Lifetime Care Limited

Mayfield Residential Care Home

Inspection report

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Date of inspection visit: 14 and 15 April 2015
Date of publication: 29/06/2015

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?	**Good**

Overall summary

Mayfield Residential Care Home provides accommodation for up to twenty people who require personal care. At the time of our visit there were four people living at the home.

We carried out this inspection over two days on the 14 and 15 April 2015. At our last inspection in June 2014, there was no registered manager in place who was responsible for the day to day operation of the home. 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.

During our last inspection, staff were not managing people's needs effectively and there was little staff

Summary of findings

supervision. Safeguarding was not appropriately reported and people were not involved in the running of the home. The service had a history of non-compliance. We issued compliance actions to ensure the provider made improvements. The provider sent us an action plan to show how they were going to do this.

At this inspection, improvements had been made. A registered manager was in post and present throughout the inspection. They began employment at the home as a consultant to improve people's care plans and became the registered manager in October 2014. The registered manager had a clear action plan which detailed their vision and future plans for the service. Many of the items on the action plan had been addressed and others were in the process of completion. However, whilst changes had been made, work was needed to ensure they were embedded in practice and the improvements sustained.

Throughout our inspection, the registered manager was visible, undertaking tasks and monitoring staff. This included the administration of people's medicines, assisting people to the table for lunch and clearing used dishes away. They reminded a member of staff to document they had applied a person's topical cream and asked another to make sure they offered the person the opportunity to use the bathroom. Whilst the registered manager's presence was positive in order to promote good practice, we raised concerns about the sustainability of this, especially as there were only four people using the service. The registered manager did not share this view and said it was their nature to be involved so this would not be a problem. Whilst acknowledging this, we remained concerned about the impact it would have on their overall management responsibilities. In addition, there was a risk that the standard of the service would not be maintained in the absence of the registered manager.

Improvements had been made to people's care. People looked well supported and any resistance to support was being managed appropriately. People had up dated, comprehensive care plans in place. These detailed people's needs, the support they required and individual preferences. All plans had been updated with the involvement of people and their families.

Risks to people's safety such as malnutrition, pressure ulceration and falling had been appropriately assessed. However, the hot surfaces of radiators in the dining room presented a risk to people's safety. This had been identified at a previous inspection. The provider had identified the risks but the assessments gave conflicting information. Other environmental risk assessments were in the process of further work to ensure they were more robust.

In situations where people lacked capacity to make a decision, their safety and well-being were promoted. However, necessary records of capacity assessments and best interest decisions were not always in place. Some completed assessments in relation to day to day activities and whether a person was able to go out on their own safely, lacked sufficient information. Staff had not explained and recorded the evidence for the decisions made.

Staffing levels were sufficient for the numbers of people currently living in the home. The registered manager told us they were in the process of recruiting more staff in order to accommodate new admissions. Whilst recognising the home needed higher occupancy, the registered manager said any admissions would be staggered, to ensure staff were competent in meeting their needs. A robust staff recruitment system was in place.

People's medicines were administered in a safe manner. Staff's competency to administer medicines had been assessed and some shortfalls were found. Training was to be undertaken and competency reassessed, before staff were permitted to administer further medicines. Until this time, the registered manager was administering all medicines whilst on duty. We raised concern about the sustainability of this and what would happen if the registered manager was not available for a period of time. The registered manager did not see this as a problem.

Improvements had been made to the nutritional content of the meals with greater emphasis on fresh produce, baking and cooking "from scratch". People told us they liked the food and had enough to eat and drink.

People told us they liked the staff and responded well to them. Staff felt supported in their role. A new system of formal staff supervision had been implemented and was working well. This gave staff the opportunity to talk about their role, their training needs and any challenges they were facing. A range of training courses had been arranged to help staff undertake their work more

Summary of findings

effectively. Training included topics associated with older age as well as mandatory subjects such as safeguarding and infection control. Staff were aware of their responsibilities of reporting a suspicion or allegation of abuse.

The registered manager had implemented the organisation's quality monitoring processes. This consisted of various audits and encouraging people to give their views about the service they received. They could do this informally on a day to day basis, within newly introduced meetings or more formally with the use of surveys. People were clear that they would raise any concerns they had with the staff on duty or the manager. They said the good things about the home were the staff and the food. Improvements to the service had been recognised. However, suggestions for further improvement included improved décor and furnishings, en-suite facilities and outdoor space.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Not all risks to people's safety in relation to the environment had been properly addressed. Appropriate assessments and care plans were in place to minimise people's risk of malnutrition, pressure ulceration and falling.

Robust medicine administration systems were in place. However, there was a high reliance on the registered manager to administer people's medicines. This was because of the limited number of staff available to administer medicines safely.

People felt safe at the home. Staff were clear about their responsibilities of recognising and reporting potential abuse.

Organised recruitment procedures were in place, which ensured people were supported by staff with the appropriate experience and character.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2015 and its Code of Practice were not always followed when best interest decisions were reached on behalf of people who lacked capacity to make their own decisions.

Staff felt supported in their role and had undertaken a range of training courses to enable them to undertake their role more effectively. The training included topics associated with older age as well as mandatory subjects such as safeguarding and health and safety.

Improvements had been made to the nutritional content of the meals with greater emphasis on fresh produce, baking and cooking "from scratch". People told us they liked the food and had enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

There were positive interactions between staff and people who used the service. However, particularly at lunch time there was little conversation and no pleasantries from staff. People were given their food and were not informed of the meal's content or asked if they wanted any assistance.

People knew staff by name and responded to them well. There were positive comments about the staff and the care which was given.

Summary of findings

Staff were confident when talking about the ways in which they promoted people's rights to privacy and dignity. People told us this was applied in practice and they were encouraged to make choices and follow their own routines.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to the support people received with their personal care. People looked well supported and any resistance to care was being appropriately managed.

People had a detailed, comprehensive plan of care in place which reflected their individual needs and preferences. All care plans had been written by the registered manager in conjunction with the person and their family. Staff were to receive training in care planning so they could add to the plans accordingly.

Is the service well-led?

Good

The service was well led.

Whilst recognising, the registered manager was using role modelling to improve standards, they were undertaking tasks which were usually associated with care staff. We raised concern regarding the sustainability of this and the risk that the same standards would not be maintained if the registered manager was not on duty.

Improvements had been made to the service in areas such as care delivery, care planning, staff training and supervision. Whilst these developments were recognised, people associated with the service felt more improvements were required. The improvements also had to be embedded and maintained.

There were compliments about the registered manager and staff were engaged in the changes taking place. People were being encouraged to give their views and clear systems were in place to enable this.

Mayfield Residential 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 April 2015 and was unannounced. We returned on 15 April 2015 to complete the inspection. The inspection was completed by two inspectors 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 service.

Before the inspection we reviewed previous inspection reports and all other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with four people who lived at the service and one person who was staying for the day. We spoke with five staff and the registered manager. We spoke with two people's relatives and two health care professionals on the telephone after the inspection. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for three people. We also looked at records about the management of the service including staff recruitment and training and quality auditing.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. On this occasion, the registered manager was not asked to complete a Provider Information Return (PIR). 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. We obtained the information that would have been provided on the PIR during the inspection.

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Is the service safe?

Our findings

On the first day of our inspection, the radiators in the dining room were hot to touch. This created a risk of people burning themselves if they fell against the hot surfaces and was identified at the last inspection. There were two risk assessments in a file regarding the radiators, which gave conflicting information. One assessment indicated all radiators should be covered to protect people from harm. The other assessment stated the radiators in the dining room did not need to be covered but if possible, furniture should be placed against them. This had not been undertaken. The registered manager told us they had questioned the provider, as to why the radiators had not been covered but were not sure of the reason. They said they would arrange for this work to be completed without delay.

An external company had been contracted to test the water supplies in relation to the risk of Legionella. The report dated May 2014 identified recommendations such as the replacement of the water cylinders. There was no evidence to indicate this work had been undertaken. The registered manager told us the testing had been undertaken before they were in post and it had not been drawn to their attention. They said they would check if any work remained outstanding and would address this accordingly.

Other risks to people's safety had been identified and addressed appropriately. This included people's risk of malnutrition, pressure ulceration and falling. Plans were in place to inform staff of any action to take to minimise the identified risks. There were assessments, which identified potential risks in relation to the environment and tasks staff were to complete. The registered manager told us they were in the process of reviewing these assessments, as they did not feel they were detailed enough.

People's relatives told us they did not have any concerns about their family member's safety. People told us they felt safe within the home. One person told us this was because there were no restrictions. Another person said "Yes I feel safe here. I have no worries in here". Another person told us they felt safe but they did not know why this was so. People told us they had not been mistreated by staff or had witnessed any practice, which they were concerned about. One person told us, if they saw any mistreatment, they would report it to a member of staff immediately. Another person told us "I would tell them off". Another person was not sure what they would do but said "I have never seen anyone mistreated'.

Staff had no concerns about people's safety. One member of staff told us they ensured people's safety by asking a GP or district nurse for advice or to visit and by sourcing any equipment required. In addition, they told us it was important to monitor people's needs, be familiar with their care plans and keep necessary notes of incidents such as falls and observations including fluid intake. Another member of staff told us keeping people safe was not just about the environment. They said it involved having "a sense of love and care" which included people feeling safe without "being made to feel timid". They said the home should be "a holistic safe place" and this was achieved by following policies and procedures and providing person centred care.

Staff told us they would report any suspicion or allegation of abuse to the registered manager. They said if the registered manager was not available, they would contact a senior manager within the organisation or other agencies such as CQC. Contact details of on call managers were identified on the staffing roster so they could be easily contacted, if required. Records showed staff had received up to date training in safeguarding people. This enabled them to gain the required information about recognising abuse and their responsibility to respond appropriately. Staff were confident when describing forms of abuse and how to recognise associated signs. They told us there was a whistleblowing procedure in place but they had not needed to use it. One member of staff told us they would have no hesitation in "blowing the whistle". They said they would not stop until action had been taken. The member of staff told us they could "honestly confide" in the registered manager or the deputy and had confidence that the matter would be "set right".

The registered manager told us there had not been any incidents which required referral to the safeguarding team since they had been in post. The registered manager was aware of the reporting criteria and said they would make an alert, as necessary.

People told us there were sufficient numbers of staff on duty to help them when needed. They said they did not have to wait for assistance. One person told us there were sufficient staff available but they were not sure what would

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happen when more people moved into the home. They told us "I suppose they would have to get more staff". A relative commented that it often took staff a long time to answer the front door, which implied there were staff shortages. However, they said "it might not be, perhaps it's just that the doorbell doesn't work properly. There have been lots of issues with it". The registered manager confirmed that the door bell had since been replaced. Another relative told us "it's not so much there aren't enough staff it's the high turnover. There have been a lot of staff changes, which makes it difficult to ensure consistency". After the inspection, the registered manager told us that two staff had left the home since July 2014. Other staff had left before this timescale. A care professional told us "staffing levels have increased and so the home is able to provide a better safer service".

During our inspection, the home was calm and relaxed. People were not waiting for assistance and staff had time to spend with people. There were two care staff on duty with four people who used the service. Between 10am and 2pm, one of these members of staff left their caring responsibilities to work in the kitchen. They were responsible for preparing, cooking and serving lunch, washing up and cleaning the kitchen after the meal. There was one housekeeper who worked on a Monday to Thursday basis. At other times, care staff undertook cleaning responsibilities.

Staff told us that as there were only four people in the home, staffing levels were adequate. One member of staff was confident that when occupancy increased to a certain level, the registered manager would be increasing the numbers of staff on duty accordingly. The registered manager confirmed this and said the increase would also include more housekeepers and a designated cook. The registered manager told us they were actively recruiting staff so they would be in place when the number of people in the home increased.

People told us they received their medicines appropriately by staff. One person told us their sleeping tablet was important to them and they received this, at a time that was convenient to them. Other people did not know what their medicines were for but said they took them when they were given by staff.

At lunch time on both days of our inspection, the registered manager administered people's medicines in a safe, organised manner. They looked at the medicine administration record before dispensing medicines from the monitored dosage system. They offered people a drink and waited for them to take their medicines. People were not rushed and interactions were discreet. One person refused some of their medicines. The registered person told us this was not unusual and their GP had been informed. They said they encouraged the person to take the most important medicines first so when they began to resist, it was not so important.

The registered manager said they had recently assessed staff's competency regarding medicine administration. As a result it was identified that some staff were not proficient and required more training. These staff were not permitted to undertake medicine administration until their competency had been reassessed. One member of staff told us they did not administer medicines, as they were new to the role and had not received training to do so. They were expecting this to take place once they had been in their role for longer. New staff and a review of competence had reduced the number of staff available to administer medicines. The registered manager said this was not a problem and they or their deputy manager administered medicines when they were on duty. They said they were happy to undertake this role to ensure people's safety until staff were competent. We acknowledged that whilst there were only four people living at the home, this responsibility was manageable. However, with additional people and increased management duties, this could become a challenge and was not the best use of the registered manager's time. There was also a risk if the registered manager was unwell and not available for their duty. The registered manager disagreed with this view and continued to explain that it would not be a problem, as they had previously managed homes of 33 and 64 people. In addition, they said other staff would provide cover if required and they were in the process of recruiting new staff, who would be able to undertake the role, after a period of training.

Medicines were stored securely in a metal trolley which was attached to the wall. People did not have any medicines which required specialist storage facilities. The medicine administration records were consistently completed to show people had been given their medicines as prescribed. Any hand written instructions had been countersigned by another member of staff to minimise the risk of error. There were protocols in place for those medicines, which were

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prescribed to be taken "as required". This ensured a consistent approach and maximum effectiveness. Information about the administration of medicines was available for staff reference.

The registered manager told us they were passionate about ensuring they had the right staff for the job. They said they wanted prospective staff to have the right attitude, a passion for caring and a good intellect. The registered manager told us in order to increase the size of the staff team, they were actively recruiting new staff. They said they had a robust recruitment procedure in place and were being selective, to ensure the right calibre of staff. One member of staff told us they had recently started employment at the home and checks were being undertaken on another applicant to ensure they were suitable for the role. This included gaining information about their performance and character from previous employers and a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. Records showed that the registered manager's recruitment processes were ordered and well managed.

Requires Improvement

Is the service effective?

Our findings

When a person living in a care home lacks mental capacity to consent to arrangements for their care or treatment, including their accommodation, a deprivation of liberty is likely to occur if those arrangements mean the person is under continuous supervision and control, and is not free to leave. In such circumstances, the Mental Capacity Act 2005 (MCA) requires the care provider to apply for a Deprivation of Liberty Safeguards authorisation (DoLS). This is so that independent checks can be made on whether the arrangements are in the person's best interests and other safeguards can be put in place. The registered manager had submitted all necessary DoLS applications. In situations where people lacked capacity to make a decision, their safety and well-being were promoted. However, necessary records of assessments of capacity and best interest decisions were not always in place for people who lacked capacity to decide on the care or treatment provided to them by the home. This included decisions such as the use of covert medication and assistive technology including pressure mats. A pressure mat is a device used at times for people at risk of falling, which is linked to the call bell system. The mat would activate the call bell once stepped on, alerting staff to the person's whereabouts.

There were completed assessments of capacity in relation to day to day activities and whether a person was able to go out on their own safely. However these assessments lacked sufficient information. Staff had not explained and recorded the evidence for the decisions made. The MCA Code of Practice requires the statutory best interest checklist to be used when any best interest decision is made on behalf of a person who lacks capacity. There was no record that this was used. The registered manager agreed that the 'action taken' section of the forms currently used did not follow the best interest checklist or the recording process. The registered manager said these forms were already under review by the provider.

Records showed that the provider had been consulted in relation to 'do not attempt cardiopulmonary resuscitation' forms (DNACPR). The DNACPR forms were not supported by records of assessments of capacity or by records of best interest decisions. This meant the DNACPR forms held by the provider for use in relevant medical emergencies did not meet the requirements of the MCA.

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

Staff told us they felt well supported by the registered manager. They said they were fully informed about things they needed to know and were asked their opinion regarding developments. Staff said they could ask for advice at any time and felt listened to. They said the registered manager had introduced a formal staff supervision system, which was working well. This enabled staff to discuss their performance and raise any issues they felt challenging. There was a schedule of staff supervision sessions within the office, which showed a consistent frequency of sessions. Records showed that the supervision sessions had taken place so all staff had received the opportunity to discuss their role.

The registered manager told us they were qualified to train staff in subjects such as moving people safely. This enabled staff to receive training "on the job" whilst working with people. The registered manager had also achieved Dementia Champion, Train the Trainer course and was progressing work in this area. Records showed that staff had recently undertaken a range of training. This had included mandatory subjects such as safeguarding vulnerable people, infection control and fire safety. Staff had also undertaking training in relation to conditions associated with older age. One member of staff told us the training opportunities within the home were very good. They said they only needed to ask for a specific training course and if relevant, the course would be sourced. Another member of staff told us all their training needs were covered at present. They said they were able to discuss training needs in supervision and had recently completed training in relation to end of life care, administering medicines and dementia care. Another member of staff told us they had completed "quite a lot of training" since commencing employment at the home. This member of staff also confirmed their training needs were discussed in supervision.

Staff told us that staff meetings regularly took place. They said the meetings were clear, concise and involved information sharing rather than being "talked at". Staff said the meetings were productive and gave another opportunity to raise any concerns, if required. Staff told us the meetings were supportive and the registered manager

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welcomed their opinions. They said they felt staff worked well as a team and they felt valued. Another member of staff confirmed this and said "the home is a family environment. We support each other".

People told us they liked the food and they had enough to eat and drink. One person told us "the food here is good. I have the same as everyone else". A member of staff told us this person required a diet low in sugar but they were concerned about their sugar intake. During the first day of our inspection, the person ate a main meal and two desserts of crème caramel. For dessert at teatime, they were offered a mousse. These foods did not appear conducive to the person's dietary needs. However, the registered manager told us all foods were now made, with low sugar content, which enabled the person to have to the same as other people. They said there were no problems with the person's sugar intake. Another person told us "the food is what I would have at home. I have what is available". They told us however that they did not have any food after 5.30pm so their family brought things in for them to eat during the evening. The registered manager did not feel this view was accurate. They said people were able to have a choice of biscuits or sandwiches with a hot drink at supper time. Another person told us "they ask what food we want the day before, I always eat it". After the inspection, the registered manager told us that people were asked what they would like for their lunch, in the morning. People's choice of supper was gained at afternoon tea time.

On the first day of our inspection people had chosen mixed grill for lunch. The dessert was homemade upside down pineapple pudding. Staff told us the registered manager had made improvements to the meals provided. There was now an emphasis on fresh produce and cooking "from scratch" rather than processed or packaged foods. Local suppliers were being sourced and deliveries were being made twice a week or more often if needed. There were a range of fresh vegetables within the refrigerator. A new four week menu based on healthy eating and people's preferences had been introduced. The menus incorporated a choice of two dishes for each main meal. Staff told us people could have an alternative if they did not like what was on the menu. They said there was now more baking with cakes and desserts, regularly made.

People's risk of malnutrition had been assessed and their weight was regularly monitored. Staff told us one person was trying to lose weight so their portion sizes had been reduced. They said this had been positive, as the person was doing well and losing weight gradually. Records showed that other people were successfully maintaining or had increased their weight.

The registered manager told us when they started work at the home, they had made contact with all associated health care professionals. They said they did this to enhance relationships, improve the services received and to build the reputation of the home. The registered manager told us as a result of the meetings, GPs from a local surgery routinely visited the home on a monthly basis. This enabled consistency and a review of people's health and their medicines. The registered manager told us that if a GP was required between visits, they would be called in the usual way. One person told us "if I'm not well, they get a doctor".

Requires Improvement

Is the service caring?

Our findings

There were some positive interactions between people and some members of staff. This included a member of staff joking, singing and laughing with people. However, one comment the member of staff made was not appropriate although the person laughed and enjoyed the jovial banter. The person confirmed they liked the member of staff and said "they are my friend". Other interactions were less compassionate and did not reflect any relationship between the member of staff and the person. This was particularly apparent at lunch time when staff placed meals in front of people without any pleasantries. People were not asked if they wanted any assistance or if they were enjoying their meal. One member of staff sat next to a person to supervise their eating. They wrote in people's care files without any engagement with the person. The registered manager told us this practice would not normally happen. The registered manager said they would address this practice with the member of staff.

People told us they were happy with their care and they liked the staff. People knew staff by name. One person told us "the staff are friendly and caring. I am happy with my care. I choose when I get up and go to bed and I have a bath at the end of the day. This is important to me". Another person told us "I can go into town with a member of staff, they let me make my own decisions. They let me to go to bed when I want". This person told us staff were familiar with their routines and their personal preferences. Another person told us 'I am happy with the care and how the staff look out for me. They let me have a bath when I want. The staff are friendly and I am confident to ask for what I want. If I am feeling low the staff will chat to me". Another person told us "we never discuss treatment – I am just here to be looked after. There are only 4 people and we do get looked after".

People told us staff promoted their privacy and dignity. One person told us "the staff ask consent, knock on doors and are very respectful". Another person told us "the older staff, you can have a laugh with and they are very kind". However, one person told us they found the staff, whose first language was not English, difficult to understand at times. This did not promote their dignity, as they said they had to ask the staff member to keep repeating themselves. A relative confirmed this. They said particular accents could also be difficult for some people to understand. The relative told us they expected communication skills to be taken into account during the recruitment process and if there were difficulties, they felt the candidate should not be appointed. The relative said they hoped the registered manager would take this on board.

People told us they liked their bedroom. One person told us they enjoyed their personal possessions around them. Another person said "I have a nice room and all my own furniture. It is like a home". A member of staff told us bedrooms were in the process of being redecorated to enable a more homely feel. They said they enjoyed the period features of bedrooms so believed these would be to the taste of some people, newly admitted to the home. The member of staff told us people were encouraged to bring their own furniture and personal possessions with them on admission. They showed empathy when thinking about moving into residential care. They said "all those things which are familiar to you and all those memories, just gone. It must be terrible. I'd be awful so we have to be mindful of that".

We asked staff what they thought was good about the service. Comments included "care", "the care and teamwork" and "it fosters independence and has good activities". They told us they encouraged people to make choices and gave examples of food, times to eat, when to get up, when to have personal care and links with the community. The member of staff told us they used a sense of humour to help people feel relaxed and comfortable. Another member of staff explained they aimed to provide person centred care. We asked the staff member what they meant by this and they said "ensuring the person is the most important thing in the world at that moment". They continued to say "I get to know them, do what they would like and let them choose. It also means dignity, explaining things to people - Don't just appear with a wet flannel". They said they felt that care should not be given in a way that imposed "how we think or feel". The member of staff confirmed these areas were applied at the home.

Good

Is the service responsive?

Our findings

At the last inspection, people's care needs were not being met effectively. We told the provider they needed to ensure improvements were made. At this inspection, improvements had been made. People looked well supported with clean, brushed hair and well-manicured nails. People had clean clothing and were more animated than previously seen. Two relatives told us that since the appointment of the new manager, their family member had been "much better presented" and "looked more cared for". They said staff had got into a better routine with people's personal needs and people were responding to this in a positive manner. The relative told us "care is more organised now, not so random". Another relative told us "there's now more importance given to people's appearances. They're better presented, as they're now routinely receiving personal care".

Following our inspection, a health care professional told us "I have found them to be very helpful and give good care. We have a good level of communication and are regularly updated on any medical concerns the staff have, in a prompt and appropriate manner". They continued to tell us that there was one person in particular who had shown a real improvement in their general wellbeing over the last 8 months. They felt that in part, this was due to the "warm, friendly and caring atmosphere the staff generate".

We asked a member of staff how they managed people's resistance to care or possible behaviour that could challenge. They told us they liked to get to know the person really well and "know when to talk and when to back off". They said they worked with one person who liked routine but did not like new faces. The member of staff told us "you must do things gradually with them. We have found that the peak time for this person being amenable to having personal care, is now between 4-7pm". The staff member confirmed this was applied and the person's resistance had reduced. Another member of staff told us it was important to "understand their mental capacity" and the "best ways to get around things". They said staff should give explanations before giving care and always use encouragement. They confirmed that when a person understood what they were trying to do for them, they were "successful, 90% of the time". Another member of staff told us a person had recently begun to accept personal care from them when they would not in the past. They were pleased with this achievement and said care should be "tailored" for people and given in a way that enables people. They gave an example of slowly reading the menu to a person, who had dementia and was hard of hearing, so that they could choose what they want to eat.

One person told us the home has recently got better although others did not recognise any recent changes. People told us they choose their own routines. This included getting up and going to bed when they wanted to. One person said "I tell them I want a bath and they let me. I can get up when I want. I mentioned once I like salmon and I get that now". Another person told us "the manager looks in on me and the staff know me well". They said they could have visitors at any time, which was appreciated. One person told us they sometimes went into town with a member of staff. Another person said a staff member regularly supported them to the garden so they could have a cigarette. They said they had a good relationship with the member of staff and "got on well with them".

During our inspection, people spent time in their room or in the communal lounge and dining area. In the afternoon, three people took notice of the PAT dog (Pets as Therapy). One person took the dog for a walk in the garden, which they enjoyed. At other times, staff showed people reminiscence cards. There were some discussions although people were not fully attentive and spent time looking around as if not interested or preoccupied. One person was supported to go outside on a regular basis to have a cigarette. Another person chose to spend some time sitting in the garden as the weather was good. A relative told us they believed the social opportunities available to people had improved. They said "there is talk about people getting out and about more which will be good. I think when there wasn't much going on, it affected people's confidence and they wanted to do less. It wasn't good for them but I think they're addressing that now".

The registered manager told us they were passionate about social activity and had introduced a range of sessions for people to participate within. There was an activities file which contained various ideas for activities and each person had an activity plan in place. The plans detailed people's preferences and there were evaluations about the activities undertaken. There was a notice board which detailed events, key themes and information of interest about the particular month.

Good

Is the service responsive?

Whilst the registered manager was positive about the social activities now in place, people did not share the same enthusiasm. One person said they often felt bored and believed the activities to be childish. Another person said the activities were "not their cup of tea" but they felt obliged to join in. The registered manager told us they were disappointed with this response but said people joined in with the activities regularly and were animated whilst doing so. They said people looked as if they were enjoying the interactions and did not show any signs, which indicated they did not want to participate. In addition to views about activities, two people told us staff did not talk to them about things of interest or importance to them. One person did not feel anything was done to improve their quality of life.

Each person had a detailed, up to date care plan which identified individual needs, wishes and preferences. The plans showed the support people needed from staff to meet their personal care and health care needs. All information was well written and informative. There was a summary of the support plan for easier access to information. The registered manager had written all care plans following discussion with the person and their family. They told us this responsibility would be shared with staff once they had received training in the care planning process and were fully competent in this area. The registered manager told us they would then continue to monitor the plans and would ensure all were applied in practice.

People told us they knew how to complain and would speak to a member of staff if there was anything they were not happy about. One person told us they had complained before but they could not remember what the issue was. Other people told us "I have never complained as there is no need to". One member of staff told us they had not needed to raise any concerns, but if they needed to, they would confide in their managers with confidence that matters would be put right.

The registered person told us they were trying to "draw a line on the past" as they were not able to alter what had happened and felt the home needed to move on. However, they said any concerns raised in the future would be addressed and resolved, as quickly as possible. They said a copy of the home's complaint procedure would be given to any new people on their admission to the home.

Good

Is the service well-led?

Our findings

Throughout our inspection, the registered manager was visible, undertaking tasks and monitoring staff. This included administering medicines to people, assisting people to the table for lunch and clearing used dishes away. They reminded a member of staff to document that they had applied a person's topical cream and asked another staff member to make sure they offered the person the opportunity to use the bathroom. The registered manager encouraged staff to serve smaller, more appropriate portions of food at lunch time and rearranged the cutlery on the dining room tables for lunch. Whilst doing this, they informed staff of the need to place serviettes on a particular side of the place setting. They encouraged staff to write the menu board in larger, clearer writing so that people could see the choices more easily.

Whilst recognising, the registered manager was using role modelling to improve standards, they were undertaking tasks which were usually associated with care staff. Due to this, there was a heavy dependence on the registered manager and their leadership. We asked the registered manager how they would be able to maintain this, with more people in the home and a larger staff group. They told us they did not see this as a problem, as they felt it essential to be involved, to ensure a good service. The registered manager confirmed it was also their nature so they would always find time to be actively involved in whatever was going on. We noted in addition, that whilst the registered person was now in post, time would be required to embed and maintain all improvements made. This was particularly apparent as the home has a history of not maintaining compliance with regulation.

The registered manager was first employed at the home, as a consultant in April 2014. At this time, their role was predominantly to develop and improve people's care plans and to ensure the information was kept up to date. The registered manager told us they were asked to become the registered manager whilst within their consultancy role. They said initially, they did not want this responsibility but as time went on, they became attached to people and staff. They accepted the manager's role in July 2014, subject to receiving the resources they required to improve the service. They became the registered manager in October 2014.

When first in post, the registered manager identified clear action plans regarding their vision and the development of the service. This included revising food provision, staffing rosters and staff training provision. They implemented systems such as formal staff supervision and gained staff support to adopt and engage in change. They moved their office from the top of the building to a central, more prominent area near the communal lounge. They said this enabled them to be more visible to people, visitors and staff but also to hear and see what was going on in the home. The registered manager had started to implement the redecoration of bedrooms and had gained quotations to replace carpets and furnishings. All old furniture had been removed, the front of the home including the flower beds had been tidied and external windows were being painted. The registered manager told us they felt these issues were important to enhance people's first impressions when visiting the home.

The registered manager told us they had introduced themselves to people's relatives and informed them of the planned changes. They undertook a formal review of each person's care needs to ensure they were happy with the service they received. After the inspection, the registered manager told us these reviews continued six monthly and they also were in regular contact with people's families in between. The registered manager told us they had met with health care professionals involved in people's care to inform them of planned improvements and to rebuild the home's reputation.

The registered manager told us they had established links with local tradesman to ensure any work was undertaken quickly by known people. They said they had ensured equipment such as the stair lift had been serviced. They said initially, they had considered the stair lift "out of use" as they could not find evidence that it was safe to use. This had been identified at a previous inspection. One person told us they had a pipe leaking in their hand wash basin but it was quickly sorted. Work had been undertaken on the fire alarm systems to confirm zones, which promoted people safety in the event of a fire. The registered manager was in the process of replacing signage to further highlight all escape routes.

The registered manager told us they received support from senior managers within the organisation but were also "left alone" to make the changes they wanted to implement. The registered manager told us they appreciated this. They

Good

Is the service well-led?

said they were 110% committed to the challenge of developing the service and its occupancy. They had a wealth of experience and were passionate about providing high quality, individualised care. The registered manager told us the staff team had readily embraced the changes made so far and were motivated to progress further. They said the team had many positive attributes but these had not been fully exercised due to the lack of consistent leadership in the past.

Staff were very complimentary about the registered manager and the recent changes made to the home. One member of staff told us "the manager is just what we needed. It's so much better now. The atmosphere is better, people and staff are happier. She [the registered manager] is approachable, firm but supportive and listens. She involves us with what's going on." The member of staff continued to tell us "I've listened to her talk to relatives. She's well educated and knows what she wants to achieve. She comes across well in discussions. I think we'll go from strength to strength. It's good". Another member of staff told us "It's so much better now. It's nowhere near as stressful. Everything is about improving things and the focus is about the residents. That's how it should be. I'm very happy with the way it's going". Another member of staff told us "the home has improved an awful lot. We've got a super-duper manager and deputy manager now".

Records showed the registered manager was implementing the quality auditing systems the provider had in place. This included audits of medicine administration, infection control and staff training. Actions from the registered manager's own action plan were being ticked off once completed. There were records of "resident's meetings" which enabled people to give their views about the service they received. The registered manager told us these had been introduced in August 2014 and people were becoming more confident in raising their views. There were organisational surveys which had been used as a more formal system to gain people's views. The registered manager showed us surveys they had developed, to gain views about specifics such as meal provision.

We asked people what they thought was good about the home. One person said "the staff", whilst another said "the food". Two relatives told us they had noted improvements had been made to the home. However, one relative told us "it's much better but they're not there yet. It's the little things such as the old sign on the road to advertise the home, the bland garden with little seating that people can't walk around easily and the tired state of the décor and furnishings. Also the building needs investment and with only four people, the financial viability of the service is an issue so that means an unsecure future for people". The other relative told us the home could do with improved décor to enhance people's environment.

One member of staff told us the home could be improved by "new décor, en- suites and an electric bath seat in the downstairs bathroom". Another member of staff said "the care has always been good but the paperwork was not good. The care is now less task centred and people have more choice". We asked whether the member of staff had raised the issue about task orientated care in the past. They told us they had not because "either there was no manager or the previous manager would not listen". Another member of staff told us the service could be improved by having more people, a change of décor, new curtains and some en-suite facility. A care professional told us "improvements have been made to care planning, activities and some improvements to the environment. From talking to my colleagues and the home, it is understood that some improvement still needs to be made, but they need more customers through the door to allow them the funding to improve the service".

As there were only four people in the home, the registered manager told us they would facilitate new admissions on a gradual, staggered basis. They said they would undertake all pre-admission assessments to ensure they could meet the person's needs effectively. The registered manager told us if there was any doubt, a place at the home would not be offered. They said that initially they were looking to admit people with low dependency needs as this would give staff time to adapt to the increasing numbers. The registered manager told us they were planning to admit people with more complex needs, when the new staff had been recruited.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2015 and its Code of Practice were not always followed when best interest decisions were reached on behalf of people who lacked capacity to make their own decisions.