Indigo Care Services Limited

Loxley Court

Inspection report

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South Yorkshire
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Date of inspection visit:
07 August 2018
08 August 2018

Date of publication:
30 May 2019

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 and 8 August 2018 and the first day was unannounced. This meant no-one at the service knew we were planning to visit.

We checked progress the registered provider had made following our inspection on 15 May 2017 when we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were Regulation 12, Safe care and treatment; Regulation 18, Staffing; and Regulation 17, Good Governance.

Following the last inspection, we asked the registered provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective and well-led to at least good. During this inspection we found the registered provider was no longer in breach of Regulations 12 and 17. However, we found a further breach of Regulation 18; a breach of Regulation 10, Dignity and respect; and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

Loxley Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Loxley Court is located on the outskirts of Sheffield. Accommodation is provided over three floors, accessed by a lift. Loxley Court accommodates up to 71 people across four separate units, each of which have separate adapted facilities. One of the units specialises in providing care and support to men living with mental health difficulties and associated behaviours that can challenge. There were 55 people living at Loxley Court at the time of this inspection.

There was not a registered manager at the service. The improvement manager had been acting as manager for four weeks at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff told us there were usually enough staff employed to keep people safe. However, they felt there were too many agency staff employed and this impacted on their ability to meet people's needs in a timely and effective way.

Staff told us they knew what it meant to treat people with dignity and respect. However, we saw this did not always happen in practice.

CQC had not been notified when a Deprivation of Liberty Safeguard (DoLS) had been authorised for a person living at Loxley Court. These notifications were retrospectively submitted following this inspection.

The design and adaptation of the premises did not fully meet the needs of people living with dementia. We

spoke with the deputy manager about this and recommended they consider good practice guidance regarding 'dementia friendly' care homes.

The registered provider had recruitment procedures in place to make sure staff had the required skills and were of suitable character and background. We found three instances where these had not been followed. The head of improvement took immediate action to rectify this.

Systems were in place to ensure people were supported by staff who had the knowledge and skills necessary to carry out their roles in meeting people's needs. Staff were suitably trained. However, staff did not receive regular supervision in line with the registered provider's own policy and procedure.

Staff were knowledgeable about how to protect people from harm and what they would do if they had any safeguarding concerns. They were confident any concerns would be taken seriously by management.

We saw the premises were clean and well maintained.

Medicines were stored securely and procedures were in place to ensure people received their medicines as prescribed.

Staff understood the requirements of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The registered provider's policies and systems supported this practice.

People were assisted to maintain their health by being provided with a balanced diet and supported to access a range of health and social care professionals.

People and their relatives told us the staff were kind and caring. We saw positive interactions between people, their relatives and staff throughout this inspection. Most staff knew people and their preferences well.

There were activities available to people living at Loxley Court and additional activity coordinators had recently been employed. This was to ensure every person had the option to be involved in group activities and have 1:1 time.

People's care records reflected the person's current health and social care needs. We saw these were evaluated monthly and if there was a change in the person's circumstances.

There was an up to date complaints policy and procedure and this was displayed in the reception area.

The service had up to date policies and procedures which reflected current legislation and good practice guidance.

Safety and maintenance checks for the premises and equipment were in place and up to date.

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.

The manager used a high number of agency care staff to cover vacancies and sickness. The agency staff did not know the people living at Loxley Court and this meant people's care and support needs were not always met in a timely way.

There were systems in place to help keep people safe. Staff told us they were confident any concerns they raised would be taken seriously by the manager and deputy manager.

We found systems were in place to make sure people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

The design of the premises did not fully meet the needs of people living with dementia.

Systems were in place to ensure people were supported by staff who had the knowledge and skills necessary to carry out their roles in meeting people's needs. However, staff did not receive regular supervision in line with the registered provider's own policy and procedure.

People were assisted to maintain their health by being provided with a balanced diet and supported to access a range of health and social care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw people were not always treated with dignity and respect.

Staff spoke warmly about the people they supported. It was clear most staff knew people well.

Is the service responsive?

Good

The service was responsive.

There were activities available to people living at Loxley Court and additional activity coordinators had recently been employed.

People's care records reflected the person's current health and social care needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider had effective quality assurance and audits systems in place to monitor and improve service delivery. These needed to be fully implemented and sustained.

The service had up to date policies and procedures which reflected current legislation and good practice guidance.

Loxley Court

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 August 2018 and the first day was unannounced. The inspection was carried out by two adult social care inspectors, one adult social care assistant inspector and one 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. The expert by experience had experience in caring for older people and people living with dementia.

Due to the timescales of this inspection we did not ask the registered provider to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before this inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. Statutory notifications are information the registered provider is legally required to send us about significant events that happen within the service. For example, where a person who uses the service has a serious injury.

Before our inspection we contacted staff at Healthwatch, Sheffield and they had no concerns recorded. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted members of Sheffield council contracts and commissioning service and the NHS Sheffield Clinical Commissioning Group.

During the inspection we spoke with two people who lived at the home and six of their relatives. We also carried out a Short Observational Framework for Inspection (SOFI) to observe people's experience of life at Loxley Court. We met with the manager, deputy manager and head of improvement. We spoke with 11 members of staff. We spent time looking at written records, which included nine people's care records, eleven staff personnel files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the time of this inspection Loxley Court was divided into four units. Each unit was separate with their own lounges and dining areas. Churchill unit was on the ground floor and can support up to ten men living with mental health issues and associated behaviours that can challenge. At the time of this inspection four people living on Churchill unit required 1:1 support. Endeavour unit was on the first floor and provided support to people living with dementia who also had nursing care needs. Four people living on Endeavour unit had been also assessed as needing additional 1:1 support. Where people required 1:1 support additional staff were utilised. The manager told us 1:1 support was provided by permanent staff wherever possible, as they knew these people well.

We asked the manager how they ensured there were enough staff employed to keep people safe. The manager told us they used a dependency tool which calculated the number of hours required on each unit based on the assessed level of need of each person living on the unit. We were told care staff and nurses generally worked 12-hour shifts from 8am to 8pm, and 8pm to 8am. During the day we were told there was one nurse and five care workers employed on each unit, apart from Bronte unit, where there was one nurse and four care workers. During the night there was one nurse and three care workers employed on Churchill unit and on Endeavour unit. There was one nurse and two care workers on Bronte unit and on Nightingale unit.

On the first day of this inspection we saw there were seven agency care workers employed to cover sickness and vacancies. It was difficult for us to tell who were agency staff, who were permanent staff and who were visitors as not all staff were wearing name badges. The deputy manager told us they had changed the main agency they used three weeks ago and this meant most of the agency staff were new to the service and had no knowledge of the people they were supporting.

Staff told us there were usually enough staff employed. However, staff we spoke with told us they felt there were too many agency staff employed and this impacted on their ability to meet people's need in a timely and effective way. Comments included, "Sometimes there are more agency [staff] than we need, that don't know the units", "We can't be relying on agency [staff] all the time. If we got the regular staff who knew the residents, this care home could be very good. One weekend, there was fourteen agency staff. There was more agency [staff] than regular staff. We need to cut the agency [staff] out", "It can be unsafe with agency [staff]. The agency [staff] aren't used to this place. They don't know the residents very well, the routine, what medication they have, it can be a great risk" and "People [permanent staff] are leaving. We're getting agency [staff] who obviously don't know the residents."

We spoke with the manager about this and they told us they had recently recruited care staff to provide 200 hours of care per week. They were in the process of completing recruitment checks. However, at the time of this inspection there were not sufficient competent, skilled and experienced staff deployed in order to meet people's care and support needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We checked eleven staff personnel files to see if the process of recruiting staff was safe. Four of the files were for staff who had been recruited in the last 12 months. We found a recruitment and selection process was in place that specified the checks needed to confirm the staff member's suitability to work with vulnerable adults. For example, last employer references, health checks and exploration of their working history. We saw these checks were completed on eight of the files we looked at. Two of the files had gaps in the person's employment history with no explanation as to why recorded. One file did not contain a reference from the most recent employer. We spoke with the head of improvement about this. They obtained an acceptable written reference from the member of staff's most recent employer and we saw they had started to investigate the gaps in employment histories. We were given reassurances by the head of improvement that this would not happen again and all staff personnel files would be audited.

All staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and help employers to make safer recruitment decisions and prevent unsuitable staff being employed. We also saw evidence where applicable, that the nurse's Nursing and Midwifery Council (NMC) registration had been checked.

We checked progress the registered provider had made following our inspection on 15 May 2017 when we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. This was because we found the information contained in the care records we reviewed was inconsistent and in some cases contradictory; Accident and incident records were not analysed to see if any lessons could be learnt to reduce the risk of incidents occurring again; and staff did not have all the necessary equipment to meet people's needs. During this inspection we found improvements had been made and the service was no longer in breach of this regulation.

All the care records we looked at contained risk assessments. Any risks to the person were recorded in the person's care plan, with information on how best to support the person to reduce the risk. We saw risk assessments were completed for areas such as skin integrity, nutrition and falls.

We were told accident and incident forms were completed by the staff involved at the time of the incident and reviewed by the nurse to ensure immediate actions to resolve the situation were completed. The forms were completed electronically and the significance of the incident was recorded. We saw the manager printed out a summary of these forms every month to ensure action was taken to mitigate against further incidents and to identify any trends. We cross referenced three completed forms with the person's care records to see if the incidents had been recorded and care plans updated where required. We saw they had.

We checked all three floors in the home which included communal bathrooms, toilets, dining areas and lounges and found all to be clean and in a state of good repair. We saw plastic gloves and aprons were used by all staff at appropriate times throughout both days of this inspection. Staff told us they had sufficient equipment to meet people's needs and reduce the risk of the spread of infections.

All staff we spoke with confirmed they had received training in safeguarding adults from abuse. They were able to explain to us what possible signs of abuse could look like and what they would do if they suspected abuse had taken place. They were confident any concerns they raised would be taken seriously by management. The manager kept a record of safeguarding concerns raised with the local authority. We saw 16 had been raised since the beginning of the year. We saw on people's care records the concerns had been investigated or were in the process of being investigated.

We saw the service had an up to date safeguarding adults and whistleblowing policies and procedures. Whistle blowing is one way in which a worker can report concerns, by telling their manager or someone they

trust. All staff we spoke with were aware of how to report any unsafe practice.

This meant there were systems in place to help keep people safe.

We found medicines were stored securely and administered correctly. Each unit had a room where the medicines and the medicines trolley were securely stored. Fridge temperatures and medicine room temperatures were documented daily. The temperatures recorded for August on three of the units had frequently been over the recommended maximum of 25 degrees Celsius. If medicines are not stored properly they may not work in the way they were intended. We saw fans were being used in an attempt to reduce room temperatures. The head of improvement showed us advice from Sheffield Clinical Commissioning Group (CCG) regarding the storage of medicines due to the unprecedented hot weather. They told us they had also referred this issue to maintenance services.

Controlled drugs (CDs) were stored in a locked cupboard in each of the medicine rooms. CDs are subject to additional requirements to those for other medicines. This is because they may cause serious problems like dependence and harm if they are not used properly. Two staff signatures were required to confirm when CDs had been administered. We saw quantities were checked twice a day to confirm they tallied with the amount recorded.

We observed part of a medicines round on all four units. We saw each person had a Medication Administration Record (MAR). This should be signed and dated every time a person is supported to take their medicines or record a reason why any medicine is declined. We saw MARs were appropriately completed after medicines were administered. Each MAR had a current photograph of the person to aid identification. Any allergies and people's preference for how they took their medicines were also recorded.

Some people were prescribed topical medicines, such as creams and lotions. We saw these people had a body map to indicate where on their body the topical medicine needed to be applied. We saw staff had signed the topical MAR when the cream had been applied. Where people were prescribed PRN (as required) medicines we saw there was clear guidance for staff on how to manage these medicines.

We saw the service had up to date policies and procedures covering all aspects of medicines management. We saw evidence of regular audits of the storage and administration of medicines. Where errors had been recorded we saw actions had been taken to reduce the risk of them happening again. Nurses we spoke with confirmed they had their competencies checked by the manager every year.

Requires Improvement

Is the service effective?

Our findings

We checked whether the premises were appropriate for people living with dementia. We saw some people's rooms had their names and photographs on them and some had personalised memory boxes outside to further aid recognition of their own room. However, some bedrooms did not have names on doors even though they were occupied. Some doors to communal areas were also not signposted, such as some of the bathrooms. We saw there were two papers on the Churchill unit, both were 'The Mail on Sunday', this was on Tuesday. We saw only one clock over the four units which showed the correct time. This does not aid orientation.

The premises were decorated with photographs and pictures which could prompt reminiscence, however we did not see any tactile displays or sensory materials available to people. We spoke with the deputy manager about this and recommended they consider good practice guidance regarding 'dementia friendly' care homes.

We checked progress the registered provider had made following our inspection on 15 May 2017 when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. This was because although some staff had received training to support them in their role, further work was needed to ensure staff had the right skills, knowledge and experience to work alongside people who may challenge the service. During this inspection we found further improvements needed to be implemented and sustained.

All staff we spoke with confirmed they had an induction. We saw evidence of these being completed on the staff personnel records we looked at. The induction was specific to the member of staff's job role. For example, care staff shadowed more experienced members of staff before working alone. However, every induction included familiarisation with the building and fire procedures, as well as training in statutory areas such as health and safety and emergency first aid at work. The service had a 'Learning and Development' policy which categorised training as statutory if it was a legislative requirement. Training took the form of online and/or self-directed learning supported by workbooks or other appropriate learning resources. In addition, the service provided face-to-face training where this was required, such as moving and positioning training.

The head of improvement showed us the training record for Loxley Court and we saw there were high rates of staff compliance for all statutory and mandatory training courses. Where the compliance was less than 100% we were told there were plans in place for the relevant staff to undertake the training.

Where staff were new to the role of care worker they were supported to complete The Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers should adhere to in their daily working life. The Care Certificate should give everyone the confidence that care staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Nursing staff were supported to maintain their registration with the NMC with regular training relevant to their role. We saw records of nurses and care staff being observed providing care and support to

check their competency.

The registered provider had an up to date supervision policy. This stated, 'Supervision will be offered to all staff at least six times a year on a one to one formal basis. Supervision may also take place more often on a group or team basis.' Supervision is regular, planned, and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing.

Staff we spoke with told us they received supervision, however they were unsure of the frequency of this. The staff personnel records we looked at did contain records of one to one supervision, however not as often as the supervision policy stated. We saw supervision records contained the exact same information. This was about what was required of the member of staff's practice rather than an opportunity to reflect and discuss their wellbeing. We spoke with the manager about this who told us staff were given the opportunity to talk about issues specifically relevant to them during these sessions and this was recorded, however not many staff took this opportunity. The manager told us they were in the process of implementing more reflective supervisions with a greater emphasis on supporting the member of staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked and found the service was working within the principles of the MCA. We saw there were restrictions on people's freedom to leave and move around the home as key codes were required to enter and exit the building and to move between the three floors. Some of the people living at Loxley Court were also subject to constant supervision. This meant some people's liberty at Loxley Court was being restricted. We saw the manager kept a record of all the DoLS applications made to the local authority with the outcome, where known. Some people were subject to DoLS authorisations with conditions attached. Where this was the case we saw this was reflected in their care records with guidance for staff.

The manager understood their responsibilities under the MCA. Staff told us they received training in understanding MCA and DoLS. The registered provider also had an up to date 'consent to care and treatment' policy. The members of staff we spoke with had an understanding of the MCA and the need to obtain consent before providing care and support to a person.

The care records we looked at demonstrated people's mental capacity had been considered. Throughout their care records we saw it detailed whether the person had the capacity to make and communicate decisions about their day to day care, such as what to eat, along with more complex decisions, such as where to live. Where a person lacked capacity we saw records of best interest meetings taking place regarding potentially restrictive care and support interventions. For example, where a person lacking capacity had movement sensors in place to alert staff to their whereabouts. We did also see records of best interest decisions being made for every element of a person's day to day living, and this is not required. We told the deputy manager about this.

We observed lunch being served in all four units. All the food was prepared in the kitchen and delivered to

each of the units on heated trolleys. In three of the units we saw dining was a pleasant and relaxing experience. The dining tables were fully set prior to everyone being seated and the food served looked and smelt appetising to us. There was plenty of it. We saw people were asked what they wanted to eat and given a choice of drinks. People who required support to eat were supported in a dignified and unhurried way. Staff sat next to the person at eye level and chatted with the person explaining what they were doing and asking the person if they were enjoying their meal.

On the Nightingale unit on the first day of this inspection we saw the lunchtime dining experience was not as pleasant and relaxing as on the other units. The tables were not set and the menu was not clearly displayed. No drinks options were offered. The radio was playing loud pop music and was not conducive to a calming atmosphere. We did speak with the manager about this. When we returned for the second day of this inspection we observed breakfast and lunch being served on the Nightingale unit. We saw It was a much more pleasant experience for people.

Some people had specific dietary needs for health or cultural reasons. We saw these needs were catered for. There was a list of people's specific dietary requirements in the kitchen. We saw staff were attentive to how much people ate and drank and recorded this where required.

People were supported to access health and social care professionals. GP visits were discussed and arranged at the daily flash meeting we attended. One relative told us, "Staff keep me informed, they tell me about any visits from the doctor." This meant people were assisted to maintain their health by being provided with a balanced diet and supported to access a range of health and social care professionals.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they were liked the staff at Loxley Court. Comments included, "I'm very happy here and the nurses are lovely", "I haven't met any [staff] that I don't like", "The staff are ok because there's a lot of them [people living at Loxley Court] that get a one to one care, so others are ok. Staff are reasonable", "Friday, I go down to the entertainment [with staff]. I love it, they come in and we have singsongs its brilliant" and "We couldn't have found a better place for [relative]. As soon as we walked in we could feel how nice it was [at Loxley Court]."

We were not able to fully communicate with some people living at the home. We spent time observing staff providing care and support to help us understand the experience of people who could not talk with us. Throughout both days of this inspection we saw many positive interactions between people, their relatives and staff. It was clear to us that most staff were compassionate and caring, and they knew people well. At the daily flash meeting we attended, nurses spoke knowledgeably about the needs of people and were keen to find solutions to any concerns raised. Permanently employed staff we spoke with knew people's likes and dislikes and spoke with warmth about the people they supported and their relatives. We saw staff dancing and singing with people, we heard laughter and lively conversations.

We saw people's dignity was promoted and privacy respected by most staff. We saw staff knocking on people's doors before entering their rooms. Staff were discreet when supporting people with personal care. Staff could tell us what it meant to treat people with dignity and respect. Comments included, "Speak to people. Knock on the door first, walk in. Ask if they want a shower or bath, if they don't, ask them if they want a wash. If they can't speak, you look at eye contact" and "Knocking on the door when you walk in. With respect, I would speak to them how I would like them to speak to me. For dignity, when you're washing them, you cover with a towel. Use another towel whilst you're drying them. Just basically how you would like to be treated."

On the first day of this inspection we did see some staff who were not caring, this was on the Nightingale unit. For example, one person was shouting out for their spectacles which were out of their reach. The member of staff who attended did not offer any conversation, or attempt to make the person more comfortable as they were slumped in a chair with their shirt unfastened and trousers falling down. The member of staff passed the person their spectacles and left the room. We saw another person wandering on the corridor wearing only a pair of underpants and they stood on a piece of glass. We gave the glass to a care worker and suggested they check the person's feet and offer to get their footwear. No attempt was made to check and sweep the corridor and this person had no shoes and socks on for the remainder of the morning we spent on that unit. During the same morning we saw four members of care staff sat in the lounge at the end of the unit. They were chatting amongst themselves. There was one other person in the lounge, who was sleeping. Outside of the lounge we could hear a person shouting out, none of the four care workers responded to this and carried on with their conversation.

As care staff did not always treat people living at Loxley Court with dignity and respect this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and

respect.

The service had a 'Confidentiality: Employees' policy and staff we spoke with understood the need to respect people's confidentiality. We saw there were secure rooms to lock care records away when not in use. On the first day of this inspection was did see two people's care records left unattended on a table in a communal area. We spoke with the nurse about this and the care records were locked away.

We saw people's care records contained information about people's personal preferences and any cultural and religious beliefs they held. This meant staff should be aware of people's individual needs, and support could be provided in a way that respected their choices. There was also space to record if the person had an advocate they could contact if they needed independent support to express their views or wishes about their lives. Advocacy services can help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The deputy manager told us a number of people living at Loxley Court were supported to access advocacy services.

Good

Is the service responsive?

Our findings

There were three activity coordinators employed at Loxley Court. There was a picture timetable at the entrance of each unit listing which activities were available on each day of the week. This did not change from week to week. However, we were told additional ad hoc activities did take place, such as visiting entertainers.

The weekly activities included ball games, baking, and arts and crafts. One member of staff told us if people did not want to join in activities they would sit down and chat with them. They would also suggest a pampering experience, such as a manicure or a foot massage as a way to spend 1:1 time with people.

Loxley Court had a large room off the main reception area which was open to all. It was set up as 'The Happy Hour' bar. On the first day of this inspection we saw two activity coordinators supporting two people with arts and crafts in this room. We were told it was also regularly used for a 'Gentleman's Club' where the men living at Loxley Court were encouraged to spend time together and play dominoes, pool and darts. We were told there was also a regular 'Lunch with Ladies' session.

We were told there had been the opportunity for trips out, however the bus driver post was currently vacant. The deputy manager told us this post would be recruited to, and in the meantime taxis were used.

People's care records contained a section focussing on the person's 'social interests, hobbies, religious and cultural needs'. The care records we looked at varied in the amount of detail they contained. We were told part of the activity coordinator's role was to gain more information about people living at Loxley Court and develop this section of their care record. We saw this on some of the care records we looked at.

We spoke with the deputy manager about the activities and social opportunities available to people at Loxley Court, particularly for those people who displayed behaviours that challenge. They told us two of the activity coordinators were new to the post and part of the reason for employing more was to ensure every person could be involved in group activities and have 1:1 time. We saw minutes of meetings with the activity coordinators which had recorded discussions about developing new ideas and purchasing new equipment.

We looked at the care records for nine people living at Loxley Court. They each followed the same format. At the front was a laminated Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR), where appropriate. A DNACPR is a way of recording the decision a person, or others on their behalf have made that they are not to be resuscitated in the event of a sudden cardiac collapse. There was also a laminated photo of the person and a two-sided summary of their care and support needs. The rest of this section contained contact details for those who knew the person well and information about the person's life history.

There were the 14 sections covering all areas of daily living activities, such as 'personal care and physical well-being', 'diet and weight' and 'mental state and cognition'. Each had a tick box section with pre-populated options to identify the person's abilities, needs and preferences in that area. For example, whether a person preferred to wear slippers or shoes. These were not person centred as the options were

limited. However, these answers were then used to complete a detailed care plan which set out the action to be undertaken by staff to ensure the person's health and social care needs were met in relation to each of the 14 sections. We saw information surrounding people's preferences for the end of their life was also recorded.

We saw each care plan was evaluated at least monthly and when there were any significant changes to the person's circumstances. In addition, we saw short term care plans were completed for specific situations that should be resolved within two weeks. For example, one person had a number of these plans for when they had been prescribed antibiotics for an infection.

At the back of people's care records were forms to be completed to record visits by health and social care professionals, such as GPs, district nurse and social workers. There was a form to record contact with family. Daily communication records were also held at the back and we saw these were completed by night staff and again during the day. We saw these were regularly completed and gave a continuous record to staff about the person's general health and well-being.

The service had an up to date complaints policy and procedure. It gave addresses and telephone numbers of who to contact to make a complaint and who to contact if people were unhappy with the original response. We saw the policy was displayed in the reception area.

We saw the manager kept a complaints log. There were 11 complaints recorded so far for this year. We saw each of these had been investigated or were in the process of being investigated.

Requires Improvement

Is the service well-led?

Our findings

We checked progress the registered provider had made following our inspection on 15 May 2017 when we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. This was because the registered provider had failed to address and improve service delivery to ensure a safe, high quality service. During this inspection we found improvements had been made regarding quality monitoring and the registered provider was no longer in breach of this regulation.

Quality monitoring and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered provider used a 'Five point Managers` Toolkit' within each of its services. This included a manger's daily walk around, a manager's night audit, resident of the day, staff member of the day and daily flash meetings. We saw each of these audits were regularly recorded and any actions identified were followed up.

We attended the flash meeting on the first day of this inspection. This was where the nurse for each unit and a representative from each department attended and any concerns were shared and plans made for the day ahead. Staff told us they found these meetings useful. The manager told us the staff member of the day was selected from across all job roles and departments. They were going to use this a further opportunity to meet and talk with every member of staff. The staff member's personnel file was also audited as part of this process. We saw evidence of completed audits place on some of the personnel files we looked at. Where gaps had been identified actions had been taken to rectify this.

In addition to the manager's toolkit the registered provider had a series of audits which were to be undertaken daily, weekly, monthly or quarterly. These included care plan audits. We saw evidence of completed audits on people's care records.

The registered manager left the service last year. A temporary interim manager was appointed while the registered provider recruited to this vacant post. However, at the time of this inspection they had not yet been successful and the interim manager had now left. The improvement manager was now acting as the manager and had been in this post for four weeks at the time of this inspection.

Most staff we spoke with told us they felt supported by the manager and deputy manager. Comments included, "I would be confident to go to [name of manager]. I have a strong belief that she would look into the matter" and "I think since [name of manager] has come, we have improved." Several members of staff did tell us they would like to have a permanent manager in post in order to promote consistency and stability for people, their relatives and staff.

Not all the people and relatives we spoke with knew who the new manager was. The manager told us they were planning to meet with people and their relatives to introduce themselves. The last recorded meeting was in March this year. We asked people and relatives if they were asked for their views on the service and given opportunities to make any suggestions for improvement via questionnaires or surveys. This can be

another useful way to gain people's opinions. We saw the results from the registered provider's 'customer satisfaction survey' undertaken in April this year. We were told this was undertaken every year. All the respondents agreed or strongly agreed the care was of a high standard at Loxley Court

We saw records of regular meetings with staff. Staff we spoke with confirmed there were regular meetings.

We reviewed the service's policies and procedures. The registered provider had created the policies and procedures for all its services. We saw they covered all areas of service provision and were up to date. This meant they reflected the most recent legislation and good practice guidance. Staff we spoke with told us they had access to paper versions of the policies and procedures and we saw these were available in the manager's office.

The service had a comprehensive maintenance schedule in place. We saw the regulatory tests required, such as water safety and legionella testing, and electrical installation and equipment servicing records were listed with required frequency of testing and the next date each test was due. We saw they were all up to date.

A notification should be sent to the Care Quality Commission every time a significant incident has taken place. The current manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. However, CQC had not been notified when a DoLS had been authorised for a person living at Loxley Court. These notifications were retrospectively submitted following this inspection. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

The registered provider continued to ensure the ratings from their last inspection were clearly displayed in the home and on their website.

During this inspection we found two breaches of the Health and Social Care Act 2008, one breach of the Care Quality Commission (Registration) Regulations 2009, and we have made a recommendation within this report with regard to the design and adaptation of the premises. We recognise the manager and head of improvement are already taking action to improve the service, however until these actions have been fully implemented and sustained Loxley Court continues to be rated as 'requires improvement'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care staff did not always treat people living at Loxley Court with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient competent, skilled and experienced staff deployed in order to meet people's care and support needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The current manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. However, CQC had not previously been notified when a DoLS had been authorised for a person living at Loxley Court. These notifications were retrospectively submitted following this inspection.

The enforcement action we took:

To issue FPN