Mrs Mary Crook

Southernhay Residential Home

Inspection report

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Date of inspection visit:
17 May 2016

Date of publication:
29 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Southernhay Residential Home is registered to provide accommodation and care for up to 20 people living with dementia. At the time of this inspection, 14 people were living in the home.

The home was managed by the registered provider. Therefore, it did not need to have a registered manager. 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.

This inspection took place on 17 May 2016 and was unannounced. The last comprehensive inspection was carried out on 17 and 22 June 2015. At that time, the service was rated 'inadequate' and placed in 'special measures'. We found the service was not meeting the regulations in relation to person centred care, dignity and respect, consent, safeguarding, notifications, staffing, quality assurance and safe care. We served warning notices in relation to quality assurance and safe care. After our inspection, the provider invited the local authority quality monitoring team to support them to bring about improvements. We met with the provider and told them they needed to make improvements. We carried out a focused inspection on 22 October 2015 to check whether the warning notice relating to safe care had been met. Improvements had been made and the Safe key question was rated 'requires improvement'. The provider sent us an action plan telling us what they were going to do to ensure people received a good service. They told us all of the improvements were to be completed by 4 December 2015.

The provider information return told us the service now had a quality assurance system in place which was followed by staff, monitored and audited. On this visit in May 2016 we checked and found some improvements had been made, however people were still not receiving a safe, effective, responsive or well led service. The quality assurance system was not robust and had not picked up the shortfalls we identified. The provider was developing their quality system, which was not yet in place. The deputy manager had designed a quality assurance planner which was to be introduced. Medicine audits had been carried out regularly. Staff recruitment files were checked to ensure all the required information was in place.

Risk assessments had been carried out for each person. Although most risks were being managed to ensure people were kept safe, people's choking risks were not being fully managed. Two people had been identified as needing supervision when eating due to the risk of choking. However, we observed people were left a number of times with food on their own. People were protected from other risks as appropriate arrangements were in place. This included risks relating to harm to themselves and other people, medicines, and pressure sores.

People's nutritional needs were not always well managed. One person did not eat their lunch. It was taken away and no other food was given to them until they were offered a snack later in the afternoon. Another person was enjoying their food and looked for more food in the bottom of the bowl. Staff came and took away their bowl and did not offer them any more food. People who did not require support with eating had to wait to have their meals until the people who required support were finished. This meant people in the

living room watched as other people ate for about twenty minutes before they were offered their meal. However, we also saw occasions where staff took their time when supporting people to eat and came down to their eye level. People clearly enjoyed their meals and these had been freshly prepared. We observed staff show one person, who had problems with communication, different cups in order to identify whether they wanted a hot drink or a cold drink. They were then able to point to the cup they wanted and staff brought this choice. People's weights were recorded regularly. One person had lost weight in the last few months. Staff had referred them to the GP in relation to their reduced appetite. Staff were able to tell us why this had occurred and what they were doing to try to increase the person's weight.

At our last inspection we found the provider had not followed the principles of the Mental Capacity Act (MCA) 2005 for those people who did not have the capacity to make their own decisions. Although there was evidence that people's relatives and representatives were now involved in their care planning and decision making, the provider displayed a lack of knowledge of the MCA. 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. Although the provider had made applications to the local authority in relation to this, they lacked understanding of the Deprivation of Liberty Safeguards (DoLS).

At our last inspection, care plans did not give clear information to ensure people's needs were met. At this visit, we found improvements had been made but further work was needed. Staff knew people well. When we spoke with them about individual people they were clear about what they needed to do to meet their needs. Care plans contained more detailed information and were reviewed monthly. However, information about one person's moving and handling was not clear. This posed a risk of inappropriate care. Information about people's personal histories and interests had been added to the care plans. We observed that staff used this information when chatting with people, who enjoyed these interactions.

Although we observed a number of caring interactions, there were also occasions when staff were not respectful and did not acknowledge people. Staff spoke about people with compassion and concern. They gave us examples of how they tried to make people's lives better. This included a staff member bringing in adult colouring books for people. Another staff member got a person a newspaper and chocolate while they were in hospital so they knew they were thinking about them. The provider went to visit this person in hospital after they had finished work in the evenings. Relatives told us they were always made welcome. One relative said "If you ring up, they put your mind at ease. We're very lucky to have [person] here".

Relatives told us they felt people were safe. We observed people were comfortable with staff and smiled in response to them. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies. Safe staff recruitment procedures were in place. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable people.

There were sufficient staff to meet people's needs. Staff responded to people's needs and requests in good time. Staff did not seem rushed and remained calm and attentive to people's needs. People were given one to one time with staff who sat and spoke with them. One person told us "They sit and have a chat with me". Staff said "We can do a lot more one to one" and "it's become more person centred. We used to do a lot of group activity but now we can do one to one more. People like that one to one time". During the morning staff spent time with one person doing a jigsaw and then painting their nails. As a result the person's mood improved and they were laughing. However, we saw that during this time, there was very little interaction with the other three people who were sitting in the lounge. During the afternoon a musical entertainer visited the home. Staff got up and danced with people and made it enjoyable for them.

At our previous inspection, staff had not received training to ensure they had the knowledge and skills to

meet people's needs effectively. At this inspection, we checked and found improvements had been made. Staff said "I have done lots of training" and "All my training is up to date". There were still some gaps in staff training but there was a plan in place to ensure staff completed these. Staff told us they felt well supported and had regular opportunities to discuss their work.

The premises and equipment were maintained to ensure people were kept safe. For example, checks had been carried out in relation to fire, hoists, and gas safety. There were arrangements in place to deal with foreseeable emergencies. The provider had sought guidance for supporting people with dementia in an enabling environment. They showed us information relating to bedrooms, corridors, and bathrooms. Work had not commenced. They said they planned to start this work after they had finished improving the garden. Additional seating areas had been built in the garden which meant it was easier for people to go outside.

The provider worked within the home alongside the staff team. They had a very good knowledge of the people who lived there. Staff told us they found the provider approachable. A staff member said "(name) is approachable and listens to my ideas".

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We are taking further action in relation to this provider and will report on this when it is completed. The overall rating for this service is 'Requires improvement' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although most risks were being managed to ensure people were kept safe, people's choking risks were not being fully managed.

Relatives told us they felt people were safe. We observed people were comfortable with staff and smiled in response to them. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies.

Safe staff recruitment procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional needs were not always well managed. Food was taken away with no offer of an alternative or more. However, people clearly enjoyed the food.

Although there was evidence that people's relatives and representatives were now involved in their care planning and decision making, best interest decisions had not been recorded.

Staff had received training. There were still some gaps in training but there was a plan in place to ensure staff completed these.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we observed a number of caring interactions, there were also occasions when staff did not acknowledge people.

Staff spoke about people with compassion and concern. They gave us examples of how they tried to make people's lives better.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained more detailed information and were reviewed monthly. However, information was not always clear.

People were receiving more social interaction and activity. However, some people did not receive as much interaction as others.

Staff knew people well. When we spoke with them about individual people they were clear about what they needed to do to meet their needs.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not yet developed a quality system. Therefore, they had not identified the shortfalls we found.

The provider worked within the home alongside the staff team. They had a good knowledge of the people who lived there. Staff told us they found the provider approachable.

Southernhay Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 17 May 2016 and was unannounced. Two social care inspectors carried out the inspection.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We met, spoke with or spent time with the 14 people using the service, two relatives, two health care professionals, the provider, deputy manager, and four staff. We looked at three care plans, records relating to medicines, quality assurance, and staffing. We looked around the premises including bedrooms, bathrooms, and communal areas.

Requires Improvement

Is the service safe?

Our findings

Risk assessments had been carried out for each person. Although most risks were being managed to ensure people were kept safe, people's choking risks were not being fully managed. One person had been assessed by the speech and language therapist (SALT). Their advice was to ensure the person was given full supervision when eating due to the risk of choking. There was clear guidance for staff in the care plan about how to observe them and what to do in the event of choking. Staff told us "We sit with [name] when they're eating breakfast. We control how much they eat at once" and "If [name] is eating there is always somebody next to them". Staff assisted this person at times. However, we observed this person was left on their own a number of times with food. We observed them eating an entire pudding without a member of staff checking them. Later on in the afternoon we observed them eating a biscuit without there being a member of staff in the room. A member of staff occasionally looked up to see how they were from the dining area but this staff member was not sitting next to them. Following our inspection visit, the SALT confirmed the person needed full supervision due to the risk of them putting too much food into their mouth. They recommended staff sit with this person whilst they were eating to slow their pace but said staff could move away. However, staff were not aware of this guidance at the time of our visit. Prior to our inspection, the provider had not asked for a review of this person's swallow. Another person's care plan stated they were on a soft diet, were at risk of choking and needed to be supervised when they were eating. We observed they were left on their own with a plate of food and a spoon on a number of occasions.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were at risk of pressure sores, risk assessments had been carried out. These included information about action to be taken to minimise the chance of these developing. We saw that equipment was in place; such as pressure cushions and pressure relieving mattresses. This meant the risk of skin breakdown was reduced. No one living at the home had a pressure sore.

People were protected from the risks associated with behaviour that may put themselves or others at risk. One person could behave in a way that put themselves and others at risk. Staff knew how to manage this person's behaviour. Staff knew the triggers that may result in the behaviour, signs to look out for, and steps on how to manage the situation. The person's care plan gave clear information for staff to follow. Staff told us the strategies in place were working and records confirmed there had not been any incidents.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. Medicines were stored safely and securely. There was a separate fridge for medicines needing cold storage. Records were available to show that the fridge temperature was checked daily to make sure that these medicines were stored correctly and would be safe and effective for people. There were suitable arrangements for the storage, recording and destruction of medicines and records showed that regular checks were undertaken by staff. Records of medicines administered confirmed people had received their medicines as they had been prescribed by their doctor to promote good health. Regular audits were being completed by senior staff. Staff who administered

medicines had completed training.

Relatives told us they felt people were safe. One person told us they felt safe. All of the other people were living with dementia and they were unable to tell us if they felt safe. We observed people were comfortable with staff and smiled in response to them. People were protected from the risk of abuse as staff had received training in safeguarding people. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies. The provider had safeguarding policies and procedures in place. Staff told us they felt confident the provider would respond and take appropriate action if they raised concerns.

Where accidents and incidents had taken place, the provider had reviewed practice to ensure the risks to people were minimised. For example, one person had fallen a number of times. Accident reports were completed and staff had sought the GP's advice during a visit. An alarm and crash mat had been put in place to alert staff if the person fell and protect them from injury. Records showed the person had not sustained any injuries since this had been introduced.

There were sufficient staff to meet people's needs. Staff responded to people's needs and requests in good time. Staff did not seem rushed and remained calm and attentive to people's needs. They had time to have individual conversations with people. The deputy manager was on duty with a staff supervisor and two care staff. In addition, there was a cook and a cleaner. The provider also employed maintenance staff. There were two waking staff on duty overnight. The provider had worked the previous night duty to cover staff sickness but came in and was available throughout the inspection.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed. The staff files included evidence that pre-employment checks had been made. These included written references, satisfactory police checks [Disclosure and Barring Service clearance (DBS)], health screening and proof of their identity had also been obtained. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable people.

The premises and equipment were maintained to ensure people were kept safe. For example, checks had been carried out in relation to fire, hoists, and gas safety.

There were arrangements in place to deal with foreseeable emergencies. For example, each person had a personal emergency evacuation plan that was to be used in the event of a fire. The plans were detailed and gave staff information on how people were to be assisted from different rooms and different positions. For example, lying in bed or sitting in a chair. First aid kits were available to staff and included a burns kit and a catering first aid kit.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in June 2015, this key question was rated 'inadequate'. Whilst some improvements had been made, further improvement was needed.

At the previous inspection, we found the provider had not followed the principles of the Mental Capacity Act 2005 for those people who did not have the capacity to make their own decisions. Although there was evidence that people's relatives and representatives were now involved in their care planning and decision making, the provider displayed a lack of knowledge of the MCA. The provider was not able to tell us about any best interest decisions which had been made for people and we did not see any evidence of best interest decisions within people's care files. We saw that one person's bedroom door was alarmed to monitor their movements. No best interest decision had been made in relation to this. This meant the decision had not been made in accordance with the MCA and may not have been in the person's best interests.

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. People's relatives and representatives had been involved in their care planning and decision making. The provider had a copy of the Mental Capacity Act Code of Practice but they were not following it.

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.

One person's mental capacity assessment stated they lacked capacity. However, the boxes were ticked that they could understand information, assess information whilst considering a decision and communicate their decision. This indicated that they did have capacity. The provider told us they were unsure whether the person had capacity or not because of their difficulties in communicating. A staff member told us they didn't think the person had capacity to make decisions. The staff member said "We do ask and they will say yes or no". They said they asked the person's spouse about lots of things. There was no evidence staff had used any other methods to support the person to communicate their decisions. This meant that the person's right to make decisions may have been taken away from them.

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). DoLS applications had been made for all those living in the home. The provider had applied for a DoLS for a person who had capacity. The DoLS only applies to people who lack capacity. This meant the person may have had their liberties restricted unlawfully. This showed the provider did not have a clear understanding of the MCA and DoLS and how this should be employed to uphold people's rights.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people living in the home did not have the capacity to make their own decisions in relation to their care. Staff sought consent on day to day decisions where people were able to respond. For example, staff checked people were happy before they provided any support. One staff member said "Can I put this on your clothes to protect them". The person responded saying "yes".

At our previous inspection in June 2015, staff had not received training to ensure they had the knowledge and skills to meet people's needs effectively. At this inspection in May 2016, we checked and found improvements had been made. Staff said "I have done lots of training" and "All my training is up to date". Staff had completed face to face training in first aid, fire, moving and handling, and continence care. Other courses which were workbook based included dementia, infection control, food safety, safeguarding, and medicines. There were still some gaps in staff training in relation to infection control and food safety but there was a plan in place to ensure staff got up to date. Two staff had completed level 2 diplomas in health and social care. Two staff were working towards this. Two staff had completed level 3 diplomas.

Staff told us they felt well supported and had regular opportunities to discuss their work. Comments included "They're there to help me" and "I receive support and we discuss 'what would you do in this scenario' to help my learning". Appraisals had been carried out in February 2016. Staff set three objectives for the year ahead. One staff member told us they had already completed one objective of getting their training up-to-date and were looking forward to starting a diploma.

People were at risk of not having enough to eat. Staff tried to assist one person to eat at lunchtime, but they did not respond to staff. Different staff came to support the person and offered encouragement. Staff left the person with their food but they did not eat anything. After trying to encourage the person, their food was taken away and was thrown out. It was not saved for later and no other food was given to them until they were offered a cup of tea and snack later in the afternoon. Another person was enjoying their food and looked for more food in the bottom of the bowl. Staff came and took away their bowl and did not offer them any more food.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw occasions where staff took their time when supporting people to eat and came down to their eye level. People were told what was on their plate and staff chatted to them whilst assisting them.

The meal for lunch was toad in the hole with mashed potato, peas, carrots and gravy. People clearly enjoyed their meals and these had been freshly prepared. If people did not like the meal choice they could have alternatives such as sandwiches, omelettes, or salad. There was plenty of fruit, vegetables and fresh meat in the fridge. People had a varied, balanced diet which included meals such as roast chicken, fish pie, cottage pie, fish and chips, liver and onions and lasagne.
The cook knew people's preferences, likes and dislikes. They told us one person required a low sugar diet and we saw a separate low sugar chocolate cake had been prepared for them for pudding. The cook knew who was on a soft diet and prepared their food individually so it looked and tasted more appetising.

People's weights were recorded regularly. One person had lost weight in the last few months. Staff had referred them to the GP in relation to their reduced appetite. Staff were able to tell us why this had occurred and what they were doing to try to increase the person's weight. The cook presented food in small amounts

as this encouraged the person to eat. Where people were at risk of weight loss, the cook prepared enriched foods by putting cream in the custard and using full fat milk.

People were offered drinks regularly. We observed showing people different cups in order to identify whether they wanted a hot drink or a cold drink. They were then able to point to the cup they wanted and staff brought this choice.

People were supported to receive treatment from health care services. Care plans contained records of what happened when healthcare professionals visited people. People had seen GPs, district nurses, the optician, and the dentist. We spoke with a visiting nurse who told us "It's very positive here. I've always found it to be really good. They link very well with our practice. Absolutely they communicate concerns. I feel confident coming here. They seem to be very knowledgeable".

The provider had sought guidance for supporting people with dementia in an enabling environment. They showed us information relating to bedrooms, corridors, and bathrooms. They said they planned to start work on this after they had finished improving the garden. Additional seating areas had been built in the garden which meant it was easier for people to go into it. Staff told us people enjoyed sitting out on the decked area.

Requires Improvement

Is the service caring?

Our findings

We observed a number of caring interactions. However there were also occasions when staff did not acknowledge people. We spent 30 minutes carrying out a Short Observational Framework for Inspection (SOFI) observing people. We observed three staff members having a break together in the dining area. They were sitting where people could see them but did not interact with people. One person was sitting in the dining area and staff did not acknowledge them. One staff member sat with their back to the person, close to where they were sitting. During the day we saw a number of staff did not interact with this person but sat with their backs to them as though they weren't there. This did not show respect for people who lived in the home.

Staff didn't always show skill and compassion when relieving people's distress. For example, one person was worried about their family. Staff said they would find a solution later and encouraged them to have their lunch. This did not address the person's concerns.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were also some nice interactions between staff and people. One member of staff was having her hair brushed by a person who was clearly enjoying what she was doing. Whilst this was happening the two of them were chatting and laughing. We observed staff get down on their knees to speak with people. Staff gave two people soft toy animals to hold which clearly gave them comfort. Before providing support to people, staff explained what they were doing. For example, one staff member said "I'm going to help you stand up, are you ready?"

Staff spoke about people with compassion and concern. They gave us examples of how they tried to make people's lives better. This included a staff member bringing in adult colouring books for people. Another staff member got a person a newspaper and chocolate while they were in hospital so they knew they were thinking about them. The provider went to visit this person in hospital after they had finished work in the evenings.

Staff respected people's privacy and dignity. For example, one person, spilt their tea on the table and their trousers. Staff came very quickly and organised for the person's trousers to be changed in private. They were very kind about it and did not say anything to the person about what had happened. Staff wanted to support the person so they were clean.

Relatives told us they were always made welcome. They had been involved in the care planning process and told us they were kept informed of any changes. One relative said "If you ring up, they put your mind at ease. We're very lucky to have [person] here". Compliments received at the home included "I really do not know how to thank you for the love and best care". Relatives and representatives thanked staff for their kindness and support. Feedback from surveys showed relatives were happy with the care at the home. Comments included "We couldn't be more happy with the care and attention received from all staff" and "[name] seems

very settled in the home and says they like the staff and their friends there".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2015, care plans did not give clear information to ensure people's needs were met. At this visit in May 2016, we found improvements had been made but further work was needed. Care plans contained more detailed information and were reviewed monthly. However, one person may have been placed at risk of inappropriate care as there was no guidance in the care plan for staff to follow. Records showed the person's mobility had reduced and they needed two staff to help them mobilise. There was no information on whether any equipment was used. Staff told us the person's mobility was variable and told us what they were doing. They said sometimes they would use a handling belt and frame; other times they would use the hoist.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other care plans contained a good level of detail for staff to follow. For example, one person's care plan contained some very good information about how they were to be supported with moving and handling. There were details about how staff should transfer them from different positions and included details like "Dress [name]'s lower half whilst still on the bed and swivel legs over the edge of the bed".

People's care was not always person centred. People who did not require support with eating had to wait to have their meals until the people who required support were finished. This meant people in the living room watched as other people ate for about twenty minutes before they were offered their meal.

Where one person had difficulties in communicating, the provider had not used different ways of presenting information or giving support .This meant the person did not have a voice in their care planning and the care they received may not meet their needs and preferences.

We saw staff spent time with one person doing a jigsaw and painting their nails. During this time, there was very little interaction with the other three people who were sitting in the lounge area. This showed us their individual social and emotional needs were not being met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew people well. When we spoke with them about individual people they were clear about what they needed to do to meet their needs.

People were given individual time with staff who sat and spoke with them. One person told us "They sit and have a chat with me". Staff said "We can do a lot more one to one" and "it's become more person centred. We used to do a lot of group activity but now we can do one to one more. People like that one to one time". Staff were aware some people were at risk of becoming socially isolated. One staff member commented "When somebody's lonely or has had a bad day you can just sit with them and hold their hand. I like people"

and "I tell families to show up anytime, day or night".

Information about people's personal histories and interests had been added to the care plans. We observed that staff used this information when chatting with people, and they enjoyed these interactions.

During the afternoon a musical entertainer visited the home. Staff got up and danced with people and made it enjoyable for them. People were asked if they wanted to join in and came into the lounge from their bedrooms and other rooms.

The service had a complaints procedure. The provider told us they had not received any complaints since their last inspection. A relative told us "No complaints at all". Staff knew to look at facial expressions, body language, and changes in behaviour to tell if a person was unhappy.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in December 2013 and July 2015, the provider did not have an effective system to regularly assess and monitor the quality of the service people received. At our inspection in July 2015, we found eight breaches of regulations. We served two warning notices relating to safe care and quality assurance. We carried out a focused inspection on 22 October 2015 to check whether the warning notice relating to safe care had been met. Improvements had been made and the Safe key question rating changed from 'inadequate' to 'requires improvement'. The warning notice relating to quality assurance told the provider they must take action by 24 November 2015. The provider sent us an action plan telling us what they were going to do to ensure people received a good service. They told us all of the improvements were to be completed by 4 December 2015.

The provider information return told us the service had a quality management system in place which was followed by staff, monitored and audited. On this visit in May 2016 we checked and found some improvements had been made, however people were still not receiving a safe, effective, responsive or well led service. The quality assurance system was not robust and had not picked up the shortfalls we identified.

The provider had invited the local authority quality improvement team to visit the home. They provided support and guidance to the service. The team were still supporting the home at the time of this inspection. They told us they had given the provider the information they needed to make the required improvements.

At our previous comprehensive inspection, we identified one person was at risk of choking as staff were not following the speech and language therapist's advice. We served a warning notice relating to safe care. We carried out a focused inspection on 22 October 2015 to check whether the warning notice had been met. Improvements had been made. However, at this inspection, we again found this person was left on their own at times and placed at risk of choking.

We found people were not always treated with dignity and respect. At our previous inspection in June 2015, we found three staff took a break at the same time. This meant people were not supervised and became distressed. The provider told us in their action plan that staff had been spoken with and monitored. However, at this inspection we again found that three staff took a break at the same time, in the dining area, and did not interact with people. There were also occasions where staff did not acknowledge people.

The provider's information return told us "The home conforms to the design and layout of the registration requirements of the CQC". At our inspection in June 2015, we recommended the provider researched and implemented guidance for supporting people with dementia in an enabling environment. At this inspection we found improvements to the environment were still needed. The provider had sought guidance for supporting people with dementia in an enabling environment. However, they had not yet implemented anything within the building.

Improvements in record keeping had been made. Most care plans were accurate and up-to-date. However, some records relating to people's care were not completed. One person's care plan contained blank

documents. The manual handling risk assessment did not have an overall risk highlighted and the safe handling plan was blank. The environmental risk assessment was also blank. Another person's care plan had a document relating to medical services received. This was blank. The accident and incident book contained the name of the person but no clear description of the incident. Although individual accidents were monitored, there was no method for monitoring accidents for trends or patterns for the whole service. Records relating to staff training were confusing with information being held in several places.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had appointed a deputy manager who was working with them. The deputy manager was working towards their level 5 diploma in leadership and management. We spoke with the deputy manager and they told us they were keen to make improvements. Staff commented "[name] has taken charge of things" and "It's a lot better than last time, so much better".

The deputy manager had designed a quality assurance planner but this had not been introduced. This included staff training and supervision, audits, cleaning, and monitoring reports. We found improvements had been made in relation to medicines management, safety of the premises, staff training, and care planning. We saw medicine audits had been carried out regularly. Staff recruitment files were checked to ensure all the required information was in place.

The provider information return told us the provider had an open door policy where people could be confident they will be listened to. The provider worked within the home alongside the staff team. They had a good knowledge of the people who lived there. Staff told us they found the provider approachable. A staff member said "[name] is approachable and listens to my ideas". A relative said "[name] is very easy to talk to". Staff told us they got on well as a team. Staff said "It's the best place I've ever worked in" and "We all get on really well". A staff meeting had been held in November 2015. Items discussed included the CQC inspection, new staff, training, people's health and nutrition. The most recent meeting had been cancelled due to staff sickness. The provider told us they planned to hold more regular meetings.

Feedback was received from relatives and representatives through the survey carried out in September 2015. There were 12 responses which were mostly positive. Where suggestions for improvements had been made, the provider had taken action. For example, one response said there were a few trip hazards in the garden. The provider and maintenance staff walked around the garden to check for any hazards. A new decked area had been built out from the conservatory so people could safely go outside.

The provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.