

RYSA Highfield Manor Limited

Highfield Manor Care Home

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 

Overall summary

This inspection took place on 16 and 17 March 2015 and was unannounced. The aim of the inspection was to carry out a full comprehensive review of the service and to follow-up on the six compliance actions made at the previous inspections carried out on 1, 2 and 15 October 2014 and 8 January 2015.

People living at the home felt safe. For example one person told us, ““The staff know what’s wanted; they’re alright, they wouldn’t hurt you”. Relatives overall were also generally positive about the care provided at the home.

Medicines were managed safely in the home. People had their medicines administered as prescribed and staff had been trained in safe medication administration. There was less use of ‘as required’ medicines that we had found on previous inspections to be over used. Care plans gave guidance to staff on when it was appropriate to use these ‘as required medicines’. Pain assessment tools were now being used for people who could not inform staff that they were in pain. There were suitable storage facilities for storing medicines.

Summary of findings

Since the last inspection the safeguarding procedure had been updated as required and staff were trained and knowledgeable about how to raise concerns appropriately.

We also found that there was better risk management to keep people safe. Bed rail risk assessments were now in place and each person had a personal evacuation plan.

There was improvement in record keeping. At the last inspection we identified that some records were out of date or had not been completed. At this inspection records were up to date and accurate.

At the last inspection we had found there were not enough staff to meet people's needs. At this inspection people, relatives and staff all said that the staffing levels were appropriate. There were less people accommodated at this inspection and we saw evidence of staffing levels being increased if there was an increased need. The acting manager agreed that a dependency tool would be used in future to better inform the assessment of staffing requirements.

There were robust recruitment procedures being followed to make sure suitable staff were employed to work at the home.

Overall, at this inspection the home was more effective in meeting people's needs. Part of this had been brought about as better training in core subjects had been provided. For example, moving and handling training and dementia care.

At the last inspection we found staff were not receiving adequate supervision. Action had been taken at this inspection to address this.

At the last inspection the requirements of the Mental Capacity Act 2005 were not being carried out, with particular reference to making 'best interest' decisions on behalf of people who lacked capacity. At this inspection we found the home was now compliant with better records and assessments to evidence this.

There was also an improvement at this inspection with regards to food provided. Drinks and snacks were now available to people throughout the day. Visual prompts to assist people living with dementia in choosing meals had been adopted and the home had sought advice about improving menus and overall nutrition. Where people were at risk of not having enough to drink, there was better monitoring and care planning to make sure people did not become dehydrated. People were weighed regularly and action taken if people lost weight.

Improvements could still be made to make the physical environment more suitable for people living with dementia.

People and relatives were positive about the care staff and how people were looked after and supported.

Management had made sure that changes in staff practice of getting people up early, washing and dressing them and putting them back to bed had ceased.

More activities were being provided and this should improve further when the new activities coordinator starts work at the home.

At this inspection we found an improvement in care planning. Care plans were up to date and reflected the needs of people whose care we focused on. New format care plans were being developed.

Action had been taken to make the complaints system more effective. The procedure had been updated and was prominently displayed in the reception area. Complaints had been investigated and there was monthly auditing to make sure that lessons could be learnt.

At this inspection we found there was more openness and transparency in how the home was managed. Staff and relatives said they were comfortable with the management and felt that they were listened to.

There were better systems in place to monitor the quality of service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Overall the service was safe.

People felt safe and staff treated them respectfully.

The safeguarding procedure had been updated as required. Staff were aware of who to contact should they suspect abuse.

There were sufficient numbers of appropriately trained staff to meet people's needs.

Medicines were managed safely and there was better risk management in the home.

Good



Is the service effective?

Staff were effectively supervised and supported to carry out their role.

The home was now compliant with respect to the requirements of the Mental Capacity Act 2005.

Improvements had been made with regards to the food provided to people.

People accessed the services of healthcare professionals as appropriate.

Good



Is the service caring?

People were treated with respect and dignity by staff who were caring.

Staff were knowledgeable about people they were looking after.

People were supported to take part in activities that they enjoyed. People said their visitors were always made welcome.

Good



Is the service responsive?

People's needs had been assessed and care was planned and delivered to meet their needs.

The provider had made improvements to the system for dealing with complaints.

There was an improvement with regards providing more meaningful activities for people.

Good



Is the service well-led?

The culture of the home was more open and transparent than when we last inspected. People and relatives felt better able to express views which could influence how the home was run.

Quality assurance procedures had improved.

Good



Highfield Manor Care 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 checked 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 16 and 17 March 2015 and was unannounced. The aim of the inspection was to carry out a full comprehensive review of the service and to follow-up on the compliance actions made at the previous inspection that was carried out on 1, 2 and 15 October 2014 and also on 8 January 2015. That inspection had been carried out over a period of time in response to ongoing concerns about the home at that time.

Two inspectors carried out this latest inspection. During the inspection we met with all 37 people who were accommodated at the time and had discussions with those people happy to speak with us, which was about half of those accommodated. Most people were living with dementia so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Highfield Manor has a registered manager; however, they were not working at the home at the time of the inspection. We were assisted by one of the three deputy managers. This person had been identified by the provider as the named member of staff in the registered manager's absence and had overseen the improvements identified in this report. Throughout the report they will be referred to as the acting manager.

We spoke with the acting manager, eight visiting relatives, one of the other deputy managers and eight members of staff.

We looked at five people's care and support records, as well as samples of monitoring records, the medication administration records for people accommodated on the ground floor and documents relating to the overall management the home. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of.

A Provider Information Return (PIR) was sent to us on 12 November 2014 before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make.

Is the service safe?

Our findings

People who were able to tell us of their experience of living a Highfield Manor had no concerns about their safety. One person told us, “The staff know what’s wanted; they’re alright, they wouldn’t hurt you”. Another person, when asked if they felt safe in the home, said, “Absolutely”. They went on to tell us that they were able to lock their room at night to prevent people who may be confused entering their room. Relatives told us that the investigations and findings of previous inspections had caused them some concern but overall they had been pleased with the service and care provided at the home. One relative told us, “If I have any concerns, I can always speak with the manager who always answers my queries”.

When we visited Highfield Manor on 1, 2 and 15 October 2014 we identified a continued breach of medicines management regulations and a warning notice was issued. We therefore visited the home on 22 December 2014 when we were assisted by a pharmacist to follow up on the warning notice. On that visit we found that the home had complied with the warning notice and made improvements.

At this inspection we looked at the medicines management for one floor of the home. There was a reduction in the use of ‘as required’ medicines, as GP’s had prescribed most medicines with directions for administration at set times. Where ‘as required’ medicines were prescribed, care plans were in place to guide staff on the circumstances when these medicines should be offered and administered to people. We also noted that there was less use of sedative medication in the home to help manage people’s behaviour. One person, who did not have the capacity to let staff know if they were in pain, had ‘as required’ medicines for pain relief. We saw that a pain assessment tool was being used appropriately to make sure that the person was kept free from pain.

Medication records showed that people had their medicines administered at times prescribed. We also checked the unit administration system and the remaining medication records balanced with the records. The records showed that when a variable dose of a medicine had been prescribed, the number of tablets administered had been recorded so that staff knew how much medicine had been administered.

At the front of the medication administration records there was a sample of staff signatures to identify which member of staff had administered medication. We checked and found that the staff who had administered medicines had been both trained in safe medication administration and also that they had had their competency to administer medicines assessed.

There were suitable and safe systems for storing medicines with controlled drug storage facilities, three locked medicines trolleys and a system for accountability of keys to make sure only the person responsible for medication administration held the key. There was also a small fridge for storing medicines requiring refrigeration. We checked the small fridge and found that medicines with a shelf-life after opening, had the date of opening recorded to make sure that these were not used after their cut off date. Records were also maintained of the the fridge temperature to make sure that medicines were stored at the correct temperature.

Where care staff applied creams, there were charts with body maps to show where medicines should be applied and records for administration.

When we visited the home in October 2014 the safeguarding policy was out of date, did not make references to offences under the Mental Capacity Act 2005 and did not include the correct details for the local authority for staff to report any allegations of abuse. At this inspection we found the policy had been reviewed with amendments made to provide the missing information.

Staff had been trained in safeguarding as part of their induction and later went on to have a more in depth course on abuse and safeguarding. At this inspection all the staff we spoke with were knowledgeable about types of abuse and how to report any allegations.

In October 2014 we found that people had risk assessments and management plans in place for falls, pressure areas and nutrition. However, there were not always assessments in place for risk management of bed rails or for people who could exhibit behaviours that challenged others, or personal evacuation plans. We issued a compliance action with regards to these matters. At this inspection these additional risk assessments were in place for the people whose records we looked at in depth. A more detailed and better risk assessment tool was being introduced for people who had bed rails in place. This

Is the service safe?

meant that there was better risk management with plans in place to make sure that people did not get entrapped where bed rails were used, that staff knew how to support people in a safer way should a person present challenging behaviour and staff would know how to support people in an emergency.

At the inspection in October 2014 we also issued a compliance action in relation to record keeping. This was because we found people's care and monitoring records were not consistently maintained to accurately reflect the care and support provided to people. At that inspection one person's daily records had not been completed for one night and for another person their name was recorded differently in different records. Three people's fluid records had not been added up to make sure they had enough to drink and two people's weights were inaccurately recorded on their care plans and food and monitoring records.

At this inspection we found there was better record keeping. Records were up to date and readily available to us when requested.

At our inspection in October 2014 we had found that there were not enough staff employed to meet the needs of the people accommodated at that time. At this inspection people, staff and relatives felt there were overall enough staff to meet people's needs. People told us that there were periods when the staff were stretched and they were always busy but in general staffing levels were appropriate. One person told us, "Usually my call bell is answered quickly". A member of staff told us, "At the moment staffing levels are okay". The acting manager told us that although dependency profiles were not used to

determine staffing levels, through staffing handovers and feedback from staff each day, staffing levels were set accordingly. The acting manager showed us staffing rotas and how an extra person had been put on duty on the day of our inspection because one person was presenting behaviour that challenged others and needed extra support from staff to keep them safe. The acting manager agreed to look into the use of dependency assessment tools to assist in making a more robust assessment in determining appropriate staffing levels.

The acting manager told us that since the last inspection in October 2015 no new members of staff had been recruited to work at the home. Two agency staff, who carried out regular work to cover vacancies had been taken on through an agency. Records were in place to show that these two staff members had been recruited in line with regulations, which included a check against the register of people barred from working in the care sector, proof of identity, health declaration references and investigation into their employment history. This meant there was a system to make sure that suitable people were recruited to work at the home.

There were systems in place to ensure that equipment and the premises were safely maintained. The acting manager was able to show us that required cyclical servicing and testing of equipment in the home had been carried out. This included testing of the fire safety system, servicing of the boilers and gas, thermostatic mixer valves (to make sure people were not at risk of scalding water) and servicing of the lifts.

Is the service effective?

Our findings

Overall, Highfield Manor was providing a more effective service than at the previous inspection. People were complimentary about the staff, who they said were kind, although for some people the accent of some staff and communication remained a barrier. One person told us, “The staff are very nice and always very helpful”. One relative commented, “I would recommend the home to anyone”.

At our inspection in October 2015 we found that staff did not receive adequate supervision, appraisal and training to enable them to fulfill their roles effectively and we made a compliance action for the home to improve in this respect.

The staff we spoke with at this inspection all confirmed that a system had now been put in place by the acting manager to make sure that staff supervisions were carried out to the timescale of the home’s policy. Staff all confirmed that they had received one to one supervision with a line manager and had an annual appraisal. The staff also said that they felt supported in day to day work and that more training had been put in place in various subjects that had made them more aware of best practice in how to meet people’s needs. Records were in place to show that each member of staff had received one to one supervision with dates set for further supervision sessions.

The acting manager told us about the training that had been put in place since October 2014. Six members of staff had started National Vocation Qualification training at level 2. At the last inspection we found that although some dementia care training had been provided, staff were not knowledgeable about best practice in caring for people living with dementia. The manager had investigated training programmes in dementia care seeking a training course that would equip the staff with in depth training. Ten members of staff had now started this training and they provided positive feedback about the course and how it assisted them in understanding how to meet people’s needs.

Health care professionals who had been supporting the home had identified that moving and handling by the staff could be improved. The home had worked with the local authority who provided trainers in the home to give staff practical guidance in better moving and handling procedures. The acting manager showed us new slings used for hoisting some people who could not weight bear

that had been ordered following the training. One of the senior staff had a moving and handling training qualification and dates were being set to assess each staff member’s understanding and practice in moving and handling.

At the last inspection in October 2015 we found that although staff had been provided with some induction training, it was not based on the the induction programme provided through Skills for Care, Common Induction Standards. No new permanent members of staff had been recruited since October 2015, however, the acting manager told us that all new members of staff would be provided with induction training using the induction framework prescribed by Skills for Care, the nationally recognised induction standards.

At the last inspection of Highfield Manor in October 2014 the service was not meeting the requirements of the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. The acting manager and deputy manager had some understanding of who had restrictions placed on them and they had made applications for these to be authorised under Deprivation of Liberty Safeguards (DoLS). However, staff were not aware of the Mental Capacity Act 2005, making best interest decisions, or which people were being deprived of their liberty and who had DoLS authorised. One person’s DoLS authorisation documents detailed they needed specific care plans for staff to follow but these were not in place. People’s care plans included the blanket statement: “(person) has no capacity”. This showed us the managers and staff did not understand the presumption that people have capacity to make decisions for themselves. Capacity assessments had not been completed so specific decisions could be made in people’s best interests. We therefore set a compliance action for the home to make improvements. Following the inspection the acting manager sent an action plan with a compliance date for April 2015 to make improvements.

Since that inspection, staff had been provided with further training in the Mental Capacity Act 2005, ‘best interest decisions’ and the Deprivation of Liberties Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty.

The acting manager told us that they now ensured that that they investigated whether relatives had legal powers to make decisions on behalf of their relatives with respect

Is the service effective?

to care and welfare or finances where a person did not have capacity in these areas. Relatives we spoke with told us that they were consulted or kept informed about their relatives care appropriately and they reported no concerns to us.

There was a system in place to ensure that people were not deprived of their liberty unlawfully and the appropriate referrals had been made to the local authority where there was a deprivation of a persons liberty. Records were in place to demonstrate this.

Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 and people were given choices in the way they wanted to be given their care and support.

There was better evidence for people who lacked mental capacity in the way records were set out to demonstrate that capacity was assessed with respect to specific decisions rather than a blanket assessment that people 'lacked capacity'. This ensured that people were able to make decisions for themselves in those areas where they had the ability to do so. For example, one person's care plan reflected that they could make decisions with regards to choosing what clothes they would like to wear, what they would like to eat and what activities they would like to take part in but also detailed areas where they did not have capacity, such as managing medicines. Through the inspection we saw staff consulting with people when they were supported in managing their daily lives.

At the last inspection we made a compliance action as although people had their nutritional needs assessed, care plans to manage these were not consistently put into place. People's weight was monitored monthly but prompt action was not always taken when people lost weight and care plans had not always updated to reflect what action staff needed to take. Food and fluid monitoring did not always start after weight loss was noted. The care plans and food records did not detail whether people were to receive fortified foods (e.g. added full fat cream, full fat milk with milk powder added, full fat cheese). Some people's records did not show whether they were having fortified diets in response to weight loss.

At this inspection we found nutritional assessments had been carried out and recorded with people weighed each month and their body mass index (BMI) calculated. Where people had lost weight, care plans detailed action staff

should take, such as people's meals fortified or referral to their GP or whether weekly monitoring of a person's weight was required. There was still some confusion by the way actions were recorded as to whether a person was receiving a fortified diet or whether they had been supplied nutritional supplements by their GP. We discussed this with the acting manager who agreed that they would check care plans to make sure there was no confusion as to the appropriate action that should be taken. Overall, there was improvement in the way people's nutritional intake was monitored.

The acting manager explained the system for monitoring people's risk of dehydration. Fluid monitoring charts were put in place in cases where staff identified that people were not drinking well, or in the event of a period of hot weather or for people newly admitted to the home. Overall, we found there was better monitoring of fluid intake than we found at the last inspection.

At the last inspection we noted that snacks, fresh fruit and drinks were not always available to people who could benefit from this provision. On this inspection jugs of drinks, cooled trays of sandwiches, fresh fruit and other snacks were available in all the communal lounges. Staff commented that this had been very successful and people's nutritional needs were being better met, particularly for people who did not eat well at set mealtimes. The acting manager had also engaged with a local authority regarding nutrition and a date had been set for a trainer to spend time with the cook, looking at diet and nutrition for people living with dementia. The trainer had already looked at the current menus and offered suggestions for improvement, some of which had already been adopted.

At this inspection we gained a range of views of the standard of food provided. One relative commented, "He now says that he gets too much to eat". Another relative said, "I know that the food is okay, as I have often eaten here with my relative". Some people had negative views on the food provided, particularly the evening meals and the frequency of minced meat at lunchtime. One person said that some meals were repetitive and that they were sick of baked beans. As mentioned plans were in place to develop menus with some advice already taken on board and actioned.

Another improvement was that the menu on display for the day had pictures of the meals for assisting people with

Is the service effective?

cognitive impairment in choosing their meal. Our observations of the main meal at lunchtime were generally positive. Staff were aware of the people who needed assistance with eating and where this was provided, staff were patient and encouraging in helping people eat their meals. People were provided with a choice and if they did not like their meal, staff sought other choices that appealed to people.

As we found at previous inspections, coloured crockery was used throughout the home to assist people living with dementia to see food more easily and some people were provided with specialist cutlery to assist them with eating.

Records showed people were registered with a GPs and chiropodist and referrals to district nurses and community mental health professionals were made appropriately. Since the last inspection the home had received a lot of support from the local authority and health services in effecting improvements and the feedback from these agencies was that staff had been both willing and effective in making improvements.

Some people had been assessed as being at risk of developing pressure sores and position charts were put in place to make sure people were regularly repositioned to

relieve pressure. Records of their position throughout the day were kept and generally reflected that staff were completing this task to maintain people's skin integrity. People requiring specialist equipment such as pressure-relieving cushions and mattresses had been provided with this equipment to meet their needs. We found that there was a system to make sure that should a person be provided with an air mattress, staff knew what the correct setting of the mattress should be to correspond with their current weight.

At the last inspection in October 2014 we reported that improvements could be made with respect to signage in the home so people could identify and recognise toilets and bathrooms. Some people's doors had a current photograph of the person and their name on but people living with dementia may not recognise themselves in the photographs. There was also nothing on bedroom doors to make it easier for each individual to recognise their bedroom. We discussed this with the acting manager who said that this was still an area for improvement and plans were in place to take action to make the physical environment more amenable to people living with dementia. This will be followed up at future inspections of the home.

Is the service caring?

Our findings

People and relatives were positive about how people were cared for at Highfield Manor. One relative who told us they visited regularly said, “The girls are very good...wonderful”. Another relative said, “I am very happy with the care”. Responses from people were also generally favourable about the staff saying that they were caring and very helpful.

When we visited the home at 6:30am in January 2015 we found that people living with dementia, their preferences and dignity were not respected as these people were being got up very early, washed and dressed and then put back to bed. This practice was for the benefit of the staff and not the people living at the home. We made a compliance action in respect of this matter.

On the second day of this inspection, we again arrived early at 6:45am to check whether practice had changed. We found the practice had changed and people in bed were in night clothes and had not been woken to be washed and dressed. Staff we spoke with confirmed that people were now able to stay in bed until they woke. Care plans still did not reflect people’s preferred times of getting up or going to bed. This was discussed with the acting manager, who said that this information would be added to care plans. We will follow this up at future inspections.

Staff, as we had found at the previous inspection, were warm and friendly in their approach to supporting people. Staff responded when people called out or looked as though they needed assistance from staff. One person gained comfort from a soft toy and staff were mindful to make sure this was available to the person. Staff were also seen spending time talking with people when they asked for staff attention.

At lunchtime staff supported people appropriately, sitting beside people who needed assistance with eating, talking with them and encouraging them to eat.

The staff we spoke with were knowledgeable about people and demonstrated a strong commitment to the people in their care. One member of staff told us, “Each person is an individual so it is important to get to know them and their individual ways”.

At the last inspection in October 2014 we found people were not routinely consulted in developing their care plans. Although relatives had been involved in people’s assessments and had signed some people’s care plans, the information gathered on people’s life histories and personal preferences was not used to plan people’s care, support and social stimulation and occupation. People were therefore not able to engage in meaningful activities and were not kept occupied doing things that were important to them. We had recommended that people and or their relatives be involved in planning their care and support, with people’s life histories and personal preferences used to inform how care was planned and delivered.

At this inspection we found that more was being done to meet people’s social and recreational needs. The acting manager told us that an activities co-ordinator was in the process of being recruited and that in the meantime staff had been delegated to spend specific time on providing meaningful activities. On both days of the inspection a member of staff was involved in activities in the main lounge involving people in craft activities. We noted that some people were provided with newspapers and magazines that they were occupied with. One relative commented that they had observed more activities were taking place when they visited. They also said that they had been involved in planning for their relative’s care and had seen the care plan that had been developed.

People we spoke with raised no concerns about how their privacy and dignity were maintained. The home had appropriate door locking facilities in bedrooms, whereby people could lock their room from the inside without a key and unlock the door by using the door handle. One person told us how this had been effective in ensuring no one wandered into their room at night time.

Is the service responsive?

Our findings

At the last inspection in October 2014 we made a compliance action as we found that care plans were not always updated when people's needs changed; such as when a person's mobility declined and they experienced falls. We also found that the home was not responsive in meeting people's individual needs, particularly with reference to meeting their social and recreational needs.

At this inspection, as detailed earlier in the report, there was an improvement in the level and range of activities provided to people and so the home was now more responsive in meeting individual needs.

The acting manager told us that one of the registered provider's carried out and completed pre-admission assessments for people who wished to move to the home, to make sure people would be given the correct care and support. Records of these assessments were in place for people who had been admitted to the home since the last inspection in October 2014.

The people whose care we focused on through the inspection had a care plan in place that had been developed when the person entered the home. A range of assessment tools had been used as part of this process. These included, the Malnutrition Universal Screening Tool, assessments for management of people's skin care, medication and personal care needs and mental capacity assessments. A life history had also been developed that included information about people's personal preferences and likes/dislikes with regards to food.

The acting manager told us that new care plans were in the process of being developed that they thought would be more useful to the staff with less cross-references to other specific care plans. Not all care plans had been updated to the new format; however, the care plans we looked at were up to date and reflected the needs of the people we pathway tracked.

At this inspection there was better fluid monitoring for people identified as being at risk of not having enough to drink. Fluid monitoring charts provided staff with a target fluid input for each person so that the staff would know if the person had had enough to drink. There was evidence that staff were adding the amounts a person had drank each day to make sure they were not de-hydrated. Where people did not meet a target input, we saw notes from the

acting manager to remind staff on the next shift to try and encourage these people to drink more. We also attended a staff handover between a shift and noted that reference was made to one person and their need to drink more fluids as they had a suspected urinary tract infection. Care records had been completed fully for the people whose records we looked at in depth.

Relatives we spoke with said that they were kept informed about the care of their relatives and could ring the home and speak with staff or the acting manager if they had any concerns.

At the last inspection in October 2014 we made a compliance action as some people did not feel comfortable in raising concerns and complaints directly with the registered manager and deputy manager. There were also two examples of where health and social care professionals had needed to raise concerns with the registered manager because relatives did not feel their concerns had been identified or addressed. The complaints procedure was not displayed in the home and was not readily available to people or visitors. The procedure did not include how people could complain to their funding authority, the correct role of CQC and the ombudsman. The complaints records included one complaint from a relative, a complaint from a staff member and two recent safeguarding allegations. However, complaints records did not show that complaints were investigated, responded to or the outcomes recorded as detailed in the complaints policy. There was not any evidence of how learning from complaints was regularly shared with staff to improve the quality of the service.

At this inspection we found that the complaints procedure had been updated with changes made to reflect how people could complain to their funding authority, the correct role of CQC and the ombudsman. The acting manager told us that a meeting had been convened with families and they had been told how to make a complaint. A copy of the complaints procedure had been placed at the front reception of the home and so was now accessible to people at the home and to visitors.

The complaints showed that one complaint had been raised since the last inspection. This had been logged, investigated within the home's timescale for investigation

Is the service responsive?

and had been resolved to the satisfaction of the family who had raised the complaint. The acting manager told us that complaints were reviewed by management to see if there could be lessons learnt.

Is the service well-led?

Our findings

At the last inspection in October 2014 we made a compliance action as there was not an inclusive and open culture. The registered manager and deputy manager told us they did not routinely consult with people. Some people who were able to, told us they were not involved in developing the home or consulted about things like activities. People living with dementia were not given the opportunity to share their views and contribute to the running of the service.

At this inspection we found there was a much more open culture. The staff we spoke with were open in talking with us and said they felt free to speak their minds. One member of staff told us, "I love working here, there is now a good staff team". Another member of staff said, "I can talk with managers and think they listen to us". The staff confirmed that staff meetings were held, the last being held in March 2015. The minutes of the meeting showed that staff were able to contribute their views on the running of the home.

Relatives told us that they found the acting manager approachable and that they could always speak to them if they had a concern. A meeting for relatives was held in January 2015 and again minutes reflected an open meeting where people could share their views.

Surveys had been carried out earlier in the year and the acting manager said that any concerns identified had been addressed with families concerned.

We joined a staff handover when staff were able to discuss each person and any important changes in their condition or behaviours. They also discussed any urgent matters and plans for the day.

Staff told us they knew how to whistleblow and there were policies in place to support this.

At the last inspection we made a compliance action as the registered manager had not notified us of safeguarding allegations and investigations as required by the regulations. Since that time the acting manager has informed us of all notifiable incidents.

At the last inspection we also made a compliance action as the quality assurance systems in place were not effective and did not drive improvement in the quality of care and service provided. Since that time, the acting manager completed action plans to address the breaches in regulations, which were sent out to us. At this inspection we were able to see that the action plans had been followed through leading to improvements in the service. The acting manager told us that they had carried out spot checks to make sure that staff were abiding by care plans and the home's procedures. This had included a spot check at night and early morning to ensure that staff were not getting people up early in the morning.

At the last inspection accidents and incidents were recorded but no audit of these had been carried out since October 2014. At this inspection we found that various audits had been carried out, including accidents and incidents and complaints. By these means, the management was better able to know in which areas changes could be made to improve the quality of the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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