Five Stacks Residential Home Limited

Five Stacks Residential Care Centre

Inspection report

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Date of inspection visit:
08 February 2018
13 February 2018

Date of publication:
11 April 2018

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Five Stacks Residential Care Centre is a residential care service that provides accommodation and personal care for up to 30 adults including those living with dementia. The service includes a self-contained wing specifically for up to seven people with learning disabilities. There were 26 people in the service when we inspected on 8 and 13 February 2017 plus one person staying on a respite basis on the 13 February 2018. This was an unannounced inspection.

There was a registered manager in post. 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.

At our last inspection in September 2016, we found breaches in regulations 9,11,12,13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed conditions on the provider's registration requiring them to make improvements in relation to their risk management and quality assurance systems.

At this inspection, we found that improvements had been made and the provider was no longer in breach of the regulations. However, there were some areas where further improvements were still needed.

There were improvements in some areas of risk management but some areas still needed further work, particularly in relation to risks associated with specific health conditions and environmental risks. There were improvements in the management of people's medicines.

People presented as relaxed and at ease in their surroundings and told us that they felt safe. Systems in place to reduce people being at risk of potential abuse were now more robust. People knew how to raise concerns and were confident that any concerns would be listened and responded to.

Improvements had been made to the care records. They were written in a person centred manner and gave details about what was important to people, their likes and dislikes. Work was ongoing to ensure care records accurately reflected people's current care and support needs. People told us that they received personalised care which was responsive to their needs.

Staff understood the importance of gaining people's consent and were compassionate, attentive and caring in their interactions with people. They understood people's preferred routines, likes and dislikes and what mattered to them. Staff were trained and supported to meet people's needs effectively.

The management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way

possible; the policies and systems in the service supported this practice.

People's nutritional needs were assessed and met. People were offered meals that were suitable for their individual dietary needs, however further work was needed to give people more choice and improve the mealtime experience.

People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

The service had improved their quality assurance systems and additional audits and checks had been put in place to monitor safety and quality of care. However, the provider had not yet demonstrated that their quality assurance systems were robust enough to independently identify shortfalls and recognise where action is needed. They now need to demonstrate that improvements will be sustained and embedded in practice, so that people can be confident they are receiving safe, effective and responsive care.

The management team were open and transparent throughout the inspection and sought feedback to further improve the service provided.

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 consistently safe.

Not all risks to the health and safety of service users had been assessed, mitigated and reviewed appropriately.

Procedures were in place to safeguarded people from the potential risk of abuse.

People were provided with their medicines when they needed them and in a safe manner.

There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People nutritional needs were assessed, however further work was needed to give people more choice and improve the mealtime experience.

Staff were trained and supported to meet people's needs effectively.

The service was up to date with the Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

Staff understood people's preferred routines, likes and dislikes and what mattered to them.

Is the service responsive?

Good

The service was responsive.

People were provided with personalised care to meet their assessed needs and preferences.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

People were supported when making decisions about their preferences for end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had not yet demonstrated that their quality assurance systems were robust enough to independently identify shortfalls and recognise where action is needed.

The service provided a positive, open and inclusive culture.

People were asked for their views about the service and their comments were listened to and acted upon.

Five Stacks Residential Care Centre

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 unannounced inspection took place on 8 and 13 February 2018 and was carried out by an inspector, a specialist advisor who had knowledge and experience in nursing care, and an expert by experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with fourteen people who used the service and eight relatives. We also received feedback from a health care professional who visits the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered manager, deputy manager and two directors representing the provider. We also spoke with seven other members of staff.

To help us assess how people's care and support needs were being met we reviewed 11 people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that risks to people injuring themselves or others were not always appropriately managed. We also found that there was a lack of assessment relating to environmental risk. At this inspection, we found that there had been improvements in some areas of risk management but some areas still needed further work.

Risks to people's daily lives had been assessed and there were plans in place about how to manage and monitor risk including falls, mobility, risks associated with medicines and use of bed rails. Risks associated with peoples reduced levels of mental capacity due to dementia or other mental health conditions had been considered. For example, one person was at risk due to their lack of understanding of other people's personal boundaries and these risks had been highlighted to staff so they knew to be aware of potential situations that could put the person at risk.

Staff recognised that some people's behaviours due to anxiety or agitation put the person and others at potential risk of harm. When required, behavioural risk assessments for people included potential reasons for changes in behaviour. Details were also included to guide staff in how to manage these behaviour changes. This helped staff to be aware of potential triggers which may upset people and allow them to take appropriate steps to minimise the risk of distress and harm in the least restrictive way.

However, there were some risks associated with people's health conditions which needed further explanation to ensure that staff knew how to support people effectively. For example, there were several people with diabetes but no assessments to alert staff to the risks associated with this condition or how to recognise the signs and symptoms which may indicate that their blood sugar levels were causing them to become unwell.

The care plans were in the process of being updated and new moving and handling plans were very detailed to ensure clear guidance was available for staff. One person's care plan gave specific details regarding how to use the hoist, what type of hoist sling to use and how. There was also information which guided staff how the persons moving and handling needs may differ depending on how they were feeling that day. Information was included to give staff a better insight for the person on a 'good' day and on a 'bad' day. This meant that staff had the details they needed to respond to changes in people's needs and keep them safe when assisting them to mobilise.

On the first day of this inspection, we found that record keeping relating to pressure care management was inconsistent and unclear. The moving and handling plan for one person with a pressure ulcer stated that they were to be repositioned every four hours, however the daily monitoring sheet where this was to be recorded did not state how frequently repositioning should take place and did not evidence that this was occurring as directed in the care plan. We asked a member of staff how often the person should be repositioned and they told us it should be every two hours. We were concerned that the person was not receiving the support they needed and discussed this with the management team. They told us the frequency of repositioning had recently changed as directed by the community nursing team as the person

found it painful and often refused, however this had not been recorded in the persons care plan. The lack of guidance for staff put the person at risk of further deterioration of their skin integrity and additional pressure ulcers.

On the second day of inspection, we found the person's care plan had been updated to include clear guidance for staff and daily monitoring records had also been amended to guide staff regarding the level of assistance required. If repositioning had not taken place in line with the care plan the new records also prompted staff to record why this was. This would help them to establish if there was any pattern to refusals for assistance so they could seek to find alternative ways to support the person.

Despite the shortfalls we found with the record keeping relating to repositioning, a member of the community nursing team visiting the person told us that they were happy with the care being provided and said, "They seem to have it sorted." Although records and guidance for staff had needed to be improved they felt staff knew the person well and were doing all they could to support them with the management of their pressure care.

At our last inspection, we found there was a lack of assessment relating to environmental risk. Some risks found during the inspection had not been previously identified by the management team and appropriate action had therefore not been taken to keep people safe. At this inspection, we found that the risks highlighted at our last inspection had been addressed and additional control measures put in place to protect people.

However, there was still no structured approach to identifying and taking action on environmental risks, which meant people continued to be at risk of harm. We noted that several of the radiators around the service were not covered and were very hot to touch. This put people at risk of a severe burn should they fall against them and be unable to move away. We also found that window restrictors in one part of the building were not of a type recommended by the Health and Safety Executive as being effective. This put people at risk of a fall from the first floor should the old restrictors not be effective if someone leant out against a window. We discussed these concerns with the management team and providers. They took immediate action following the inspection to address both these issues in order to keep people safe.

Despite the above instance, we found that steps had been taken to assess all other risks on a daily basis and the management team completed a daily hazard monitoring tool following a walk around the service each day. This had identified issues such as a call bell buzzer not working which had then been fixed the same day. A hoist seen to be in front of a fire exit had been moved and a note put in the communication book for staff. This demonstrated that the management team were aware of the importance of identifying risks to people but needed a more structured approach to ensure that all potential risks to people, staff and visitors were identified, appropriate control measures put in place and that these were frequently reviewed and updated.

At our last inspection in May 2017, we found that the inappropriate management of people's medicines placed them at risk of harm. At this inspection, we found that there had been improvements in this area. Suitable arrangements were in place for the management of medicines and people received their medicines in a supportive way. People were prompted, encouraged and reassured as they took their medicines and were given the time they needed.

At our last inspection, we found poor practices in relation to storage of medicines and disposal of some types of medicines. There had been improvements in these practices and medicines were now stored safely and disposed of appropriately.

Staff had been trained to administer medicines safely and they were observed to ensure that they were competent in this role. Medicines administration records (MAR) showed when medicines had been given or if not taken the reason why. Medicines that were prescribed to be taken as and when required [PRN], were given according to the individual's choice as to whether they felt they needed it. We observed a member of staff check with a person, "Have you any pain, do you want your Paracetamol?" Protocols were in place to give clear guidance to staff on what each PRN medicine was for, when it should be given and how often, and any proactive strategies to use prior to administering the medicine.

People told us that they felt safe living in the service. One person commented, "If ever there was a problem I'd talk to the supervisor, and if the problem was them, I'd speak to somebody else. But I really feel very safe here, and the staff are all lovely." Another person told us, "I feel very safe, it's all good here." At our last inspection in May 2017, we were not assured that all incidents which could constitute abuse had been appropriately referred to the relevant safeguarding authority. At this inspection, we found that staff had completed training which enabled them to identify different types of abuse and they were confident in the actions that they would take to report any concerns both within the service and to outside agencies. The management team had a good understanding regarding safeguarding procedures and took appropriate action to report concerns when needed in order to safeguard people from the risk of abuse.

People told us they felt there were sufficient numbers of staff to care for and support people according to their needs. One relative told us, "It's very well staffed for the number of people here." Another relative said, "There has never been any occasion I've turned up and staff are not there." When support was being provided on a respite basis to those with a learning disability a designated staff member was on shift to provide one to one support to the person. A relative of a person using the respite service told us that they were confident that their relative always received one to one care. A visiting healthcare professional also told us that there were always enough staff on duty.

Employment records confirmed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the vulnerable adults who used the service.

We observed the home to be clean and a member of staff responsible for domestic tasks told us about how they took pride in their work and worked as a team to protect people against the spread of infection. They commented, "If something needs extra we get a team together to get it done in an evening." Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE).

Clinical waste bins located in each communal toilet and bathroom did not have a foot pedal and therefore had to be opened by hand. We were concerned this meant staff would be unable to operate these without the risk of spread of infection and discussed this with the management team on the first day of our inspection. They took our comments on board and immediately ordered an alternative type of bin to trial which had arrived by the second day of our inspection. They told us they planned to replace all current clinical waste bins with the new type as soon as possible.

Good

Is the service effective?

Our findings

At our last inspection, we found that although people were complementary about the food people were not always aware of the choices available to them. At this inspection we found that although there were plans to make improvements in this area these had not yet been implemented. People told us that they enjoyed the food but we saw that there was only one main option available at lunchtime. Alternatives were available if people requested but some people did not always know what these were. One person told us, "The food is very nice here, but sometimes I don't like what's offered."

In the dining room at lunchtime we saw that everyone other than one person, who had a vegetarian alternative, had the same meal. Meals were already plated up in the kitchen so people did not have the opportunity to decide for themselves which vegetables they would like or how much gravy they preferred for example. One person commented, "I don't normally have peas and carrots, but somebody's put them on my plate so I'll have a taste." There were also no condiments available for people to help themselves to on the tables.

We discussed the menu with the chef and with the management team. The chef had recently started working at the service and commented, "If someone doesn't like it they can have something else but it would be nice to go down the route of two options. I want to put on a proper alternative. I can do omelettes or a jacket potato if they would like one, but they should be having a proper alternative choice." The deputy manager explained their plans for developing and expanding the menu including the provision of homemade milkshakes to help to reduce the risk of malnutrition. The management team were considering ways in which people could be offered more choice and given more control regarding their meals such as introducing jugs of gravy or custard to allow people to pour this for themselves if they were able.

People were given the support they needed with their meals. We observed that one person had a plate guard fitted to the rim of their plate to allow them to eat independently and with dignity. We also observed a member of staff assisting a person with their meal, they chatted with the person as they assisted and made sure that food was offered at a steady pace, allowing them time to chew and swallow food between mouthfuls.

Peoples nutritional needs were assessed, details were included in their care plans and staff were aware of these and how people should be supported. A member of kitchen staff commented, "I definitely have all the information I need." Where people had been assessed as being at risk of malnutrition or had swallowing difficulties referrals had been made to relevant healthcare teams.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. The management team understood when applications should be made and the requirements relating to MCA and DoLS.

At our last inspection, we found the service was not always working within the principles of the MCA. Staff sought people's consent before providing support or care and acted in accordance with their wishes. However, there had been some restrictions about which areas of the service could be accessed during the day and we found that no mental capacity assessment had been carried out in relation to the administration of covert medicines for one person.

At this inspection, we found there had been improvements in this. Although the door through to the part of the service designated for use by people with a learning disability was closed, it was no longer locked. Arrangements had been made so that people whose bedrooms were in this part of the service had access if they wished. A member of staff explained how they were able to move to another part of the unit with the person they were supporting if they would be unsettled by people wanting to access their bedrooms.

The service was now working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles. Where people lacked capacity, the appropriate best interest processes had been followed and mental capacity assessments were specific to the decision to be made. For example, in relation to the use of bed rails or assistance with nutrition. Detailed guidance was available for staff to help them to support people in the least restrictive way possible. For example one care plan said, "If you were to ask [person] if they would like a drink then [person] could tell you yes or no. Consent would be given by you placing the straw to [person's] lips and them sucking on the straw or pushing away." This helped staff to understand how they could support people to make their own decisions as much as possible.

People's needs were assessed in order to develop individual care plans in consultation with people, relatives, professionals, keyworker's and through observation. Care plans were in the process of being updated to ensure they reflected people's needs, choices and preferences.

Since our last inspection, work had been completed to ensure the design and layout of the premises was able to meet people's needs. This included the introduction of dementia friendly signage to aid people's orientation around the service. One person told us, "I do feel safe. I am nearly blind, but the way the home is laid out is good for me, and I can get around on my own with my frame."

People had access to health care services and received ongoing support where required. We spoke with two visiting healthcare professionals who gave positive feedback regarding the way staff communicated changes in people's needs to them. A family member also spoke positively regarding the way staff had supported their relative during a recent period of poor health. They said, "They were brilliant. Really good. They had the doctors in. I could see the chart, how much [staff] had been in, how much [relative] had to drink. [Relative] started getting up gradually and is looking so much better." This demonstrated that prompt action was taken to involve relevant healthcare professionals in people's care in order to keep people in good health.

People were supported by knowledgeable and skilled staff who received training relevant to the needs of the people who used the service. This included training on how to safeguard vulnerable adults, manual

handling and medication. One person commented, "There is nothing they can't do." A family member told us how confident they were that the staff knew their relative well and had the skills and knowledge they needed to support all of their needs, some of which were complex at times. They commented, "They will ring us and say, 'this is happening, what do you think?' Everything we've asked them they have done. We learn from them and they learn from us."

New staff received a thorough introduction to the service. Staff told us that when they started in their role they had spent time working alongside colleagues, which had helped them to understand people's needs and feel confident in their new role.

The registered manager had made arrangements with the manager of another service for them to carry out a medicines competency assessment on them. This meant the registered manager was also being assessed in their role and best practice in medicines management was being shared across organisations.

Staff had access to regular formal supervision sessions and in addition to this the management team informally supported them with any concerns that arose. Supervisions give staff the opportunity to talk through any issues, seek advice and receive feedback about their work practice. Annual appraisals took place and provided an opportunity for the management team to look at staff's performance and to support them in their continued professional development.

Good

Is the service caring?

Our findings

The atmosphere within the service was warm and welcoming. One person told us, "The carers look after me so well. It's lovely here." A family member said, "It's a lovely home for [relative]. Really, they can't do enough for them. I'm so happy [relative] is here, we know [relative] is being looked after and we feel part of the family here."

People and their families were positive and complimentary about the care they received. A person told us, "[Member of staff] is a real help to me. They are all very considerate." A family member commented, "[Relative] has been attending Five Stacks for respite for almost two years now and I cannot fault them for their care and attention in looking after my [relative]." Another family member said, "This is the best place I could ever wish for my [relative] to be. There is great care here."

Staff knew people well. They understood people's preferred routines, likes and dislikes and what mattered to them. A person told us that staff, "definitely" knew them well. A family member of a person who stayed regularly on a respite basis explained, "If [relative] likes something they will sometimes push your arm away. You have to learn [relative]. They all seem to understand [relative]. I think they are just wonderful."

Staff showed a genuine interest in the people they were supporting and spoke affectionately about them. A family member told us, "I believe they take a good care of [relative]. The staff are friendly, kind and very easy to deal with."

One member of staff said, "It's the silly little things, simple things. We put smiles on people's faces. Like picking up fig rolls for [person] because I know they like them." We observed how staff members took the time to say goodbye to people at the end of their shift. A family member told us about the strong connection between their relative and a member of staff they were particularly fond of. They explained how much this meant to their relative and how it improved their quality of life. The person told us, "It makes my life a very happy one."

People and their relatives told us about staff who showed empathy and understanding. We observed this throughout our inspection. We saw a member of staff checking with a person who looked upset, "What's the matter? Do you not feel well? Is something hurting?" A member of staff supporting a person who had limited speech on a one to one basis explained what the person was communicating through the sounds they were making. "We get to know [person] well. This is happy sounds. You know when [person] is upset and doesn't want to do something. This demonstrated that staff understood what was important to people and supported them in line with their specific needs, both physical and emotional.

People wherever possible were encouraged by staff to make decisions about their care and support. This included what activities they wanted to do and where they would like to be. One person told us, "I choose when to get up and what to do." A family member commented, "[Relative] always has a say in what they do." We observed a member of staff checking with people before putting some music on in the dining area, "Would anyone like some music on? I'll need to know what music you want. The Shadows? I'll bring the

DVDs over and you can choose."

People were involved in the planning of their care and where appropriate, people's family were also involved. A family member commented, "We did a review of [relatives] care plan with [registered manager] I was quite impressed." We saw that the registered manager had written a letter to another family member who had been unable to attend a review of their relatives care plan in order to keep hem updated.

People told us that they felt that their choices, independence, privacy and dignity were promoted and respected. One person commented on a survey they had recently completed, "I feel very respected." A family member gave an example of how staff respected their relative's dignity, "Shaving. [Relative] has always been very particular on that and they help with it. It's all very good." We observed staff discretely supporting a person when they had been unable to make it to the bathroom in time and needed assistance. They placed a blanket around the person to preserve their dignity and calmly led them to the bathroom without drawing attention to the situation. This demonstrated that staff understood the importance of treating people with dignity and respect and supported them accordingly.

Good

Is the service responsive?

Our findings

At our last inspection, we found that although care records were written in a person centred manner they did not always reflect people's current care and support needs. At this inspection, we found that improvements had been made with this. The management team were in the process of changing the care records to a computer based system and were taking the opportunity to carry out a full review of each person's care plan. The records which had been updated gave staff detailed guidance about every element of peoples care and support needs, both physically and emotionally. For example, the care plan for one person living with a specific type of dementia explored what this meant for the person and how staff could best support them.

On the first day of our inspection, we found that some care plans which had not yet been updated contained conflicting information which could be confusing for staff and lead to inappropriate care being provided. We discussed our concerns with the management team who agreed that they should prioritise the work to be completed on the records which still needed updating to ensure that staff had the information they needed to care for people safely and effectively. By the second day of our inspection, work had already begun on this. The management team also recognised that they needed to ensure the new care plans were completely tailored to each individual as some wording used was still generic. Care staff told us that they felt they had the information they needed to provide personalised care. One member of staff said, "It's quite clear exactly what you should be doing. All of their personal care needs are on the wall [in people's bedrooms] so you know exactly what you are doing."

People and their families told us that they received personalised care which was responsive to their needs. One family member told us, "I've noticed if we ever use the buzzer, it's answered very quickly." Another family member commented, "My [relative] said, 'I don't want to go anywhere else.' They call it their hotel. [Relative] has settled, started to eat well again. They have given all the right encouragement, it's nice and clean and tidy, they are very good with laundry and baths and showers." We observed that staff recognised when people needed additional assistance and responded quickly. For example, we were talking with a member of staff when they noticed that someone needed some help, they politely excused themselves from our conversation so they could immediately assist the person. This demonstrated that meeting the individual needs of people was the top priority for staff.

In the area of the service used for people with a learning disability staying on a respite basis, we saw that their bedroom was changed each time a different person stayed according to their needs and preferences. A member of staff told us, "[Person] has their own bed linen which [person] loves. Everyone has their own routine. It's the little bits that make a difference." The person's care plan gave details about what was important to them such as preferred colours and lighting. We saw that these elements had been included in their bedroom for the duration of their stay and furniture re-arranged to accommodate their needs. A family member told us, "It's brilliant. We've had issues with other places but here [person] is out the car and to the front door. They've accommodated [person] fantastically. They've bent over backwards to accommodate their needs."

Each morning a 'ten at ten' meeting was held between a member of the management team and the senior member of staff responsible for the shift. This meeting included discussion about whether anyone needed to see a GP or other healthcare professional for any reason or whether there were any other concerns which needed to be responded to. Records of these meetings showed that they were used effectively to respond promptly to changes in people's needs. For example, calling a GP when it was noted that a person's fingers were a little blue and testing for a potential urine infection when it was recognised that a person was particularly unsettled.

At our last inspection, we found staff were encouraged by the management team to spend time socialising with people throughout the day. However, opportunities were being missed to involve people in activities which were of specific interest to them. At this inspection, we found that although there was still no structured approach to the provision of activities people were encouraged by staff to be involved in everyday tasks and pastimes. For example, we saw that a group of people got involved with arranging flowers for the tables in the dining room and one person helped to lay the tables for lunch. We also saw another group of people enjoying having their nails done by a member of staff. Each day people were provided with a newspaper specifically designed to prompt reminisce, provide entertainment and keep people informed about current issues. These activities provided mental stimulation and helped to achieve a sense of purpose and well-being.

We saw that a church service took place on the first day of our inspection and people told us about other social events which provided opportunities for people to enjoy time together. One person commented, "You can do whatever you like here. There are outings but you don't have to go on them, you can choose whether to go or not." One person's care plan gave details about what interested them and stated, "The vicar who attends church services would be happy to go to [name]'s room but when I asked [name] they said 'no thank you.'" This demonstrated that people were able to decide for themselves how they spent their day.

There were still mixed views regarding whether there were enough opportunities to take part in activities specific to people's interests and needs. Some people told us they were every happy with the way they spent their day. One person told us, "I have my talking book which I enjoy here in my room." Another person commented, "It's all very nice here, and I'm very satisfied indeed. I hope to go for a walk later." One family member said, "There are lots of activities if people want to join in." However, some people felt that their social needs were not always being met. One person told us, "I really do miss going out. There's not really much to do here." One person told us they liked watching a certain television channel but was only able to do that in the main lounge as they did not have access to it in their bedroom. We discussed the provision of activities with the management team and providers. They told us about the steps they were taking to continue to improve on this aspect of the service provision. This included the introduction of memory boxes to aid reminisce and prompt conversations with people living with dementia. One family told us how they had been asked to provide things of importance to their relative to form part of this box and they were looking forward to the positive memories this would help the person to recollect.

There was a complaints procedure in place which explained how people could raise a complaint. Records of complaints showed that they had been responded to appropriately and dealt with in a timely manner by the registered manager. People and their families told us that they felt comfortable about raising any concerns. One relative told us, "There aren't any problems, but if we need to we speak to the manager and it's all sorted very quickly. They are really easy to talk with." Another relative commented, I am informed immediately of any concerns which may have occurred. I feel confident in leaving [person] in the capable hands of the staff who have become like an extended family." This showed that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right.

People were supported when making decisions about their preferences for end of life care. The service kept important information, which included advanced care plans and preferred priorities for care documents. Where appropriate a DNACPR was in place. A DNACPR is a way of recording the decision a person, or others on their behalf had made that they were not to be resuscitated in the event of a sudden cardiac collapse. People and their families had been involved in these discussions. One family member told us, "Preferred priorities of care we have done now and the do not attempt resuscitation document was discussed. [Deputy manager] went through everything and said to [relative], if you were poorly where would you want to be cared for? It gives [relative] peace of mind." We saw in one person's care records that their wishes regarding the care and treatment they would like to receive at the end of their life had been documented. They had specific requirements relating to their religion, which had been recorded to ensure their wishes were followed.

We saw how one family had expressed their gratitude to staff for the care provided for their relative at the end of their life. A thank you card from them read, "I wasn't sure how to express the deep gratitude that [relative] and I feel for the love which was shown to [relative] by your whole team. I was very deeply touched by how staff members who had ended their shift came and said goodbye to [relative] before they went home on the evening [they] died. This epitomised the caring attention [relative] has received."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2017 we found shortfalls in the systems in place for monitoring the quality of the service. At this inspection we found that some improvements had been made in this area and additional audits and checks had been put in place to monitor safety and quality of care.

However, there were still some areas where quality assurance systems had not identified shortfalls, specifically in relation to environmental issues which put people at risk of harm. For example, uncovered radiators which were hot enough to burn people should they fall against them and window restrictors which did not meet the current recommendations from the Health and Safety Executive. Some areas of risk relating to individuals specific healthcare conditions and support needs had also not been identified. We discussed all these issues with the management team and providers who took immediate action to make the required improvements.

There were areas where the new quality assurance systems had been used to enhance the quality of care being provided. For example, one audit picked up that the kitchen had not been updated with regard to the dietary requirements of a person who had moved in the day before and this was immediately rectified. In addition to these audits, the management team's daily 'ten at ten' meetings and daily walkabouts were used to check that people's needs were being met and they were happy with the service provided.

All care providers have a statutory requirement to notify us about certain changes, events and incidents affecting their service or the people who use it. At our last inspection, we found that we had not always been notified of these significant events. At this inspection, we found that the management team and providers had a greater understanding of their role and responsibilities in ensuring that the service provided care that met the regulatory standards. They had notified us of incidents and events when required to do so and had also kept us informed of their progress regarding the improvements they were making to the service provided.

There continued to be an open and inclusive culture in the service. A member of staff told us, "It's a family place." One relative commented, "It's not just the management, all of the staff are nice. Whatever I say is always listened to with courtesy. They are a lovely crowd here." A visiting healthcare professional told us, "I'm always given a good welcome. It's lovely."

Families told us how they were always made to feel welcome and that their involvement and input into the service provided was valued. One relative told us, "I can't find any faults. There are no 'buts.' After about a month of visiting I knew we had landed on our feet." Another relative commented, "They don't just pull out all the stops when [CQC] are here. They are always the same."

People and their relatives gave positive feedback about the management and leadership of the service. They described the management as visible and approachable. One person commented, "If I want anything I can always ask to see them." A relative told us, "The management team are very flexible and accommodating with regard to offering the respite time and dates. If I have any concerns they are also

reassuring and act professionally."

Staff were encouraged and supported by the management team and were clear on their roles and responsibilities. They were encouraged to support and value each other to ensure they worked effectively as a team. One member of staff who had recently started work at the service told us, "Everyone has been really helpful. I haven't seen anything that raises any red flags which has got to be a good thing. It means people know what they are doing."

People, their families and staff were provided with a range of ways in which they could express their opinions including surveys and meetings. Results of these surveys were mostly positive. For example, one healthcare professional had commented, "Warm cheerful welcome, very good care, very good home, safe, comfortable, well led by effective caring team, good accurate documentation." Where people had made comments in a survey carried out in September 2017 these had been responded to and action taken to make improvements to the quality of care provided. For example, one person had commented on wrong clothes being put into their wardrobe so action had been taken to rectify this and put a new system in place to reduce the risk of this occurring again. There was an emphasis on continually striving to improve in order to provide a high standard of care.

The management team had an openness and willingness to learn from incidents, investigations and complaints in order to improve the quality of the service. At our last inspection, we found that they were open and transparent throughout the inspection and sought feedback to improve the service provided. This continued to be the case and the provider and management team were keen to demonstrate how they were using feedback provided to continue to learn and improve the service they provided. The registered manager commented, "We listened to what you said. It was taken as constructive. We have also been working together with other homes. It's all improvement."

The registered manager had formed links with another local residential home and they were working together with other managers to share best practice and provide an opportunity to learn from each other. The service had also been recognised in the Tendring local business Blue Ribbon awards in September 2017 winning the award in the Health and Social Care category.

Although progress had been made in improving the service, the provider had not yet demonstrated that their quality assurance systems were robust enough to independently identify shortfalls and recognise where action is needed. They now need to demonstrate that the improvements they are continuing to make will be sustained and embedded in practice, so that people can be confident they are receiving safe, effective and responsive care.