Broadening Choices For Older People

Anita Stone Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 28 March 2018 with a second day that was announced on 04 April 2018.

We had previously inspected this service on 05, 06 and 11 April 2017. Following that inspection we rated the provider 'requires improvement' under is the service 'effective', 'caring' and 'well-led'. At this most recent inspection we found the provider had made a number of improvements, however there were some areas that required further improvement.

Anita Stone is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Anita Stone is registered to provide accommodation for up to 33 people, some of whom are living with dementia. On the day of the inspection there were 27 people living at the home.

At the time of our visits, there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. However, at the time of writing this report, the manager had submitted their application to become the registered manager of the home.

People, relatives and staff felt the home had improved and was well managed. A number of relatives and staff we spoke with told us they would recommend the home to others. The management team had taken on board feedback from the last inspection and had made a number of improvements to the service; although there was further improvement required to ensure quality assurance processes that monitored the service were more robust. Staff felt supported by the management team and that their views were listened to and respected. People and relatives had been asked for their views on the delivery of care.

People received their medicines and systems used to manage and store medicines were safe. Improvement was required when recording the amount of liquid medicines dispensed for audit purposes. These improvements were implemented immediately following the first day of the inspection. People were protected from the risk of infection by a clean home environment and the provider had established systems to monitor the standards of cleanliness throughout the home. Where incidents and events had occurred the provider and management team learned from these and where appropriate, implemented changes to raise standards within the home.

Peoples' needs and preferences were assessed prior to them moving into the home. People were supported by staff who had received an induction and training for their role and who were supported by the provider

and management team. People received food and drink that met their nutrition and hydration needs and where people required specific dietary support, this was provided by staff. Improvements were required to the monitoring and recording of peoples' weights. The staff team worked well with other agencies to ensure people's needs were met and referrals to external agencies were made in a timely way.

People were asked for their consent before care was provided and where people's rights were restricted to protect them from harm, this had been done lawfully. However, where people had been restricted to protect them from harm, the provider had not always ensured this had been done in line with conditions that had been applied

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People were supported by staff who were kind and caring and were supported to make their own decisions, where possible, about their day to day lives. Staff were aware of people's life histories and individual needs. Some improvement was required to ensure people's cultural food preferences could be met. Staff treated people as individuals and recognised that each person's needs were different. People's privacy and dignity was maintained by staff and family members and friends felt welcomed when they visited the home.

People told us they felt safe. Staff received training in protecting people from harm and knew how to escalate any concerns for people's safety and well-being. Risks were assessed and managed to reduce the risk of harm and there were sufficient numbers of staff to respond to people's care and support needs. Checks had been undertaken on new staff to ensure they were suitable for their roles.

People and relatives were involved in the assessment, planning and review of their care and support. Where people's needs changed the care provided by staff was responsive to the changes and was reviewed and planned to reflect any additional needs. A range of activities were available that took into account people's interests and hobbies. The environment was well maintained and appropriate for the needs of people living at the home.

People knew how to make a complaint if they were unhappy about the care they received and the provider had systems in place to ensure people's views were listened to. Complaints were investigated by the management team and, where appropriate, any improvements would be made.

The management team demonstrated a good understanding of the responsibilities of their role and staff described the management team as approachable and supportive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safeguarded from the risk of harm because safeguarding issues had been reported to the appropriate authorities. Risk assessments were completed which meant there was guidance for staff on how to safely care for people.

People were supported by sufficient numbers of staff that were safely recruited to meet people's care and support needs. People received their medicines and there were systems in place to ensure medicines were administered, managed and stored safely.

People were protected from the risk of infection and cross contamination. Where incidents and events took place the provider and management team took learning from these and made improvements to ensure similar events did not occur.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to access sufficient amounts of food and drink in order to maintain their health. Improvement was required with the monitoring of people's weight and cultural dietary requirements.

Procedures were in place to act in accordance with the Mental Capacity Act 2005. However, where people had been restricted to protect them from harm, the provider had not always ensured this had been done in line with conditions that had been implemented. People were asked for their consent before care and support was provided.

People had their needs and choices assessed to ensure they could be met. People were supported by staff that had received training and had the skills and knowledge required to meet people's needs. People had access to a range of healthcare professionals to support their needs. The home environment was well maintained and spacious.

Is the service caring?

Good

The service was caring.

People received support from staff who were, caring, friendly and kind.

People were supported, where possible, to make their own decisions about their care.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

People were involved in the assessment, planning and review of their care. Where people's needs changed guidance on how to meet the person's needs was updated and available to staff.

Staff had a good knowledge about people's likes, dislikes and interests and encouraged people to take part in both group and individual activities.

People knew how to complain if they were unhappy about the care they received and the provider had a system in place to manage complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made to the systems used to manage the quality of care provided and these had been effective in making improvements. However, further improvements were required in order to maintain sustainability and to ensure the quality assurances processes were more robust.

The service did not have a registered manager in place at the time of the inspection. A manager was in post and had applied to become the third registered manager since the opening of the home in April 2016.

People, relatives and staff felt the home was well managed. Staff felt supported by the management team and able to approach them with any concerns or suggestions.

Anita Stone Court

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 the 28 March 2018 and was unannounced with a further announced visit on 04 April. On day one, the team consisted of one inspector, a specialist advisor and an expert by experience. The specialist advisor was a nursing practitioner with experience of working within a dementia setting. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service. On day two, the team consisted of two inspectors.

As part of the inspection process we looked at information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. We also contacted the Clinical Commissioning Group for information they held about the service and reviewed the Healthwatch website, which provides information on health and social care providers. This helped us to plan the inspection.

We used a number of different methods to help us understand the experiences of people who lived at the home. We spoke with eight people, 11 relatives, nine staff members that included nursing and care staff. We spoke with the manager, clinical lead and the head of care quality. We also spent time observing the daily life in the home including the care and support being delivered. As there were a number of people living at the home who could not tell us about their experience, we undertook a Short Observational Framework for Inspection (SOFI) observation. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.)

We looked at seven people's care records to see how their care and treatment was planned and delivered and 11 medication records to see how their medicine was managed. Other records looked at included two recruitment files to check suitable staff members were recruited. The provider's training records were looked at to check staff were appropriately trained and supported to deliver care that met people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Good

Is the service safe?

Our findings

At the last inspection in April 2017, we rated the provider as 'Good' in this key question. At this inspection the service remained good.

People we spoke with told us they felt safe. One person told us, "I do feel very safe here." Another person said, "I'm safe enough, or I'd complain to the manager." Relatives we spoke with believed their family members to be safe. One relative explained, "I would say [person's name] is safe. They have been here for a while and if we saw anything worrying we'd discuss it together and take it to the manager." Another relative told us, "Yes, [person's name] is safe. I'd speak to someone here [the staff] but I've no worries at all, it's absolutely wonderful." Some people living at the home were unable to tell us about their experiences, but we saw their interactions with staff appeared relaxed and were comfortable in their presence and people were happy to approach staff when they required assistance. Staff we spoke with recognised the signs of potential abuse and knew how and who to report any concerns to. One staff member said, "People are safe here and if someone suddenly started to pull away from us or their behaviour was different, we'd know that something was not right." Another staff member told us, "Any unexplained marks or bruising is reported to the nurse and I would not hesitate in contacting you [CQC] if I had to if I thought nothing was being done about it." We checked the daily records and reviewed all incidents and accidents and found the provider had acted accordingly and, where appropriate, had reported incidents to the local authority safeguarding team as well as CQC, as required by law. The management team had demonstrated a clear understanding of their responsibilities around safeguarding and where incidents had taken place they had worked with external agencies to ensure people were protected from harm.

Risks to people's health, safety and wellbeing were assessed and managed in order to protect them from avoidable harm. People's care records offered staff guidance about how to manage risks. For example, we saw one person was at risk of harming themselves; information was available in their care plan to ensure staff were aware of this risk and how to manage it. We saw that another person was at risk of seizures, their care plan contained information for staff that explained how to support the person in the event of a seizure. Some people living at the home could at times present with behaviours that may cause others harm or distress. We observed staff reacted quickly and calmly to these situations and used distraction techniques to reassure and calm people for example, distracting people with a drink, something to eat or asking if they wanted to go for a walk.

We found on the days we visited the home, there were sufficient staff numbers on duty. People told us there were enough staff available to meet their care and support needs. One person told us, "When I press my call bell, they [staff] come quite quickly. When I have had to press the red button they come immediately." Relatives also told us they were satisfied with the numbers of staff available. One relative explained, "There was a slight issue in December but since then everything has been fine, no problems, there is always staff around." Staff we spoke with told us there were sufficient numbers of them to meet people's needs. We found staff were available to support people and responded to people in a timely manner. Where we heard people using the call bell system; these were answered promptly by staff.

There was a robust recruitment procedure in place to ensure all staff employed in the home were checked against the Disclosure and Barring Service, (DBS) and had two references. We reviewed two staff recruitment files and found the provider had completed their pre-employment checks to ensure staff were suitable to work with people. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people. This demonstrated the provider had systems in place to ensure people received care from staff who were safe to support them.

People we spoke with told us they received their medicines promptly and when they needed them. They were confident they received their medicines consistently and on time. We reviewed Medication Administration Records for 11 people and found they were completed to reflect when people received their medicines. Some medicines had been prescribed on an 'as required' basis, we found the nursing staff had written information to support them on when and how these medicines should be administered. We found the information was detailed enough to ensure that the medicines were given in a timely and consistent way by the nursing staff. We found that where people needed to have their medicines administered directly into their stomach through a tube, the provider had ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely.

We found the medicines refrigerator temperatures were being measured correctly to ensure the medicines stored would be effective. We looked at how Controlled Drugs were managed. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that the Controlled Drugs were being stored securely. This demonstrated the provider's systems used for storage and management of medicines were safe.

We looked at the cleanliness and hygiene of the home. No concerns were raised with us about the upkeep and cleanliness of the home. We completed a visual check of the environment. We found that the day to day cleaning of the home was good. Gloves were available for staff to use when providing care. People were protected from the risk of infection because the home was clean and well maintained. There were no unpleasant smells and we saw planned and responsive cleaning throughout our time on site. Infection control checks and audits were completed regularly. Audits were also used to identify any equipment that needed to be repaired or replaced. For example, during our visits, we saw maintenance of equipment and furniture took place and where appropriate, had been repaired or replaced. We saw the home was to a high standard of cleanliness.

We found that the management team had learned from incidents and events and made improvements where possible. Staff we spoke with were aware of the improvements the new management team planned to make and felt confident they had worked together as a team to raise standards at the home. One staff member told us, "We have definitely improved from the last inspection; we have all worked so hard to make this an excellent home." The management team shared with us their learning from the last inspection. They explained about the changes implemented to address issues identified at the last inspection and they felt confident the service was moving forward.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in April 2017, we rated the provider as 'requires improvement' in the key question of 'Is the service effective?' This was because people's mealtime experience was not consistently pleasant and there had been inconsistencies in the weight recordings for some people. As this inspection, we found that some improvement was still required.

We spoke with people about the quality of the food and their responses included, "The food is excellent and you get a choice." "The food is lovely, I've put weight on since moving here." "The food is okay there is some choice," and "The food could be better." We noted there were menus on display and people were offered a choice of drinks and staff used the trays of meals to assist people to make their choices. People were encouraged to use hand wipes to clean their hands. The choice of having salt and pepper was also offered to people. Over the two days we were on site we saw that two people had encountered some difficulty eating their meals. For example, on day one of the inspection we saw one person was unable to use cutlery effectively which meant they had not eaten most of their meal. We did not see staff offer support to the person. On day two of our visit, we saw another person struggling to manage their food but on this occasion it was noted by staff who offered them some support to which the person replied 'Yes please'. We did not see the use of adapted cutlery and/or plate guards. This type of equipment could support people who have difficulty managing standard cutlery to maintain their independence when eating their food. We checked this person's care plan and found it did not reflect the level of support that may now be required at meal times. Also on day two, we saw a further person was sat for 40 minutes before staff noticed that they had not received their meal. We saw the person sat with their eyes closed. A staff member sat down with the person and put a spoon of food to the person's mouth, while they still had their eyes closed. A second staff member sat down with the person and had brought them a fresh meal and a pudding. They gently woke the person up, helped to reposition them to a more comfortable seated position and supported them to eat. We looked at the person's care plan to check it reflected their nutritional needs. We saw the person had been assessed by a Speech and Language Therapist (SALT) because they were at risk of aspiration. Their notes stated the person required support to eat and should be alert. This showed there was some inconsistency in staff practice to support this person with their meals. Our observations showed that not all staff followed the guidance in the person's care plan. We discussed our observations with the management team and they agreed to ensure people's needs would be reviewed.

We had found there were inconsistencies in the monitoring and recording of peoples' weights. We checked seven people's records to review how their weights were being monitored and whether appropriate action had been taken. We found those people at risk of losing weight had been referred to a dietician and their food and fluid intake was being monitored. However, the quantity of food being eaten was not being consistently recorded. We discussed with the management team our observations that records were not clear about what triggered or prompted closer monitoring of people's food intake and keeping accurate records to support this.

We reviewed the menu available for people and noted meals were not always culturally appropriate for one person. This was raised with the inspection team on the day and discussed with the provider at the time of

the inspection visit. The provider agreed that more could be done to support the person and assured us this was being addressed and a meeting with the kitchen staff and the family members had already been arranged to implement changes with immediate effect.

We observed interactions between people and staff and saw people were offered choices and asked to consent to their care and support. Where people used non- verbal communication we observed staff offered choices to support the person to make their own decision. For example, we saw staff asked people if they were happy to participate in a planned activity and where people refused, their decision was respected.

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. Staff we spoke with shared examples with us of how they ensured people consented to their care. One staff member told us, "I've been here a while now and have got to know people really well, so I can tell by their responses what it is they like or prefer. I show [person's name] two or three items of clothing and they will smile at the one they like so that's the one I offer to them." Another staff member said, "It's all about the person's choice and helping them to make a decision so we make sure we ask them, if they didn't want us to do anything for them, they would soon let us know by pulling away or by their facial expressions, we wouldn't force anyone."

Staff we spoke with understood their responsibilities in assessing people's capacity and told us this was reflected in people's every day choices. One staff member said, "Quite a few people living here can make their own decisions." We reviewed people's care plans and saw that where people lacked capacity to make specific decisions, there was an assessment of their mental capacity to consent to their care and support had been completed and any decisions made in their best interests were clearly recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. The manager had only moved to Anita Stone in January 2018 and was still in the process of monitoring applications and authorisations of DoLS. There were a number of people living at the home who were subject to an authorisation to deprive them of their liberty, in their best interests. Where the authorisation contained conditions, to ensure the person's restrictions were lawful, we saw the provider had not consistently complied with the conditions as required by law. Staff had not been made aware of the conditions two people were subjected to. However, post inspection, the provider submitted evidence to support communication with appropriate agencies had now taken place, to comply with the imposed conditions and we will look at this at the next inspection.

People told us their needs had been assessed prior to them moving into Anita Stone. One person told us, "They [staff from Anita Stone] visited me in hospital and we talked about coming here." A relative explained, "Yes, we met with the manager and went through what [person's name] would need to support them." We saw pre-admission packs were completed prior to people being admitted into the home. It is important that these assessments are completed, as this would enable the care plans to be developed to meet the needs of people and assist all the staff that are providing care and support. We saw the pre–admission packs were reviewed and completed with relevant information to meet the needs of people at the time of their admission.

People told us they felt supported by suitably trained staff. One person said, "I think the staff are well trained, they know how to look after me properly." Another person told us, "Staff are skilful." Comments we received from relatives included, "Some residents can be very abusive to staff and I have never seen a bad reaction." "The staff are very good," and "I can't fault the staff, they can't do enough for you." We saw one staff member support a person to walk along the corridor. They were patient and took their time reassuring the person all the time they were supporting them. Staff did not complete the Care Certificate but told us they had completed training that reflected the Care Certificate standards. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. We saw that all new staff completed a two week induction on site. One staff member explained their induction to us that included shadowing more experienced staff members. Another staff member said, "I've come from one of the [provider's] other homes but I still had to complete my induction and shadow another staff member before I could work on my own." Staff we spoke with felt supported by the management team and were satisfied with the level of training they had received from the provider. Comments from staff included, "My induction was good. I completed all the mandatory training in fire, manual handling, nutrition and the mental capacity act." "The induction gave me the information I needed," and "We have very good training." Staff we spoke with confirmed they had received supervision from a member of the management team and told us they felt supported. One staff member said, "The managers are very good, very comfortable to approach and they spend time on the floor." This was confirmed by the other staff we spoke with.

People had been supported with their health care and support needs and records we looked at demonstrated that people had access to local health care services. For example, the GP, dentist, the optician, podiatrist and psychiatrist. Staff spoken with explained how they supported people with the healthcare needs. We saw from reviewing people's care plans that health care professionals visited regularly, one person told us, "The doctor comes in every week". During our inspection site visits, we saw a number of different health and social care professionals visit people to assess their health and wellbeing. One person told us, "If I need to see a doctor, staff will call one for me." Another person said, "If I am ill the staff come quickly to get me any medical help." We saw from people's care plans that referrals were made in a timely way when there were concerns about people's health. For example, people had been supported to attend hospital appointments.

We walked around the home to assess the environment for people living with dementia. We found the home had dementia friendly signage, bedroom doors were individualised with pictures that were important to the person and represented their hobbies or interests. The corridors were clear of clutter and lounge chairs were positioned throughout the home for people to sit and relax. There were age appropriate memorabilia displayed on the walls and soft music playing in the background that complimented the relaxed atmosphere around the home. There was a large, wheel chair accessible, rear garden. One person who had recently moved into the home explained to us how much they were looking forward to the weather improving so they could spend more time in the garden.

Good

Is the service caring?

Our findings

At the last inspection in April 2017 we rated the provider as 'Requires Improvement' in this key question. This was because people had been left in an undignified manner for periods of time and the use of staff language was not always appropriate when referring to people living at the home. At this inspection there had been an improvement and we are now rating this question as 'Good.'

Everyone we spoke with told us they felt staff were kind and caring. One person told us, "I'm pleased with my care. I feel really lucky." Other comments included, "Staff are there when I need them. They [staff] are lovely, kind and quick." "I have met the new manager. They seem very nice. They come into my bedroom and have a chat with me and asks me how things are." "Oh yes they [staff] are caring, what ever you ask they [staff] try and get. 10 times a day I ask for a cup of tea, even in the middle of the night and they will get it for me." "Some staff are exceptionally kind and take extra care." We saw interactions between people and staff throughout the day and noted staff were kind, patient and sensitive.

People told us and we saw, they were able to make decisions about their daily lives and where possible, were actively involved in their own care and support. One person told us, "Staff do ask me what I want and they do listen to me." We saw people were offered choices when being supported by staff, for example, what they wanted to drink, where they wanted to sit and if they wanted to participate in the group activities. Staff were discreet when transferring people from their lounge chairs to their wheelchairs and used a privacy curtain that also supported the person's dignity. We saw that staff were respectful and gave people time to make their own decisions and understood the importance of supporting people to make their own choices.

Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people, they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. For example, we saw one staff member asked a person if they wanted to go into the dining area for lunch. The person became anxious and started to raise their voice telling the staff member "No". We saw the staff member gently reassure the person and told them, "I'll come back in a little bit and see how you feel then, is that okay," to which the person replied, "Yes." This showed the staff member respected the person's wishes and their decision not to go into the dining area for lunch at that moment in time. We saw that people who were independently mobile had their walking frames close to hand and those spoken with considered themselves to be able to be independent for getting up and doing as much as possible for themselves.

People told us staff treated them with dignity and respect. One person told us, "Staff are polite and knock my door before they come in." People we spoke with all told us they thought staff respected their wishes. People's personal appearance had also been supported, for example a number of ladies had their finger nails painted and some people were dressed in clothing that reflected their ethnicity and culture. We saw one person had their prayer book with them, one staff member told us how important it was for the person

to have the book close by. The provider also explained how they were in the process of preparing a prayer room for people to use and had involved family members in planning the decoration of the room. People also received visits, if they wished, from members of a local church. People could be confident their individual preferences and choices relating to their culture, faith and gender would be respected by staff.

Staff ensured confidentiality was maintained and we saw that staff were discrete when talking to each other in public areas so as not to be overheard. Information held about people was kept safe and secure in locked cabinets that only authorised staff had access to.

The bedrooms we were invited into were well maintained by the provider and individualised with pictures and personal belongings that were important to the person. One person told us, "I've just moved into this room and I love it, it's big enough for my friends to come in and visit me, I have my own fridge and tea making facilities, everything I need."

Everyone we spoke with told us there were no restrictions when visiting and they were always made to feel welcome. Two relatives we spoke with told us, "Every time we come we are offered a cup of tea, the staff are so accommodating." We found people living at the home were supported to maintain contact with family and friends that were close to them. Care plans we reviewed demonstrated a person-centred approach that reflected people's individual choices and preferences. Staff we spoke with were aware of people's likes and dislikes and relationships that were important to people.

Good

Is the service responsive?

Our findings

At the last inspection in April 2017, we rated the provider as 'Good' in this key question. At this most recent inspection the service remained good.

People and relatives we spoke with confirmed they had been involved in the assessment, planning and review of their care. One person told us, "[Staff member's name] comes up and asks me if everything is alright, do I need anything, and things like that." A relative we spoke with said, "We are always involved with [person's name] care, they call us if there are any changes." Another relative explained, "My wife is very involved and comes to all meetings." Records we looked at included information about people's care and support needs and gave staff guidance about how to meet people's needs. Staff we spoke with gave us examples of how they ensured people received care that was individualised to them. One staff member told us, "This is people's home and we do our best to help them feel that it's their home and knowing people's likes and their dislikes, what they did before moving here, their job, it all helps to build up a picture of someone which helps us to support them." At the time of our visit, the provider was in the process of transferring care plans to a new system that was introduced in January 2018 and there were a small number that still required reviewing. This meant that some of the care plans had not yet been reviewed were not consistently up to date. However, the management team assured us all care plans would be reviewed and up to date within the next few weeks.

Where people's needs changed records reflected this and had been reviewed and updated. We saw that staff had involved health and social care professionals in supporting people when their needs changed in order to ensure they continued to receive appropriate care and support. All the staff we spoke with told us that they received updates about changes in people's needs, in handovers between staff at shift changes and would also read people's care plans. One staff member explained, "If you're unsure of anything you would read the person's care plan or ask the nurses or managers." The provider also held a daily morning meeting with the seniors for all departments. We observed one meeting and noted discussions included new admissions, GP visits, any concerns, incidents, accidents, complaints and health and safety. The provider also had 'resident of the day'. Resident of the day is an initiative that helps staff members to understand what is important to each person, and includes an in depth review of their needs that helps staff offer a person centred approach to people's care and support.

People told us and we saw there was a programme of activities available that they were invited to participate in. We found there were two dedicated staff members that planned and delivered a programme of activities for people. We saw there were one to one and group activities offered to people. On both days of our visit, one of the communal lounge areas was being used for games, music and craft activities. We saw people planting seeds into plant pots, reading or choosing to relax in their bedrooms. We could see that staff were enthusiastic about supporting people to take part in activities. In addition, the provider had small animals that could be brought into the home for people to pet. There was also a separate bistro area where people could choose to relax with their friends or family members. One person told us, "I don't get bored. I've got a lot of interests; TV, DVDs, I read, I text my family and friends. I'm lucky in that respect." Another person explained, "I don't go to any of the activities, I read books, I'm happy with my own company. My

family come to see me and that's alright." A relative said, "The activities are good, [staff member's name] is good. They have the qualities of a teacher. [Person's name] likes joining in the singing. They [staff] do this every afternoon I come. It was particularly good today. One or two staff are a bit mechanical, but others [staff members] make people laugh."

People told us they knew how to raise a complaint if they were unhappy about the care they received. One person said, "Complaints, no I haven't made any, though the only time was when one staff said give me two or three minutes and didn't come back for 15 minutes; that was my only complaint, and they couldn't apologise enough." Another person told us, "There is nothing to complain about but if I did I'd talk to the manager." People we spoke with told us they felt staff listened to them and respected their views and opinions. Relatives told us they were confident the new manager would address any concerns and felt able to express their views. We saw there was a suggestions box in the home's reception area. There was one ongoing complaint at the time of our visit and the management team explained to us the action they had taken and were planning to take to try and resolve the issues that had given rise to the complaint. Information was also provided to complainants about any improvements that had been made following their suggestions or complaints. This demonstrated the provider took complaints seriously and acted in accordance with their own policies and procedures.

People and relatives we spoke with explained the provider discussed their end of life preferences. One person told us, "End of life, yes they [staff] did ask me about if I'd like to go into hospital, I said I preferred to be cared for here [Anita Stone] they [staff] said they would be quite happy for me as long as I don't need special help. They [staff] do that [ask about future wishes] when you first come in here [Anita Stone]." We saw that end of life care plans were in place. The plans were reviewed and contained the appropriate paper work that followed the Gold Standards Framework. The framework helps staff members provide the highest possible standard of care for people who may be near their end of life. It does this by providing staff with the training they need to deliver person-centred care, so that no matter what stage of the person's illness, everyone involved in their care knows about their wishes and ensure those wishes are fulfilled.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in April 2017, we rated the provider as 'requires improvement' in the key question of 'Is the service well led?' This was because the provider did not have a registered manager and the systems in place to monitor and improve the quality of the service, had not been effective in identifying areas of concern and consistently meeting people's needs. At this inspection, the service remained without a registered manager, although it is noted the manager had submitted their application to CQC. We also found that there had been an improvement with the provider's quality assurance processes however further improvement, in order to further improve and sustain the service, was still required.

When reviewing the provider's governance systems, we took into consideration the previous manager had left the home and another manager started in January 2018. In addition, to support the manager a new clinical lead (January 2018) and a head of care quality (November 2017) had also been appointed. The provider operated another two established homes therefore, it was reasonable to anticipate that the issues identified at our last inspection, would have been addressed.

The provider had been working to an action plan to implement improvements from the last inspection and monitoring visits completed by other agencies, for example the Clinical Commissioning Group (CCG). We found that the majority of the work in progress or work completed, to improve the provider's governance systems, had only taken place within the last three months. There had been a failure of provider oversight to ensure the improvements required had been implemented immediately following the last inspection. For example, audits had not identified that two people had DoLS conditions in place for a year that had not been updated to staff or referred to in the peoples' care plans. The provider's audits had not identified that some care plans and risk assessments had not been updated to reflect the care and support that staff were providing for people. The clinical lead agreed that systems in place to effectively record people's weight were not robust and had started to take action to improve these. However, audits had not identified information on the Malnutrition Universal Screening Tool (MUST) charts were sometimes incorrectly scored. For example one chart had scored one person as a 'low risk' when they should have been 'medium risk'. Audits did not effectively monitor the stock of liquid medicines. However, it is acknowledged this was addressed immediately by the management team on the day and a monitoring system was now in place. We also saw the management team had started to develop and improve the systems and audits used by the provider to ensure they become more robust but further improvements were required.

We saw supervision records and 'spot checks' had been completed where staff had been assessed for their competence in certain skills. We saw from team minutes that feedback had been given to staff about things they did well and any improvements required. Staff we spoke with all told us how much the home had improved with the arrival of the new team. Comments included, "It's awesome working here," "You can see the difference," "We feel we have leadership and support," and "Everything is more settled now." The management team explained how hard they had worked with the staff to reduce the use of agency and employ their own staff which had been successful. One relative told us, "There has been a big improvement in the consistency of staff since the new managers have come." The head of care quality explained their role was to support the provider, the staff members as well as ensure high standards were maintained. They also

took some responsibility for auditing and quality monitoring checks. They explained to us how much they wanted to improve the service and that they were striving to maintain an excellent service for everyone at the home.

Staff we spoke with expressed confidence in the manager and told us they found them to be approachable. One staff member said, "The manager is professional, they are visible on the floor, not locked away in an office, we have a good support network." All the staff we spoke with shared similar views. The manager demonstrated an understanding of the responsibilities of their role and they had reported significant events to us, such as safeguarding incidents as required by law.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and there was a whistle-blowing policy in place. They continued to explain the management team were approachable and if they had concerns regarding the service and they would speak with them. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concern properly.

Relatives spoke positively about the management of the home. One relative told us, "There have been some changes but I think they are for the better, the atmosphere is different." People told us resident's meetings took place and gave people an opportunity to share their views, opinions and ideas. We saw satisfaction surveys were completed and included comments, "I think the environment and atmosphere is pitched at just the right level." "I am more than happy how you look after [person's name]." "The home is very welcoming." Relatives we spoke with told us they felt well informed about their family members and confirmed the management team kept them updated with any changes.

People and relatives we spoke with told us they were happy with the quality of care provided at the home and were pleased with the atmosphere and environment of the home. One person told us, "I feel very lucky to be here." One relative said, "We went to another three homes before coming here and I have to say this is by far the best." Where people, relatives or staff had made suggestions we saw the provider had listened to their views and made changes. The provider held bi-monthly meetings for people and relatives and any suggestions were acted upon quickly. We found that minutes were circulated and one relative we spoke with confirmed they received copies if they were unable to attend.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The manager was able to tell us their understanding of this regulation and we saw evidence of how they reflected this within their practice. Where issues had been found, the management team addressed them immediately to put measures in place to prevent reoccurrences. We found that the management team had been open and transparent in their approach to the inspection and co-operated throughout. At the end of our site visits we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively.

We saw evidence to support the service had worked in partnership with other organisations, stakeholders and healthcare professionals, for example, the local authority and Clinical Commissioning Group.