CU Care Ltd

Wexford House Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Overall summary

Wexford House is a privately owned cared home which provides accommodation for up to 10 older people living with dementia who need support with their personal care. The accommodation is arranged over three floors with the third floor, being office accommodation. There are 10 single bedrooms set over the first two floors. The second floor is accessed via a stairway and a stair lift. At the time of our inspection there were eight people living at the home and they were joined by a new person who moved in while we were there.

The inspection was carried out over the 6 and 10 November 2014.

At the time of inspection the manager was not registered, because the previous registered manager had recently left. The new manager had started the process to become the registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered

Summary of findings

provider's, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run.

We conducted this inspection because we had concerns about the service following a previous inspection carried out on the 31 July 2014, which had identified systemic failings by the provider. People were not protected from abuse, treated with respect and dignity and their legal rights were not protected. There was insufficient staff available with the necessary skills to meet people's needs. People's care and treatment was not planned and delivered in a way that ensured their safety. Their medication was not managed effectively and they were at risk of inadequate nutrition and dehydration. The home was not clean and hygienic and people were not protected against the risks from unsafe or unsuitable premises. There was no effective system to monitor the quality of service people received, or to identify, assess and manage risks. These failings had a major impact on people using the service. As a result of our findings we required the provider to put in place an improvement plan to bring the service up to the required standard.

During this inspection we found that the service had improved in respect of the standard of care provided across all of the above areas. However, there were still failings in respect of people's care and welfare, respect and dignity, the management of medicines and an additional concern in respect of requirements relating to workers.

We observed care within the home and spoke with the families of three people using the service. The family members we spoke with told us they thought the home was now well led and the new manager had made a "big difference". They said they did not have any concerns over the level of care provided to their relatives.

However, we found that staff did not always manage people's health risks effectively. For example, one person had lost weight rapidly over a short period but there was no evidence that this weight loss had been investigated and there was no referral to a health professional. We did see other occasions where healthcare professionals, such as GPs, district nurses and chiropodists were involved in people's care where necessary.

People were at risk of unsafe care because their care plans did not always contain up to date information regarding their care needs. For example one person's care plan had not been fully updated since 2012. In another person's care plan there were records of unexplained bruising, which had not been investigated to ensure the person's safety and allow preventative measures to be put in place.

There was no guidance available to assist staff in understanding when to administer "as required" medicine to people. The home did not have an effective medicine stock management system in place, which meant that on occasions the number of tablets or sachets of medicine held in stock did not always correspond with the amount shown on the record.

Prior to their admission to the home people's needs were not adequately assessed. On the day of our inspection, the home received a new admission following their discharge from hospital. They arrived at the home without any supporting documentation. The pre-assessment completed by the home did not contain sufficient information to enable staff to meet the care and support needs of the person who became distressed and agitated on arrival at the home.

The checks the provider is required to do before recruiting a new member of staff were not always completed correctly, which meant that the home may employ staff who were not of good character and suitable for the role.

The home had a safeguarding and whistleblowing policy, and the manager and the staff we spoke with told us they had received safeguarding training and could say what they would do if concerns were raised or observed. The family members we spoke with told us they felt their relatives were safe in the home. The home had also recently increased its staffing levels which meant there were enough staff available to meet people's needs. Staff told us they felt supported by the new management regime and had regular supervisions.

We observed care being provided in the communal areas of the home and saw staff did not always interact with people in a positive way. We saw a mixture of both poor

Summary of findings

and positive interactions by staff. People's rooms were personalised with their family photographs and memorabilia. Staff respected people's right to privacy and dignity

The home was clean and appropriately maintained. People in the home appeared happy and well looked after.

People at the home lacked capacity to make some decisions and were subject to restrictions to their personal lives. Staff were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. We found that capacity assessment were not readily accessible to staff. We have recommended that the service considers the current guidelines regarding record keeping and accessibility of records relating to people's capacity assessment.

People at the home who were living with dementia. However, the home did not have decoration or signage that aided people to find their way around or to be as independent as possible. There were no dementia friendly signs to indicate toilets or to identify people's rooms. We have recommended that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

There was a complaints policy and a system to record and investigate complaints. The provider told us they had not received any complaints since our last inspection. Accidents and incidents were recorded and remedial actions identified. However, there was no evidence available to show the remedial action had been completed and people were now safe.

The provider had arranged for a series of audits to be carried out at the home by external professionals. However, there was not a structured audit process/ system in place to ensure standards were maintained. The provider encouraged visitors, family members were kept fully informed, and they were open to feedback and showed a desire to improve. They had also developed links with external organisations and professionals to help enhance the staff's and their own knowledge and experience.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken 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?
The service was not safe.

Medicines were not managed safely and appropriately. There were inconsistencies and errors in the recording and storage of medicines and no guidance available to help staff administer "when required" medicine.

Staff failed to identify potential health related risks and take action to mitigate those risks. Some risk assessments were out of date.

There were enough staff available to meet people's needs. However, the recruiting process was not robust and checks on staff did not ensure they were suitable to work with the people using the service. The home was clean and appropriately maintained.

Inadequate

Is the service effective?
The service was not always effective.

Prior to their admission people's needs were not adequately assessed to ensure the service was able to meet their needs.

Staff had received some training in respect of the Mental Capacity Act and Deprivation of Liberty Safeguards and understood their responsibilities. However, documentation relating to people's capacity were not readily available to staff. Staff received regular supervision and were supported to carry out their roles.

People were provided with a choice of suitable and nutritious food and drink. They were referred to healthcare professionals when appropriate.

Requires Improvement

Is the service caring?
The service was not always caring.

Staff did not always respect and interact with people in a positive way. We saw a mixture of both poor and positive interactions by staff.

People's privacy was respected and staff knocked on people's doors and waited before entering.

People's bedrooms were personalised with family photographs and memorabilia.

Requires Improvement

Is the service responsive?
The service was not responsive.

People were at risk of unsafe care because their care plans did not always contain up to date information regarding their care needs

Inadequate

Summary of findings

Staff did not always follow best practice guidance and published research in respect of pain management and providing meaningful activities for people with dementia.

Family members told us that things had changed and the home was now more responsive to their relative's needs.

The home had a complaints policy. Accidents and incidents were recorded and remedial actions identified but it was not always clear if they had been followed up.

Is the service well-led?

Requires Improvement

The service was not always well led.

The values and ambitions of the provider were not being delivered in practice.

The home had arranged for external professionals to carry out a series of audits but there was no system in place to ensure that standards were maintained.

Family members told us they thought the home was now well led.

The provider have developed links with external organisations and professionals to help enhance the experiences of people living in the home.

Wexford House 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and was carried out on 6 and 10 November 2014. The inspection team consisted of an adult social care inspector and for the first day a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge of working in the field of frail older people and in particular those living with dementia.

Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send tell us about by law. We also gathered information from the West Sussex Local Authority Adult Services team.

We met with the eight people who used the service and a resident to the home, all of whom had complex needs, dementia related condition and were not able to fully verbally communicate with us. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three family members, four members of the care staff, the cleaner, the manager and the provider. We made detailed checks of records of two people using the service from the start of them using the service. We looked at care plans and associated records for eight people using the service, staff duty rota records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures, and quality assurance records.

Is the service safe?

Our findings

During a previous inspection carried out on the 31 July 2014 we identified systemic failings and breaches. People were not safe and protected from risk because their care and treatment was not planned and delivered effectively, medicines were not managed appropriately and there were not enough qualified, skilled and experienced staff employed to meet their needs. The home was not clean and staff did not understand what constituted abuse or when to report any concerns.

Risks were not managed effectively. Seven of the eight risk assessments in the care plans had been updated during August 2014. However, the risk assessments for one person, including their moving and handling assessment and their Waterlow assessment had not been updated since October 2012. The Waterlow assessment is a means of assessing a person's skin integrity and their risk of sustaining pressure ulcers. Therefore staff may not be aware of people's current risks and the care they required to mitigate it.

The records for a different person using the service identified that they had lost over eight kilograms in weight during a one month period. There was no evidence of this weight loss being investigated or referral to a health professional. There was no related risk assessment or use of the malnutrition universal screening tool (MUST). Their nutrition care plan was brief and stated 'Does have a problem with diet. [The person's] diet depends on how they are feeling'. This did not provide sufficient information to enable staff to effectively manage their nutritional needs and ensure their health was maintained.

In another person's care plan there were records of unexplained bruising, which had not been recorded effectively or investigated to ensure the person's safety and to allow preventative measures to be put in place.

People were at risk of dehydration or malnutrition because records relating to food and drink intake were inconsistent and incomplete. The fluid charts for two people were incomplete staff were unable to assure themselves that people were drinking the recommended level of fluids and were at risk of dehydration. The Royal College of Nursing (2007) has identified that good hydration reduces the risk of pressure ulcers, urinary infections, incontinence and cognitive impairment.

Although there were risk assessments in place in relation to individuals' care needs, the provider told us they had not completed any generic risk assessments in respect of the running of the home, such as using the stairlift, or risks associated with the kitchen or external environment. Therefore people were at risk because the provider did not have effective arrangements in place to identify and mitigate risk.

The home had an appropriate crisis and service continuity plan and a fire safety and evacuation plan. However, people did not have personal evacuation plans in place, in respect of the support they would need if they had to be evacuated.

The failure to identify and manage of people's health risks and the risk of dehydration or malnutrition are a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected against the risked associated with the unsafe management, handling and safekeeping of medicines The care plans and medicine administration record (MAR) did not contain any guidance or information to support the administration of "when required" (PRN) medication.. One person was prescribed a controlled drug on a PRN basis. A controlled drug is a prescription medicine controlled under the Misuse of Drugs legislation. However, there was no guidance to help staff to understand when this medication should be given. We compared the entries for when the controlled drug had been administered and found there were inconsistencies between the controlled drugs register and the respective MAR Another person was prescribed paracetamol four times daily. The entry in their MAR chart stated "Do not take anything else containing paracetamol". They were also prescribed a stronger pain killer on a PRN basis containing paracetamol. There was no guidance, in the person's care plan or on their MAR chart for staff to follow to help them understand when this PRN should be given.

The National Institute for Health and Care Excellence (NICE) guidance "Managing medicines in care homes" March 2014 identifies the need for PRN guidance within care homes. The absence of clear guidance to support staff administering PRN medication means that people were are at risk of receiving their PRN medication in a safe and

Is the service safe?

effective way. NICE guidance states that care home staff should make appropriate records when administering a controlled drug, which should be recorded in both the drugs register and the person's MAR chart.

The home did not have an effective medicine stock management system in place; For example, we checked the records relating to one person's medicine and found the records did not correspond with the amount of medicine held in stock. It was not clear from the records whether the person had received their medication or not.

The above issues in respect of the management of PRN medicine and the lack of an effective stock management system are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A safe and effective recruitment process was not in place to ensure that staff who were recruited were fit to work with people using the service. Although, Disclosure and Barring Service (DBS) checks were completed on all of the staff, three of the five recruitment files contained missing information. All three only contained one reference, two contained no identity records and one did not have their full employment history. Therefore, the provider was not able to assure themselves that the staff they employed were of good character and suitable to carry out the role.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were enough staff to meet people's needs. The minimum staffing was three care staff on each of the day shifts. The night shift was covered by one member of staff on a waking night and one sleep-in staff. The manager and the provider were also available to provide support when appropriate. There was a duty roster system, which detailed the planned cover for the home, with short term absences being managed through the use of overtime or previously used staff from an agency. Therefore, there were management structures in place to ensure staffing levels were maintained.

The home had a safeguarding and whistleblowing policy, which was based on the local authority's policy and procedures for safeguarding adults. Since our last inspection on the 31 July 2014, the care staff and manager had received safeguarding training and were able to demonstrate their role and responsibility in protecting people from potential abuse. They could also say what they would do if concerns were raised or observed. The manager had sought advice from a member of the West Sussex Local Authority Adult Services team to develop a greater understanding as to whether incidents between people using the service should be reported to the local authority safeguarding adults team. The family members we spoke with told us they felt their relatives were now safe in the home. One said "I have worked in care so I know what to look for".

The home had an infection control policy, which detailed the relevant infection control issues and guidance for staff. The manager told us they were now the infection control lead for the home. Since our last inspection on the 31 July 2014, the home had employed a cleaner and we saw there were detailed daily cleaning schedules and checklists to confirm when the cleaning had been completed. We viewed the communal areas of the home, the kitchen, bathroom and looked in people's bedrooms. The provider told us that an external company had been used to deep clean the kitchen and other areas of the home. We saw that everywhere was clean and appropriately maintained. All of the mattresses and bedding had been replaced since our last inspection.

Personal protective equipment (PPE), such as gloves, aprons and alcohol hand wash were available for staff to use throughout the home. We spoke with four members of staff and the manager, who all confirmed they had received infection control training. While observing care we saw staff and the provider using their personal protective equipment when it was necessary.

Is the service effective?

Our findings

During a previous inspection carried out on the 31 July 2014 we identified systemic failings and breaches. People were cared for by staff who had not received appropriate training to meet their needs. They were not protected against the risks of inadequate nutrition and dehydration or from unsafe or unsuitable premises. Their consent was not obtained before care was provided and their legal rights were not protected.

During this inspection we found that prior to their admission to the home people's needs were not adequately assessed before starting to use the service On the day of our inspection, the home received a new resident following their discharge from hospital. They arrived at the home without any discharge papers from the hospital. While at the home they started to become agitated and distressed. A member of staff responded to them in a caring way but was unaware of their specific care needs. They told us "I have been told to sit here. I am doing the best I can. I have not seen any records". Prior to the person's arrival at the home an assessment of their care needs had been completed. However, this assessment was incomplete and did not contain sufficient information to enable staff to know what care and support needs the person required on arrival at the home. For example, in the section "Mental Health and Cognition", there was no assessment of capacity or risk. Capacity is the person's ability to make specific decisions for themselves. The assessment states "verbal/physical aggression. Has slapped a member of staff and sworn" and then a note at the bottom of the page "calms down if diverted". There was no information to assist staff regarding possible triggers or what diversion strategies to use. This meant the person was at risk of receiving inappropriate or ineffective care as staff were unaware of how their needs should be met.

The above issue is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's families told us their relatives now received good care. One told us "It is much improved since the summer following one of your reports". Another said their relative was "doing really well [at the home]".

The home was currently undergoing a review of its approach to training. The manager was reviewing the current total reliance on a DVD approach to training and were looking to develop a more practical based approach. Staff had received additional training from the dementia matron for the local hospital, the local pharmacist and staff from Adult Services. There was a distance learning package in respect of safeguarding vulnerable adults. Staff told us they felt the training had improved and following the training with the dementia matron they now felt confident when supporting with people. We observed care being provided in communal areas of the home and saw staff were able to support people during incidents where a person's behaviour challenged others.

People at the home lacked capacity to make some decisions and were subject to restrictions to their personal lives. The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The home had a current MCA, DoLS and restraint policy. Since our last inspection on 31 July 2014, staff were now guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

However, the capacity assessments were held in a separate file in the provider's office, and were not easily accessible to staff to enable them to understand what decisions a person can make when supporting them with care.

Therefore, we have recommended that the service considers the current guidelines regarding record keeping and accessibility of records relating to people's capacity assessment.

All of the staff had received awareness training in respect of MCA and DoLS, as well as specific inputs from the dementia matron in respect of the needs of the people within the home.

Staff offered people a choice, seeking their views either verbally or by actions. For example, staff would take a person and show them the bathroom and if they walked away staff knew they did not want a bath at that time.

People were provided with a choice of suitable and nutritious food and drink. Staff were aware of individual people's dietary needs and preferences. There were cold drinks and tea and coffee available throughout the day. Care plans contained information about people's dietary

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preferences. We viewed menus which listed two main alternatives at lunch and included a hot option for the evening meal. Meals were prepared by care staff. Different options were provided at lunch time and in the evening and that other alternatives could also be provided. We looked at the home's "Residents' Menu Choice Form" and saw people's choices had been recorded. A family member told us "staff are aware of mum's needs". Therefore, there were systems in place to encourage and support people to meet their nutritional and hydration needs.

Healthcare professionals such as GPs, district nurses and chiropodists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they had given regarding people's care. The manager had recently arranged for all of the people's health care needs to be reassessed by their GP to ensure they were up to date and reflected their current needs.

There was one bathroom available for use by the eight people using the service. This was on the first floor and was not easily accessible to everyone. Each bedroom had its own vanity unit but there are no other shower or bathing facilities available to people. We raised this with the provider who told us that this "was sufficient" to meet the needs of the people currently living at the home. People at the home looked clean and well groomed. The daily records of care showed people were able to bathe when they wanted.

People had been admitted to the home who were living with dementia. The home did not have decoration or signage that aided people living with dementia to find their way around or to be as independent as possible. There were no dementia friendly signs to indicate toilets or to identify people's rooms.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

Is the service caring?

Our findings

During a previous inspection carried out on the 31 July 2014 we identified systemic failings and breaches of the regulations. People's privacy, dignity and independence were not respected and they did not experience care in an environment where they were valued as individuals.

During this inspection we observed care in the communal areas of the home and saw staff did not always interact with people in a positive way. One person was standing in the dining area of the home, distressed and becoming agitated. A member of staff came in and led them out of the room. They did not engage with them or try and find out what the problem was. They spoke to them in an authoritative, parent to child manner. On another occasion, we saw a member of staff, who had just come on duty, enter the lounge area and engage in conversation with another member of staff about how the morning had gone. They did not interact with, or acknowledge, any of the four people sitting in the room. However, we did see other occasions where staff provided positive support to people. During the lunch period one person started coughing, which became severe and they were having difficulty in catching their breath. A member of staff responded and provided reassurance and support for the person. A different person was expressing agitation and the manager responded discreetly asking them if they needed the toilet. The manager then supported the person to leave the dining room.

Documentation did not always promote respectful staff interaction. For example, the medicine administration folder contained the instructions that when people refuse their medicines staff should "explain the consequences" and record "the reason for refusal". However, this did not respect the individual needs of the people using the service, all of whom had a diagnosis of cognitive impairment resulting from dementia. Some of these were in the advanced stages. People were unlikely to be able to understand any explanation or express the reasons for refusal. Being asked these questions could lead to people becoming frustrated because they may not understand what is happening.

The above issue in respect of treating people with dignity and respect is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The family members we spoke with told us they did not have any concerns over the level of care provided to their relatives. One family member said staff "know [their relative's] needs, they are attentive. I feel she is looked after". Another said "Staff are so patient and caring with [their relative]. She is happy there".

Records showed that, where appropriate, people's families had been involved in decisions about their care. The provider was able to show us records of letters sent to family members with copies of their care plans to seek their input. We saw that people's wishes were respected and these were reflected in their care plans.

Staff respected people's privacy while supporting them when they became anxious or upset. When one person started to act inappropriately in view of other people, staff responded quickly to intervene and take them to a private place where they were supported. Staff knocked on people's doors and waited before entering. They ensured doors were closed when they were delivering personal care.

All of the bedrooms were individualised and personalised with people's personal photographs and ornaments on display. A family member told us they were encouraged to bring in photographs and items from their mother's home to "try and make her room more homely".

People in the home appeared happy and well looked after. Their clothes were clean and they were well groomed. People were relaxed in the company of staff who appeared to know them well.

Is the service responsive?

Our findings

During a previous inspection carried out on the 31 July 2014, we identified systemic failings and breaches of the regulations. People's care and treatment was not planned and delivered in a way met their needs. There was not an effective system in operation to regularly assess and monitor complaints and comments relating to the service.

During this inspection we found people were at risk of receiving treatment or care which was inappropriate or unsafe because their care plans did not always contain up to date information regarding their care needs. The care plans we looked at all contained behavioural charts where incidents and behaviour that challenged was recorded. However, the records were not analysed, therefore staff were not able to develop anticipatory care and support plans to meet people's needs. In addition, not all occurrences of behaviour that challenged were recorded or documented effectively.

One person become agitated, shouting and swearing at another person. Staff who were present intervened and told us "Oh, she often does that". On looking at the care records for the person later, we and found the incident we had observed had not been recorded. A review of their daily records of care showed that their behaviour was only commented on in a general manner which did not provide sufficient information to enable staff to understand their needs and develop care and support plans to meet their needs.

Staff did not always respond to changes in people's health care needs. One person's care plan stated they were continent. However, their daily records of care recorded several incidents of incontinence. These instances did not trigger staff to carry out any investigation, refer the person to a health professional for investigation into possible causes, such as urinary tract infections or reassess their previous continence assessment.

Another person's care plan contained a body map which recorded "Medium size bruise to elbow noted". There were no measurements of the actual size of the bruise, no photographs and no on going monitoring recorded. A second entry in the care plan records "Bruise/cut noticed today". There was no body map, photograph or further record made. Staff had not responded to these injuries and there was no investigation into either of these two injuries to ascertain how they occurred and allow preventative measures to be put in place.

We observed several incidents where people using the service, who have complex needs and who were not be able to communicate their needs verbally, became agitated. Staff did not react to this behaviour or consider the person may be in pain and carry out a pain assessment. The National Institute for Health and Care Excellence (NICE) best practice guidelines state "If a person with dementia has unexplained changes in behaviour and/or shows signs of distress, health and social care professionals should assess whether the person is in pain". One person's daily records showed they regularly became very agitated and distressed. However, there were no corresponding records of pain assessments being carried out in their care plan.

The Alzheimer's society has identified the benefits of providing meaningful activities for people with dementia; these include improving behaviour that challenges; encouraging closeness with people around them and improve feelings of comfort and security; and providing mutual enjoyment and companionship, which can support the relationship between the person with dementia and their carer. The home has a structured approach to activities and during our inspection we observed a number of group activities taking place within the lounge of the home. However, there were no activities available which focussed on the individual and their needs. In addition, all activities took place within the home and people were not provided with the opportunity of taking part in activities outside the home environment.

The above issues in respect of failing to respond to people's changing needs and providing appropriate activities are a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The family members told us they felt that things had changed and the home was now more responsive to their relative's needs. One family member said "They keep me updated with what's happening". Another family member said "Mum is very happy there now. They understand her needs. Mum is still independent in many ways; they know her well and are attentive. I feel she is looked after".

Accidents and incidents were recorded and remedial actions identified. However, there was no evidence that its

Is the service responsive?

been responded to which meant that staff may not be aware of agreed changes to people's care. For example, one record showed a person had received an injury to their back and knee following a fall on the stairs. The remedial action identified was for staff to "ensure [the person] is always supervised" and "to take extra precautions to help [the person]". There was no record to show this information had been passed on to staff. We raised this with the manager who confirmed there was no record and added "I trust my seniors to have passed the information on".

Since our inspection on 31 July 2014, the home had put in place a complaints policy which provided detailed information on the action people could take if they were not satisfied with the service being provided and included information in respect of advocates, if one was required.

The policy was included in the information given to people and their families. The policy included information as to where people could take their concerns if they were not satisfied with the response they had received. The manager showed us their complaints log and told us they had not received any complaints since our last inspection. They were able to explain what action they would take if any complaint or concern was raised. The family members we spoke with told us they knew how to complain and found the provider and the manager very approachable. One family member said "I have spoken with [the provider]. They are very receptive and have time to speak to you. They want to hear our thoughts and feedback and tell us what their plans are".

Is the service well-led?

Our findings

At our last inspection on 31 July 2014, we identified systemic failings by the management team leading to major concerns in respect of the safety and wellbeing of people using the service. We required the provider to put in place an improvement plan to bring the service up to the required standard. During this inspection, we found the leadership of the home had become more robust and the service had improved. However, there were still failings with regard to, people's care and welfare, respecting people using the service, the management of medicines and requirements relating to workers.

The family members told us they thought the home was now well led and the new manager had made a "big difference". One family member said "we visit twice a week and there has been quite a change in the place. [The manager] is good and seems to be on top of things". They also told us the provider "introduced themselves and told us what is happening. They are always updating us".

The values and ambitions of the provider were aspirational and were not always being delivered in practice. For example, the home's "philosophy of care" detailed in their service user guide the provider's aim to "provide a safe, secure, comfortable and supportive atmosphere" and "to ensure [people] are able to live as part of the community". However, people did not always receive care that was safe, and did not have access to activities outside of the home.

The home has had a series of quality assurance audits carried out by external professionals including infection control, health and safety, and medicines. The provider showed us copies of these audits and the action plans to respond where issues had been identified. These plans were being monitored by the management team and we saw evidence that they were being actioned. However, there did not appear to be a structured audit process in place follow on from the external audits and demonstrate a sustainable approach to quality monitoring. This would ensure that standards were maintained and should have identified the errors, omissions and inconsistencies we identified with medication management and people's care records.

Following the replacement of the registered manager, the provider was taking a more proactive approach, working closely with the new manager in the day to day development of the home. The manager told us "I feel well supported. We work as a team; I don't see them as the boss but as part of the management team". The staff we spoke with told us that morale was good. One of them said "Things are so much better now, real improvements. If things need doing now they get done". They told us they felt motivated and valued.

There was an effective system in place to ensure there was good communication between the provider and staff. The provider was at the home on a daily basis and accessible. There has been an increase in staffing, which has freed up time to allow the senior care staff and the manager to not be involved in the day to day care role. One senior member of staff told us "the extra staff means I can do the job I should be doing".

Staff received regular supervisions where they were able to discuss their role and responsibilities, the standard of their work or their training needs. Records of the sessions were kept in staff recruitment files. There was a staff meeting structure, where staff could raise any issues or concerns. Copies of the previous meetings' minutes covered a variety of topics, including resident issues, future training sessions and questions/feedback. Staff told us they felt supported by the new management.

The provider had developed links with external organisations and professionals to help enhance the staff's and their own knowledge and experience regarding people living with dementia. This has enabled them to improve the experiences of people living in the home. These include support from the dementia matron, pharmacist and the local authority adult services team. They have also made contact with members of the Alzheimer's Society.