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Lyndhurst Residential Home

Inspection report

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Date of inspection visit:
18 July 2017
19 July 2017

Date of publication:
31 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Lyndhurst Residential Home took place on 18 and 19 July 2017 and was unannounced. The home had previously been inspected during January 2017 and was found to require improvement at that time, with multiple breaches of regulations in relation to safe care and treatment, staffing, good governance and consent. During this inspection, we checked to see whether improvements had been made. Improvements were evident and we found no breaches of regulations during this inspection.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Lyndhurst Residential Home is registered to provide care for up to a maximum of 15 people, some of whom are living with dementia. Accommodation is provided over two floors, which can be accessed using a stair lift. Eleven rooms are single occupancy and two rooms are shared, accommodating two people in each room. There were ten people living at the home on a permanent basis at the time of our inspection and three people staying at the home on a temporary, respite basis.

The home had a manager in post, who had recently been appointed. They had not yet registered with the Care Quality Commission, although they told us this was their intention. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had a safeguarding policy in place and the staff we spoke with understood the signs to look for which may indicate potential abuse. Staff were clear about who they would report safeguarding concerns to.

Sufficient numbers of staff were employed to keep people safe and staff were recruited safely.

Risks had been assessed, such as those relating to diabetes or falls. Measures had been introduced to reduce risk and we saw moving and handling plans were in place which provided staff with information in order to safely assist people to move.

Regular safety checks took place and fire, gas and electrical systems had been tested. Plans and evacuation equipment were in place to safely evacuate people in the case of emergencies. Staff had been trained how to use evacuation equipment effectively.

Medicines were managed, stored and administered effectively and in a safe way and the new manager was

introducing new, improved systems to reduce the risk of error.

Staff received regular training and supervision, which included observations of their practice. Staff told us they felt supported.

The home was in need of cosmetic improvements such as redecorating and carpeting in some areas.

Team leaders had received training in relation to the Mental Capacity Act 2005 and demonstrated a good understanding of the requirements of the Act. This training had not yet been provided for care and support staff, although they demonstrated they understood the principles of the Act. Decision specific mental capacity assessments had been completed for people who lacked capacity to make specific decisions, as required by the Mental Capacity Act 2005.

People received appropriate support in order to have their nutrition and hydration needs met. Mealtimes were a pleasant experience and people enjoyed the food.

All of our observations indicated staff treated people with kindness and compassion. People told us staff were caring and we observed people's privacy and dignity being respected. Advocacy was accessed for people when this was appropriate. There was a pleasant atmosphere in the home.

Care plans contained person centred information, including people's personal histories, likes and dislikes. Staff were aware of people's needs and preferences and care was provided in line with care plans.

Some people told us, and records showed, activities were not meaningful for some people living at the home.

Audits and quality assurance systems had continued to develop and improve since the previous inspections and these had identified areas for improvement. Actions resulting from audits were evident.

Regular meetings with residents and relatives had not taken place and people's views had not been gathered through other means, such as questionnaires.

There was a permanent manager in post, although they had not yet registered with the Care Quality Commission. The new manager was working with the registered provider and a consultant who had developed an action plan in order to continue to make improvements in the quality and safety of service provision.

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 told us they felt safe.

Risks to people were assessed and measures were in place to reduce risks.

Sufficient numbers of staff were deployed to help keep people safe.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act 2005 were applied.

Staff had received induction and ongoing training and supervision.

People received support to access health care services and to meet their nutrition and hydration needs.

People told us, and we observed, the home was in need of cosmetic improvements such as redecorating and carpeting.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity was respected and personal information was kept confidential.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people and their relatives told us activities were not meaningful and there was not enough stimulation to keep people occupied.

Care plans included information relating to people's likes and dislikes as well as their care needs.

People were encouraged to maintain contact with people who were important to them.

People and their relatives felt able to complain if the need arose.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a new manager in post, who needed time to develop the service further. People and staff told us they had confidence in the new manager.

Regular residents' and relatives' meetings had not been held, although the new manager planned to meet with residents and relatives following this inspection.

Improved audits were in place and these had resulted in improvements to the quality and safety of the care and support provided.

Relevant policies and procedures had been updated and implemented since the last inspection.

Lyndhurst 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 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.

The inspection took place on 18 and 19 July 2017 and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with ten people who lived at the home and three relatives. We spoke with two care and support staff, a cook, a team leader and the manager. We also spoke with a consultant who had been commissioned by the registered provider to implement systems to improve the safety and quality of the service.

We looked at five people's care records, four staff recruitment files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

All of the people we asked told us they felt safe living at Lyndhurst Residential Home. All of the relatives we spoke with confirmed this. One person told us, "All of the staff are good to us. This is a safe place." Another person said, "It's as safe as houses here," and a further person confirmed, "This is such a safe place to live."

Relatives echoed their family members' views. Comments from relatives included, "We have such peace of mind knowing [name] and [name] are safe," and, "They will call me if there are any problems."

The registered provider had an up to date safeguarding policy and the manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. A member of staff said, if they suspected any abuse, they would not hesitate to report this and would escalate further if they felt their concerns were not acted upon. The manager was aware of a registered manager's duty to report specific incidents, including allegations of abuse, to the Care Quality Commission (CQC) and was knowledgeable about safeguarding procedures. This helped protect people from abuse because staff were aware of appropriate action to take if they had concerns anyone was at risk of abuse or harm.

The inspector and expert by experience were asked to sign a record of their attendance when they arrived at the home and identification was checked. This showed measures were in place to keep visitors, as well as people living at the home, safe because the manager knew who was present at the home and entry was authorised.

The previous inspection found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risk assessments were inconsistent and, in some cases, no risk assessments had been completed despite risks being present. During this inspection we checked and found improvements had been made. We found risks, such as those associated with falling, were assessed and we saw these were regularly reviewed and risk reduction measures were in place. Other risks, such as those relating to nutrition or skin integrity, were assessed using recognised assessment tools and these were regularly updated. Risks associated with moving and handling people were considered and care records contained moving and handling plans to enable staff to assist people safely, for example when using the stair lift or bath hoist. An assessment of risk had been developed for a person with diabetes which helped to ensure appropriate risks were identified and could therefore be reduced. Having risk assessments in place helped to ensure people were encouraged to be as independent as possible whilst associated risks were minimised.

We observed staff assist people, giving appropriate support. For example, there was a stair lift in use at the home and we observed staff assist people using the stair lift. Staff ensured the lap belt was in place to reduce the risk of harm and we observed the staff member remained close to the person, without obstructing them. A member of staff told us, "There are risk assessments and we share information at handovers. I'm always aware of risks, like scalding. We make sure we don't leave hot drinks around. You have to be careful." This showed staff demonstrated awareness of risks.

Fire evacuation procedures had been developed, which included emergency contact numbers and a safe place for temporary shelter. Following some information the CQC had received prior to this inspection, which raised questions about fire safety at the home, the fire safety service had recently visited the home and they confirmed to us there were no breaches of fire regulations. The automatic detection system had been recently tested. Fire equipment was serviced in June 2017. We saw evidence of regular fire tests and faults had been recorded and actioned, such as when batteries needed replacing. Emergency lighting had been tested regularly and there was evidence actions were taken such as when units needed replacing. Fire doors were inspected monthly. Gas and electrical safety had been tested, and found to be safe. We saw the stair lift and bath hoist had been recently serviced and tested, as well as other lifting equipment such as hoists and slings. This helped to ensure the building and equipment was safe.

Personal emergency evacuation plans had been developed for individuals living at the home. Information was included such as the equipment needed and how staff should assist each person to evacuate the building in an emergency. A member of staff told us they had been in the evacuation sledge during training, so they had experienced what it would be like for the person being evacuated. Emergency evacuation procedures were displayed. There was a box accessible to staff which contained items that would be useful in an emergency such as a high visibility vest, a torch and emergency contact details. This showed measures were in place to help keep people safe in an emergency.

We looked at how accidents and incidents were managed. We saw these were recorded appropriately and actions were taken and recorded when necessary, such as additional observations. Records showed some incidents resulted in referrals to health care professionals, such as occupational therapists, where appropriate. Monthly analysis took place which helped to identify any trends.

Staffing levels were determined based on the level of need and the support people required. There were three members of care staff to provide care and support to ten people who lived at the home and three people who were residing at the home on a temporary (respite) basis, as well as the manager, a cook and a domestic member of staff. Overnight there were two members of care and support staff. Records showed the number of staff identified as being required were deployed.

One person told us, "If you use the nurse call, they come straight away." Another person said, "There are enough staff," and a further person told us, "All the staff keep a close eye on you. That makes me feel safe." A relative told us, "There always seems to be enough staff but they look very busy at times." The staff we asked told us they felt there were sufficient numbers of staff to keep people safe, although one member of staff told us they felt more activities could be provided if there were more staff.

The previous inspection identified unsafe recruitment practices. During this inspection we inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, the manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at how medicines were managed. We found medicines were stored securely and regular temperature checks took place to ensure they were stored at the correct temperature. Medicines were labelled and well organised in the locked trolley. Dates of opening were written on creams which helped to ensure they were not used beyond their used by date. The person administering medicines was wearing a tabard indicating they should not be disturbed. This helped to reduce the risk of errors.

The medication administration records (MARs) contained a photograph of each person which helped to

reduce the risk of medicines being given to the wrong person.

Medicines were administered by staff that had received training to do so. Records showed staff competency was regularly assessed. We observed a staff member administering medicines. This was done in a kind and patient manner and the staff member gave the person their preferred drink with which to take their medicines. The member of staff was aware of which medicines were time specific and should therefore be administered at particular times of day and they showed us how they recorded this on the records. This helped to ensure people were given the correct medicines at the correct time. People told us they were given their medicines on time. One person told us, "I get my medicines on time," and another person said, "They are always on time."

Some medicines, such as paracetamol for example, were administered on a PRN (as required) basis. We found PRN protocols were in place which helped to ensure these medicines were administered appropriately and at safe intervals. Where creams were administered to people, we saw body maps were in use which helped to ensure the cream was applied to the correct area.

We looked at a sample of MARs, which contained relevant information and were fully completed by staff. Where medicines had been refused, this had been appropriately recorded. We checked a random sample of medicines and these reconciled with the records and showed the correct amount of medicines remained. However, for a person residing at the home on a temporary basis, the information on the MAR made it difficult to determine how many tablets the person should have had remaining and the number of tablets remaining did not correspond with the record. This was because records had not been created and completed effectively in order to record the medicines administration. The manager acted immediately upon this and, on the second day of the inspection, action had been taken and new measures had been introduced and shared with staff. This meant, although the recording of the medicines in one person's case was not accurate, immediate action was taken to address this.

People told us staff wore personal protective equipment (PPE) when providing personal care and all of the staff we asked told us they had access to adequate supplies. We observed staff using PPE. This helped to prevent and control the risk of the spread of infection.

We asked people whether they felt the home was clean. People told us they felt the home was kept clean, but commented the outside of the building required some attention. Comments included, "The home is clean on the inside but it gets very untidy outside," and, "The outside bin areas need to be tidied up."

Good

Is the service effective?

Our findings

People told us they received effective care. One person told us, "Staff do all they can to keep us happy and safe," and another person said, "The staff give me good attention and I don't have to wait long for anything."

The previous inspection found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing because staff had not received appropriate training and supervision. At this inspection records showed staff had received supervision and regular observations of practice had taken place. The records of staff supervision indicated staff felt supported and achievements and improvements were acknowledged, although formal appraisals had not taken place. We saw regular observations of the administration of medicines, mealtimes and observations of care took place. Staff told us they received feedback on their practice. Staff had received an induction, which included shadowing more experienced members of staff and learning in essential areas such as fire safety, health and safety as well as introductions to people living at the home.

We saw certificates of safeguarding training for four members of staff. However, evidence of safeguarding training for other members of staff was not evident, although the team leader assured us staff had received training. The consultant and manager agreed to forward further evidence of training to us following the inspection and this was forthcoming. The training matrix showed staff had received training in areas such as safeguarding, fire awareness, infection control, moving and handling and dementia awareness. This demonstrated improvements had been made in relation to staff training since the last inspection.

A member of staff we asked told us they felt they received sufficient training in order to provide safe and effective care. Staff told us they would feel able to request additional training, if they felt this was necessary, with confidence this would be provided.

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. The previous inspection found a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent and the Mental Capacity Act 2005. We checked and found improvements had been made in this area.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate authorisations had been sought where people lacked capacity to consent to care and treatment and where it was deemed they were being deprived of their liberty.

The previous inspection found a lack of decision specific mental capacity assessments. During this

inspection, records showed where people lacked capacity to make specific decisions, a mental capacity assessment had been completed and decisions were made in the person's best interests, for example in relation to the administration of medicines and when referrals were made to other health care professionals. Where a person occupied a shared room and was not able to consent to this, records showed a decision had been made in the person's best interests, taking into account other relevant people's views such as the person's close family.

The team leaders had attended a number of training courses in relation to the MCA and DoLS. One of the team leaders told us, in relation to their understanding of the MCA, "The penny finally dropped." This training had not yet been shared with other staff members and we were told there was a plan in place to do so.

Staff sought verbal consent from people prior to providing care and support and were respectful of people's choices. Records showed, since the previous inspection, consent forms had been introduced and some people had signed to consent to their care and support. Where family members had provided this consent, the manager had written to families to request evidence of their Power of Attorney. However, it was not yet clear whether those who had signed consent on behalf of family members had the power to do so. When we spoke with the manager, they were aware this needed to be followed up to ensure only those with the power to consent to care on behalf of others were doing so.

We looked at whether people's nutrition and hydration needs were being met. Everyone we spoke with was complimentary about the food quality. Staff were observed offering people choices and encouraging people to eat fresh fruit and drinks throughout the day. Staff were calm and patient when serving meals and people were given choices.

Dining tables were set with tablecloths, condiments, flowers and napkins. The cook was visible and asked people whether they enjoyed their meals. We heard staff ask, "Have you had enough?" before taking food away. A person responded, "Oh, I couldn't eat any more. It was lovely."

Everyone we spoke with was complimentary about the food and meals provided at the home. Comments from people included, "I cannot fault the food," and, "It's good home quality cooking," and, "I can assure you my appetite has improved since I came to live here." One relative we spoke with said, "[Name] loves the food and always mentions it." We were also told, "Nothing is too much trouble for the cook." On both days of our inspection, we saw a person asked for something which was not on the menu and this was accommodated.

The cook told us they cooked fresh food and we saw a delivery of fresh vegetables had arrived on the day of our inspection. The cook said, "If there is anything that is different they would like, we will get it."

We spoke with a person who ate independently who told us they preferred to take their meals in the, 'quiet lounge.' A small table was set in this lounge and the person told us they enjoyed their meal. The person ate independently and staff asked the person if they required any assistance, whilst respecting the person's privacy and choice to eat in a quiet area.

We saw people's rooms were personalised and contained photographs and items of sentimental value. Communal areas were decorated in traditional, homely styles and this was in keeping with the relaxed, informal atmosphere at the home. However, the home would benefit from some refurbishment and the design of the home was not conducive for those people living with dementia. Environments can be made dementia friendly by giving consideration to contrasting colours and signage for example.

Comments from people included, "This place could do with decorating," and, "Some of the windows need painting." A relative told us, "It would be nice to have some decorating done," and a further relative told us, "The home needs to be tidy outside. You should see the pile of broken furniture outside, it looks so unpleasant." A member of staff confirmed the interior of the home looked, "Tired."

We saw evidence of referrals to other healthcare professionals such as GPs and district nurses. One person told us, "I have my own optician. The staff make me an appointment when the time comes around." Another person told us, "The staff have just made me an appointment with the optician." A relative told us, "[Name] has various health care professionals coming in. Staff are good at communicating this." This showed people received support to have their health care needs met.

Good

Is the service caring?

Our findings

Everyone we spoke with made positive comments about staff. One person told us, "I have nothing but praise for the staff," and another person said, "The staff here are great. I cannot fault them." A further person commented, "The staff are good to us all."

A relative told us, "We are so happy with the care [name] is receiving." Other comments from relatives included, "I have always found the staff to be extremely caring," and, "When I come to visit, kindness is shown to all." One relative told us, "We travel a long way to visit. The staff always ask us if we want a meal. They're so hospitable."

A staff member said, "I love working here. It's like a big family."

The interactions we observed between people who lived at the home and staff working at the home were mutually respectful.

We observed a member of staff assist a person, who was using a wheelchair, into the lounge after they had been outside. The member of staff was heard saying, "Are you okay there? Do you want the remote control?" This was the only person in this lounge and they were watching their choice of programme on the television. The member of staff ensured the person could retain control over this.

People appeared comfortable in the presence of staff and were seen to make frequent requests of staff, to which staff responded positively and in a timely manner. We saw one person often appeared anxious. Staff took time to reassure the person in kind tones and using appropriate distraction techniques to good effect.

We observed a member of staff assisting a person to choose the music they would like to play. The member of staff took time to listen to the person's choices and the person then chose their preferred music and the staff played this.

All of the records we reviewed, such as daily records and care plans were written in a professional, respectful manner. Steps were taken to ensure confidentiality was respected and personal information was stored securely.

Leaflets for an advocacy service were displayed. In one of the care plans we reviewed, we noted a person's advocate had been contacted. An advocate is a person who is able to speak on other people's behalf, when they may not be able to do so, or may need assistance in doing so, for themselves.

We observed staff respected people's privacy and dignity. Staff were seen knocking on people's doors and announcing themselves before entering rooms. A relative told us, "Staff are always respectful to people. They knock on the door before entering and always call their name."

A 'dignity in care' audit had taken place in May 2017 and this examined different themes such as the

environment, privacy, respect and personal care. The audit showed what actions had been taken to promote privacy such as a cordless phone being available, having access to the quiet lounge and having discussions with people who shared rooms to ensure privacy was being respected.

Requires Improvement

Is the service responsive?

Our findings

We inspected five people's care records. We found care plans included information regarding people's care needs in relation to their physical health, mental health, medication, skin integrity, nutritional need, mobility, communication, personal care and continence care, for example. Care needs were reviewed monthly and changes were recorded.

We saw evidence people were beginning to become more involved in their care planning since the last inspection. This was evident through the signing of consent to care and support, which was an area that had been developed since the last inspection. The manager told us a priority was to review everyone's care plan and the manager understood the importance of people being involved in this. We saw a review of a person's care had taken place in May 2017 and the person had been recorded as commenting, 'It's lovely here. They look after me. I do share my room with [name] and I like the company.' The manager acknowledged there was further work to be done in order to ensure everyone was able to contribute fully to their care planning.

Plans included information relating to people's choices, likes, dislikes and previous occupation and we saw a document titled, 'This is me' which contained information regarding people's life history. People's preferred name was included in care plans. Including information such as this in care plans helps staff to provide personalised care and support to people.

The plans we reviewed included hospital passports. The aim of a hospital passport is to provide hospital staff with important information about a person and their health when they are admitted to hospital. Having a hospital passport can make hospital visits less stressful for people because healthcare staff are made aware of their needs and preferences.

Some of the care records we sampled contained detailed information to enable staff to provide effective care and support. For example, one person often became distressed. The plan included detail of which subjects to talk about and, importantly, what not to talk about in order to distract the person, should they become distressed. We observed staff using these techniques effectively. Another person's care plan indicated specifically the type of clothing the person liked to wear and we observed they were wearing their preferred attire.

Daily records, which documented the care and support people had been offered, were recorded each day. Records showed when people had received support in relation to oral care and personal hygiene, for example. Where people had declined or refused care and support, this was also recorded. This meant records were kept of the care and support offered and provided to people.

We saw some activities taking place such as dominoes and card making for some people and we saw there had been a church service at the home during the month prior to the inspection. One person we spoke with told us about an allotment style garden area they engaged in at the home. This person displayed a sense of pride at their achievement and told us some of their produce was used by the cook.

However, some people felt there was a lack of activities. Comments from people included, "There are no proper organised activities," and, "Sometimes the days are long and the activities are not meaningful or stimulating." A further person told us, "There is absolutely nothing to do." One relative we spoke with said, "There are not enough activities. I think people would like to go on trips and outings." Another relative said, "There never seems to be enough activities."

We reviewed the daily activity records and these also indicated a lack of meaningful activities. For example, one person's records we sampled showed the activities they undertook in the four weeks prior to the inspection were, 'Walked around the home, chatted to staff, laid on bed, watched TV and listened to music.' Another person's records showed in the four weeks prior to the inspection their activities were, 'Watch TV, sat in garden, talk to staff, clothes party, chatted to other residents, watch a movie.' This person told us they felt the activities were not meaningful to them. We shared our findings with the manager because this demonstrated there was a lack of meaningful activities for people to engage in.

Family and visitors were welcome to visit the home. One person told us, "My family come whenever they want." This can help to reduce social isolation.

We observed people were given choices throughout the day, such as where they wanted to sit, and what they wanted to eat. People's choices were written into their care plans and they told us staff respected these. For example, one person's care plan stated they liked to go to bed at around 10pm and they would let staff know when they wanted to go to bed. This person confirmed they were able to make their own choice.

People were not able to choose between bathing and showering. This was because there was only one communal bathroom in use and this contained a bath only. We asked a member of staff what would happen if a person preferred to shower and we were told, "They can't, there isn't one." A staff member told us a quotation had been obtained in order to convert an unused room into a wet-room so people could choose to shower and this had been shared with the registered provider. However, work on this had not been planned at the time of the inspection.

A complaints procedure was displayed. People told us they would feel able to complain if they needed to. A relative told us, "I would feel comfortable making a complaint if I had one." Another relative said, "I can talk to the senior staff about anything and it is dealt with straight away." No complaints had been received since the last inspection.

We looked at handover records which showed appropriate information was shared between staff to enable continuity of care when staff changed.

Requires Improvement

Is the service well-led?

Our findings

The previous inspection found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance because management arrangements at the home were unclear and there was limited structured support for team leaders and the systems in place to improve the quality of service were not yet effective. A new manager had been appointed since the last inspection and they had been in post for five days prior to this inspection. They were therefore not yet registered with the Care Quality Commission, although they told us their intention was to apply to register.

People told us they were gaining confidence in the new manager. One person said, "I, for one, am happy we have a new manager." Another person told us, "The new manager is very nice. She is getting to know us all. She asks you if everything is alright."

The manager told us they felt supported by the consultant, which the registered provider had engaged prior to them being appointed, and by the registered provider. The manager told us, "They're reachable if I need support."

The manager had begun to develop action plans and had identified areas for improvement which required prioritising. The consultant had also developed an action plan since the last inspection and this had been shared with us.

The manager was visible throughout the home and appeared caring and attentive to people. We observed the manager speaking with people and relatives. A member of staff told us they felt the new manager was, "Very professional."

The last residents' meeting was in January 2017. People had not been asked for their views through use of other means such as questionnaires. One person told us, "I have not been asked what I think about things," and another person said, "I have been to one residents' meeting ages ago, but I'm not bothered anymore." A relative shared with us, "I wish they would call a relatives' meeting to discuss the future." The manager told us they were planning a meeting for the month following the inspection with residents, relatives and staff in order to introduce herself and discuss future plans for improvements.

On the first day of our inspection, the manager told us a meeting had been arranged with the consultant for the following day, in order to discuss priorities and action planning. We attended the home for a second day when this meeting took place. We were shown the agenda for the meeting and saw items such as contact with residents and families, documentation, health and safety, medication, quality assurance and maintenance were discussed.

A full staff meeting had been held in January 2017 and issues such as medicines, management and staffing were discussed. We also saw records showed a staff meeting was held during June 2017, which the manager attended prior to commencing in the role of manager. This was an opportunity for the manager to introduce herself to staff and for staff to ask questions of the new manager. Meetings are an important part of a

manager's responsibility to ensure information is shared with staff appropriately and to come to informed views about the service.

The previous inspection found a lack of structured support for the team leaders, in the absence of a manager. During this inspection, a team leader showed us records of the support they had received in the interim period between the last inspection and a permanent manager being appointed. Records showed regular support had been provided by the registered provider and a consultant and a clear action plan was in place, which the team leaders had been working towards, in order to drive improvements.

We saw, since the last inspection, quality audits were regularly undertaken. A health and safety audit was completed monthly and this checked areas such as floor coverings, personal protective equipment, lighting, heating and water temperatures. We saw evidence action had been taken where this was identified as necessary, for example, carpets being cleaned and external contractors being contacted to undertake works. Other audits such as those in relation to domestic services, kitchen equipment and cleanliness also took place.

Medication audits were completed monthly. These considered different aspects of medicines management such as storage, administration, incidents, random counts of medicines and documentation. We saw action had been taken such as when information was missing from a medication administration record. The new manager had introduced a new recording system for medicines, in order to make improvements, and was implementing this with staff at the time of this inspection.

Some care plan audits had taken place and further work was planned to continue this. We saw a care plan audit which considered whether the file was clearly labelled, care plans were fully completed, risks were assessed, records of health care professional visits were recorded and records such as food and fluid were completed. A key priority for the new manager was to develop and review care plans.

The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities.

The previous inspection found the registered provider's policies and procedures were out of date and related to obsolete legislation and regulation. During this inspection we found significant improvements had been made in this area. For example, up to date policies were in place in relation to safeguarding, health and safety, staffing, medicines, infection control and data protection. Having up to date policies and procedures in place help to ensure current, up to date, guidelines are followed.