Caring Homes Healthcare Group Limited

Rendlesham Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Rendlesham Care Centre provides accommodation and care for up to 60 people, some living with dementia and some requiring nursing care.

There were 58 people living in the service when we inspected on 26 and 27 October 2016. This was an unannounced inspection. There are four units in the service, on the ground floor Oak 1 accommodates people living with dementia and Oak 2 which accommodates people living with dementia and who may also require nursing care. On the first floor Chestnut 1 and 2 provide both personal and nursing care.

There was a registered manager in post. 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.

At our comprehensive inspection of 25 November 2015, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which were: Regulation 12 Safe care and treatment, Regulation 18 Staffing and Regulation 17 Good governance. We set requirement notices relating to these breaches, the provider wrote to us and told us how they were taking action to improve.

An unannounced focused inspection carried out on 12 July 2016 was prompted in part by notification of an incident following which a person had died. This incident, and previous incidents, are subject to an investigation and as a result this inspection did not examine the circumstances of the incident. We found that the provider had not taken appropriate and swift action to ensure that people were safeguarded following incidents of choking. We took enforcement action to ensure the provider took the necessary actions to protect people.

You can read the reports from our last comprehensive and focused inspection, by selecting the 'all reports' link for Rendlesham Care Centre on our website at www.cqc.org.uk.

This unannounced comprehensive inspection on 26 and 27 October 2016 found that improvements had been made to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which were identified in our last comprehensive inspection of 25 November 2015 and the focused inspection of 12 July 2016.

Improvements had been made in relation to assessing and managing risk for people at risk choking and associated training for staff.

Improvements were needed in the staffing levels in the service. This had been identified by the registered manager and they were in the process of addressing it.

Improvements had been made in the quality assurance processes which were used to identify shortfalls and address them. The improvements made need to be sustained over time and embedded in practice to ensure that people are provided with good quality care at all times.

Improvements had been made to ensure that people were supported safely to eat and drink. Detailed risk assessments and care plans were in place for people who were at risk of choking. These improvements needed to be sustained over time. People's fluid intake was monitored to reduce the risks associated with dehydration.

Improvements had been made in people's care plans and risk assessments and these guided staff in how people were provided with person centred care which was tailored to meet their specific needs. People were provided with the opportunity to participate in meaningful activities. There had been recent changes in the activities staff in the service and they were in the process of seeking people's preferences in preparation for developing an activities programme that would include people's interests.

Improvements had been made in the systems in place to store, obtain, dispose of and administer medicines safely and maintaining records relating to medicines management.

However to improve the rating to 'Good' would require a longer term track record of sustainability and embedded staff practice.

There were systems in place to keep people safe and this included how to report abuse. Staff were trained in safeguarding and understood their responsibilities in keeping people safe from abuse. The recruitment of staff was done safely and checks were undertaken on staff to ensure they were fit to care for the people using the service.

The service was up to date with the Mental Capacity Act (MCA) 20015 and Deprivation of Liberty Safeguards (DoLS). People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

People were treated with respect and care by the staff working in the service.

There was a system in place to manage complaints and use them to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements had been made in the risk assessments and guidance provided to keep people safe who are at risk of choking. These improvements needed to be sustained over time and embedded into practice.

Improvements were needed in the staffing numbers in the service. The registered manager was aware of this and was taking action to address it. The systems for the safe recruitment of staff were robust.

There were systems in place to minimise risks to people and to keep them safe from abuse.

People were provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had been made in how staff were trained to meet the needs of the people who used the service and how people's nutritional needs were assessed and professional advice and support was obtained for people when needed.

The Deprivation of Liberty Safeguards (DoLS) were understood and referrals were made appropriately.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

To improve the rating to 'Good' would require a longer term track record of sustainability.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted.

People and their relatives were involved in making decisions about their care and these were respected.

Is the service responsive?

Good

The service was responsive.

People's wellbeing and needs were assessed and planned for to ensure their individual needs were being met.

People were provided with the opportunity to participate in meaningful activities.

There was a system in place to manage people's complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made in the quality assurance systems. As a result the service had identified shortfalls and took action to address them. Action had been taken to reduce risks to people. The improvements made need to be embedded and practice and sustained over time to ensure that people are provided with a good quality service at all times.

The service provided an open culture. People were asked for their views about the service.

To improve the rating to 'Good' would require a longer term track record of sustainability.

Rendlesham Care Centre

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 unannounced inspection took place on 26 and 27 October 2016 and was undertaken by two inspectors, a specialist in nursing and dementia care 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. Our Expert had experience of caring for older people.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with 15 people who used the service and 11 visitors, including people's relatives and friends. We received feedback from another relative following our visits. We observed the interaction between people who used the service and the staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service with us.

We looked at records in relation to 11 people's care. We spoke with the registered manager, and 10 members of staff including nursing, care, activities and catering staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service. We also spoke with a visiting professional. We attended a meeting with the local authority, the registered manager and two members of the senior management team, where we received feedback about the service and plans for improvements.

Requires Improvement

Is the service safe?

Our findings

Our focused inspection of 12 July 2016 found improvements were needed in how people were provided with safe care and treatment. This was because the provider had not taken action to minimise the risks to people associated with choking. We took enforcement action and imposed conditions identifying where the provider needed to improve. By the 25 July 2016 the provider was required to assess the risks to all people in relation to swallowing difficulties, this included that these risk assessments must be personalised and relevant to each person, completed and reviewed by a staff member with the knowledge, skills and competence to do so, include detailed information for managing the risks of choking and provide CQC with a report of the systems put in place to ensure that people with problems with swallowing and at risk of choking were provided with food and drink that were of the correct prescribed consistency to improve their safety. By the 15 August 2016 the provider was required to provide written evidence that all staff employed in the service, including catering staff, had received appropriate training on dysphagia and that all care staff were involved in assessing the risks of people choking. During this inspection we found that improvements had been made. The provider should ensure that these improvements are sustained over time and embedded in practice.

The provider had provided a report of actions taken, as required, this included evidence of staff attending training in dysphagia and swallowing difficulties. This was confirmed during our inspection. Improvements had been made in the risk assessments and care plans relating to people who were at risk of choking or had issues with chewing and swallowing their food. There were now detailed risk assessments in place and guidance had been sought from health professionals. The risk assessments included guidance for staff about the actions they should take if a person choked. This meant that appropriate measures had been taken to improve people's safety and minimise risks. Staff had been provided with training on this subject and training in emergency first aid was being rolled out to all of the staff team, where it had previously only been provided to nursing and senior staff.

Our comprehensive inspection of 25 November 2015 found that improvements were needed in the staffing levels in the service to ensure that people were provided with safe care. The provider wrote to us and told us how they were addressing this.

At this inspection we found that some improvements had been made in the staffing levels in the service, but due to the recent departure of some staff, this left vacancies. The registered manager told us about the actions they were taking to ensure that care staff vacancies were filled and to ensure that there were sufficient staffing numbers. This included the active recruitment of staff and the use of agency staff to fill vacancies. They said that three staff had been employed and would soon be starting work in the service, which would improve the regular and consistent staffing levels on units. We also saw one care staff member being inducted into the service on the second day of our inspection visit. The registered manager told us how staffing levels were adjusted according to the numbers of people using the service and any changes in needs. They explained that on one unit people's needs were changeable from day to day. The improvements in staffing levels were ongoing and the registered manager was aware of where shortfalls were and these were being addressed.

The comments we received from people and relatives varied relating to the staffing levels in the service. We found that whilst on Oak 2, where incidents of choking had happened, the staffing levels had increased. The registered manager told us that the dependency levels of people on Oak 2 were higher than in other units so the decision to increase the staffing numbers had been based on this. On this unit people, staff and visitors told us, and we observed, that the staffing levels were sufficient to meet people's needs. One person's relative said, "There are always enough staff, we have no problems." One staff member told us, "We have more staff, I think there are enough."

On other units we received varied feedback from people, relatives and staff who felt that sometimes staffing needed improvement. On Chestnut 1 one person's relative described the service as, "Short staffed," and told us that there were times when the person had to wait to be supported with their continence needs, which caused them distress. They said that when there were three staff working, the risks of this happening were less but when there were only two, the person had to wait because they needed two staff to support them with their personal care needs. There were two staff working on this unit on the first day of inspection the registered manager told us that ideally three staff worked on this unit and there were three on the second day of our inspection. A staff member told us that when there were three staff on the morning shift they managed better than when there were two. They explained how many people required the assistance of two staff, however they also said that they felt that people were safe and their needs were met. The registered manager told us that the staff could call on other units or the registered manager and deputy manager for support, however we did not see this happen on the day of inspection. Another relative told us that staff, "Are always very helpful and attentive," but because the person required two staff there was often a delay in getting help due to the need to find two staff free at the same time.

On Chestnut 2 one person said that they felt that the staffing levels were sufficient and when they needed help it was provided promptly. However, they did say that they sometimes had to wait longer at nights and weekends and commented, "But then they can't visit everyone immediately if they all call at the same time." One relative commented that whilst they could not fault the care provided, there were times when two staff were required to assist a person which left no staff available in the communal lounge and said, "Sometimes they seem to be too stretched." Recent improvements had been noted by some. For example a relative, commented, "Other staff have been brought in for more support at lunchtime, so this is being addressed." However this was not consistent as we observed at lunch time that a person's meal was interrupted because the staff member supporting them was called away to support a colleague.

On Oak 1 one person told us, "We understand that there is a delay as the carer takes time to get from place to place, it's horrible to have to sit and wait but they come as quickly as they can." One person's relative told us, "[Person] tells me that they push the button and have to wait, usually when they are on the toilet." They added, "I feel there is a lack of staff." The person confirmed that they agreed. A staff member said, "I feel that we are short staffed sometimes on this unit especially in the mornings. Six people require double assistance and if we are supporting one of them and someone else requires assistance, we can't support them as there are only two of us. This usually happens when the senior is doing medication." Another staff member said, "It can be a struggle to support everyone fully as we [staff] spread ourselves thinly."

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. Records also showed that checks on nursing staff were made to ensure that they were allowed to practice in the United Kingdom.

People told us that they were safe living in the service. One person's relative commented that they visited the person daily and could leave in the evenings knowing that the person was safe and well cared for.

Another person's relative told us about the measures in place to ensure the person's safety when mobilising, which took into account the person's wishes. A visitor gave an example of how staff were ensuring that a person was safe due to a reduction in their mobility and were using two staff rather than one to ensure that the person was moved safely.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "I have had safeguarding training in the last couple of months." Another staff member told us "I would report it verbally immediately and write it down. If I didn't feel that the manager was doing anything, I would take it higher."

Where a safeguarding concern had been raised, the service had taken action quickly to report this to the appropriate organisations. Actions had been taken to reduce the risks of future incidents, which included disciplinary action, staff training and improvements in people's care records.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks associated with mobility, pressure ulcers, nutritional needs and falls. The risk assessments were kept under review and identified when people's needs had changed. For people who were at risk of falling there were sensor alarms in their bedrooms, we had activated these when we visited two people in their bedrooms. Staff responded promptly to the alarm and checked that people did not need assistance. This meant that there were systems in place to reduce risks and keep people safe.

Where people were at risk of developing pressure ulcers, actions were taken to reduce these risks. This included regular repositioning and pressure relieving equipment. One person's relative told us that the staff ensured that the person was, "Moved every two hours," to ensure that they were comfortable and to reduce the risks associated with being in the same position for long periods of time.

Risks to people injuring themselves or others were limited because equipment, including hoists, had been serviced and regularly checked so that they were fit for purpose and safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. People's records held information of how people were to be supported to evacuate the service if needed in an emergency.

People told us that they were satisfied with the arrangements for their medicines administration. One person's relative explained how the staff respected the person's choices regarding when they took their medicines. We saw that medicines were managed safely and were provided to people in a polite and safe manner by staff.

Improvements had been made in the safe management of medicines. Medicines administration records (MAR) were appropriately completed and identified staff had signed to show that people had been given their medicines at the right time.

Where people were prescribed with medicines to be administered 'as required.' There were protocols in place which guided staff on each of these medicines and when they should be provided to people. This showed that the risks of inappropriate administration of PRN medicines were assessed and minimised.

People's medicines were kept safely but available to people when they were needed. Staff were provided with training in the safe management of medicines. Regular checks and audits on medicines were completed which ensured that any shortfalls were identified and addressed.

Requires Improvement

Is the service effective?

Our findings

Our last focused inspection of 12 July 2016 found that improvements were needed in how staff were provided with training to minimise the risks associated with people who had difficulties choking and how these risks were assessed. We were concerned that the provider had not taken swift action to make these improvements and we took enforcement action to ensure that these improvements had been made. This enforcement action was to impose conditions to tell the provider what action they should take. During this inspection we found that improvements had been made. These improvements needed to be sustained over time and embedded in practice to ensure that people are provided with an effective service at all times.

Staff had been provided with training in supporting people with their nutritional needs, including risks associated with choking. One staff member told us about how this training had been informative and as a result they were more aware of the different consistencies of meals that people required. During lunch they explained what support each person required and the type of softer meals they were provided with to reduce the risk of choking. Another staff member told us about this training and how they had adapted their approach due to what they had learned, including how long it took for mouthfuls of food to be swallowed by people. We saw this staff member working with one person during lunch and they reminded the person to take small sips of drink in between mouthfuls of food, which was also identified in their care plan. This showed that the training had been effective. In addition, further training was booked for staff to attend in the malnutrition screening tool (MUST).

People told us that the staff had the skills to meet their needs. One person described the staff as, "Brilliant, really good." One person's relative commented on how the staff used, "Team work," which they saw as positive to ensure that people were cared for effectively. Another relative said that they had spoken with the staff who cared for the person and were reassured when they had said that they enjoyed working in the service and with the people living with specific conditions, which they were skilled in. One relative told us that they felt that the registered manager had a, "Total understanding of dementia and all that goes with that."

The service had systems in place to ensure that staff were provided with training and support and the opportunity to achieve relevant qualifications for their role. Staff told us that they were provided with the training that they needed to do their job and meet people's needs. One person told us that they found it difficult being supported by carers who used English as their second language and said, "It causes me distress as they don't understand me and I don't understand them." The registered manager told us that staff who used English as their second language were supported to access English classes to ensure that communication with people was effective. They told us they would explore this concern and look at what else could be done to support people and staff.

New staff were provided with an induction course and shadowed existing staff as part of their induction. New staff had the opportunity to undertake the care certificate. This is a recognised set of standards that staff should be working to. One staff member said, "I am aiming to get all of my induction training done in three months and the seniors observe me doing certain tasks and witness these towards my care

certificate." This showed that the service had kept up to date with changes in the staff induction process and took action to implement them.

Staff were knowledgeable about their work role, people's individual needs and how they were met. The majority of staff had regular supervision. One staff member said, "I have just had a supervision." This provided staff with a forum to discuss their concerns and work role and receive feedback on their work practice.

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

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

The registered manager understood when applications should be made and the requirements relating to MCA and DoLS. Referrals had been made appropriately when people did not have the capacity to make their own decisions to ensure that they were not deprived of their liberty unlawfully. Staff were provided with training in MCA and DoLS.

People told us and we observed that the staff asked for their consent before providing any care, such as if they needed assistance with their meals and where they wanted to spend their time in the service. One person's relative said, "They [staff] have a good grasp of mental capacity and will never force [person] to do anything they do not want to do."

Care records identified people's capacity to make decisions. The records included information about when people needed assistance with decisions to be made in their best interests. These records had been improved and were more detailed since our last inspection and provided clear guidance for staff about people's capacity, how it could change over time and any assistance they may need.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. People told us that they were provided with choices of good quality food. One person said that they were unable to eat a certain food and that the chef, "Cooks an individual pie for me without the onions." Another person commented, "I think the food is very good and we get a choice of two menus." One person's relative said that the food was, "Good and wholesome," and, "Exactly what [person] likes." Another relative commented, "Food is very good, no cause for complaint there."

People were encouraged to eat independently and staff promoted this where possible. Where one person's care records identified that they may be at risk of choking and provided guidance to staff on how they should support this person, we saw that a staff member supported this person in the way that was identified. This included sitting with the person and encouraging drinks when they were eating.

People were provided with choices of hot and cold drinks throughout the day. This meant that there were drinks available for people to reduce the risks of dehydration. Improvements had been made in the

assessment of people's hydration needs and fluid monitoring. Two staff members discussed one person's fluid intake and how they were regularly encouraged to have drinks. However, on one unit we did not see any drinks on the tables during the lunchtime meals although water was provided for one person at their request. We told the registered manager about this and they assured us that they would look into it because the usual routines were that people were always provided with drinks with their meal.

Staff, including catering staff had a good understanding of people's dietary needs, abilities and how people were supported to maintain a healthy diet. This information was on the wall in the kitchen and was updated weekly and included who had a fortified diet, who preferred finger foods and any allergies that people had. The catering staff told us how they spoke with people about their preferences on the menu and made additions if people said that they wanted a particular item.

People's records showed that people's dietary needs were assessed and met. Where issues had been identified, such as weight loss and difficulty swallowing, guidance and support was sought from health professionals, including a dietician and their advice was acted upon. For example, providing people with food and drinks to supplement their calorie intake. One person's relative told us that the service had recently made a referral with the speech and language team (SALT) which they saw as positive.

People's health needs were met and where they required the support of healthcare professionals, this was provided. Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support.

Good

Is the service caring?

Our findings

People spoken with said that the staff were caring and treated them with respect. All of the relatives we spoke with were very complimentary about the approach of the staff. One relative said, "Staff are very caring, speak kindly to [person]…they are polite and kind." Another person's relative said the care was, "Amazing," and described how staff demonstrated a caring attitude physically and verbally. Another relative shared examples of how they felt that the staff were caring in their approach and respected the person's privacy. Another relative described the staff as, "Tip top and absolutely first class." Another told us how the staff communicated with their relative in a way that they preferred, "They are all brilliant with [person], loves banter and hates to be smothered."

People told us that they were supported to maintain their independence by staff. One person commented that they were happy with the support they had received since moving into the home and had gained more independence. Another person said, "Wonderful carers, they do or assist with all those things I can't manage for myself. They are worth their weight in gold."

Staff spoke about people in a compassionate way. There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Staff communicated with people in a caring and respectful manner. They communicated in an effective way by making eye contact with people and listening to what people said. Staff changed their interaction style to suit people's preferences, for example, one person was called, "Sir." One person became upset and spoke with the registered manager about their condition. The registered manager was compassionate and caring in their interaction with the person. They talked about the person's feelings and was reassuring. Staff were observed asking people if they were warm enough, they provided blankets and warm drinks to people when requested. One person was worried that they did not have enough money to pay for an activity, which they did not have to do, and staff calmly reassured the person, "That's alright, we can sort that out another day."

People's privacy was respected by staff who communicated with people quietly to ensure they were no overheard by others, for example when they had asked for assistance with their continence. One person showed us the notice on the door which showed if the toilet was vacant or occupied. They were changing it to vacant after they had used it and said, "Makes sure people know someone is on there."

One person's relative told us how they respected the person's choices, for example where they wanted to spend their time. People's views were listened to and their views were taken into account when their care was planned and reviewed. Records showed that people and their relatives, where appropriate, had been involved in planning their care and support, for example in individual preferences questionnaires. This included people's participation of care reviews. Records showed that relatives, where appropriate, had been shown the care plans by staff and that they were provided with the opportunity to raise any issues. The relatives had signed agreements to review the care plans at timescales which they preferred. One person's relative told us how they and the person had written items for the person's care plan and risk assessments and these were used. This meant that the person's preferences and the knowledge of relatives were used when planning care and support.

People's bedrooms were personalised which reflected their choices and individuality. People's records included information about how, for example, people took pride in their appearance and their preferences. Staff told us that people could get out of bed when they wanted to, "It's okay if they want to have a lie in, but if they want to get up early, fine." This showed that people's dignity and preferences were respected.

Good

Is the service responsive?

Our findings

Our last comprehensive inspection of 25 November 2015 identified that improvements were needed in relation to people's care planning and person centred care. At this inspection we found that there had been improvements in the ways that people's care needs were assessed and planned for. People's care plans identified the specific care that people required to meet their diverse needs. These included any triggers for people's anxiety and distress and how staff should support them, for example by providing a calm and relaxed atmosphere and explaining the actions of staff throughout their support. For a person who did not verbally communicate their care plan advised staff of how the person demonstrated they may be in pain. The records were now written in a person centred way which identified the care, support and preferences of people using the service and provided guidance to staff on how people's needs were to be met. Assessments were in place which had been completed with people prior to them moving into the service. This showed that there was a system in place to ensure that the service considered whether it could meet people's needs.

People told us that they felt that they were cared for and their needs were met. One person said that the staff were, "Very helpful," and, "If you need anything they would go out of their way." Another person described the service they received as, "Fantastic," and, "I couldn't praise the home highly enough." They told us about how they had been immobile when they had moved into the service but with the patience, support and encouragement of the staff they could now mobilise confidently around the service using a walking aid. One person's relative told us that they had observed that all people were, "Treated differently," which they saw as positive and that people's individuality was respected. They said that the staff kept them informed of any changes in their relative's wellbeing. Another relative commented how the service had responded to the person's preferences and routines, for example when bathing and the staff that the person allowed to support them with their personal care needs. Another said that, "Staff seem to know what is needed," for the person, "Before you've even asked." Another person's relative told us about the positive experience the person and their family had with the service from telephoning the service, visiting it, having a pre admission assessment and moving in to the present.

People told us that there were social events that they could participate in. One person listed the activities that they enjoyed and said, "I just love it here."

We saw people participating in several activities throughout the day. This included having their hair styled in the service's hairdressers, playing bingo, doing art, watching television, listening to music and talking to each other, staff and visitors. Following the bingo activity one person said to another, "I quite enjoyed the game of bingo today." Both people talked about this activity and how they had liked it. People were doing art with a visiting professional. The activities coordinator told us that they were introducing this art activity using the community service to see if people enjoyed it. The professional explained how they supported people in the community to develop their artistic skills. People told us that they were enjoying this.

There were items in the service that people could use to stimulate their senses and memories. This included a crib, and items such as aprons with, for example, buttons that they could handle. There were reminiscence

boxes in the service to evoke memories and we saw one person looking at a ration card and a staff member was encouraging conversation about the war with this person.

There was an activities programme in place which showed that people were provided with activities to reduce the risks of boredom and isolation. There were two new activities coordinators working in the service. We spoke with one of them who told us how they were working with people to gain suggestions of activities and interests that they had. They showed us questionnaires which had been completed by people. They were in the process of introducing activities which were preferred by the people using the service, including outings. One person's relative told us, "They have just employed a new activities staff and [person] went out the other day which [person enjoyed], it was something we never thought [person] would do." The activities coordinator told us how they were in the process of completing risk assessments to ensure that any risks associated with the outings were assessed and minimised. One person's relative told us that their relative did not participate in the active activities in the service but did enjoy the more passive activities, such as the visits from the local church and listening to music. We discussed this with one of the activities coordinators who told us that they had recognised the differences in people's abilities to participate in activities and were planning different types to ensure that all people were provided with the opportunity to join in with activities that they preferred.

People told us that they could have visitors when they wanted them. This was confirmed by people's visitors and our observations. We saw people entertaining their visitors and they were welcomed by staff. One person's relative said, "We can go in at any time, there has never been a time we are made to feel that it is inconvenient." This meant that the risks of people becoming lonely or isolated were reduced and people's relationships were respected.

People told us that they knew how to make a complaint and that their concerns and complaints were addressed. People's relatives told us that they were confident that if they raised concerns or complaints they would be addressed. One relative said, "I am confident that I can go in and talk to [Registered manager] at any time and I know it will be addressed."

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. Records of complaints showed that they were investigated and responded to. An instance where a complainant had not been satisfied with the response received, this complaint was reopened and reinvestigated. Where complaints were upheld the service had offered an apology, in line with the service's duty of candour policy. In addition, action plans were in place which reduced the risks of future incidents and to improve the service. This included supervision with staff and improving risk assessments.

Requires Improvement

Is the service well-led?

Our findings

Our focused inspection of 12 July 2016 found that the provider had not taken appropriate and swift action to ensure that people were safeguarded following incidents of choking. Our concerns were serious and as a result we took enforcement action where we imposed conditions to tell the provider the improvements they needed to make. At this inspection we found that improvements had been made. However, due to the seriousness of our concerns we need to be assured that these improvements will be sustained over time and embedded in practice.

Our previous inspection of November 2015 identified the lack of consistent management in the service. This had resulted in the service not sustaining improvements made at previous inspections. Since this inspection the manager had registered with CQC and was making improvements. The registered manager understood their role and responsibilities and was committed to providing good quality care for the people who used the service. They were supported in their role by senior management and there was a new deputy manager working in the service who assisted the registered manager in the managerial duties.

Our previous inspection of November 2015 identified that the service's quality assurance systems were not robust and had not independently picked up shortfalls in the service. During this inspection we found that improvements had been made. The service had accepted the support from the local authority in improving the service, including in record keeping. They had also improved their quality assurance systems, including increasing the numbers of regional managers to check that data and monitoring was more robust. Monthly regional manager visit reports incorporated the five domains used in CQC methodology; safe, effective, caring, responsive and well-led. These reports identified how the service was monitored in areas, such as risks of choking, health and safety and care records, and actions taken in response to incidents and accidents were appropriate. There were monitoring systems in place for mealtimes and medicines administration and where the need for improvements were identified, this was actioned and monitored, such as the completion of medicines administration records. The quality assurance system was used to identify any trends, for example with falls, and prompt actions taken to address these to minimise risks to people using the service and to provide a good quality service. The registered manager had a clear vision of improvements they were making to ensure that they were sustained and the service continued to improve.

All of the relatives we spoke with were complimentary about the registered manager. One relative said that the registered manager had, "Worked so hard," to improve the service and that they were accessible when needed. Another relative described the registered manager as, "Very dedicated." They commented on how the registered manager had told another relative to speak with them if they had any suggestions on how they could improve the service. The relative saw this as positive and said, "We are very impressed." One relative said, "I want the senior management to realise what a gem they have in [registered manager]. [Registered manager] is pro-active and calm and does the things that they say they will do." Another told us, "It is evident that [registered manager] want to make a difference and improve, all of these we can see filtering through."

There was an open culture in the service. People and relatives were involved in developing the service and

were provided with the opportunity to share their views. This included in quality assurance questionnaires. There were notice boards in the communal areas where people and visitors could record their comments in sections of what they thought the service did well and what they thought they could do better. One relative told us that a relative's group was in the process of being set up to further develop the good communication between the registered manager and the relatives. This would allow ideas and areas for improvement to be discussed. Another relative told us how they had attended one of these meetings and felt that their comments were valued and listened to, "We have the relative forum, but we have only been able to get everyone together once so far."

Staff understood their roles and responsibilities in providing good quality and safe care to people. The majority of the staff that we spoke with felt well supported by the management of the service. One staff member explained that they had applied to work in the service after working there on an agency basis because they were impressed with the teamwork they had experienced and staff being willing to accept and implement positive changes to practice. Another staff member said, "It is very friendly and the manager is very approachable, I can put my concerns forward." Another staff member told us. "I feel I can ask anybody if I am not sure and I always get the answer." However, one staff member said, "I do voice my opinions but it is not always listened to especially around staffing. They don't want to hear anything negative." Another commented, "I think the manager could be a bit more supportive. I have endlessly raised my concerns about the shortness of staff." We spoke with the registered manager about staffing and the improvements required are identified in the Safe section of this report.

The registered manager told us about how they managed whistleblowing in the service and empowered staff to report any concerns they had about the people using the service and how their needs were met. As a result of a staff member's concerns, the registered manager and the provider had taken action, including disciplinary action, to ensure that the morale of staff in the service improved. The registered manager told us that once all actions had been finalised they would be having a staff meeting to reassure staff and encourage them to voice any concerns they had. One of the senior management team told us how they had improved the whistleblowing system in the service which included the use of an external agency as well as the provider's in house whistleblowing line. This provided staff with a choice of how they reported concerns and received feedback.

Records of staff meeting minutes showed that staff were provided with the opportunity to discuss the service provided. Recent meetings showed that staff discussed recent training, learning from incidents and how they would use this learning to improve the service and minimise the risks of future events. 'Ten at ten' meetings were held which was attended by the heads of department, including domestic, catering and activities. The minutes of these meetings showed that the service delivery and effectiveness were discussed and any areas of improvement which were to be shared across teams.

The service had an action plan which was kept under review and identified the planned improvements to be made in the service. This had clear timescales for when the improvements should be made and this was updated as required. This included improvements made in care planning, how people could share their views about the service and in medicines management.

Discussions with the registered manager, which was confirmed by the local authority, showed that the registered manager took prompt action to provide staff with updated moving and handling training when an issue had been identified. The registered manager told us that they had made the decision to provide refresher training on this subject on a six monthly basis rather than annually to ensure that staff knowledge was up to date. This meant that the registered manager had made changes to reduce the risks to people using the service and ensure that the service improved.