Reason Care Limited

Elm Lodge Care Home

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 1 and 8 July 2015. The inspection was unannounced on 1 July and announced on the 8 July 2015. At our previous inspection in April 2014 we found that the essential standards of quality and safety were met.

Elm Lodge Care Home provides nursing and personal care for up to 40 older adults, most of who are living with dementia. At the time of our visits, there were 31 people were living in the home. There was no registered manager at this service. A new manager had been recently recruited and they intended to apply to become the registered manager at the service. 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.

The provider's arrangements did not always ensure that sufficient numbers of suitably qualified, competent,

Summary of findings

skilled and experienced persons were deployed to meet people's needs. People, their relatives and staff were not always confident that people received safe care, because they were concerned that staffing levels were not always sufficient to meet people's needs. Action was being taken to recruit to staff vacancies and by our second inspection visit, the provider had taken some steps to improve their interim staffing arrangements. However, the provider's interim measures did not always ensure that staffing arrangements were sufficient to meet people's needs.

The provider's arrangements for the prevention and control of infection and the cleanliness and hygiene of the premises, did not fully protect people from health risks associated with cross contamination. At our second inspection visit on 8 July 2015, work had commenced to improve some areas of cleanliness and hygiene in the home through recorded checks. However, the checks did not take full account of recognised national guidance for this, which was not always being followed.

The provider's arrangements did not protect people against the risks of care being provided without appropriate consent or authorisation. Staff had received training, but did not always follow the Mental Capacity Act 2005 when required for people's care. They did not have all of the guidance they needed to help them to do so. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this.

People's medicines were being safely managed and people received their medicines when they needed them.

People felt safe in the home and their relatives felt they were generally safe there. Staff, were trained and they were provided with and mostly knew the procedures to follow in the event of their concern about the harm or abuse of any person living at the home. This helped to protect people from the risk of harm and abuse. A few staff did not understand the role of relevant external authorities concerned with protecting people from harm or abuse or how to report any concerns to them to protect people when required. The manager agreed to ensure that all staff had the correct knowledge.

The provider's arrangements for staff recruitment were robust, which helped to make sure that people were fit to work at the home. Improvements to fire safety arrangements were being made by the provider, through their agreed action plan with the local fire authority.

Overall, staff understood people's health needs, which were being met in consultation with external health professionals when required. People's care plans did not always give accurate or up to date information for staff to follow relating to people's health conditions, how they affected them and their related care needs. This potentially increased the risks to people from receiving ineffective or inappropriate care and treatment. However, improvements were being made to help to make sure that people's care plans would provide staff with the information they needed to support people to maintain or improve their health.

Staff received most, but not all of the training they needed to provide people's care. Following our first inspection visit, the provider took appropriate action to address staff training deficits.

People were provided with the support they needed to eat and drink sufficiently. People received a balanced diet, which they often enjoyed, but felt sometimes lacked variety or choice. Menus and records of people's food preferences, allergies and other dietary requirements were provided, which staff followed. People were also provided with the appropriate consistency of food and drinks, which met with their dietary requirements and the related instructions from relevant health professionals.

Staff, were kind, caring and helpful. They treated people with respect and promoted their privacy, dignity and independence. However, information about people was not always handled respectfully or kept confidentially. Recognised methods that may help to support, involve and inform people living with dementia, about their care at Elm Lodge, were not always fully considered or used to help promote their choice, dignity and independence. We have made a recommendation to the provider to help people living with dementia to stay as independent as they can.

Staff knew people well and people often received personalised care that met their needs. Improvements were being made to develop people's care plans in a personalised way to better inform staff about people's

Summary of findings

individual care requirements. Some improvements were also being made to help re-establish and improve the arrangements for people's social and occupational engagement to meet with known their preferences and needs.

People and their relatives were supported to maintain their relationships. They were involved in agreeing the care to be provided and its on-going review. People able to express their views and their relatives were comfortable to raise any concerns about people's care with senior staff. Action had recently been taken to re-establish the provider's complaints process for the recording and handling of any complaints received about the service. Improvements were planned to regularly seek and obtain people's views about their care.

The home had not been effectively or consistently managed during 2015. The provider's checks of the quality and safety of people's care were not always being followed or acted on to protect people against the risk of inappropriate or unsafe care and treatment. This resulted in their failure to act on areas of concern that we found at this inspection.

However, people and staff were more positive following the recent appointment of a new manager who was visible and approachable. The manager had commenced a working review of some of the provider's arrangements for the quality and safety of people's care. They had begun to make agreed improvements in consultation with relevant parties, such as service commissioners and the local fire authority; to help make sure that people received safe and effective care.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to meet people's needs. The home was not always clean and hygienic and people were not fully protected from the risks of a health acquired infection through cross contamination.

People's medicines were being safely managed. People felt safe and they were protected from the risk of harm and abuse. Staff recruitment arrangements were robust. Agreed fire safety improvements were being made in consultation with the local fire authority.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not fully protected against the risks of receiving ineffective or inappropriate care and treatment, or from their care being provided without appropriate consent or authorisation.

Overall, people's health needs were being met in consultation with external health professionals where required. Improvements were being made to people's health and personal care plans, to accurately inform staff about people's related needs. Staff usually received the training they needed and training deficits were being addressed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff, were kind, caring and helpful. People were often treated with respect and their privacy, dignity and independence was often promoted. However, this was sometimes compromised as confidentiality was not always maintained and people living with dementia were not always appropriately informed and involved in their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Environmental adjustments were not always properly considered to help people living with dementia to stay independent.

Staff mostly knew people well, who often received personalised care that met their needs. Improvements were being made to develop people's care plans to inform staff in this way. Action was also being taken to help to improve people's opportunities for appropriate social and occupational engagement.

Summary of findings

People and their relatives were involved and supported to maintain their relationships. The provider's complaints procedure and arrangements for handling complaints were re-established.	
Is the service well-led? People were not fully protected from the risk of unsafe care and treatment because the provider's checks of quality and safety had not always been proactively followed or acted on. The manager had begun to set out and agree and make some of the improvements that were needed to the service and for people's care, in consultation with relevant parties.	**Requires Improvement** 

Elm Lodge Care Home

Detailed findings

Background to this inspection

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

Before our visit local authority care commissioners, the local fire authority, relatives and staff working at the home shared some concerns with us that people's care and safety needs were not being met at Elm Lodge Care Home. We visited the home on 1 and 8 July 2015. Our visit on 1 July was unannounced and the visit on 8 July was announced. On the 1July the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We gave the provider short notice of our visit on 8 July. This was carried out by one inspector and used to corroborate some of the findings from our inspection on 1 July.

Before this inspection, we also looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law.

During our inspection we spoke with six people who lived at the home and five relatives. We spoke with eight care staff including three seniors and one apprentice; one laundry person, one domestic, a relief cook, an activities co-ordinator and a volunteer. We also spoke with the manager and the provider's regional manager. We observed how staff provided people's care and support in communal areas and we looked at eight people's care records and other records relating to how the home was managed. This included staff and cleaning rotas, training and recruitment records, medicines records, meeting minutes and checks of quality and safety.

As many people were living with dementia at Elm Lodge Care Home, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

All of the people we were able to speak with said they felt safe in the home. People's relatives were confident that people were generally safe. However, people, relatives and staff were concerned that staffing levels were not always sufficient to meet people's needs. One person's relative said, "Staff work hard, they are brilliant and they really care, but lately, there's not always enough of them." All said that activity and cleaning staff were being regularly redeployed from their roles to provide cover for absent kitchen staff. Care staff felt that staff rotas were not sufficiently planned to cover for care staff absences, including holidays and that agency care staff were not always being used when required. All said that this was having an impact on some people's general well-being, the time staff had to engage with people and also cleanliness in some parts of the home. Senior staff said that care plans records were not always being kept up to date because of staffing constraints, which we also saw.

We found that staffing levels were not always sufficient staff to ensure that people's needs could be safely met. The provider used a staffing tool to determine safe and appropriate care staffing levels. However, this was not being accurately completed or followed. For example, for 17 out of the 31shifts before our inspection, staffing levels were either not safely planned or maintained. At our first inspection visit staff deemed to be required by the service were not provided.

We observed that staff, were pressured for time to spend with people. For example, the activities co-ordinator was not able to organise and support people in their planned activities as they were redeployed to the kitchen for catering duties, which they were appropriately trained to do. We observed three incidents when people living with dementia became restless with agitation. This resulted in incidents of aggression towards other people receiving care. For example, some people living with dementia became restless and agitated while they waited unsupervised for staff to serve their lunchtime meal, which was served late. This resulted in two of those people who were sitting together, shouting at each other.

A new manager had been successfully recruited and had recently commenced working at the home. The provider's senior manager told us about the steps they had taken to recruit to care, kitchen and cleaning staff vacancies at the service. They also described the provider's interim staffing arrangements and showed us staff rotas. This confirmed what people, relatives and staff had told us; that staff hours lost through their redeployment to catering duties had not been replaced.

At our second visit of this inspection on 8 July 2015, we found that staffing arrangements were being reviewed by the provider in consultation with local authority care commissioners and that some improvements had been made. There was a much calmer atmosphere in the home and the activities co-ordinator was supporting some people to relax and engage socially with others. However, staff rotas did not fully assure us that the improvements were either being, or would be sustained.

We found that the registered provider had not always ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection, people and their relatives told us that the home was usually kept "spotless" and "clean." However, some felt that standards of cleanliness had recently fallen. One person's relatives said, "Standards of hygiene have fallen lately." Another said, "The home was always clean and spotless but it's not always as clean now."

We found that people were not always protected from the risks of acquiring a health related infection. This was because recognised guidance for cleanliness and prevention and control of infection in the home was not always provided or being followed. Not all parts of the home or the equipment used for people's care were kept clean or hygienic. For example, grab rails used by people in some toilets had ingrained dirt, which showed they were not being effectively or regularly cleaned. A communal bathroom and a sluice room were dirty and untidy.

Cleaning schedules did not provide staff with the information they needed. This included information about the areas and equipment to be cleaned in the home; how often and the products to use. Staff that we spoke with about this did not show a consistent understanding of the cleaning measures and practice for the prevention and control of infection and their responsibilities for this.

Guidance was not being followed for the transportation of dirty or soiled linen and the safe storage of waste and other

items. For example clean items such as unused incontinence products and people's personal toiletries were stored alongside dirty items, such as used commode pots. Staff did not always wear appropriate personal protective equipment (PPE) when handling dirty linen. Used PPE was left discarded on the floor in a sluice room, with no appropriate waste container provided for their disposal. This meant there was an increased the risk to people from acquiring a healthcare related infection through cross contamination.

We raised these issues with the manager and at our second inspection visit we found that some work had commenced to help improve cleanliness and hygiene in the home. Recorded checks relating to this had been completed for some areas. However, the provider's checks and arrangements for cleanliness the prevention and control of infection in the home did not take full account of nationally recognised guidance for this; known as 'The Code of Practice.' The 'Code' helps registered providers to understand what they need to do to comply with the requirements for cleanliness and infection control.

Although some improvements had been made we found that the premises and equipment were not always clean and hygienic and the provider's arrangements for the prevention and control of infection did not fully protect people from the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People said they received their medicines when they needed them. We observed senior care staff giving some people their medicines and saw that this was being done safely and in a way that met with recognised practice. For example, people were offered a drink of water to help them swallow their medicines. The care staff checked the person had taken them, before signing the medicines administration record (MAR) to show they had been safely given.

Some people were prescribed medicines to be given when they needed them rather than at regular intervals. For example, for relief of their pain or anxiety. However, because of their medical conditions, some people were not able to request those medicines when they needed them. Care plans, known as protocols, were attached to each person's MAR to help staff to make consistent decisions about when to give people the medicines. Two out of four of the protocols that we looked at were not completed properly. For example, they did not provide all of the information that staff needed, to give people their medicines in a consistent way. This included the reasons they were prescribed. However, both senior care staff giving people's medicines knew the reasons they were being given. We were assured us that the medicines protocols would be reviewed to provide accurate information.

The manager told us that a senior care staff had been recently appointed to a vacant post to take on a lead role for the management of people's medicines at Elm Lodge. They were working with the manager to review the provider's medicines policy and arrangements against recognised practice. This had led to additional medicines training being arranged for staff responsible, to further them all to an advanced level. A revised medicines' competency assessment to the one in use was also being introduced, which staff were due to complete following the advanced training. This helped to make sure that people's medicines were being safely managed by staff who received appropriate training.

People felt safe in the home and their relatives felt they were generally safe there. All staff we spoke with knew how to recognise abuse and mostly the action to take if they suspected or witnessed the abuse of any person living in the home. Three staff were not aware of the role of relevant external authorities concerned with protecting people from harm and abuse or how to contact them. We discussed this with the manager and found that training and procedural guidance was provided for all staff to follow. This included relevant local reporting procedures and information was also displayed about how to recognise and report abuse. This helped to protect people from the risk of harm and abuse. The manager agreed to ensure that all staff had the correct knowledge.

Staff described appropriate arrangements for their recruitment and the provider's arrangements for this were robust. They showed that required employment checks were obtained before staff commenced their employment at the home. For example through the required national vetting and barring scheme. This helped to make sure that staff, were fit and safe to work with people receiving care. Emergency plans were in place for staff to follow in the event of any emergency in the home. For example in the event of a fire alarm. The provider has given us written assurance of their improvements to fire safety

Requires Improvement

Is the service safe?

arrangements in the home. This was being done through an action plan, agreed with the local fire authority following concerns they had received about the provider's fire safety arrangements at the service.

Requires Improvement

Is the service effective?

Our findings

At this inspection we found that staff did not always follow the Mental Capacity Act 2005 (MCA) to obtain people's consent or appropriate authorisation for their care when required. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this.

Staff told us they had received training about the key principles of the MCA, but did not have all of the guidance they needed to help them to put this into practice. Most people were not always able to consent to their care because of their type of health condition, such as dementia. Staff, were often unable to describe how they gained people's consent for their care, or how decisions were being made about people's care and treatment in their best interests when required. Most people's care plans that we looked at had no recorded mental capacity assessments or best interest discussions recorded. This meant they often did not show how decisions about people's care and support were being made in their best interests. The manager told us that she did not know if the home had policies or guidance relating to the MCA or restrictive care.

One person had been assessed as lacking capacity to consent to restrictive care. A best interest meeting had been held involving the relevant local authority to decide on the least restrictive way to provide care to keep the person safe. Some people's care plans showed that they did not have the capacity to make important decisions about their care and that their freedom was being restricted in a way that was necessary to keep them safe. This meant they were being monitored by staff at all times and were not free to leave the building of their own accord. However, the manager told us that applications had not been made to the relevant authority to assess whether those people were being unlawfully deprived of their liberty or to formally authorise this where appropriate. This type of authorisation is known as a Deprivation of Liberty Safeguard (DoLs), which is part of the MCA.

Several people's care plans showed that a relative had been granted legal power, known as a Lasting Power of Attorney (LPA), enabling them to make specific decisions on the person's behalf. However, they did not always specify and staff did not know who the relative was or the decisions they were able to make under the LPA. Copies of the LPA documents were also not held at the service. This meant that staff, were not provided with the information they needed to follow, if important decisions needed to be made in the person's best interests. For example, relating to their health and welfare needs.

We found that the provider's arrangements did not always protect people against the risks of care being provided without their consent, or without following appropriate legislation when people were unable to give their consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with and people's relatives felt that people's health needs were being met. One person told us, "Staff are really good, they know my condition and make sure I see my doctor when I need to." Another person's relatives told us the person's health had improved since their admission to the home.

Overall, people were supported to maintain and improve their health. Staff understood people's health needs and they consulted with external health professionals and usually followed their instructions for people's care and treatment when required. We noted that staff had overlooked a written instruction for them to book a specialist health screening appointment for one person, relating to their medical condition. We discussed this with the manager and senior care staff responsible, who told us they would take the required action to secure the appointment for the person concerned.

People's care plans did not always show the care they needed or the care provided to maintain or improve their health. Most people's care plans we looked at did not give accurate or up to date information about their health conditions, how they affected them or their related care needs. Many people's care plans stated they 'required assistance' with particular daily living tasks, such as eating and drinking. However, they did not specify the actual care interventions that staff needed to follow to provide this assistance. Some people's care plans showed that staff needed to monitor their body weights or their daily fluid intake because they were at risk from either malnutrition or dehydration from their health conditions. However, records of this were not being consistently maintained to show this. This increased the risk of people receiving ineffective or inappropriate care and treatment.

Requires Improvement

Is the service effective?

The manager was aware of this and had commenced work to review and update people's care plans and related monitoring records using a revised format. They showed us three people's care plans, which had been revised in this way. They were also preparing instructions for staff to follow for the completion of people's related health monitoring records. This helped to make sure that people's care plans provided staff with the information they needed to support people to maintain or improve their health.

Staff told us they mostly received the training they needed to provide people's care, including regular updates when required. All staff had either achieved, or they were working towards a recognised care qualification. Arrangements were in place for all new staff employed to undertake a new standardised approach for this, which was recognised nationally and known as the Care Certificate. However, some staff expressed concerns that a few staff had not received moving and handling training.This meant they were unable to effectively support people's moving and handling needs. Before our visit, concerns were also raised with us that most care staff covering night duty, had not received medicines training. Records that we looked at reflected this, but showed that training was planned and imminent. They also showed, that no one receiving care was prescribed any medicines to be given regularly at night. However, some people's care was potentially compromised, if they needed their medicines that were prescribed to be given when they needed them, such as pain relief. We discussed this with a senior care staff who worked night duty. They told us that, this was rarely required, but that on call management arrangements were in place, if this was needed before training was completed.

People and their relatives told us that good nutritious meals were provided, which were often enjoyed, but sometimes lacked variety and choice. One person said, "There's always plenty, it's wholesome." Another person told us, "There's no choice on the days when it's a roast dinner." A group of people sitting together told us they particularly enjoyed their breakfasts, which always provided a range of appropriate hot and cold food and drinks to choose from.

We observed that people were offered plenty of drinks throughout the day, but they were not offered a choice of food or drinks at their lunchtime meal, which was a roast dinner. Food menus showed that an alternative choice of a hot or cold meal was usually offered. The staff member deployed into the kitchen showed us a record of people's food preferences, allergies and other dietary requirements kept there, which they followed.

Some people had difficulties eating and drinking because of their health conditions. We observed that staff gave people the support they needed to eat and drink. People were also provided with appropriate consistencies of foods, that met with their dietary requirements and related instructions from relevant health professionals. This showed that people were provided with the support they needed to eat and drink sufficiently.

Requires Improvement

Is the service caring?

Our findings

People who were able to share their views and relatives said that staff were caring and described positive relationships with them. All were appreciative of the care provided and felt that staff, were helpful and respectful towards them. One person, "All of the staff, day and night, they are really good and helpful." Another said, "They are lovely, all of them, they do their job quietly, caringly and professionally. All had observed that staff knocked on people's doors and waited before entering their rooms. People's relatives said they were made welcome to visit at any time. People who were able to tell us and their relatives also said they were kept informed and involved in agreeing the care provided

Staff, were caring and usually treated people with respect and ensured their privacy and dignity. However, information about people was not always respected or kept confidentially. Records identifying people and their individual care needs were pinned to a notice board in the entrance hallway. Care plan records were stored in a ground floor walk in cupboard, accessed from the main entrance lobby, which did not have a working lock.

Most people living in the home needed significant support and guidance from staff to help them to carry out their routine daily living activities, such as washing and dressing and making meal choices. This was because they were living with significant dementia conditions. We observed that people were appropriately dressed and they were wearing suitable footwear and any aids they needed, such as their spectacles. We observed that staff promoted people's independence when they provided care and they were patient and helped people to understand what they needed to do. For example, when they supported people to take their medicines or with their preferred daily living routines, such as where to eat their lunch.

However, because of their dementia conditions, some people had difficulties understanding or responding to both written and spoken information. They were not able to understand key service information relating to the care they could expect to receive because it was only provided in a standard print format. For example, food menus could not always be used to help people make choices about their meals. Staff told us, that because of this they sometimes made meal choices for people, based on what they knew about their dietary requirements and their known likes and dislikes. This showed that people were not always actively involved in making decisions about their care and daily living arrangements where possible because they were not being given the information they needed, in a way that may assist them to do this.

Staff showed they understood people and they acted in a caring manner if people were distressed or needed assistance. For example, staff responded quickly and calmly to support one person who sometimes became anxious and uncomfortable because of their medical condition. Their calm reassurance and action resulted in the person becoming more visibly relaxed.

Requires Improvement

Is the service responsive?

Our findings

People who were able to express a view, their relatives and staff said that people were usually supported to engage in a range of social and recreational activities that met with their preferences and needs. This included reminiscence and physical activities, music and walks out. All spoke highly of the activities co-ordinator and how they engaged people. However, they also said that, staff had recently not had sufficient time to support and engage people in this way. Both staff and relatives told us they felt that this had a noticeable impact on people's general well-being.

The new manager showed they were aware of this. Recent minutes of individual meetings held with people's families and staff also showed this and some of the action that was being taken. This included recruitment of additional staff and advanced planning to support people on trips out during the summer months. There were also plans to engage staff and their families' in their own time to support people to engage in a summer fete at the home and for manager's to resurrect a regular newsletter to keep people informed of progress.

People who were able to express a view and their relatives said they were supported to maintain their relationships and peoples' relatives were made welcome when they visited. They also said they were involved in agreeing the care to be provided before people received care and were often consulted about this since. This was usually through routine periodically planned care reviews. We spoke with two relatives who attended this type of review during our inspection. They explained that they were invited to represent the person who was not able to express their views because of their dementia care needs. The review was planned to discuss the person's changing needs and agree their care. The outcome of the review was appropriately recorded and shared with staff concerned with their care. This showed that people, or those acting on their behalf were able to contribute to the assessment and planning of care as, as much as they were able to.

Most people's care plans did not show their individual care requirements relating to their needs. There was a risk that people would not receive the care they needed. For example, some people's care plans showed they had communication needs. However, their care plans did not specify the care interventions that staff needed follow in response to those needs. The new manager had recognised this. They told us about work they had commenced to develop people's care plans in this way, in consultation with people, their relatives and staff who knew people well. We looked at people's care plans, which had been revised in this way and saw they were personalised and gave appropriate care instructions for staff to follow.

We observed that staff understood and knew how to communicate with people. For example, staff told us about one person living with dementia, who was not able to communicate their needs. This person had become withdrawn and isolated following some necessary environmental repair and redecoration in the home. We observed that staff recognised the person's difficulties. They were gentle in their approach and they encouraged and supported the person to spend time out of their own room, in a quieter area of the home, where they helped the person to feel comfortable. One staff member fetched their newspaper and sat with them for a while. The person visibly became more relaxed and engaged with people nearby.

The first day of our inspection, was unusually very hot weather. Some people were visibly distressed by this. Staff made sure, that people were appropriately dressed and able to rest, or move around freely as they chose. Staff also ensured that people were provided with a plentiful supply of cold drinks.

Staff told us about some people living with dementia who were able to mobilise independently, but who sometimes needed their support to negotiate the environment. For example, to go to the toilet because they were either unable to recognise the facility or how to use it or both. We observed that apart from a few large picture signs, there were very few environmental aids or adaptations provided to help people living with dementia to stay independent. We discussed this with senior management, but found this was had not been considered as an area for improvement. **We recommended that the provider reviews people's care needs against recognised practice concerned with dementia care, to make sure that people have the equipment they need to stay independent.**

People who were able to express their views and relatives were comfortable to raise any concerns they may have about people's care. Most were unsure about where to formally direct their concerns but were confident to speak with the senior care staff, who they knew well. Two relatives said they would "go online" and contact the provider

Requires Improvement

Is the service responsive?

directly if they needed to. The provider had asked people and their relatives for their views about the service in a survey questionnaire, which was circulated to them during March 2015. At a glance, the returns showed that people and their relatives were often satisfied with the care provided. However, some felt that improvements were needed. This included not being provided with the information they needed to complain or because their complaints were not always handled properly. The new manager had not seen this information. A senior manager for the provider confirmed that the survey returns had not been checked to determine people's views or whether any changes or improvements were needed as a result. Although people's views had been sought, this showed they had not been acted on.

However, the new manager advised they had established a record of complaints in June 2015, as this had not been maintained before their appointment at the home. The record showed one complaint was received since, which was investigated and resolved to the complainant's satisfaction. The record also showed where changes were made as a result to help prevent any re-occurrence. We also saw that an appropriate complaints procedure was displayed in the home.

The new manager also showed us a 'resident listening form,' which they were planning to introduce for staff to use and record to help regularly seek people's views about their care. The form covered question topics relating to people's general wellbeing and how staff treated them and the arrangements for their medicines, meals and social activities and engagement. The new manager was also in the process of arranging a meeting with people and their relatives to discuss changes and improvements for people's care and seek their views about this. This helped to show how people's views and ideas would be taken into account for the running of the home. However, the systems were not yet implemented.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider's checks of the quality and safety of people's care were not always effective to protect people against the risk of inappropriate or unsafe care and treatment. This was because they were not always proactively followed or acted on before significant concerns were raised by other authorities relating to people's care and safety at the home. For example, concerns which had been raised by local care commissioners and the local fire authority. We saw that some improvements were being made at this inspection. This included fire safety, staff training and care plan record keeping improvements. However, the provider's arrangements had failed to identify areas of concern that we found. This included staffing levels, infection control and prevention and cleanliness in the home, the use of Mental Capacity Act 2005 and data management.

We found that the provider's arrangements did not always inform or ensure improvements to the quality and safety of people's care or fully protect people from risks to their health, safety or welfare. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

The home had not been effectively managed. A few people who were able to express their views, relatives, commissioners and the local fire authority told us that the management and provider oversight of the home had not been consistent or pro-active during 2015. Most felt this had led to their concerns about people's care and safety needs. Before our inspection, service commissioners and the local fire authority told us they had concerns about people's care and safety needs.

There have been three changes of registered manager at this service since January 2014. There was no registered manager in post at this service. The manager who assisted us at this inspection was new in post since June 2015. They told us they were commencing their registered manager application shortly.

We received positive comments about the new manager who was described as 'visible,' 'interested' and 'approachable.' All those we spoke with were hopeful that the change of leadership would result in improvements being made.

The manager told us about some of their aims and objectives for people's care, which they had agreed with the provider. Information they gave us showed they had begun to make agreed care and safety improvements in consultation with relevant parties, such as service commissioners and the local fire authority. This included a review of care and staffing arrangements and some of the provider's arrangements for checking the quality and safety of people's care in consultation with people who lived, worked or had an interest in the service. For example, revised approaches for determining and analysing risks to people from falls or from poor nutrition were being introduced. This included clear information and instructions for staff to follow. This was being prioritised to help to help make sure that people received safe and effective care.

Staff said the manager had already held meetings with them to discuss some of the improvements that were being made and how these were to be achieved. They said that because of this, they felt more confident that leadership would improve at the service. Staff knew how to raise any concerns they may have about people's care and communicate any changes in people's needs.

The manager had established a programme of regular staff meetings and showed us the minutes of the ones they already held. This showed good attendance, with relevant discussions about the service aims, people's care and some of the changes and improvements that needed to be made and why. They included instructions about care plan record keeping improvements that were needed and some related information about how this was to be achieved. The minutes also showed that staff's views were being sought.

The provider has sent us written notifications about important events that happened in the service as required by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing. The registered provider's arrangements had not always ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet people's needs. Regulation 18(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment. The registered provider's arrangements for the prevention and control of infection in the home did not fully protect people from the associated risks of unsafe care. Regulation 12(1) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 - Need for Consent. The registered persons did not always protect people against the risk of care being provided without the appropriate consent or authorisation of a relevant person. Regulation 11(1).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014, Good governance. The registered person's arrangements did not always inform or ensure improvements to the quality and safety of people's care, or fully protect people from risks to their health, safety or welfare. Regulation 17(1) (2) (a), (b) & (c).