Burlington Care Limited

Southlands

Inspection report

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Date of inspection visit:
30 January 2018

Date of publication:
04 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 30 January 2018 and was unannounced.

At the inspection on 8, 12, 13 July 2017 we had found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. These were in Regulation 9 Person centred Care; Regulation 11 Need for Consent; Regulation 12 Safe Care and treatment; Regulation 13 Safeguarding service users from abuse and improper treatment; Regulation 17 Good Governance and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The rating was Inadequate overall and the service was placed into special measures. Following that inspection we requested an urgent action plan from the provider which they provided immediately. They have provided regular action plans since that inspection.

We then inspected on 24 October 2017 and found that improvements had been made although there was a continued breach of Regulation 11 of the Health and Social Care Act Regulations (Regulated Activities) 2014 because the service was not consistently making decisions in people's best interests. The service was rated Requires Improvement overall and the service was removed from special measures.

In addition there is a current police investigation relating to historic events. CQC have not reported on these matters at this inspection.

At this inspection we found further improvements at the service with no breaches of regulations.

Southlands is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 48 older people who may be living with dementia in one building.

There was a manager employed at the service. They were not yet registered with CQC although their application had been accepted and was being processed. 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.

We found that recent changes at the service, in relation to the staffing and management, had positively impacted on the quality of the service. Quality assurance systems, although effective in identifying areas for improvement had not allowed sufficient time for actions to be completed and checked. This was discussed with the manager.

Most staff were recruited safely and appropriate checks were completed prior to people commencing work, to ensure they were suitable to work with vulnerable people. We identified that one person started work with only preliminary checks in place but they were supervised during their induction period until full checks

were completed. There were sufficient staff to meet people's care needs safely. Staff received an induction, appropriate training and supervision. We made a recommendation about staff recruitment.

Staff were knowledgeable about people's needs and we found that people were receiving the care they required. There was up to date information in care files which meant that staff had all the information they needed to ensure that people received consistent and responsive care in line with their preferences. Some records were not fully completed although the relevant issues had been identified. Food and fluid charts did not have sufficient space allowed for all records of what people had to eat and drink. The provider was aware that improvements were needed to some records and had them under review.

People's wishes at the end of their life had been identified. Where appropriate anticipatory medicines had been prescribed.

Staff had been trained in safeguarding adults and were aware of what action to take if they saw or suspected abuse. There were policies and procedures in place and the provider followed local area safeguarding procedures in reporting incidents.

People were aware of how to make complaints and there was a policy displayed around the service. Complaints had been managed in line with company policy.

Accidents and incidents had been recorded and analysed in order to identify patterns and trends and take action to repeat further incidents.

People who used the service told us that staff were caring and we found that staff supported people in a way that promoted their dignity and independence. We observed positive, friendly interactions between people and staff.

The environment had been further developed to make it dementia friendly and this work was on going. Improvements had been made and there was now an outside space that was secure and people could access freely. There was a variety of activities available at the home and visitors were welcome at any time. The service was clean and tidy.

People received appropriate support with their nutritional needs and systems were in place to ensure that people received their medicines safely. People had access to a range of healthcare professionals, to support them in maintaining their health. Health and social care professionals we spoke with told us that improvements had been made at the service.

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.

Most staff were recruited safely but we found that one person had started work before the full Disclosure and Barring service check was completed.

Although risks had been identified for people one person's health needs were not fully risk assessed and so staff had no management plan in case of a deterioration in the person's condition.

Staff had been trained in safeguarding adults and alerts had been made using local area policies. People felt safe living at the service. There were sufficient, appropriately trained staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff had followed the principles of the Mental Capacity Act. They had followed best interest decision making guidance and made appropriate decisions after consultation for people who lacked capacity to make their own decisions.

The environment supported people living with dementia. A secure outside space had been developed where people could walk freely.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

Feedback from people who used the service and relatives about staff was positive.

Staff were clear about how they would support people's privacy and dignity.

We saw positive and caring interactions between people and staff.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and had been reviewed and updated where necessary. Risk management plans had been developed to reflect how staff should manage people's medical conditions effectively.

Activities were organised and we observed that they took account of people's preferences.

Complaints were recorded and analysed in line with company policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager at the service which was a condition of the registration for this location. Their application was being processed by CQC.

Staff felt supported by the manager.

The manager carried out audits and these were checked by the regional manager. In addition a quality team employed by the provider carried out regular quality monitoring of the service.

Southlands

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.

CQC was aware of an ongoing police investigation when they carried out the inspection. A previous inspection carried out in July 2017 had highlighted serious concerns at the service and the service was placed in special measures. A subsequent inspection in October 2017 had found that improvements had been made. The provider had been providing regular action plans to show what improvements were being made.

This inspection took place on 30 January 2018 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist nurse advisor and an expert-by-experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we attended regular professionals meetings with East Riding of Yorkshire Council (ERYC) to review the progress made at the service. This feedback included that from the quality monitoring team and the safeguarding team. We checked all notifications we had received for the service. Statutory notifications are documents that the registered provider submits to the CQC to inform us of important events that happen in the service. We had not requested a PIR from this provider since the last inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the manager, regional manager, ten care workers, the activities organiser and the housekeeper. We also spoke to five people who used the service and four visitors. 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. One company director and the operations director were present during part of the day and for the feedback.

We inspected how medicines were managed, observed a group activity and observed the lunch time period in the dining room. We reviewed four care plans and associated risk assessments. We also reviewed meeting minutes, maintenance and service records, accidents and incidents and audits carried out at the service. We inspected six recruitment records and the training records for these staff. We reviewed a copy of an up to date training matrix for all staff.

Requires Improvement

Is the service safe?

Our findings

At the inspection in October 2017 we found that improvements had been made and the service came out of special measures. At this inspection we found the improvements had been sustained.

Between October and January there had been four safeguarding alerts about Southlands two of which were submitted by the provider and two by CQC after receipt of information from members of the public. These allegations had been investigated by East Riding of Yorkshire (ERYC) safeguarding team and there were no current safeguarding issues. Managers and staff recognised when issues needed to be reported and investigated and they followed company procedures and local area policies to report and manage concerns and allegations of abuse.

Staff they told us they had completed safeguarding adults training as part of their induction and had also completed updates and could clearly describe different types of abuse and the actions they would take if they had concerns.

When we asked people if they felt safe living at the service one person told us, "Yes, if anything happens I'll be looked after, I can't do anything myself, I can't stand up or anything, I'm totally dependent on staff" and, "Yes (I feel safe), the fact that there are other folks around; you're not on your own."

Relatives and visitors told us, "Yes, I think they are safe. [Relative]has never voiced any concerns" and, "Yes, I do think they are safe." One person told us, "I think [relative] is safe.[Relative] has to be hoisted; they can't get up on their own. They do need to pay attention to pressure sores. [Relative] has never had one but it gets to the point where skin starts to look fragile; they call the district nurse if necessary to have a look."

When we spoke with the local authority they acknowledged that improvements had been made by staff at the service but they wanted to be assured those improvements were sustained over time. However, they told us that there were no current investigations relating to the safety of people and although the service was still been monitored by ERYC this had reduced.

There were sufficient numbers of suitably qualified, competent and skilled staff to meet people's needs. Night staffing had been increased to ensure people's care and safety needs were met. Although staffing had reduced to reflect the numbers of people living at the service the manager had introduced additional staff to cover the early morning period and was looking at doing the same at night. This meant that busy periods were covered. During the day two senior care workers supported care workers and there was one senior care worker at night.

Staff had been recruited safely. They completed application forms and attended interviews. Prior to being offered a job they had a Disclosure and Barring Service (DBS) check and the manager had requested references. We saw that in most cases these were completed prior to people starting work at the service. However, we did see that one person had commenced their employment with the service prior to the full DBS been received. There was a check completed and the manager assured us the person had been

supervised.

People told us when asked if they thought there were enough staff, "You don't often have to wait [for staff] and if you do it's not for long, they're marvellous; nothing is too much trouble." and "Probably not, there are quite a lot of us here, it would be nice to have two to three to each person. They're all very nice; we have a laugh and a natter."

Visitors told us, "They could always do with more staff but, on the whole [Relative's] care is not affected" and, "At the moment, with the number of residents they've got, yes (there are enough)."

We spoke to the manager who told us that they continued to recruit staff. They were currently recruiting an activities organiser and a deputy manager. They told us that they were supported by a regional support manager day to day but were able to contact the operations director at any time.

The consistency of care provided for people had improved which meant that people had better outcomes. We saw a risk assessment related to a person at risk of injuring themselves or another resident or a staff member, which detailed when and where this was likely to occur, together with the actions staff should take to mitigate the risks to the health, safety and welfare of the person. In addition, risk assessments to identify the risk of skin damage were in place for those people at risk.

However, some risks had not been identified which meant people could be at risk of avoidable harm if staff were not aware of the particular risks associated with those conditions. For example, one person suffered from asthma, which was noted within information in the care file. Asthma is a respiratory condition marked by attacks of spasm in the bronchi of the lungs, causing difficulty in breathing. There was no risk assessment identifying the risks associated with asthma, such as an asthma attack causing difficulty in breathing. There had been no impact on the person and the manager assured us risk assessments would be reviewed and updated.

Accidents and incidents records showed specific detail, analysis and a summary of findings was made each month. This meant the service was learning from accidents and incidents and putting preventative measures in place so incidents were not repeated.

At the last inspection we had recommended the provider research health and safety requirements. At this inspection we saw that these matters had been addressed appropriately. Servicing and maintenance checks of the premises had been completed by contractors and in house staff. People were protected in the event of a fire because the provider had taken all necessary precautions to ensure the environment was safe and was working to ensure all staff had appropriate and up to date fire safety training. There was an emergency plan for the service in place which guided staff about what to do in the event of an unexpected event such as loss of electricity or flooding.

The current food safety rating was 2 which was not adequate. Actions had been identified for improvements and the manager had developed an action plan for completion. The environmental health officer will revisit the service to check these actions have been completed within given timescales.

We found that people were protected against the risks associated with medicines because the provider had appropriate procedures in place. A range of policies and procedures were seen which covered all aspects of medicines management. Staff told us they had seen the policies and we saw records of signatures to demonstrate they had read them. We saw examples of regular medicines management audits carried out by senior staff with a clear action plan which was regularly reviewed and updated.

Controlled drugs (CDs) are medicines that require extra checks and special storage arrangements because of their potential for misuse. We saw these were stored in a controlled drugs cupboard which was of suitable construction and was locked on the day of our visit. Access to them was restricted and the keys held securely. Other medicines were stored securely and access was restricted to authorised staff.

Fridge and medicine room temperatures had been checked and were within normal ranges.

Some people were prescribed medicines to be taken when required, or 'PRN'. The medicine administration records contained basic information which helped the staff know how, why and when these medicines should be given.

We checked communal areas and people's bedrooms and found that they were clean and tidy. A new housekeeper had been employed since our last inspection who supervised a team of domestic staff. When we spoke with them they described how they had improved cleaning schedules so that the team of domestic staff had daily, weekly and monthly cleaning tasks to complete. They told us this had improved the cleanliness at the service.

Good

Is the service effective?

Our findings

At the last inspection in October 2017 staff had not always worked within the principles of the Mental Capacity Act (MCA) 2005. This was a continued breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found that the provider had made significant improvements in this area and there was no longer a breach of regulation.

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 saw associated conditions within the DoLS were being met and that the older people's mental health services had been involved in decision making for one person.

People's plans of care showed that consent to care, treatment and photograph records was recorded and signed by people where they were able. One person had been unable to sign to give their consent and so a relative who had Lasting Power of Attorney for health and welfare (LPA) had consented on their behalf. When asked if staff asked for their consent people told us, "Oh yes they do" and, "Yes "You don't often have to wait [for staff] and if you do it's not for long, they're marvellous; nothing is too much trouble. ."Yes, they are very good."

There was a policy and procedure on the MCA and DoLS designed to protect people. However, at our inspection in October staff had not all been trained in this subject. This training had now started and all new staff had this training included in their induction. When we spoke with staff they told us, "We have a better understanding and are doing things the right way."

Best interest decisions are made when someone does not have the mental capacity to decide on their care and treatment. Decision making should include family, friends and relevant professionals in order to find the best outcome for a person. The service had followed this process and decisions had been made which were specific, for example, in relation to the use of a bed sensor mat, crash mat and interior and exterior locked doors for one person and for a second person a decision had been made about where that person should live.

The manager told us they had applied for a number of DoLS authorisations, and six had been authorised since October 2017 when we last inspected the service.

Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were completed

correctly in line with current guidance.

There had been a number of changes to staff at the service since our inspections in July and October 2017 and all new staff had completed an induction. A recently employed care worker said they had undertaken an induction and told us that they felt the training allowed them to provide appropriate care for people. Training for these and existing staff was underway in all subjects the company considered mandatory such as safeguarding, fire safety, health and safety, moving and handling of people and safe handling of medicines. Other subjects reflective of the needs of people who used services were also completed such as dementia care. We spoke with a group of nine staff who were participating in a training course and they all agreed that the training was improved.

People's care needs had been assessed prior to coming to live at the service to ensure staff were able to meet their needs and that the required equipment was in place. Staff worked with various agencies to enable people to access other services when people's needs had changed. For example, General Practitioners (GPs), community nurses, dieticians, falls team, occupational therapists and podiatrists. We saw details of appointments with, and visits by health and social care professionals.

Care plans reflected where referrals to healthcare professionals had been made and where they had sought professional advice, to ensure that the individual needs of the people were being met. For example, one person had some pressure damage to their toe. The district nurse had been made alerted and they had referred the person to a podiatrist who had organised some shoes to be specially made for the person to reduce the risk of further skin damage.

People told us, when asked if staff had the right skills to meet their needs, "Those I've come across do" and, "I think so, they seem to do." Relatives told us, "Oh yes, they [relative] get the care I want" and, "Yes I think so." All the relatives we spoke with told us they were happier with the care provided than they had been previously.

People's nutritional needs were met. People told us, "You get a choice, especially at dinnertime; definitely get plenty. At teatime you can have something warm or sandwiches, there's often trifle or something like that to follow up"; "It's quite nice"; "Not bad at all, quite good anyway, you get two choices at lunch and two choices at tea and if you want something else they'll do it for you. I've put on weight" and, "It's lovely, very good; always plenty; that's what I like." Relatives told us, "It looks ok" and, "It's good at lunchtime you can't fault the food; it's lovely, hot and tasty."

During the morning and afternoon a trolley was taken around with hot or cold drinks offered to people along with a variety of snacks. There was a list of people's names on the trolley and staff marked off when they had a drink ensuring that everybody had received fluids. People could also help themselves to juice or water as there were jugs of both in the lounges and small baskets containing snacks.

We observed the lunch period. In the dining room the tables were set with plain coloured cloths and different coloured mats with food served on plain white plates in line with current dementia care guidance produced by the Alzheimer's Society. This says that the colours of table and plates should contrast. A large blackboard indicated the choices on offer for the day with two hot meals offered at lunchtime and for the evening meal. Staff also showed people a plate of each meal and dessert on offer so that people could choose what they wanted to eat using a visual aid as well as read a menu. During lunch there was some background music being played which had a calming effect. The portions of food were adequate and the food looked appetising. People were offered hot and cold drinks throughout the meal.

Where necessary staff monitored food and fluid intake to minimise the risk of malnutrition or dehydration. Where people had issues with their weight referrals had been made to the GP or dietician in a timely manner. If people had problems with eating or swallowing their food they referrals had been made to the speech and language therapy team (SALT).

Where this was the case systems were in place to ensure people were supported to maintain their nutritional needs. For example, one person's care plan contained guidance for staff on how to support the person by cutting up food and encouraging the person throughout the day with small portions of food, finger snacks and fluids as they would not always ask. We saw that the person had been referred to the dietician and we saw that staff had proactively followed this up with the dietician and samples of dietary supplements had been obtained. We looked at the nutrition profile risk assessment tool for the person and saw that the person's weight was being recorded on a weekly basis to closely monitor their progress.

The environment had not previously supported the needs of people living with dementia and did not support good practice at the inspection in October 2017 with no access to outside space. At this inspection we saw that further improvements had been made to ensure the environment was dementia friendly. The provider had taken note of comments from professionals and made changes. In addition, we saw that they were developing an outside space for people to access safely. They had already fenced a large area to provide a boundary stopping people accidentally leaving this safe space and had added some seating with further developments of the area planned. This allowed people to be able to be out in the fresh air whenever they wished.

Handrails and bedroom doors contrasted with the corridor walls. These were now distinguishable from each other for people with visual or cognitive impairment because contrasting colours had been used. In addition, frames had been added to bedroom doors so that people could add personalised pictures or information to enable them to identify their bedroom. The service had taken note of our recommendation following our last inspection and acted to improve the environment for people living with dementia.

Technology such as sensor mats was used to improve people's safety. The sensors alerted staff when the person was active which served to assist in the prevention of falls. Best interest decision making had been used where this technology was in place to ensure this was the least restrictive option.

Good

Is the service caring?

Our findings

When asked if staff were caring and kind people said, "They're marvellous, absolutely marvellous, wonderful"; "They are very caring, I've been in a fair time and they get to know you" and, "Very pleasant, they really are very pleasant, you can talk to them, they're very caring."; "They're fairly helpful. I know some of them; I don't know them all. I don't come across all of them"; "Yes, I haven't found any I don't like, I know they've got a job to do and they're doing it, they're very good."

Relatives told us, "From what I see, yes, but they're [staff] not going to be anything else in front of visitors"; "I do, just that one [staff]; I'm sure they care but their mannerisms are a bit full on. All the others talk to them as if they were their own mums"; "Yes, I think they are, the staff they had before could never be described as uncaring but they didn't always do the right things" and, "I only see the people in here, but the staff I've seen over the last 6 months I would say so."

We observed caring, relaxed and friendly staff during the inspection. We saw two care workers attempting to assist a person to move from a wheelchair to a chair in the lounge. They struggled to carry out the task as the person did not want to move. They spent quite some time with them as they were concerned that they would not be comfortable in the wheelchair. The assistance of another care worker was sought and they knelt beside them to speak giving encouragement. Although the person still declined to move staff showed care for their comfort but respected their decision.

As care workers went about their work they were constantly acknowledging residents by name as they walked by, checking that everything was ok, exchanging a few words and enjoying a joke with people. They had a person centred approach. Having a person centred approach means ensuring the person is at the centre of decisions which relate to their life.

Staff had communication care plans in place so that staff were aware of any particular communication needs people had. However, the care plans would benefit from additional information in line with the requirements of the accessible information standard. Staff knew people and how to communicate with them. We did highlight the comments of one relative to the manager who had told us about an incident where they did not feel a care worker had the right approach with their relative. The manager agreed to discuss this with the care worker at supervision.

In addition, care files contained information about people's faith and cultural needs in their social care plan.

Staff informed people about things going on in the home and offered people choices, such as whether they wanted to join in activities, where they wanted to sit and what they wanted to eat and drink. Their choices were respected. There was a large activity notice board which highlighted activities on offer. There were also notice boards throughout the service where people could read inspection reports, meeting minutes and other relevant information.

People were kept informed about day to day issues and activities at the home. We saw one care worker

reminding people of the activity that afternoon and inviting them to join in.

We observed that staff encouraged people to maintain their independence where possible, but offered assistance when needed. People we spoke with told us they were encouraged to do things for themselves if they were able which maintained their independence. People's care plans highlighted the areas of people's daily routines they were able to manage independently.

People's privacy and dignity were respected. Throughout our inspection we observed that staff knocked on people's bedroom doors and asked permission before they entered. Staff gave us other examples of how they promoted people's privacy and dignity, for instance, by ensuring doors were closed before providing care, drawing curtains and covering people when washing parts of the body. Most of the staff we spoke with told us they were given the time they needed to support people. We heard from staff that there had been an issue at busy times of day and night but the manager told us they had now put staff on different shift patterns so that those periods were covered to assist night staff. Staff confirmed that recently this had been happening.

Visitors were welcomed at the home at any time. Relatives we spoke with confirmed this.

Good

Is the service responsive?

Our findings

Care plans were reflective of people's needs and preferences and contained sections showing people's personal history, individual preferences and interests. The care plans had been written in a person-centred way and reinforced the need to involve people in decisions about their care and to promote their independence. For example, one person's personal care plan detailed the routine they liked to follow, for example how they preferred their bath around tea time so they could then put their nightwear on; tasks they would like to complete themselves such as washing and drying their hands and face and things they would like staff to help with for example dressing and undressing.

Care records contained 'Life Map' documents and social activities profiles, which included details about the person's life history and things that were important to them such as particular events or family information. This allowed staff who had not supported the person before to familiarise themselves with that person's personal preferences.

Following an initial assessment, care plans were developed for people's daily needs such as physical well-being, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. These were reviewed and updated at least once a month.

People had care plans in place so that staff were aware of any particular communication or sensory needs people had and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people in communication care plans. This approach recognised that people living with a disability or sensory needs could still be engaged in decision making and interaction. The manager told us that for one person who was living with age-related Macular Degeneration (an eye condition leading to the loss of vision) they had included specific health-related information within their care file to inform staff.

We saw in the care records that end of life care for people had been considered and discussed; plans were in place for people. This meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected. For one person we saw that that their relative had requested to be contacted day or night and that a more detailed plan was to be put in place at the person's request. Where needed people had anticipatory medicines prescribed and available within the service. If a patient is in the last days of their life these are medicines for end-of-life symptom control which can be given if required without unnecessary delay.

People were supported to follow their interests and take part in activities. The company had recently started working with an organisation that was supporting them in developing wellbeing plans for people and training staff in the personalisation of activities. The regional wellbeing co-ordinator of this organisation had recently visited the service and reported, "There was more to do around the home, there was more to look at on the walls and activities were left out for residents to engage with daily."

During the inspection we observed people reading or chatting during the morning. A care worker was playing a game with one person. Later in the day, in accordance with the schedule a music and movement session was held. People were asked if they wanted to take part and seven people joined in. Two care workers ran the session and encouraged people to do the gentle exercise moving their arms and legs along with the music. Everyone was very enthusiastic, the care workers gave encouragement and there was lots of laughter. During the afternoon we saw two people playing dominoes together. In one of the lounges there were bookshelves full of books and there were local papers left around the service.

The activities organiser had only recently been employed at the service and appeared to be very enthusiastic and keen to engage with people and be inclusive. They told us they had read people's care plans in order to get to know their likes, dislikes and preferences which they told us they considered important before starting to work with people to develop activities. They told us they had started some activities developing a programme. Activities on offer included 'Cuppa & Catch Up', games morning, 1:1, bingo, 'Sing along Saturday', quizzes and crosswords, 'Oomph' (music and movement), 'Time to talk', craft and movie afternoon.

The activities organiser told us about one person who liked to play dominoes saying, "I make sure every time I'm in they get a game of dominoes and I get others to join in." We had seen some picture cards of birds in the conservatory which overlooked the garden. The activities organiser told us they had prepared these after they had been in the conservatory with a person who did not speak very much but had identified a robin flying by. Now this person and others could use the cards to help them identify the birds that used the bird feeders hung outside the conservatory.

One person told us, "I sit about talking to my friend. There are sometimes activities. We've just got a new lady and she had a bit of a chat. We play games sometimes and we used to have church services every two weeks with someone from the village church but they stopped a while ago. I am a Christian and there's a man who works here who's a Christian; we chat together and I've always got my bible to read. They [staff] made Christmas special, it was really, really nice, we had a lovely lunch." We spoke to the manager about the church services and they told us they had contacted the local church who planned to restart the services.

A second person said, "In the summer we can go for a nice walk, to churches and places like that." They told us that when any activities took place they joined in.

People were aware of the process for making complaints. There was a complaints policy and procedure displayed on the notice boards around the service. We saw that where complaints had been made they had been dealt with in accordance to the service policy. People told us they knew how to complain. One person said "They woke me up about three months ago. They were getting somebody ready for bed in the next room and were making a noise. I spoke to a member of staff and it hasn't happened since" and another person said, "If I did have something to say I'd go to the top, not to tell tales but to say what is happening."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2017 we had found that although improvements had been made there remained a breach of regulation. The action plans had identified area for improvement but these had not all been completed and those that had had not been completed for a long period and we needed to see that these were sustained. At this inspection we saw that further improvements had been made and there were no breaches of regulation. Improvements made previously at the service had been sustained.

The provider is required to have a registered manager as a condition of registration. There was a manager in post and their application to become the registered manager of the home was being processed at the time of our inspection. They were supported by a regional manager who visited the service regularly. The management team was led by the operations director.

Staff told us they felt the manager was doing a good job and they said that on the whole they could approach them with any issues or concerns. They said that things had improved since the new manager had started at the service but they still did not always feel listened to. One care worker told us, "We are working more as a team now." We discussed the staff comments with the regional manager who said that they had started to build on improvements and would learn from the comments moving forward.

Relatives told us, "She's [the manager] great, the fundamental things are all sorted now, [Name of relative] is clean, always looks tidy; before she wasn't getting her medication. The staff are lovely" and "I don't really know her [the manager] very well; she [the manager] is trying to make a lot of changes. I do think she [the manager] is getting to know the residents. We don't see her out on the floor very much but that might be a bit harsh as she has a lot on at the moment."

Relatives also told us that they have seen that parts of the service have been decorated. One person told us, "Last week I saw the manager as I was about to walk out and I told her, "This last month I've seen a big change." The staff have sat entertaining residents, not just the entertainment lady. I've seen staff playing cards and doing jigsaw with residents. I've never seen a staff member doing that before. I've seen 'Oomph', (a music and movement activity) and the manager and carers were involved which I think is brilliant. It makes the residents see the staff in a different light. I still think there should be a bit more interaction. The new cleaner is fab. She reminds me of the old time matron. They do listen, they're not cutting corners, the staff they've got are absolutely lovely."

A second person said, "I came here with my five year old granddaughter a week last Saturday. She sat at the table with them and they gave her lunch and it was just lovely, it felt like a family; the whole room just felt like one big family. It was a totally different kettle of fish last Saturday. One person changed the whole dynamics. Although the person did not feel they wished to make a formal complaint we spoke to the manager about this incident.

It was apparent during our inspection that the changes made by the service had had a positive impact on the service as a whole. Record keeping and quality assurance at the service had improved. Records were

more consistently completed although we noted that food and fluid charts did not have the space to be able to record everything which meant there were some gaps. The operations director told us they were looking at changing the forms as they had realised they were not fit for purpose. Some skin changes had not always been noted in care plans but were identified on body maps and incident records. The record keeping documentation would benefit from further improvement.

The provider had a quality assurance system which consisted of a comprehensive range of audits, conducted by the manager. These included monthly checks of health and safety records, fire safety records, medication systems and, finances and an accidents analysis. The regional manager also completed checks to ensure the quality of the service and check the manager's findings. In addition there was a quality team employed by the provider who carried out regular quality monitoring of the service and acted independently of individual services.

The manager had not always allowed themselves sufficient time to complete actions identified as requiring improvement. The result of this meant that the quality monitoring was not completed in the identified timescale however; all areas for improvement were being appropriately addressed. Quality assurance processes would be more effective in driving improvement if they had more appropriate timescales allowing actions to be completed.

The last staff meeting had been held in January 2018. Staff were updated on key changes at the home and were given feedback. They were also given feedback every day with a verbal and written handover.

The provider had displayed their current rating for the service on their website and in the home, which is required by law. They had also submitted relevant notifications to the Commission about significant incidents at the home since our last inspection, as required. This meant we were able to check that appropriate action had been taken in response to these incidents.