Caring Homes Healthcare Group Limited

Southlands Place

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Southlands Place is registered to provide nursing, care and accommodation to 71 people. There were 32 people living in the service when we visited. People who lived at Southlands Place were mainly older people who were living with a range of care needs, including arthritis, diabetes and heart conditions. Some people were living with dementia, and could show behaviours which may challenge. Most people needed some support with their personal care, eating, drinking or mobility.

People's experience of using this service:
People told us and we observed that they were safe and well cared for and their independence was encouraged and maintained. Comments included, "This is a good place to live, I feel safe," "I am well looked after" and "Staff are pretty marvellous"
• The service had made improvements since our last inspection. This meant people's outcomes had improved and the breach of regulations met. However, whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. For example, the monitoring of completed behavioural charts that showed aggression towards staff and other people since December 2018 had not been followed up or escalated to the management team for action. This meant that the provider had not had a full oversight of incidents that occurred in the home. We also found shortfalls in the management of some peoples' pain control and that not all peoples' social and well-being needs were reflected in peoples' care plans.
• These required further improvement, however we acknowledge that the shortfalls in respect of incidents were addressed immediately.

We have made a recommendation about seeking expert guidance regarding oral hygiene practices.

• There were sufficient staff to meet people's individual needs: all of whom had passed robust recruitment procedures that ensured they were suitable for their role.
• There were systems in place to monitor people's safety and promote their health and wellbeing, these included health and social risk assessments and care plans. The provider ensured that when things went wrong, accidents were recorded and lessons were learned.
• Staff received appropriate training and support to enable them to perform their roles effectively. Visitors told us, "Staff seem knowledgeable, look after my relative really well," and "The staff team seems to have really improved."
• People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff knew people's likes and dislikes. People gave very positive feedback about the food. Comments included, "The food is good," "Very generous with the rations" and "Good food"

• The environment was comfortable, clean and well maintained.
• People and relatives told us staff were 'kind' and 'caring'. They could express their views about the service

and provide feedback. One person said, "We are looked after."
• People were supported to keep in contact with their families. One person told us, "I text every day, I think I could skype if I needed to, I think there is a laptop I could use."
• The care was designed to ensure people's independence was encouraged and maintained.
• People and families were involved in their care planning as much as possible. End of life care was planned for and staff received training and
• There was now a happy workplace culture and staff we spoke with provided positive feedback about the management style.
• Referrals were made appropriately to outside agencies when required. For example, GP visits, community nurses and speech and language therapists (SALT). Notifications had been completed to inform CQC and other outside organisations when events occurred.

The service met the characteristics for a rating of 'Good' in three of the five key questions we inspected, with the responsive and well-led question being 'Requires Improvement.' Therefore, our overall rating for the service after this inspection was 'Requires Improvement'.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Requires Improvement. (Report published on 25 March 2019.)

This is the second time the service has been Requires Improvement. However, improvements were seen and the service had met the previous breaches of regulation.

Why we inspected:
• As part of our enforcement action following our prior inspection, we had requested an action plan as to how they were making improvements. This inspection was scheduled to look at their action plan and ensure improvements had been made in line with their action plans.
• All services rated as 'Requires improvement' are re-inspected within one year of our prior inspection. This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received and the improvements made.

Follow up:
• We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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 safe Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Southlands Place

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of three inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance services for older people.

The service is required to have a registered manager:
The service did not have a manager registered with the Care Quality Commission at the time of inspection. The manager had submitted their application to be registered. Once registered, this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The service type:
Southlands Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Southlands Place can accommodate up to 71 people in one building.

Notice of inspection:
We did not give the provider any notice of this inspection.

What we did:
Before the inspection we reviewed the information, we held about the service and the service provider, including the previous inspection report. We looked at the action plans provided monthly to CQC as part of our enforcement process. The registered provider had completed a Provider Information Return (PIR). This is

a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with:
• 21 people and observed care and support given to people in the dining room and lounges
• Nine people's relatives/visitors.
• 14 members of staff
• Three external healthcare professionals.

We also reviewed the following documents:
• Eight people's care records
• Records of accidents, incidents and complaints
• Four staff recruitment files and training records
• Audits, quality assurance reports and maintenance records

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met

At the last inspection on the 3, 5 and 10 December 2018, we asked the provider to take action to make improvements to ensure that risks to people were appropriately assessed and medicines were managed safely. This action has been completed.

Assessing risk, safety monitoring and management:
• People told us, "I feel safe, if I didn't I would tell someone why," "Very happy living here, it's not home but I don't expect it to be. Now I am not able to look after myself, I am lucky to be here" and "I rely on staff and they don't let me down." We were also told, "I feel safe living here because you are in a community" and "What would I do if I was at home, I feel much safer here. It's alright here, I'd be lonely if I went home" Visitors told us, "The care has improved, I visit every day and am more relaxed now as action has been taken to improve things," "My (relative) had several falls so being here with 24-hour care is reassuring, he is safe"
• People's individual risk assessments for their health needs were detailed and were updated regularly. They included assessments for skin integrity, nutrition, falls and dependency levels.
• Risk assessments demonstrated how people's health and well-being was identified, protected and promoted. For example, people with delicate skin had guidance on how to prevent pressure damage using air flow mattresses, regular movement, continence promotion and monitoring. All daily record checks for air flow mattresses and continence care were up to date and reflected the care directives.
• Some people lived with complex health needs that required specific care to keep them safe, such as percutaneous endoscopic gastrostomy regime (PEG). A PEG supplies nutrition and medicines via a tube straight into the stomach for people who cannot eat or drink safely orally. Care plans contained clear directives for enteral feeding (feeding by tube) and detailed the amount of nutrition to be given with fluid requirements. This was supported with fluid recording charts and a management plan for how to care for the PEG, including rotation of tubing, balloon and water changes. The nurses were supported by visits from the Community Enteral Feeding nurses.
• Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).
• Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Using medicines safely:
• People did not have any concerns regarding how they received their medicines. One person said, "I get my pills on time," and, "They give me my pills and discuss any changes with me."

• Medicines continued to be stored, administered and disposed of safely. People's medication records confirmed they received their medicines as required. We saw medicines remained stored securely. Medicines were supplied to the home in a monitored dosage system (MDS). Systems ensured all medicines were disposed of safely.
• All staff who administered medicines had the relevant training and competency checks. Nursing assistants had received support and training to ensure confidence in their extended role.
• There were protocols for 'as required' (PRN) medicines such as pain relief medicines, which included recording the effectiveness of the medicine.
• People who received covert medicines (Covert administration is when medicines are administered in a disguised format) had clear directives in place that ensured staff offered medicines in a normal way before giving them covertly.

Safeguarding systems and processes:
• People were protected from the risks of abuse and harm. There was a safeguarding folder that contained the referral and investigation document. It also contained the outcome of the investigation with action plans where required. Feedback from the local authority included "The management team have worked hard to make improvements and work very well with us."
• Southlands Place had followed safeguarding procedures, made referrals to their local authority, as well as notifying the Care Quality Commission in a timely way.
• There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff could talk through the procedure and confidently discuss the different types of abuse they may see.
• Staff continued to have a good understanding of their responsibilities and how to safeguard people. A staff member said, "We have had training, really good training, and if we have any worries we can go to the manager or the deputy." Another staff member said, "I feel supported to raise issues."
•Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. The provider had an equalities statement prominently displayed in the home, which recognised their commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age. For example, one staff member told us, "We have lots of different nationalities working and visiting here. We ensure that we respect their culture and support them with our culture as well."

Staffing and recruitment:
• Staff told us that there were enough staff to do their job safely and well. People told us, "I have no worries about staffing." A visitor told us, "They were using a lot of agency care staff but not recently so that is good." We were also told by one visitor that it was noticeable when staff did training whilst on shift, because it meant that staff weren't available. The rotas viewed confirmed that staff attended training sessions within shift, with no additional cover to rota for 3-hour training absences. This is something that the provider may like to reflect on in the future.
• Staff deployment had ensured people's needs were met in a timely manner and in a way, that met their preferences. Care delivery was supported by records which evidenced that people's needs were met. Food and fluid charts were completed in real time as were turning charts and continence records. This meant staff could monitor and ensure people's needs were consistently met.
• 32 people currently lived at Southlands Place with a range of differing needs. The provider used an organisational dependency tool to calculate staffing levels and adjusted according to people's needs.
•We looked at four staff personnel files and there was evidence of robust recruitment procedures. All potential staff were required to complete an application form and attend an interview so their knowledge, skills and values could be assessed.

• The provider continued to undertake checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Preventing and controlling infection:
• Southlands Place was well- maintained, clean and free from odour.
• Staff continued to have access to personal protective equipment (PPE) such as disposable gloves and aprons.
• Staff confirmed they had received training in infection control measures. Staff could tell us of how they managed infection control and were knowledgeable about the in-house policies and procedures that govern the service.

Learning lessons when things go wrong:
• Accidents and incidents were documented and recorded. We saw incidents/accidents were responded to by updating people's risk assessments. Any serious incidents were escalated to other organisations such as the Local Authority and CQC.
• Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. For example, one person had had an unwitnessed fall in their bedroom. Staff looked at the circumstances and ensured that risks such as footwear and trip hazards were explored. A mattress had been placed by their bed This meant staff could support the person safely.
• Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

At the last inspection on the 3, 5 and 10 December 2018, we asked the provider to take action to make improvements ensure people's health care needs were met and this action has been completed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People told us, "They give you good support, support when I need them" and "The majority (of staff) are good, they can change my bandage for me, some are not very good if they've not done it before." One person confirmed the GP had visited them and has also spoke with him on the phone, she had spoken to him on the phone the day before, "Yes, my needs and preferences are met, I don't ask for much."
• Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practices, which contributed to good outcomes for people. For example, the staff worked alongside the tissue viability nurse (TVN) to promote healing and prevent a re-occurrence of chronic wounds.
• The documentation and monitoring for people who lived with diabetes had continued to improve and provided effective care. Specialist support and advice had been sought for those people whose diabetes management was not straight forward. The advice had been shared and discussed with all staff, including the chef. This was evidenced through discussion and care records.
• People's needs continued to be comprehensively assessed and regularly reviewed. Care plan reviews took place at least monthly, or as and when required.
• People were involved in their care planning and the people we spoke with confirmed this. We asked people if they were involved in planning their move to the service, one person told us, "I was involved with all the decisions." A visitor said, "The staff came to visit my mother to ensure that they could care for her."

Supporting people to eat and drink enough to maintain a balanced diet:
• The meal time experience had been reviewed and it was seen to be an enjoyable experience for people. People chose where they ate their meals. On the nursing floor, most people chose to eat in their rooms and staff supported people as they required. People on the dementia floor chose to eat in the dining room. Staff sat with people and ate their own meal alongside them to encourage and offer support as required.
• People's food preferences were considered when menus were planned. Comments from people included, "Good food, has improved lately," "The food is very good and generous," "They offer us a choice and we can have something different if I don't want what's on the menu." Visitors told us, "Very good variety, always nicely presented." The chef brought hot trollies to each dining area and served the meals. People were shown the meal choices by the chef as the meal service began, which meant that they could visually make their choice.
• The chef was extremely knowledgeable of the people he prepared food for. He visited people to discuss their dietary requirements and knew who required special diets and fortified food. Each dining room had

freshly made cakes, tea and coffee facilities and fruit readily available throughout the day. This meant people, family and visitors could help themselves.
• There were appropriate risk assessments and care plans for nutrition and hydration.
• Choking risk assessments were completed where a risk was identified. Referrals to a speech and language therapist (SALT) had been made when necessary. Emergency equipment such as a 'Dechoker, (which is a handheld device that uses suction to remove the obstruction) was available in each dining area.
• People had correctly modified texture diets and fluids where there were risks of choking. All meals were attractively presented and staff promoted independence with the provision of specialised plates for those that need them. Coloured table cloths were now used on the dementia floor to emphasise the plates and encourage people to eat.
• Staff monitored peoples' weights and recorded these on the nutritional assessment. The registered manager had a 'tracker' which noted people's weights and malnutrition scores. These could be traced over time to check whether there were any risks and flag staff to request a dietitian's input. Staff could tell us who was at risk from malnutrition and dehydration. They could also tell us what actions they needed to take such as encouraging drinks and fortified food.

Ensuring consent to care and treatment in line with law and guidance:
• 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

• We were told that not everyone currently living at the home had the capacity to make their own decisions about their lives and were subject to a DoLS.
• There was a file kept by the registered manager of all the DoLS submitted and their status. The documentation supported that each DoLs application was decision specific for that person. For example, regarding restricted practices such as locked doors, covert medicines and bed rails.
• Staff had received further training in the MCA and DoLS. They understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty. The staff we spoke with confirmed this. We were told, "We have people who can make certain decisions about food and drinks but not about their health care. So, we go down the best interest route."

Staff support: induction, training, skills and experience:
• People told us staff were competent. One person said, "I'm sure they are well trained, staff know how to look after us." A second person told us, "Staff know exactly what I need."
• The provider provided staff with regular training to ensure they had the right knowledge and skills to carry out their roles. Staff told us that they completed essential training such as infection control, moving and handling and safeguarding. They also confirmed that they had specific training such as understanding dementia, catheter care and equality and diversity. The training records confirmed that training had been completed.
• Staff spoke positively about the training sessions they had received. One staff member told us, "I think the training is good, we also get training on the floor."
• The registered manager and records confirmed staff supervision was undertaken regularly and staff told us they felt supported. Comments included, "Supervision is good and really helpful, "I have had supervision and it's always helpful to be able to discuss things."

• Registered nurses (RN's) had a competency framework addressed through the organisational own workbook. These were detailed, reflected discussion, reflection and observations, all with scores. RNs and care workers also completed marked workbooks in respect of pressure area care, MCA, safeguarding, dementia care ('living in my world' delivered by the area trainer).
• The manager had had a recent push on appraisals as these had previously been lacking.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
• Southlands Place continued to ensure joined up working with other agencies and professionals to ensure people received effective care. People had multi-disciplinary team meetings to discuss people's needs and wishes. Such as tissue viability services and speech and language therapists (SaLT), neurology teams and Parkinson's specialist nurse.
• A range of multi-disciplinary professionals and services continued to be involved in assessing, planning, implementing and evaluating people's care, treatment and needs. This was clear from the care planning documentation and the professional visiting logs. A visiting healthcare professional told us, "Staff have been polite and lately, knowledgeable about their residents. They refer to us when necessary and this benefits the residents."
• People were assisted with access to appointments. People told us, "If I have to go to the hospital, someone comes with me," and, "If I need an urgent appointment, staff organise it."
• Information was shared with hospitals when people visited. Each person had an information booklet that would accompany the person to hospital. This contained essential information about the person, such as how they communicated, mobility and medicines.

Adapting service, design, decoration to meet people's needs:
• Southlands Place was purpose built to provide care and support for people. It had been built and designed to provide a spacious and comfortable environment over three floors.
• People could choose to sit in the reception area which doubles as a café, spacious lounges, dining areas or in their own rooms.
• People's rooms remained personalised and individually decorated to their preferences. We saw that people's rooms reflected their personal interests. For example, one person had lots of photographs, pictures and extra shelving to make it feel like home.
• The garden areas were well designed and safe and suitable for people who used walking aids or wheelchairs.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• Staff had good relationships with people, and knew them well, including their likes and dislikes. Staff spoke of people's needs and social history. Staff were caring towards people, and respected people's wishes. One person said, "They look after us very nicely." A second person commented, "I couldn't ask for nicer people, they always smile and talk to us kindly."
• People were treated with kindness and were positive about the staff's caring attitude.
• We saw friendships had developed between people, and staff supported people to sit with people they knew. One person told us they met with their friends to play scrabble and enjoyed meeting for lunch.
• People were receiving care and support which reflected their diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people using the service which included age, disability, gender, marital status, race, religion and sexual orientation. Information about people's diverse needs was explored during their pre-assessment and then recorded in their care plans. The registered manager told us that staff were recruited in line with values that ensured people were treated fairly and with respect and staff received training in equality and diversity.
• Staff made people feel they mattered by celebrating important events, such as birthdays and special occasions. One person told us, "Oh, the staff are just lovely" She told us how her friend had booked the private dining room for her and her family on Mother's Day.
• People were supported to maintain relationships with family and those important to them.

Supporting people to express their views and be involved in making decisions about their care:
• People and families were now involved in reviews. People told us they had been recently more involved in planning their care. One person told us, "I speak to staff about my health and they explain things to me, they arrange for me to the doctor and dentist." A visitor said, "They involve us in care decisions as my relative can't make decisions anymore, I can't fault them in that."
• Nationally recognised assessment tools such as waterlow, were used to determine people's support needs and there was guidance for staff in people's files which reflected good practice guidance. An example of this was advice from the speech and language therapists when people were at risk of choking. This advice was then transferred into the care plan for staff to follow.
• People were supported to make day-to-day decisions for themselves and were provided with information in formats which best suited their preferred mode of communication.

Respecting and promoting people's privacy, dignity and independence:
• People's right to privacy and confidentiality remained respected. One person told us, "Staff respect my privacy and at the same time they knock on my door and ask if I am okay." A visiting professional commented, "I've never had any concerns about the staff treating people respectfully, they respect people's

privacy when I visit."
• Throughout the inspection staff treated people respectfully. People told us, "I can have a shower every day and they make sure I have clean clothes." Families told us, "Personal care and hygiene are good" and "Always dressed nicely."
• When a person became agitated in the lounge, staff responded quickly and were calm, polite and comforted the person until they became calm. There were many examples of respectful interaction seen throughout the inspection visit.
• On two occasions during the inspection care staff noticed people had spilled food down their clothes and offered to change them.
• People were supported to maintain and develop relationships with those close to them, social networks and the community. Relatives were regularly updated with people's wellbeing and progress.
• Staff continued to treat people with dignity and respect and provided support in an individualised way.

Requires Improvement

Is the service responsive?

Our findings

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

People's needs were not always met. Regulations may or may not have been met.

At the last inspection on 4, 5 and 10 December 2018, we asked the provider to take action to make improvements to the people's care plans to ensure their needs were clearly set out their needs and that staff followed people's care plans. Whilst significant improvements had been made, there was a need to further develop and embed person centred care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Most people received care that was individual to their needs, however some peoples pain management was not meeting their specific needs. One person told us that they were in constant pain and was worried how much of a certain pain medication had been increased to, with no relief.
There was no pain chart in place to determine when the pain was more prevalent and staff had not been monitoring if the prescribed increased pain relief was effective. We received confirmation that this was immediately taken forward for a pain review.
• We received two examples from families where they thought staff had not responded quickly to changes in their loved one's health. This was shared with the management team to investigate and reflect on how to improve staff responsiveness to changes in people's health.
• From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. We saw that steps had been taken to enable people to communicate when they can't verbally express themselves. However, not all were made available to people at all times. For example, one person had a communication book, but this was not with the person during the inspection process. Staff confirmed that it had been used at night but not during the day and this was something already identified as needing action.
• Another person lived with vision loss, and there was little documented as to how staff could improve their independence and social life. Their family said "I'm not sure how much emotional support he gets for his blindness and whether activity team and entertainers consider his blindness. He loves his music but is not always woken up and taken to music sessions or to other activities."
• Peoples health needs were comprehensively reflected in peoples care plans but there was little reflection of peoples social and mental health needs and how staff could respond to these needs.
For example, one person liked to spend time in the lounge area and enjoyed reading, knitting and wasn't keen on television or music. This person had no access to books, magazines or their knitting. The person requested us to turn off the television and this was done. However, staff walking through immediately automatically turned it on again with no discussion with the person in the lounge. One activity person when asked did go to the staff room to get some magazines and told us that things disappeared, possibly tidied away.
• Staff told us, "We know activities need to improve, we do talk about it," and "When we can, we sit with

people and chat, we have singers visit which people love."
• The management team confirmed that staff discussions had taken place and there were plans to develop the activity provision and to provide support and training to the activity people. They also confirmed due to staff changes and recruitment of new staff, training and people's physical care had taken priority. We acknowledged the fact that the registered manager and staff were aware of the need to improve people's social outcomes.
• Care plans contained information about people's diverse physical, social and mental health needs. Their history, likes, dislikes, sensory needs and any preferences for the delivery of their care was recorded. However, as discussed with the registered manager, these needed to be developed to include clear individual directives for staff to follow to ensure all staff provided consistent safe care.
• Oral hygiene was an area that needed to be developed and monitored. There were several people that did not have suitable tooth brushes or dental equipment in their bedrooms. Peoples' care plans did not all have oral health assessments or guidance for tooth care in them.

We recommend that that expert advice be sought regarding oral hygiene in line with the NICE guidance 'delivering better oral health'.

• Whist there were areas to develop to ensure that everyone received emotional support to meet their individual social needs, there were activities provided. External entertainers visited regularly and activity staff organised cinema afternoons and quiz sessions. We also saw that visits out had been organised such as pub outings and visits to the gardening centres. People also told us, "One of the activity leaders has a trolley shop and you can order anything you need from him," "Activities vary, we have some people come from outside, some good musicians" and "We now have a dance once a month, the first one only one person spoke to me all evening but the second one there were more people there to chat to."
• People's religious needs were considered and we saw that different faith services were held within the home. People told us, "1st Sunday of the month there is a church service" and "I go to the church service, it is very important to me"
• Reviews took place to ensure people's needs were met to their satisfaction and involved of their family or legal representative. Where people had specific health care needs, these were clearly identified and staff could explain where and how this support should be provided.
• Where an advocate was needed, staff supported people to access this service.
• People's needs were attended too quickly. There was always a staff presence in the communal areas. Not many people could use a call bell but people who remained in their rooms were regularly checked by staff.

Improving care quality in response to complaints or concerns:
• There was a process for recording and investigating complaints.
• There was a complaints policy available in written and pictorial format. People and their families also had access to a 'service user guide' which detailed how they could make a complaint.
• Some people told us they knew how to make a complaint. One person said, "I know how to make a complaint; I would go to the manager." A second person told us, "I've got no complaints about anything and feel happy living here."
• We saw complaints and concerns were acted on within the organisations time frames. The service had logged complaints received, action taken and the response sent to the complainant. The manager told us that complaints helped to improve the service and could demonstrate what lessons had been learnt from complaints. For example, a relative's concern regarding the eye cream regime. for relative had been responded by identifying the staff responsible and arranging further training, ensuring stock of cream in place and gave reassurance of home's understanding of the importance of maintaining eye health regime.

End of life care and support:

• The management team and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment.
• This included having 'anticipatory medicines' available, so people remained comfortable and pain free.
• End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected when they reach that stage. Where people had chosen not to engage or could not participate in these conversations, with the person's permission, discussions had been held with family and those closest to them.
• There was no one receiving end of life care at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Aspects of leadership and management did not consistently assure person-centred, high quality care.

At the last inspection on the 4, 5 and 10 December 2018, we asked the provider to take action to make improvements to the quality systems and processes that assess, monitor and mitigate risks to people. Whilst improvements had been made, there were still improvements needed to be embedded in to everyday practice to ensure safe and consistent care.

Understanding quality performance, risks and regulatory requirements:
• Since the last inspection quality assurance processes had been developed. These included audits of care plans, staff files, complaints, safeguarding concerns, incidents and accidents, and quality satisfaction surveys.
• The provider's systems had not identified some of the shortfalls we found. For example, the behavioural records showed that behaviours that presented with aggression and possible harm to both staff and other residents, had not been recorded as incidents. Nor had action been taken forward for evaluation and management. This meant that the provider had not a full oversight of incidents that occurred in the home.
• Staff and the management team had identified the social needs of people were not being consistently met. They could say what needed to be done but these had not been taken forward with a plan of action such as training for all staff and social care plans for every person who lived in the service to address the shortfall. We were aware that on the dementia floor, work had started on completing care booklets for peoples' social needs.
• We spoke with the registered manager and management team who advised there were still areas of improvement to be implemented but they were proud of what had been achieved since the last inspection, which included improving the culture, recruiting new staff and reducing the use of agency staff. No agency care staff had been used since January 2019. Whilst agency registered nurses were being used occasionally, the number had decreased significantly which had improved care delivery and people had benefitted from continuity of care.
• The manager has been supported since November 2018 by two senior clinical specialist nurses, who will continue to support and develop care delivery until the improvements were fully embedded. A deputy manager had recently joined the team which had provided support on the floor to the staff team.

Working in partnership with others:
• Since the last inspection the organisation had worked hard to improve partnership working with key organisations to support the care provided and worked to ensure an individual approach to care.
• There was partnership working with other local health and social care professionals, community and voluntary organisations. Visiting health and social care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "Communication has certainly improved and we feel that the management team are now working

with us to improve care for people," and "Staff listen and are knowledgeable about the people they support."
• There were connections with social workers, commissioners and the community team for people who lived with dementia.

Managers and staff being clear about their roles:
• There was a management structure in place, which gave clear lines of responsibility and authority for decision making and provided clear direction for the staff.
• Staff had clearly defined roles and were aware of the importance of their role within the team.
Engaging and involving people using the service, the public and staff:
• There was now a positive workplace culture at the service. Staff said they had been able to raise concerns and felt listened to.
• Feedback from staff throughout the home was very positive about the improvements and they were proud of the changes made. One staff member said, "It's a different place, I have worked since the beginning and seen a lot of managers come and go, but the manager now is brilliant, supportive and I think we are well-led."
• A relative commented there had been improvements since the last inspection and they were happy with how things were at the home. The relative identified areas that in their view had improved recently, such as staff engagement and care delivery.
• Staff had team meetings and discussed various topics such as any changes in people's needs or care, best practice and other important information related to the service. The manager sought feedback from the staff through regular meetings and day to day communication meetings of all head of department meetings. The team discussed various topics in the meetings including the support and care of people, policies and procedure, tasks and actions to complete, any issues and ideas.
• Regular feedback was sought from people who used the service and their relatives or advocates. This was used to inform the provider how well the service operated. These surveys were collated and the survey outcomes shared with people, families and staff. The actions to be taken were also shared. One visitor said, "I visit everyday so continuously give feedback, they have improved, still have to moan about the call bell not being available, but much better."

Continuous learning and improving care:
• The registered manager told us they used accidents, incidents, complaints and safeguarding as learning tools to improve the service. This was confirmed by the documents seen and from the staff we spoke with. One staff said, "We monitor all falls and injuries, we then discuss and look at risk factors and if necessary, contact the falls team for advice and this has really helped and reduced falls." The lessons learnt had been used to enhance staff knowledge and to improve on the service delivery.
• Accidents were documented and recorded. Staff took appropriate action following accidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated learning from accidents took place.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
• People, family and staff felt they could talk to the registered manager and staff at any time and the regular meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One visitor said, "I feel I can talk to the staff now, they listen and take action, it's not perfect yet but definitely improved."
• The provider was aware of the statutory Duty of Candour which aimed to ensure that providers are open,

honest and transparent with people and others in relation to care and support when untoward events occurred. The service had notified us of all significant events which had occurred in line with their legal obligations.

•All staff were keen to emphasise the service would advocate for people if required. For example, in respect of ensuring medicine reviews took place. This meant people were only on the medicines currently required as opposed to taking those which were no longer relevant or the best for the person.