries needed replacing. Fire drills had also taken place. Emergency lighting had been tested monthly and there was evidence actions were taken such as when units needed replacing. Fire doors were tested monthly. Gas and electrical safety had been tested, and found to be safe. We saw the stair lift and bath hoist had been recently serviced and tested. This helped to ensure the building and equipment was safe.

The previous inspection found concerns regarding Personal Emergency Evacuation Plans (PEEPs) being ineffective. We found improved PEEPs were in place, which were signed and dated and individual to each person. Information was included such as the equipment needed and how staff should assist each person to evacuate the building in an emergency. We asked a member of staff to demonstrate how they would use the evacuation sledge and they were able to show us, with confidence, how they would use this to assist people in an emergency. Another member of staff told us they had been in the sledge during training, so they had experienced what it would be like for the person being evacuated. There was a box accessible to staff which contained items that would be useful in an emergency such as a high visibility vest, a torch, emergency contact details and plans.

Emergency plans were considered in the event of various incidents that may occur, such as power failure, burst pipe and fire. We asked a member of staff of the action they would take and they were able to outline the procedure. This showed measures and procedures were in place to keep people safe during an emergency situation.

The previous inspection found a lack of analysis of accidents and incidents. At this inspection we found they were now managed in such a way that enabled analysis to take place. We saw action was taken and advice had been sought from other healthcare professionals and the local authority safeguarding team where appropriate.

We reviewed four staff recruitment files. We found unsafe recruitment practices and, in particular, procedures relating to Disclosure and Barring Service (DBS) checks had not always been followed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. We raised this with the registered manager of the domiciliary care agency who was providing support to the team leaders and advised this be addressed immediately. However, we were later provided with evidence to demonstrate action had already been taken to reduce risk and to address this.

The previous inspection found a breach of regulation because there were insufficient numbers of staff deployed. Staffing levels had increased since the last inspection and this had a positive effect on people living at the home. All of the people we asked told us they felt there were enough staff. One person said, "I never have to wait and staff are always coming to see if I am alright. They are very conscientious." Another person said, "I rarely have to wait for anything." Since the last inspection, an additional carer and two team leaders were deployed each day. A dependency tool was now used to help ensure staffing numbers were sufficient. The staff we spoke with also told us they felt staffing levels were much improved and they had,

"Time to talk to people."

The previous inspection found concerns relating to the administration and storage of medicines. We looked at how medicines were managed and we saw improvements had been made. Medicines were stored securely and regular temperature checks took place to ensure they were stored at the correct temperature. Medicines were labelled and well organised in the locked trolley. Dates of opening were written on inhalers and topical creams which helped to ensure they were not used beyond their used by date.

We observed a staff member administering medicines. This was done in a kind and patient manner. We saw medicine administration records (MAR)s contained a photograph of each person, which reduced the risks of medicines being given to the wrong person. The staff member ensured the medicines were secured and the medicine trolley was locked in between each administration.

The previous inspection found some medicines were not administered as prescribed. We checked at this inspection and found the member of staff was aware that certain medicines were to be administered half an hour before food and the staff member showed us this was printed on the MAR. We observed the member of staff ensured the person received their medicine before their food. Another medicine was to be given with or just after food and, again, the member of staff ensured this happened in practice.

We saw records of staff competency assessments of medicines administration had been completed during December and January. Daily audits were completed to check the MARs had been completed correctly.

We asked two people whether staff wore personal protective equipment (PPE), such as gloves and aprons, when providing personal care and they confirmed this to be the case. We observed staff wearing PPE. This helped to prevent and control the risk of the spread of infection. There were no malodours and we found the home appeared clean.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they felt staff were well trained. One person said, "They are proper care staff here. They know what they are doing, they seem to have you on their mind, you don't have to shout. They come and see you are okay." Another person told us, "Most know what they're doing and are competent; it's very good care and support. They are trained well and work well together."

In relation to the food, one person said, "It's good, wholesome food here and there are plenty of drinks, snacks, whenever you want." Another person said, "If I am hungry I can eat whatever I want and I have put weight on here."

A relative told us, "The care is excellent and the meals are excellent."

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). We checked whether the service was working within the principles of the MCA.

The previous inspection found a person who lacked capacity and was being deprived of their liberty in order to receive care and treatment, without proper authorisation in place. At this inspection we found action had been taken and appropriate authorisations had been sought to protect their rights in line with the MCA and DoLS.

Where decisions were being made on behalf of people, in their best interest, there was not always an assessment to determine whether the person had capacity to make their own decision. We found a lack of decision specific mental capacity assessments in some people's care records. One person's mental health care plan stated, 'Does not have capacity to make decisions.' However, the MCA makes clear that an assessment of a person's capacity must be decision specific. Another person's care plan stated, 'Unable to make decisions about their day to day life,' but there was no evidence of a mental capacity assessment in relation to this. We saw a blank form entitled, 'Decision Assessment Checklist,' in this person's file.

We observed staff seek consent from people prior to providing care. However consent to care, in terms of people's care plans, was not always obtained from the appropriate person. Some care plans had not been signed and others had been signed by family members when it was unclear whether the family member had the authority to do so.

We found staff lacked knowledge of the MCA and no staff had received training in this area. A team leader assured us they were in the process of sourcing further training in this area of care.

The above examples demonstrated a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because consent to care was not always sought in line with legislation.

We reviewed five staff files and the training matrix and found no staff had receiving Mental Capacity Act 2005 training and not all staff had completed safeguarding training. We also found no evidence one of the cooks had completed food hygiene training and the team leaders were unable to confirm this had been completed. This meant some staff were performing their duties without appropriate training.

The last inspection identified that staff supervision was lacking. At this inspection we found evidence frequent staff observations had taken place in relation to the care and support staff were providing to people. These were effective in identifying when a member of staff required further support. This support was given and the member of staff was then observed again. However, we found few examples of staff receiving one to one supervision since the last inspection. We saw evidence a member of staff had a one to one supervision in January 2017 and another member of staff had a one to one supervision in December 2016. A group supervision was also held in December 2016. This meant staff were not yet receiving regular, ongoing supervision. The team leaders advised this was an area they were working to improve.

The above examples demonstrated a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured all staff received appropriate support and training to enable them to carry out their duties.

The previous inspection found concerns staff had not received an adequate induction. We saw evidence a newer staff member in the team had received an induction, which included shadowing more experienced members of staff and essential areas such as fire safety, health and safety as well as introductions to people living at the home.

The people we asked told us the food was good and they could eat what they wanted. We saw the cook asked people living at the home in a morning what they would like to eat at lunchtime. Choices were offered and accommodated. We heard people being asked what they would like for breakfast.

People received the necessary support to eat their meals. One person, who preferred to walk around rather than sit at the table, was discreetly followed by staff, who encouraged the person to eat and offered 'finger-food'. This was in accordance with the person's care plan. Staff knew the person well and were aware of the most effective way of supporting the person with their nutritional needs.

We saw a person's care plan indicated they should eat a fortified diet with extra butter and cream. We asked how this information was communicated to the cook. We saw dietary information was included on handover sheets which were given to the cook. This meant the cook was aware of people's dietary needs.

A variety of drinks were offered at mealtimes and throughout the day. We heard people ask staff to make them a drink and staff accommodated requests.

Two people chose to eat their meals in a quiet dining area in a lounge. They ate independently and a small dining table was set. Staff kept checking they were okay but without being intrusive.

We saw people's rooms were personalised and, where people shared a room, a screen was used to help maintain privacy. Communal areas were decorated in traditional, homely styles and this was in keeping with the relaxed, informal atmosphere at the home. We noted, however, the design of the home was not dementia friendly. Environments can be made dementia friendly be giving consideration to contrasting colours and signage for example. We highlighted this to the team leaders and they advised they were currently looking to improve in this area.

We saw evidence of referrals to other healthcare professionals such as GPs and district nurses for example. One person told us staff had called a doctor straight away when their condition had worsened. This person said, "Again, this adds to my confidence." Another person said, "They are very good at getting the doctor, there's no waiting about."

Information was shared between shifts which helped to ensure continuity of care. We looked at handover sheets, which included information regarding people's diet, appointments, visits and activities for example. A carer told us handover meetings were held at the start of each shift and these were held downstairs, away from the residential areas within the home which meant important information could be shared without compromising people's privacy in relation to information about their care.

Good

Is the service caring?

Our findings

All the people and relatives we asked told us staff were caring and we observed interactions that supported this. People told us they were treated with dignity and respect and their privacy was respected.

One person said, "I am very shy but because of the way staff treat me I am now happy to get undressed in front of them and let them help me have a bath."

A person said, "What I would call 'comfort care' and respect for people's dignity here is tremendous."

Other comments included, "Staff don't boss you about, are very friendly, you don't feel you are here to be looked after, you feel like we live in a house all together. Not rushed or agitated."

A further person told us, "I suffer from anxiety but staff help me with my worries and anxieties. They know me well."

A family member we spoke with told us, "I'd looked around numerous homes before choosing this one. It might not have all the mod-cons but I know [name of relative] wouldn't want that. This one is very warm. We can ask for anything and the staff are caring and very accommodating. It's very homely."

A carer told us, "I love speaking with the residents."

We observed staff displayed caring body language, using appropriate tones and touch to reassure people where necessary. People living at Lyndhurst Residential Home appeared comfortable in the presence of staff and were not afraid to make requests of staff, which we saw were promptly accommodated.

We observed lots of laughter and appropriate joking between people and staff, in a respectful manner. We saw people spontaneously burst into song and staff joined in and we saw people dancing with staff. We heard staff talking to people about their life histories and interests and families, showing genuine interest. One staff member was sharing her own photographs with a person, who was obviously very interested in them.

We observed staff interacting with one person who continually walked around, and who often appeared to be in an anxious state of mind. All the staff we observed took time to reassure the person and offer appropriate distraction. At no point did we observe any staff display any irritation or impatience.

A relative of a person who shared a room with another person told us staff ensured measures were in place to try and protect people's privacy, such as using screens.

Staff respected people's privacy. One person told us, "All staff knock before coming in. They open the door a little and don't just barge in, ask if it is okay to come in."

The people we asked told us staff had the correct balance between giving appropriate care and respecting their independence. We saw staff encouraging people to be independent and people were given the time they needed to make choices. One person told us, "They give me time to think and I am not rushed to make a decision."

We found improved practices since the last inspection, in relation to respecting people's private and confidential information. Measures were now in place to ensure personal information was secure.

Requires Improvement

Is the service responsive?

Our findings

Staff knew what was important to people and they were responsive to people's needs. One person told us, "It may seem like a little thing but when I come down in a morning they give me my tobacco, they know that's important to me and always ask me if I want to nip out for a cigarette first or have a cup of coffee first."

Improvements had been made to care plans since the last inspection. We found care plans included information regarding people's care needs in relation to their physical health, medication, skin integrity, nutritional need, mobility, communication, personal care and continence care for example. Care plans were reviewed and updated monthly.

The previous inspection found care plans did not contain essential information such as how staff should assist people with pressure care or what settings specific pressure relieving equipment was to be set. We found plans now included information relating to, for example, exactly how to position a person's feet in order to provide pressure relief and the correct settings for equipment were indicated. In terms of people's continence needs, the plans we sampled at this inspection included information relating to the specific products staff should use and the methods staff should use to assist individuals. However, there was also essential information missing such as safe moving and handling plans to enable staff to assist people to move safely, when using equipment.

We saw evidence people were beginning to become more involved in their care planning, since the last inspection. Care plans were being re-written and we saw evidence of some involvement of people living at the home. In one care file we inspected, the person had signed each care plan and contributed to their likes and dislikes and preferred daily routine. However, in other care plans this was not evident.

Plans included information relating to people's choices and likes and dislikes and we saw a document titled, 'This is me' which contained information regarding a person's life history, likes and dislikes. One care plan stated, 'I like my name to be pronounced [name]'. Another included detail on what subjects to talk about, in order to distract the person, should they become distressed.

One person who was nursed in bed had been assessed for a specific chair to meet their needs. A referral had been made through their GP on 1 August 2016. A handwritten note dated 5 October 2016 indicated, 'Measured for chair. Awaiting call back from [name] regarding funding.' We asked the team leaders whether anything had been done to follow up the request, particularly as a member of staff said the person, "Loved it," when they were assessed for the chair. The team leaders could not confirm this had been followed up but agreed to make enquiries following the inspection.

There was no activities coordinator working within the home at the time of this inspection and activities were not delivered in a planned or structured way. However, we observed staff asking people what they would like to do and we observed informal activities during our inspection such as nail painting, memory cards, photographs, dancing, singing, and watching a film. One person told us, "They regularly ask me if I want to go out to the shops, I've only gone twice but they still keep asking me." Another person told us, "If I

feel a bit stiff, staff help me to do chair exercises." A relative told us they felt staff were, "Good at activities. They play music that people like and dance."

A person told us, "My family live in [name of town] and didn't know where I was but my keyworker checked with me first and asked if I wanted to phone them. Now they come when they want." A relative confirmed they could visit the home whenever they wished. This helped to reduce the risk of social isolation and showed people were assisted to maintain contact with those important to them.

We saw people were given choices throughout the inspection and people told us they could make their own choices. Two people preferred to sit in a quiet lounge for their meals, as opposed to the dining room. A small dining table had been set up in the lounge for them to eat their meals.

Staff were aware of people's choices and preferences and what was important to people. One person liked to ensure they had a particular item of clothing with them at all times and staff enabled this. When we spoke with staff we asked them to tell us about particular people. Staff were able to outline people's life histories, likes and dislikes and what was important to specific people. Staff told us people could rise and retire when they wished and the people we asked confirmed this.

One person who had previously lived in another home said, "If I have a problem I can discuss it with staff but before, in the other home, I would just have gone to my room." Another person said, "If I'm worried or want to complain I tell the assistants and they sort it out immediately." A relative told us, "I've never needed to complain but if I've made the odd suggestion, it's always been acted upon. And likewise, staff have made suggestions to me if they feel something would improve my [relative]'s quality of life." A team leader we spoke with confirmed no complaints had been received. The complaints procedure was in need of updating, as this related to an obsolete organisation. The consultancy company, which was providing support to the home, confirmed they were in the process of reviewing all policies and procedures.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post and the unregistered manager was absent from work during our inspection and the staff we asked were not clear of a return to work date for this person. There were two team leaders in post whose roles were being developed and they were being trained to take on more responsibilities.

Since the last inspection, the registered provider had engaged the services of a consultancy company to develop an action plan and to help drive improvements at the home. The two team leaders told us they could access support from the registered manager of a domiciliary care agency whose office was next door to the home and which the registered provider also owned. When we asked how often the registered provider attended the home we were told this was less than a weekly basis. One staff member told us, "Possibly twice a month." We observed there was a lack of structured support for the team leaders, who were new in post, and the home did not have a substantive manager on the premises or a registered manager. We asked the team leaders when the registered provider would next be visiting but they did not know. We asked to see evidence to show what support was being provided by the registered provider but were told there was no record of this.

Following the inspection we contacted the consultancy company, who provided an update on the status of the unregistered manager but were not in a position to provide a time-line for having a registered manager in post.

On 22 September 2016, following the previous inspection, the unregistered manager completed a statement, advising they had not stated they felt unsupported. At a meeting with the registered provider on 5 October 2016, we impressed upon them the importance of providing support for the unregistered manager. Records from a discussion on 20 December 2016 between the unregistered manager and registered manager of the domiciliary care agency indicated the unregistered manager did not feel acknowledged or supported by the registered provider. We saw records of discussion between the unregistered manager and the registered provider on 29 November 2016 which indicated supervision of the unregistered manager would be handed over to the consultancy.

The people we asked said they felt the home was well managed. One person said, "The place is well managed because you just sit here and all the work is done. They're not cleaning up around you, it's done before you come in." Another person said the home was well led because, "The manager's hands on, friendly and you can go to her with anything."

The staff we spoke with told us they enjoyed working at the home. One staff member said, "I love it. We work good as a team." Another carer said, "I absolutely love it."

From our discussions with care staff, senior carers and team leaders on the days of our inspection, it was clear there was a will on their part to improve and sustain improvement at the home. One carer said to us, "We're all getting used to the changes. You've got to have change. It is improving."

A member of care staff told us they felt the registered provider was putting resources in place to improve the home such as additional staff, a new hoist, new tables and chairs.

A staff member we spoke with told us they felt supported by the team leaders and they felt the home was improving. We were told, "The team leaders are doing a marvellous job," and, "I feel 100% supported by the team leaders."

We saw a staff meeting had been held with senior staff on 21 November 2016. A staff meeting had been held on 31 October 2016, during which the concerns from the previous inspection were discussed. However, we could not find evidence of regular team meetings. Meetings are an important part of a registered provider's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

There was no evidence that residents or relatives' meetings had been held and the team leaders confirmed this. One person told us they felt residents' meetings were useful to give feedback and suggestions but said they thought meetings were not happening now because there were more people living at the home with dementia. However, a relatives' meeting had been arranged for the Friday of the week of our inspection and we saw evidence of this. A relative we spoke with, following the inspection, told us they had been informed of the meeting and had been asked for their views because they were unable to attend.

The previous inspection ratings were displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

At the previous inspection we found the registered provider was in beach of regulations in relation to good governance. We found improvements in relation to quality assurance systems and audits at the home since the last inspection. The team leaders spoke with enthusiasm about how they felt the audits had been effective in improving standards at the home. A team leader told us staff were receptive to changes and the improvements being made in the home.

Medication audits were regularly undertaken. These checked that storage temperatures had been monitored, details had been entered correctly on the MARs, medicines were stored safely and creams and ointments had dates of opening recorded.

We were shown a quality assurance file by the team leaders. The file was well organised and included a schedule, showing when each audit should be undertaken and who was responsible for ensuring the audits were completed. We found audits had been completed according to the schedule. We looked at a health and safety audit which took place monthly. This considered areas such as general housekeeping, whether stairways were kept clear, whether refrigerated items were in date and extractor fans clean for example. We saw action was taken where necessary and there was a clear system of carrying over actions to the following month when this was required. This helped to ensure any required actions were logged, recorded and followed up when necessary.

Other audits included infection control. Again, we saw action was taken when necessary, such as staff being instructed to remove their jewellery. In addition, we saw a domestic service audit which checked daily cleaning schedules were completed.

Care plans had been recently re-written and, although care plan audits were not yet in place, these were planned to begin, monthly, from February 2017.

A consultancy company had spent some time training the team leaders how to undertake effective audits and the team leaders had been provided with some audit tools. We noted that one of the audits contained the name of a different home. We highlighted this to the team leader, who agreed to advise the consultant of this.

We saw evidence meal-time observations had taken place. Where these had identified an area for improvement, this was actioned.

The last inspection found policies and procedures were not up to date and they related to out of date legislation and regulation. We asked to see the most up to date policies and found most had not been updated. The health and safety policy had been last updated February 2016 and related to out of date standards for domiciliary care agencies as opposed to residential homes.

A policy in relation to, 'The death of a client,' was last updated during February 2016. As found at the previous inspection, there was no reference to DoLS and the requirement to notify the coroner of a death if a person was subject to a DoLS authorisation.

The complaints procedure was not dated so it was not possible to determine when this was updated. However, this indicated a complainant had the right to escalate matters to the Commission for Social Care Inspection. Again, this was outdated.

The equal opportunities policy was last updated during February 2016 and referred to the Sex Discrimination Act 1975, the Race Relations Act 1976 and the Disability and Discrimination Act 1995. The policy made no reference to the Equality Act 2010, which replaced previous anti-discrimination laws with a single Act, which specifies protected characteristics.

The domiciliary care agency registered manager gave us two policies (Employing fit and proper persons policy January 2017 and Staffing Policy January 2017) which had been updated but we were told by a team leader the consultant was working on others. We asked the consultant for an update on the progress of policies and procedures. We were given an up to date safeguarding policy and told, 'Due to the volume of work that has been required and the priorities we have had to place on each item we have started reviewing the policies and procedures and I would anticipate that this will be completed by the end of February 2017.'

Although improvements at the home were evident since the last inspection we found multiple areas of concern that had not yet been sufficiently addressed and there remained no registered manager in post. The registered provider did not yet have robust, effective systems in place to improve the quality and safety of services, risks were not always assessed and mitigated, including in relation to the safe recruitment of staff, information was not always up to date, nationally recognised guidance was not implemented and decisions made on behalf of people who lacked capacity were not always made in accordance with the MCA. These examples demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.