HC-One Limited

Leighton Court Nursing Home

Inspection report

112 Manor Road
Wallasay
Wirral
Merseyside
CH45 7LX

Tel: 01516389910
Website: www.hc-one.co.uk/homes/leighton-court

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection of this service on 12, 13 and 16 January 2017 breaches of legal requirements were found. This was because risks in the delivery of care were not always properly managed. People did not always receive person centred care or care that respected their right to dignity and privacy. The provider had failed to ensure there were sufficient staff on duty at all times to meet people's needs and some staff had not received an appraisal for some time. These failings meant the service was not well led.

We issued the provider with two warning notices. These related to breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was with regard to safe and appropriate care and good governance. A warning notice is an enforcement action used by the Care Quality Commission to direct a provider to improve their service to meet requirements of a specific regulation within a set time period. We gave the provider until the 30 April 2017 to meet their legal requirements in relation these regulations.

We requested an action plan from the provider for the other breaches found during our inspection and the provider submitted an action plan outlining the improvements they intended to make.

At this inspection, we found that improvements to the management of risk; the appraisal of staff; people's right to privacy and dignity; the environment in which people lived and the way in which the service was managed had been made. These was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to staffing levels and further improvements were required with regards to the assessment and planning of some people's care needs and preferences.

Leighton Court Nursing Home is a purpose built building close to Liscard town centre in Wallasey. There are 48 single occupancy bedrooms. The home provides support for people with both nursing and personal care needs. The home also provides an intermediate care service. This means the home offers support to people discharged from hospital but who need a period of rehabilitation before they are ready to return home independently. There are 25 beds reserved for this purpose on the first floor (the IMC unit). At the time of our visit 44 people lived at the home.

There was both a home manager and a registered manager at the time of our inspection. 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 home manager had overall managerial control of the service with the registered manager acting as the deputy manager. At the time of our visit, the home manager and registered manager were not available so a manager from another of the provider's homes assisted with the inspection.

During our visit, we asked people if they thought there was enough staff on duty. Their opinions were mixed. Our observations of care were similar to our last inspection when we found that there was not always

sufficient staff on duty to meet people's calls for assistance in a timely manner. We looked at staff rotas and saw that the number staff on duty did not always correspond with the number of staff determined as safe by the provider. This was mainly at night. Some staff had also worked excessive hours without a break. Overall, we found that little improvement to the staffing levels at the home had been made since our last visit.

We looked at the care files of five people and saw a marked difference in the quality of information available to staff in the delivery of care to people who lived on the residential unit as opposed to those people who lived on the IMC unit. People receiving residential care had assessments, care plans and risk management plans that were clear, easy to follow and up to date. People on the IMC unit had limited assessment information and poor care plans. This meant staff had minimal guidance on people's needs, care and preferences. People we spoke with on the residential unit said staff knew them well whereas most of the people on the IMC unit we spoke with felt that staff did not know them very well. This showed that the lack of clear information in people's IMC care plans about their needs and preferences directly impacted on their experience of care.

The majority of people said they felt safe at the home and that staff treated them well. Safeguarding records showed that incidents of a safeguarding nature were listened to and adequately responded to. We found that one of the safeguarding concerns reported to the registered manager had not been reported to the Local Authority or CQC in accordance with legal requirements.

People told us that staff were kind, caring and respectful. They said the majority of staff treated them well and ensured their needs were met. Our observations of care confirmed this. Staff we spoke with had an understanding of the support people needed but recognised that sometimes it took them a little longer to respond to people's needs when there were fewer staff than there should be on duty.

We checked staff files and saw that staff were recruited safely and had been trained to do their job Staff had received regular supervision and were now in receipt of an appraisal. This was an improvement since our last inspection. People we spoke with felt staff members had the skills and abilities to care for them effectively.

People had access to adequate food and drink and everyone told us they had a choice. We found that improvements were still required to the way staff recorded and monitored people's dietary intake.

People's records showed that they received support with personal care and had access to a range of health and social care professionals in support of their needs. Adequate and up to date personal emergency evacuation plans were in place for people who lived at the home which meant that emergency personnel had access to important information about people's needs in an emergency situation.

The home was clean and well maintained. Equipment in use was certified as safe and regular health and safety checks on the premises and the equipment were undertaken. A new communal lounge had been organised on the IMC unit which meant people had a suitable communal space to socialise with others or simply relax outside of their bedrooms. A nurses' office had been installed downstairs where people's personal information was stored securely.

People's access to activities had improved and people's feedback at this visit was positive. We saw that opportunities for people to feedback their opinions and suggestions on the running of the service had improved. Regular resident/relatives meetings took place, a recent satisfaction survey had been undertaken with positive results and people had access to an online survey if they wished to provide feedback in an alternative manner.

We checked people's medications and saw that they were administered safely. The quantity of medication in stock was correct and matched what had been administered. This indicated that people had received the medications they needed, as prescribed.

During our visit, it was clear the home manager and registered manager had taken on board the concerns we identified at the last inspection. Overall sufficient improvements to the management of the service had been made but further improvements were still required in some areas. For example, IMC care planning and the deployment of a sufficient staff to meet people's needs. For this reason, we were unable to give the domain of well-led a rating of good.

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 and well cared for.

Staff were recruited safely but the number of staff on duty was not always sufficient to meet people needs.

People's individual risks were assessed and staff had guidance on how to mitigate these risks.

Emergency planning had improved so that emergency personnel would have adequate information on people's needs during an emergency

Medication was safely administered and people received the medication they needed.

The premises and its equipment was safe.

Is the service effective?

Good

The service was effective.

Where people were identified as lacking capacity the principles of the Mental Capacity Act 2005 and DoLS had in the majority been followed

Staff were trained and supported in their job role. Staff appraisals were undertaken.

People were given enough to eat and drink and a choice of what to have.

Improvements to the amount of communal space had been made so that people were able socialise and relax outside of their bedrooms.

Is the service caring?

Good

The service was caring.

People told us that staff were kind, caring and respectful. Our observations of care confirmed this.

People's confidential information was kept secure.

People told us that staff supported them to be independent and encouraged them to do things for themselves.

Regular resident/relatives meetings took place and we saw that people's opinions and suggestions were sought and acted upon where possible.

Information about people's end of life wishes had been improved upon.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who lived on the residential unit had person centred care plans that identified their needs and wishes. People who lived on the intermediate care unit did not.

People's care was reviewed and people had regular input from a range of health and social care professionals.

People told us that staff responded quickly when they became unwell.

People had access to a range of activities and told us they enjoyed them.

Complaints had been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The majority of the concerns identified at the previous inspection had been addressed. Safe staffing levels still remained a concern.

A range of effective audits were in place to ensure that people's risks were managed in the delivery of care.

People's feedback on the service had been sought and was positive.

Leighton Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 13 July 2017. The inspection was unannounced. The inspection was carried out by two adult social care inspectors and two experts by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last.

During the inspection we spoke with 15 people who were living at the home, five relatives, a visitor, a health and social care professional, five care staff, two nurses and the activities co-ordinator. The home manager and registered manager were not available at the time of the inspection. A registered manager from another home managed by the provider assisted with the inspection in their absence. For the purposes of this report, this manager will be referred to as the 'acting' manager.

During the visit, we looked at a variety of records including five care files, four staff files, staff training records, a range of policies and procedures, medication administration records and documentation relating to the management of the service.

We looked at the communal areas that people shared and visited a sample of people's bedrooms. Staff practice was observed throughout our visit.

Requires Improvement

Is the service safe?

Our findings

At our last visit to the home in January 2017, we found that people's risks in the delivery of care were not always properly assessed or managed. In addition the number of staff on duty was not always sufficient to enable people's needs to be met in a timely manner. During this visit, we found the way people's risks were assessed and managed had improved but our concerns about staffing levels remained.

We spoke with 15 people who lived at the home. The majority of people we spoke with told us they felt safe at the home. People's comments included "I feel safe because it's calm, no problems with staff or residents"; "I am safe because someone is always about. I can shut my door if I want. Security is fine. I haven't heard of one incident – abuse or anything going missing whilst I have been here since May." and "I feel safe because there are lots of people to look after you".

One person said they raised some concerns with the registered manager about the way their care had been provided. During our visit we spoke with the acting manager, a nurse and social worker about these concerns. From our discussions we were satisfied that an investigation in to their concerns had been undertaken and the issues resolved. We found however that the incident had not been reported to the Local Authority or the Care Quality Commission (CQC) in accordance with local authority procedures and CQC legal requirements.

We asked people if there were sufficient staff on duty to meet their needs. Opinions were mixed. People's comments included "There seems to be a lot of staff. I see several staff over the days but I see them regularly."; "I don't think there are enough as they are always rushing about."; "Occasionally we could do with a few more during lunch time."; There are lots of staff, I never wait more than two minutes for one to come and see me." and "There are lots of staff all week and at the weekend but not many at night".

We looked at a sample of staff rotas. We saw two nurses were on duty during the day supported by a nursing assistant. At night the number of nursing staff fluctuated. Most of the time there was one nurse on duty but sometimes there were two. The rotas indicated that two was the correct number. Care staff fluctuated from seven to eight carers during the day. Three care staff were on duty at night. The number of people who lived in the home during this time remained fairly stable so it was difficult to understand the rationale behind the fluctuations and why on some days fewer staff were required to meet people's needs.

We saw that some staff worked in excess of 70 hours week without a rest day. For instance we saw that the senior carer was rostered to complete 46 consecutive shifts spanning the entire month of June up to and including the 19 July 2017 without a rest day. This meant they worked 294 hours without a day off. The safe provision of care can be affected by staff who have not taken appropriate rest periods.

One staff member said "Staffing should be the same four on each floor. Residential floor people (on ground floor) need more assistance. At times we have three (care staff working on the ground floor). It causes problems when people need personal care. Another staff member said "Normally, there are four carers on the first floor (Intermediate care unit). If there are three (staff) we work through it. People get their needs

met, but it's harder". Staff on the residential unit told us that the majority of people required two carers to assist them at any one time.

We spent time observing care and monitored the time taken by staff to respond to people's calls for assistance. At times, people's call bells were not always responded to promptly and some people waited up to ten minutes for staff to respond. We also found that people who lived on the ground floor waited a significant amount of time in the dining room for their lunch to be served. These observations were similar to our observations of care at the last inspection. We were told however, that at this inspection the delay people experienced in receiving their lunch, was due to the home's dumbwaiter lift which transported people's meals down to the ground floor, breaking down.

We saw that there was now a dependency tool in place to enable the provider to determine what staffing levels were safe within the home. We saw that the home manager had gone over the total number of staffing hours specified by the provider despite only having one nurse on duty at night. We found the dependency analysis difficult to understand and correlate with people's needs and care. We saw that people's care files contained evidence that their dependency on staff was regularly assessed. We asked a nurse on duty about this. They said that the dependency assessment was not always completed by staff in a way that accurately reflected people's needs or the level of care they required. This meant there was a risk that the information used to plan safe staffing levels was erroneous.

After our inspection, we emailed the home manager for clarification over how staffing levels were determined and rotas planned. The home manager confirmed that at night two nursing staff were supposed to be on duty but acknowledged this was often not the case. They stated that two of the care staff on duty at night were previously employed in professional healthcare roles. We did not find this explanation satisfactory. One staff member was no longer registered with the Nursing and Midwifery Council and was therefore unable to practice and the other was not registered or legally able to provide clinical care in this country.

This evidence indicates a continued breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the number of staff on duty was not always sufficient to meet people's needs in a timely manner.

At our last visit, information about people's needs and risks was contradictory and confusing for staff to follow. During this visit, we found that improvements had been made. People had risk assessments and management plans that gave staff guidance on how to manage people's risks in the delivery of care. For instance risks in relation to people's nutrition, skin integrity, falls and mobility risks and moving and handling were all assessed. We saw that where people had health related risks such as epilepsy or were at risk of choking, these risks were assessed and managed appropriately by nursing staff.

At our last inspection, we had concerns about one person's nutritional care as their food and drink charts did not always show that they got enough to eat and drink. We checked this person's records again and found that improvements had been made. The person's records however did not always detail the amount of food or drink the person had consumed and there was no still no evidence that nursing staff checked this person's records to ensure their intake was sufficient.

At our last people had personal emergency evacuation plans (PEEPs) in place but they lacked adequate information on how to support people during an emergency evacuation. PEEPs provide staff and emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. During this visit, we saw that people's PEEPs now contained adequate and up to date information

about the support they would need to safely evacuate in an emergency.

The home was well maintained, clean and free from odours. People we spoke with confirmed this. One person said "It's very clean. They clean my bathroom every day. My sheets are changed regularly. I'm very happy with my room". Another person said "Yes, everything is spotless. The cleaner comes in my room every day hoovering and polishing. They don't disturb you. They wouldn't come in if you were in bed. The bed sheets are changed every few days and my laundry washed, dried and ironed in a day".

The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected and certified as safe to use. There were systems in place to monitor and mitigate the risk of Legionella in the home's water supply and regular health and safety checks were undertaken.

We looked at the personnel files of four staff and saw that they had been recruited safely. Staff files contained job application forms, photo identification, two previous employer references and a criminal conviction check. This meant that the safety and suitability of staff to work at the home had been checked and verified prior to appointment.

The management of medication was safe and well organised. Medication was stored securely and within safe temperature ranges. There were clear plans in place for the administration of people's 'as and when required' medications such as painkillers or antibiotics and people's medication records were completed clearly and accurately. We checked a sample of people's medications and found that the stock levels of all the medicines we checked were correct.

We observed a medication round on the second day of our visit. We saw that the nurse provided people's medications in a pleasant and friendly way but continually answered the telephone during the medication round. This increased the risk of a medication error being made.

We found that the systems in place to record and respond to people's accident and incidents were satisfactory. Records showed that people received the support they needed from staff when an accident or incident occurred.

Good

Is the service effective?

Our findings

At our last inspection, we found that not all staff had an appraisal of their skills and abilities in their job role. We also found that communal areas were not suitable for people to socialise. At this inspection we found that sufficient improvements had been made.

We saw that the home manager had an up to date supervision and appraisal schedule in place that showed when staff supervisions and appraisals were planned and undertaken. We saw from the home manager's schedule that the majority of staff had received regular supervision and had an appraisal of their skills and abilities.

We saw that the majority of staff had completed the provider's mandatory training. Training was provided in safeguarding, moving and handling, the safe administration of medication, infection control, mental capacity, deprivation of liberty safeguards, nutrition and hydration, food safety, fire safety and dementia awareness. We saw that where staff training had expired, additional training had been booked for staff to attend.

All of the people we spoke with told us the staff looked after them well. Everyone thought staff had the right skills and experience to look after them effectively. People's comments included "Excellent I think. Well looked after."; "Yes they know what to do. They are fantastic with me."; "The support is great here, they have got me moving again and I can go home soon." and "They are all great. They never rush me, drag me anywhere I don't want to go and they don't force me to do anything".

At our last inspection, there was inadequate space in communal lounges for people to sit and chat socially. At this inspection, we saw that this had been addressed. The physical therapy room upstairs had been moved to another part of the building and this room had been changed into a communal lounge for people to sit in. On the day of our visit, we saw that the new communal lounge was in use by people who lived in the home. We also saw that additional chairs for the downstairs lounge had been purchased so that more people were able to use this lounge at any one time.

The home was pleasantly decorated throughout with appropriate signage on toilet and bathroom doors to enable people with dementia to recognise where these facilities were. People's bedrooms were situated along a long corridor on each floor. We saw that people's bedrooms had their names on but the signage was small and above eye level which meant there was a risk that people who lived with dementia may not be able to see it easily.

We observed the serving of lunch. The environment in which people's meals were served was pleasant and tastefully set out. Flowers were on the centre of each table and there were table cloths and napkins people for people to use. Staff served people politely and with respect but it took them a long time to serve people their lunch on the residential unit (on the ground floor). For instance some people were seated at 12:15pm, yet did not receive their food until an hour later and some people were still being served their lunch at 2:00pm. This could be viewed as positive if it was in response to people's individual needs but it was

observed to be due to delays in the serving of food. This was the same observation we made at the last inspection.

People we spoke with were generally satisfied with the food on offer and the choice of meals that they had at the home. They told us they got enough to eat and drink each day. People's comments included "They ask you each day what you would like tomorrow. There is always a choice of two things. Some of the food is OK. I'm allergic to egg and they do make sure I don't get anything with egg in it."; "It's mixed, I do get fed up with carrots and peas all the time, I would like some broccoli and cabbage. I am never hungry and they bring fruit and biscuits around at tea and coffee time too."; "The food is brilliant. There is plenty of choice, plenty of flavour and plenty of food. I am never hungry. If you don't want what's on the menu they will always make you something else".

A relative we spoke with also told us "(Name of the person) likes the food and they eat it. They always have enough of everything to eat". A second relative said "Enough food. Not sure enough drink. They (the person) need help with accessing the drinks".

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 made 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

We observed good practice with regards to respecting people's right to consent to their care. For example, we saw one person at the home, considered by staff to have capacity to consent to decisions about their care, frequently refused any support. We saw that staff respected their right to decline support whenever they wanted. They told us they offered support to the person again at various times of the day in case the person now consented to having support provided. This was good practice and showed that staff respected the person's wishes.

We found people's capacity to consent was assessed in accordance with the principles of the MCA. Sometimes generic statements were made about people's ability to decide for themselves. This type of statements should be avoided.

Good

Is the service caring?

Our findings

At our last visit we found that people's care did not always respect their right to privacy and dignity. There was inappropriate signage on bathroom doors about people's mobility and people's confidential information was not always secure. During this visit, we found that sufficient improvements had been made to address these concerns.

We saw that the laminated signs on the outside of people's bathroom doors, referring to personal mobility information had been removed. A new nurses' office had been set up on the residential unit wherein people's care files were now stored and we saw that this office was locked at all times. This ensured people's personal and confidential information was secure.

Most of the people we spoke with said staff treated them well and were caring in their approach. One person said "They are very caring. My privacy is maintained at all times. They don't impose themselves on me. When I am in the bathroom they treat me with respect as I have to have someone in the bathroom with me when I have a bath. They do let me wash myself and they always have a big towel to wrap around me".

A second person said "Most are nice. If they take me to the toilet they will shut the door and give me privacy. I just don't like (staff member's name)". A third person said "Oh yes, they are very caring." and a relative we spoke with told us "The carers are very respectful when they talk to them (the person)".

Everyone we spoke with said that staff supported their ability to be independent. People's comments included "They let me rest so my broken leg gets better, but they are trying to get me to walk more, so they help me get up and get me use to the zimmer around the room."; "They take care of me but all the time encouraging me to become more independent again so I can go home."; "Yes that is their goal. They do not fuss over me they try to get me to do as much as I can." and "Oh yes they are very helpful like that. Encourage you to do things, not sitting around. You couldn't have better staff".

Relatives we spoke with echoed these comments. One relative told us "The carers are working hard to get them (the person) to walk more by themselves so they can go home. They supervise them whilst they try to walk". Another relative said "They are really supporting them (the person) to walk more".

During lunch, we observed one person who struggled to keep their food on their plate was given a plate guard to prevent this from happening. This maintained their dignity. We heard another person ask for a straw as they were struggling to hold their drink and this was provided immediately.

When we looked at the care files of people who lived at the home on a permanent basis, we found some information about their end of life wishes. One person had not wished to discuss the subject and staff had respected this. We saw that some people had agreed to a do not resuscitate decision and one person's end of life care plan had been updated with additional information since our last visit.

We saw that the dates of forthcoming resident/relatives meetings were advertised in the entrance area of

the home. At our last visit the home, the manager told us nobody had attended these meetings but the reasons why had not been explored. During this visit, we saw that people's attendance at the meetings had picked up and records showed that people now regularly attended the meetings. We saw that at these meetings people were given information about the running of the home and any factors that may impact on their care. People's opinions and suggestions were sought and where possible acted upon by the home manager. This was an improvement since our last visit. This meant that people now had an opportunity to openly express their views about the care they received.

Our observations of the interactions between staff and people who lived at the home were positive. Staff were kind, caring and patient when providing support and people looked well-dressed and well looked after. Both the nursing and care staff we spoke with spoke about the people they cared for with affection.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that people's care plans contained limited information about them as a person, what they liked and disliked and how they preferred their care to be provided. Some care plans also contained contradictory and confusing information about people's needs and care. During this visit, we found that although improvements had been made, most of these improvements focused on the care of people in receipt of residential care. We found little improvement had been made to the assessment and care planning of people's care on the IMC unit.

We asked people if they thought staff knew them well. People's opinions on this varied according to whether they lived on the residential unit on the ground floor or the intermediate care unit on the first floor.

People who lived on the residential unit all said that staff knew them well and knew what they liked and disliked with regards to their care. People's opinions on the IMC unit were mixed. People's comments included "I'm not really sure if they have got to know me. I really don't like milky tea and they keep giving it to me like that even though I say."; "I'm not sure if they know me well. They are always so busy rushing in and out. I have to tell them every time that I have sugar in my tea."; "Yes they know me now. It took quite a while but I guess they have lots of people to look after. They know my food requirements so I am not offered anything I don't like anymore".

We looked at people's care plans and saw that the amount of person centred information in each file differed according to whether people lived on the residential or IMC unit. It was obvious due to people's feedback that the lack of person centred information in people's IMC care plans impacted on the delivery of their care.

People who lived on the residential unit had information relating to their appetite, dietary likes and dislikes, daily routines, sleeping preferences and preferences in the delivery of personal care. For example, one person's care plan clearly advised staff that the person had a small appetite, liked fizzy drinks and coffee, preferred a shower to a bath and preferred to sleep with the door to their bedroom closed. Although these may appear little things, they were things that were important to the person in their day to day life.

Care plans for people who lived on the IMC unit contained little of this type of information. There was also sparse information on the actual care the person required. Most of the information focused on what the person was able to do prior to coming to the IMC unit as opposed to what they needed help with now. We spoke with the acting manager and nurse in charge of the IMC unit about this on the day of our visit. They told us they would review it without delay.

For example, we saw that one person's care plan specified what care the person had received from a home care agency prior to being admitted to the IMC unit. It simply stated "Carers visit to assist with personal care". No further information was provided to advise staff what support the person required now. We also saw that this person's care plan stated for them to "follow the therapist's instructions to remain safe" and stated that these were posted on the inside of the bathroom door. When we checked this, we found no

instructions had been posted.

Care plans and risk assessments had been regularly reviewed and there were clear records of the involvement of other health and social care professionals in the care of people who lived on the residential unit. Information in people's IMC care files about the involvement of other IMC health and social care professional was limited so it was difficult to see what support they were getting to rehabilitate. We drew this to the attention of the acting manager and the nurse in charge. We were given copies of the IMC meetings that took place each week with a range of multi-disciplinary professionals involved in people's care. This provided reassurance that people's rehabilitation needs were continually reviewed to ensure their needs were met.

All of the people we spoke with told us that staff responded quickly when they became unwell. For instance, one person told us "A few weeks ago I had terrible pains in my stomach. They phoned for an ambulance immediately and I had an x-ray to see what was wrong. I came home the next day. I really was in pain".

A relative we spoke with said "Recently (name of person) needed a doctor as they were unwell. The home called the doctor straight away, the ambulance arrived and they were sent to hospital. They were very efficient".

At our last visit, we were concerned about how the service was meeting people's social and recreational needs. At this visit, people's feedback indicated that access to social activities had improved.

On the day of our visit, there was a new well-being co-ordinator in post who provided group activities each day. These activities were advertised on a noticeboard on the entrance to the communal lounge. People who joined in the activities told us that they liked them. One person said "I go every day to the activities. I do more here than I did in my own home. The activities are really well-organised and if anyone struggles to take part they get help. I wouldn't take part in the activities if I didn't like them and they encourage me to use my brain".

Another person told us the activities had improved since the new activities co-ordinator had commenced in post. They said "It wasn't much at all until this new person arrived. They have entertainers coming to sing but not too often. People brought in snakes, spiders and dogs".

At our last visit, the access to activities for people who lived on the IMC unit was limited but during this visit, we saw that the activities co-ordinator actively encouraged people from the IMC unit to attend and if need be, escorted them down to the main lounge on the ground floor were most of the activities were provided.

On the day we visit, a 'Famous Faces' game was going on. A picture of a famous person was shown to everyone involved and the activities co-ordinator gave people clues, sang relevant songs and told stories to help people guess who the celebrity was. It was a cheerful and light-hearted session and people were observed to enjoy it.

We were still concerned that there did not seem much stimulation for people looked after in bed or those with communication difficulties who were unable to chat socially with others. One relative told us that staff sat and chatted to their loved one. They said "They do, even though they can't speak. They read postcards and messages passed to them." and another relative said "I have heard staff talking to residents on their own, so I assumed they talk to (the person) when I am not around".

Requires Improvement

Is the service well-led?

Our findings

At our last visit in January 2017, we found the service was not well led. The service was in breach of several of the Health and Social Care Act Regulated Activities 2008) Regulations 2014, some of which were continued breaches from a previous inspection in December 2015. Concerns were identified with regards to people's assessment and care planning, the delivery of safe and appropriate care, person centred support, dignity and respect, staffing and the suitability of the premises to meet people's social and recreational needs.

During this inspection, we found that improvements had been made in the majority of these areas. The number of improvements made since our last visit were sufficient to meet the requirements of Regulation 17 of the Health and Social Care Act (Regulated Activities 2008) Regulations 2014. They were not sufficient enough to give the provider a rating of 'good' in this domain. This was because a breach of Regulation 18 (safe staffing) was identified again at this inspection and further improvements with regards to the planning and delivery of care for people admitted to the IMC unit were required.

We saw that care plan audits were undertaken and that these had helped improve the quality of the care plans developed and maintained for people who lived on the residential unit. We did not see evidence that the care files for people on the intermediate care unit (on the first floor) were audited effectively and issues with the quality of information in these care files remained.

We looked at the staffing arrangements and identified similar concerns to those that we identified at our last inspection in January 2017. We saw that the provider had introduced a system for determining staffing levels, but we questioned the accuracy and reliability of this tool in the provision of safe and responsive care. We also saw at times the number of nursing staff on duty did not meet the staffing levels identified by the provider.

We found improvements in other areas of management and leadership since our last visit. For instance, the errors, omissions and contradictory information in people's care files had been removed which made it easier for staff to understand and follow them. Emergency evacuation planning was up to date, people's access to activities had increased and the skills and abilities of staff had been assessed. Improvements to the layout of the building had been made with a new communal lounge for people to socialise in on the IMC unit and a new secure nurses' office which enabled people's information to be kept securely. These improvements demonstrated that the home manager and registered manager had taken on board our feedback at the last inspection and had planned and progressed a number of improvements.

There was a range of effective audits in place as part of the provider's quality assurance programme. We found these audits to be effective. For example, a robust range of health and safety audits were effective in ensuring the home was safe and suitable for purpose. A medication audit was regularly completed and we saw that where issues were identified these had been acted upon appropriately.

A falls audit was conducted and a regular meeting took place where this information was discussed. Records showed that potential causes of people's falls and the action to take to prevent further risk were

agreed upon. An infection control audit was completed regularly and on the day of our visit, the home was clean and a pleasant place for people to live. Since our last visit, mechanisms for people to feedback their opinions of the service had improved. Resident/Relatives meetings were now a regular monthly feature and people's satisfaction with the service had been sought through satisfaction questionnaires. We saw that there was also access to an on-line survey if people wanted to provide feedback in an alternative way.

We looked at a sample of people's feedback from May 2017 and saw that it was positive. One person had written "Everything is excellent and brilliant". Another person had written "Everyone is so caring and kind".

Overall, it was evident that the managers and staff at the home had worked hard to improve the service but we found that further improvement works were still required. This meant the rating for this domain will remain 'requires improvement'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were enough staff on duty at all times to meet people's needs in a timely manner.