Amore Elderly Care Limited

Abbey Court Care Home

Inspection report

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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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 10 and 11 May 2017 and was unannounced.

Abbey Court Care home is registered to provide accommodation and nursing care for up to 88 people some of whom may be living with a dementia. The ground floor provides residential and nursing care to people in the Sunflower and Jasmine units. The first floor is split into two secure dementia care units Bluebell and Forget-Me-Not. There were 81 people living at the home when we inspected.

There was a registered manager for the home. However, they were no longer working at the home and had applied to cancel their registration. There was a new manager in place who had been working at the home five weeks when we inspected. They told us they would be submitting an application to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Our last inspection took place on 9 March 2016. We found that the provider was in breach of the regulations relating to safe care and treatment. Following the inspection the provider wrote to us and told us about the improvements they planned to make. At this inspection we found the provider had made the improvements needed to comply with this regulation. However, the provider was not meeting the legal requirements in two areas of care provided. They had not ensured that people were safeguarded from abuse and they had failed to notify us about certain incidents. You can see the actions we have asked the provider to take at the back of this report.

Systems in place to monitor the quality of care provided were not always effective. They had not identified the concerns we found at this inspection and did not support the provider to drive improvements in the care people received. However, the manager was proactive at taking action when we identified concerns.

Care plans accurately reflected people's needs and identified the care they needed. Care plans recorded the risks to people while receiving care and provided information to support staff to provide safe care. In three units the care was provided in line with the care plans and met people's needs. However, on Forget-Me-Not unit people living with dementia were often confused and displayed distressed reactions. Relatives told us that staff needed more training in caring for people living with a dementia.

Most people were happy with the activities they were able to access. However, people living on the Forget-Me-Not unit had not been provided with sufficient activities to keep them entertained and engaged.

Where people had been unable to make the decision to live at the home the provider had submitted appropriate applications for assessment under the Deprivation of Liberty Safeguards. Where people were not able to make decisions for themselves decisions had been taken in their best interest and family

members had been included in the decision making process.

People were supported to maintain a healthy weight. They were offered choices at meal times and encouraged to eat and drink enough to meet their needs. However, people's independence with food was not supported as there was a lack of food which was accessible for people living with dementia. Medicines were safely stored and staff administered the medicines in a safe methodical manner to reduce the risk of errors.

Staff were kind and caring. However, the use of agency staff impacted on the care people received as agency staff were not always aware of how to personalise their care. Staff and systems in the home did not always support people's dignity. People's privacy was respected.

People knew how to raise concerns and had a growing confidence that the new manager would take action to improve the care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff had received training in keeping people safe from abuse and knew how to raise concerns internally. However, on the Forget-Me-Not unit high levels of people who may become distressed meant people were at risk of being in conflict with other people on the unit.

Risks to people had been identified and care was planned to keep people safe.

There were no systems in place to show that staffing was adequate to meet the needs of people living at the home. Appropriate checks were completed to ensure staff were safe to work with vulnerable people.

Medicines were safely stored and administered. However, people had not been supported to access their medicine when they were out in the community.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training but this was not always reflected in the care provided to people living with a dementia.

Staff supported people to make decisions about their lives and helped made decisions in people's best interest when they were unable to make a decision.

People were supported to maintain a healthy weight. However, the food offered did not always support people with dementia to be independent.

People were supported to access advice and care from healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The use of agency staff did not support the needs of people living with dementia.

People's dignity was not always respected in the care provided.

People's privacy was supported and staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The care provided met people's needs. However, better dementia care was needed for people living on the Forget-Me-Not unit and people on this unit were not supported with activities to remain calm and settled.

Activities on three units supported people to be active and entertained.

Complaints were investigated and appropriate action taken.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The audits in place to monitor the quality of care provided had not identified the concerns we found at the inspection.

Notifications had not been appropriately submitted.

Multiple changes in manager since the home had opened had led to instability in the home. However, people were positive about the new manager.

The manager was responsive to the concerns raised and where possible took immediate action to improve the quality of care people received.

Abbey Court Care 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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 10 and 11 May 2017 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with eight people who lived at the home, 10 visitors to the home and spent time observing care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three nurses, the clinical lead, the dementia lead and the training co-ordinator. We also spoke with three care workers and the manager.

We looked at nine care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

Relatives said they felt their loved ones were safe living at the home and that the staff handled their relatives in a safe manner. Staff had received training in keeping people safe from abuse and were clear on how to raise concerns both internally and with external agencies.

In three units of the home the atmosphere was calm and settled. However, in the fourth unit, Forget-Me-Not, many of the people were unable to manage their emotions, which led to incidents. Staff had not submitted reports to the local authority safeguarding team about all of these incidents. In addition, the provider had not ensured that they had notified us of all the safeguarding concerns they had raised with the local authority.

We raised this as a concern with the new manager. They told us they would investigate the current processes in place around what concerns were formally raised with the local authority. Following our inspection the manager told us they had spoken with staff about what incidents needed to be notified to us and the local authority. The manager had met with the local authority safeguarding team to discuss the number of incidents they had identified as this increased the number of altercations to a level that was not acceptable. The manager had contacted professionals for advice, support and to review if the home was the correct placement for some people.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Two people living on Forget- Me-Not unit who were cared for in bed had gates put up in there doorways. This was to prevent other people from entering their bedroom. A relative told us, I like the gate at the door. It's a comparatively new thing. They did ask me and get my permission to put it up. A couple of the residents can still get in, but it's better than everyone wandering in. It is much safer for my husband with the gate up and it means the staff can see him and keep an eye on him with the door open."

At our last inspection on 9 March 2016 we found that risks to people had not been fully identified and management of people's medicines was inconsistent and was not always in line with good practice or national guidance. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment. Following the inspection the provider wrote to us and told us they would take action to ensure all risks were identified medicines were safely managed.

At this inspection risks had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. Appropriate equipment was in place to reduce the risk of occurrence. Safety equipment had also been put in place for one person who was at high risk of falling. People's ability to mobilise safely had been reviewed and we saw where needed appropriate equipment such as standing belts and hoists were available to keep people safe. Where people had bed rails in place risk assessments had been completed to ensure that they were safe for the person to use. Where people were at increased risks of falling sensor mats

were in place to alert staff if they started to move around their bedroom. This allowed staff to go to them and offer immediate support.

Accidents and incidents such as falls were recorded and action was taken to keep people safe from the situation reoccurring. There were emergency evacuation plans in people's care records which provided information for the emergency services of people's abilities in the case of an emergency.

Medicines were stored safely and administered to people at the correct time and in a safe manner. Staff who administered the medicines took the time to talk to people and knew how people liked to take their medicines. For example, one nurse spent time with a person giving them their tablets one at a time and encouraging them to drink plenty of water to swallow the tablet. They also advised people how they needed to take their tablets. For example, they told one person, "We have one of those tablets that you suck, can you remember?" Medicine administration charts were fully completed and contained pictures of the people for identification purposes, information on the person and any known allergies.

Where people were prescribed medicines to be taken as required, such as painkillers, we saw that the nurse discussed their pain with them and helped them to make a decision whether pain relief was needed. Where people were unable to verbalise their pain we saw that the nurse spent time to assess if they were in pain. In three of the units we saw that staff had recorded why they had administered medicines prescribed to be taken as required. However, in the residential unit this information had not been recorded.

There were systems in place to check when medicines were reordered that they were all completed correctly to ensure people had a continuous supply of their medicine. Where people needed their medicines crushed they had got advice from both the doctors and the local pharmacist. Where staff had concerns that people's medicines were no longer supporting them to stay well, they requested that the person be reviewed by their doctor to see if changes in medicines would improve their health.

The provider was now meeting the requirements of Regulation 12 safe care and treatment.

Four people had been offered the opportunity to go out for the day. However, one person needed medicines at lunchtime and these had not been taken with them. We raised this as a concern with the manager. Following our inspection the manager told us they had held supervision meetings with staff who administered medicines to ensure they were aware of and followed the provider's medicines policy.

Two relatives we spoke with raised concerns about the staffing levels. One relative told us, "Often in the sitting room there are no staff and the residents sometimes have fall outs and things get heated." Another person told us, "They always seems so understaffed in here and often it's me and the other visiting relatives left to keep an eye on the residents. The agency staff just don't know the residents, it's not their fault but they just don't know them."

The four units were all staffed at different levels dependant on the needs of people living on each unit. For example, the two units for people living with dementia and the unit for people who needed nursing care all had a nurse on duty each day. A senior care worker was in charge of the residential care unit. We spent time in each unit of the home and saw that call bells were answered in a timely fashion. In the one unit, Forget-Me-Not, people had higher needs and displayed more distressed reactions and so needed more support from staff. While there were more care workers on this unit than the others it was not clear if there were enough to meet people's needs due to the ongoing high level of incidents.

The staffing levels were set by the provider. However, there was no account taken of how much support

each individual person needed. During the inspection the manager contacted the area manager to discuss how they could reflect people's dependency needs in the staffing levels. The area manager explained that there was a staffing tool they could use and arranged for the manager to have access to it.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

At times the provider had needed to use agency staff to ensure that the home was staffed in line with their corporate staffing levels. Staff told us that they were short of staff and that they used agency staff each day. There were systems in place to ensure that the correct checks had been completed so that agency staff were safe to work with the people living at the home.

Requires Improvement

Is the service effective?

Our findings

Relatives told us that they felt that staff were trained in some areas, however, they felt that there was a lack of understanding about dementia care. One relative said, "I think the staff all need specific training in all the different dementias. Because for instance vascular dementia isn't the same as the other dementias." Another relative told us, "I think the staff could be better trained in dementia. Especially the younger ones, they don't seem to understand the needs." We raised this as a concern with the manager and following the inspection they told us that dementia training had been arranged for staff on 22 June 2017 and that more advanced dementia training was also planned.

There was a training lead in place who managed all the training needed for the home. New members of staff spent time in the class room learning the skills and knowledge they needed to provide safe care. They were also supported to complete the care certificate. This is a set of national standards which supported staff to have the skills needed to care for people safely. In addition, they spent time shadowing a more experienced member of staff to learn more about people's needs and to have their competencies observed. The training lead conducted regular supervisions with new staff while they completed their induction and probationary period. A member of staff told us how they found the training lead helpful. They said, "She is brilliant and I can go to her for help."

Staff were required to attend refresher training in key areas that helped them to provide safe care for people. In addition, staff told us that they were offered learning in more specialised areas to expand their skills and knowledge. The nurses told us this supported them to maintain their registration. The training lead also engaged with external agencies to arrange training, for example, in wound care. All the training was recorded on a computer system, this allowed the administration staff to monitor when people's training needed to be refreshed and they would provide a list for the training lead on a monthly basis.

Staff told us they had regular supervisions with their line managers and records showed supervisions were scheduled every two months. In addition, care workers told us that they could talk to the nurses on their unit if they had any concerns and the nurses had regular meetings to support each other and discuss people's care needs.

People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Their food was modified to increase their calorie intake, for example, cream was added to their porridge. Where necessary people had been supported with extra high calorie treats such as smoothies. If needed people had been referred to healthcare professionals for advice and support and some had been prescribed high calorie supplements.

People were given the right adaptive equipment they needed at mealtimes in order to eat independently. For example, one person was given a plate guard to enable them to eat his lunch. Where people needed support to eat and drink care workers were encouraging and took their time to ensure the person had enough. Where people may be unable to eat and drink safely the staff had arranged for the person to be assessed by a healthcare professional. Where people had been advised to eat a mashed or pureed diet this

was offered to them.

People were offered a choice at mealtimes. People living with dementia were shown the food on offer while sat at the table to help them a make a choice. Staff told us that if people did not like any of the choices on the daily menu then the chef would cook them whatever they wanted. During lunch we saw that people were able to personalise their meals, saying what they wanted and how big a portion they desired. Where people were not eating well staff took action to help them eat enough to stay well. For example, one person was not eating their main course, staff offered support and encouragement but when they did not want it they removed it and offered the person a pudding which they ate. Another person was not eating at the table and staff supported them to a quieter area and got them something different to eat.

One person had been reluctant to have a hot drink. Staff encouraged them saying to go and see the care workers who were handing out free drinks. The person was taken by this idea and went and got themselves a hot drink. People were also able to access healthy snack such as fruit which was out on the side for them to eat and offered when staff were handing out drinks.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other healthcare professionals such as GP's and the community mental health team had been included in people's care when needed. Healthcare professionals we contacted told us that the home raised concerns about people's health appropriately.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Appropriate applications had been completed for people to be assessed under the DoLS where they were unable to make a decision about where they lived. No one living at the home had any condition on their DoLS. However, we had not received any DoLS notifications. The manager was not aware that these had not been submitted and they told us they would submit these to us immediately. Care plans recorded when people had made legal arrangements for others to make decision on their behalf when they were no longer able to make that decision for themselves.

Staff had received training in the MCA. Where people were unable to make decision about their care needs a mental capacity assessment had been completed and decisions had been made in their best interest. For example, where people had refused to take their medicines a best interest decisions was made that they needed to take certain medicines to stay comfortable and pain free and so these medicines were given to them covertly. Covert administration of medicine is when medicine is hidden in people's food. A member of staff told us how when people were unable to make decisions about their lives they had included family members in making decision in people's best interest as family knew their likes and dislikes.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. A relative told us, "Staff are compassionate and give our loved ones the care they need." There was a guest book in one unit and we saw visitors had noted their thoughts on the home. One person had written, "The carers are wonderful, they all work really hard. They are all friendly and nothing is too much trouble." Throughout the day we saw staff members taking time and making the effort to pay one to one time with individual residents.

However, a number of relatives raised concerns that the high use of agency staff had impacted on the care that people received. One relative told us, ""The staffing varies, its different at weekends. There is a lack of continuity because they get agency staff in who don't know the residents of course."

Relatives raised concerns that at time's people's dignity was not maintained. One relative told us, "Sometimes I come and they haven't shaved him, but I just say and they do it." Another relative told us that on the Forget-Me-Not unit people's dignity was not respected. They said that there were no napkins at mealtimes. That the bed linens were mismatched and the pillows were not comfortable. In addition, a relative told us that staff had requested that they bring in jogging pants for their husband as it was easier for staff. However, their husband had never wore these types of trousers before.

Most people we spoke with raised concerns about the laundry process. One relative told us, "Clothing still goes missing. I come to visit and he has the wrong clothing on which makes me sad!" A person living at the home said, "One thing that could be improved would be the laundry. Things go missing and then things turn up that don't belong to me. It's a bit annoying especially when everything has name tags in." Another relative commented, "I wish they took more care with their laundry. I don't think they iron things, only last week I came and clothing was just chucked in a drawer. It really matters to me. They just don't seem to care about the laundry and its things like that which really makes a big difference."

Following our inspection the manager told us that they had ordered more linen so that coordinating bed sets could be used. In addition, staff received training in Dignity on 18 May 2017. This had included information on how respecting people's preferences was important. The manager told us they would monitor this is daily walks around the home.

Kindness and caring was shown to people's relatives. A relative told us, "I come up most days and sit and eat my meals with him, it saves me cooking at home. It's nice that we can eat our meals together." We also saw that other family members were supported to be involved as much as they wanted in caring for their relatives. One relative went every day to help their loved one at lunchtime. We saw they sat at the table with a group of people and chatted to them. This was a warming and heartening interaction which everyone enjoyed. The dining experience was calm and well organised and people enjoyed their meals. It was not rushed and staff helped people at their own pace.

Where people had limited ability to communicate care plans contained information to support staff to maximise the skills they had. For example, one care plan noted that the person responded best to yes or no

questions and that staff needed to go down to the person's level and to maintain eye contact. We saw staff gain eye contact when they wanted to communicate with people living with dementia.

We saw that for a home which helped people living with dementia that at times the support did not support them to retain their independence. For example, one person's care plan recorded that they needed support to eat a meal but that they could eat finger food independently. We raised this as a concern with the manager. Following our inspection the manager wrote to us and told us they had met with the chef to discuss how different food, such as food that could be eaten with out cutlery, could be used to support people living with dementia.

People in the units for people living with a dementia had memory boxes on the wall. Staff respected people's choice in how they wanted to use these. For example, one person living at the home had been a policeman before retiring. Their privacy was important to them so they did not put anything in the memory box which identified them.

People's privacy was respected. We saw that staff knocked on bedroom doors before entering bedrooms. In addition, a notice was put on doors when people had personal care so that other staff knew not to enter. There were some quiet areas in the home where people could spend time with their families in comfort and privacy.

Requires Improvement

Is the service responsive?

Our findings

One unit for people living with a dementia, Forget-Me-Not, was more unsettled especially in the afternoons. This was because there were a large number of people who were displaying distressed reactions. In addition, most of these people were men which had increased the levels of conflict. A family member told us that at times there were personality conflicts on the Forget-Me-Not unit. In addition, these people had high care needs. For example, staff told us how one person needed three members of staff to provide their personal care as they became aggressive.

The environment on this unit was also lacking the interest needed to support people with dementia and there were no objects for people to interact with. A relative said, "Downstairs it is very nice but you open the door up here and it's a big empty space with no pictures. There is a lack of stimulation and it's supposed to be a dementia unit." Planned activities in their unit appeared to be missing as staff were busy providing care for people. In addition, while staff were kind and caring there appeared to be a lack of dementia specific activities to help people be settled and engaged.

We discussed our concerns with the manager, who had already identified this as an area of concern for the home. They told us that they were at present being careful on who they admitted to the unit and were only admitting females at present to try and rebalance the unit and reduce the levels of conflict. They had also requested that the dementia lead spend time on the unit to observe and suggest ways care could be delivered to reduce people's anxiety which would also mean people's personal care could be delivered with less staff.

We spent time talking to the dementia lead for the home and could see that they were knowledgeable and enthusiastic about providing person centred care for people living with dementia. They had received training in providing for people with dementia and understood how using distraction techniques could support people to remain calm. For, example by guiding people to quiet areas and providing engaging activities.

Before people moved into the home they were visited by a senior member of staff and assessed to ensure that the home was able to provide the care they needed. Care plans accurately reflected people's needs and reflected how people's behaviour related to their lives. For example, one person had been a long distance lorry driver and did not like to go to bed to sleep. Instead they spent their nights in an armchair.

People had been involved in planning their care and they or their relative had signed their care plans to show they were in agreement with the care recorded. A relative told us, "The carers are very good, I can't praise them enough. I lean on the nurse and they explain everything to me about the dementia and the care needs." Another relative said, "I was involved in the care plan when he came into the home. There have been one or two things which have needed sorting out over the past months, but the good thing is they have now been sorted." Another relative told us, "They always keep me informed and let me know if he needs the GP or is not very well or anything. I like that. The fact that they ring me if need be. It reassures me."

People's nursing care needs had been effectively met. Records showed that where people had developed pressure ulcers appropriate care had been put in place to support them to heal. We saw that records had been kept of the healing process so that they could monitor if the care was effective. If needed the nurses were able to get advice and support for the NHS tissue viability nurse.

We saw that in three units care was tailored to meet people's individual needs. For example, one person was unsettled in the unit in which they had their bedroom, staff tried to see if a change of environment would help the person and they went to a different unit for lunch. We also saw that one person who was unsettled in their bed had been supported to have a larger hospital bed so they had more room to move around and to be comfortable. In addition, one person who needed to be supported to move using the hoist found that this was a very distressing process for them. The provider had arranged for them to have a special sling which they could sit on all day to reduce their distress when being got ready to be moved

Staff were able to tell us about the care that people needed. This matched what was recorded in their care plan. Staff told us how they would try to distract people if they became distressed. They noted how people responded to different members of staff and if they preferred to be supported by certain staff. For example, staff told us how one person would be more aggressive if supported by male staff. A relative told us their loved one could be resistant to care, but how one member of staff would be softly spoken and gentle with them and this supported their husband's dignity as it enabled them to be shaved.

People were supported to maintain their links with the community. One relative told us, "Because my husband and I are Christians, and it's very important to us, they used to take my husband down to the service. Now he is cared for in bed the vicar now comes up to my husband to ask him if he wants to take communion and although I don't think he does take it. The vicar does read the gospel and prayers still to him."

Apart from the concerns with activities on the Forget-Me Not unit, other people were happy with the support they received to entertain them. The provider had two activity leads on for the dementia units and one for the nursing and residential units. In addition, a member of staff on each unit had been identified as an activities link to support the activity leads and provide activities when they were not available. We saw that people received one to one support from the activities lead. For example, we heard them reading to one person who was cared for in their bed. In addition, group activities were in place and we saw people engaged with a sing along session.

We saw that one person enjoyed bird watching and had their binoculars which they spent time with looking out of the window. They had also spent some time in the morning with the gardener helping them to cut the lawn. However, the garden was currently closed for unsupervised access as the path was uneven.

When people were alone in their bedroom staff ensured that there was some entertainment available for them. One relative told us, "I know they must put his TV and videos on for him because I see different DVDs in the slot like bird programmes and I know they do read to him sometimes."

The service user guide included information on the complaints procedure and was available in people's bedrooms. We saw there was also a notice telling people how to complain in the main entrance. People told us they were happy to raise complaints with the manager or other staff. Relatives we spoke with said they knew who to go to if they had any worries or complaints. Records showed complaints had been responded to in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

We had not been notified of all the incidents that the provider was required to tell us about by law. They had not notified us when people's liberty had been restricted under the Deprivation of Liberty Safeguards or if people had been referred to the local authority safeguarding team for minor concerns, such as when two people had an incident but neither of them were hurt. We discussed this with the manager who told us they would ensure that all information was submitted in the future.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider had monthly audits in place to monitor the safety and quality of care that people received. For example, we saw that monthly audits of people's weights meant that people who were at risk of not being able to maintain a healthy weight were identified so that support could be offered. In addition, safety audits were completed in areas such as the use and condition of bed rails and the number of falls in the home. The accidents and incidents were reviewed and any trends identified and action taken to keep people safe from identified risks. However, none of the audits had been effective in identifying the concerns we found with the care on Forget-Me-Not unit and therefore people on this unit were receiving a lower standard of care than they should expect to receive.

People had their views of the care they received gathered. This was done through regular residents' and relatives' meetings. Relatives told us that they attended these meetings and we saw a list of the upcoming meetings were displayed on the notice board. In addition, the staff supported relatives to contact the local dementia support group to gain more insight into dementia and the quality of care people should receive. There was also a food forum that people and their relatives could attend to discuss the quality of food and any changes needed. The next food forum was scheduled in June 2017 and was open to people living at the home, relative and staff. However, the history of multiple managers at the home had left some people frustrated. One relative told us that the changes in managers had led to a lack of consistency and forward drive of quality. They said that they attended the meetings but that the same things kept being discussed but with no progress.

The manager was open and honest about the problems in the home and prior to our inspection had identified many of the concerns that we found. Following the inspection they were proactive in responding to the concerns identified to ensure that the quality of care that people received immediately improved. In addition, they followed through on the important concerns that we raised about the safely of people in the Forget-Me-Not unit. They had worked with the local authority safeguarding team and healthcare professionals to improve the safety of people on this unit.

The manager had only been in post for five weeks. However, everyone we spoke with told us that they were approachable and were optimistic that they would be good for the home. Staff told us that the manager was visible on the floor and spent time speaking to people and getting to know them and their care needs. The manager had set up a meet and greet session for people living at the home and their relatives to come and say hello. One relative told us, "I think it's well run now and well organised, and I think its improving lately."

Another relative said, "My hope is that this new manager will be here all the time. The place seems cleaner. The room is perfectly clean and tidy and the corridors are too. It's improving here already."

There was a structured management team in place which consisted of the manager, a deputy manager and the clinical lead. In addition, the nurse provided the day to day line management for care workers in each unit. The manager had set up meetings with staff on a regular basis so they could discuss the changes in the home and maintain an overview of the home.

Staff told us that the new manager had been encouraging and supportive. They said that they were able to go to them at any time and they would stop what they were doing to listen. Staff had also been supported with supervisions and team meetings which they told us gave them the opportunity to raise any concerns. Furthermore, staff also said that the nurses and clinical lead were approachable and would listen to any concerns and take appropriate action.

There were systems in place to ensure that the care in the home continued to develop with the latest guidance and tools. For example, there was an infection control lead for the home. They attended the local authority infection control meetings to help them stay up to date with changes in guidance and best practice. In addition, they completed a monthly infection control audit in the home. The nursing staff told us how they kept up to date with changes in best practice by reviewing government guidelines and journals and liaising with other healthcare professionals. The manager had signed up to be part of the pilot for a product called talking mats. This is a communication method that helps together the views of people who were unable to verbalise their needs. We saw that this was a positive experience for people and that staff had been able to gather more information about people's likes and dislikes.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications for abuse or suspected abuse and the outcome of Deprivation of Liberty Safeguard applications. Regulation 18 (2)(e)(4B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from abuse. Regulation 13(1)