Care UK Community Partnerships Ltd

Addington Heights

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 4 and 5 January 2017.

Addington Heights is a residential care home that provides nursing and personal support for up to fifty older people who have a range of nursing, and other care needs associated with old age. The service is separated into five clusters that can accommodate a maximum of ten people. Each unit specialises in providing care to people with either nursing, residential or respite needs. The units are self-contained and each have their own lounge and open plan kitchen/dining areas.

The home had a registered manager. 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 and associated Regulations about how the service is run.

In January 2016, our inspection found that the home did not meet all the regulations we inspected against. At this inspection the home had followed their action plan and made improvements. They had met all the regulations from that inspection. However there was a new breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18. The manager had not sent in a timely manner the notifications required by regulation where Deprivation of Liberty Safeguards (DoLS) were in place. We identified other areas that required further improvement. See what actions we have taken at the rear of the report.

People and their relatives told us the home provided a relatively good service that continued to strive for improvements, the environment was comfortable and people liked living there. They found that staff were caring, attentive and provided the care and support they needed in a friendly and kind way.

Although the staff team continued to experience a turnover of staff there were fewer changes in personnel. Management addressed staff absenteeism and practice issues and these were managed more effectively. Staff received appropriate training and support to be able to effectively offer safe care and treatment. Staff understood people's needs and preferences for the way they wished their care to be delivered.

People enjoyed their meals and were protected from risks associated with nutrition and hydration they had balanced diets that also met their likes, dislikes and preferences. People and their relatives were positive about the improvements to the choice and quality of food available.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The registered manager was aware of DoLS and had made referrals when required, a number of people were subject to restriction under the DoLS guidelines. Staff understood how to support people to make choices.

Staff had a good understanding of how to identify if people were at risk of abuse and knew what to do in these circumstances. The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Risks to people's health and welfare were assessed, and appropriate provision was made for staff to manage these effectively thus reducing or eliminating the risk.

People and their relatives when appropriate, were involved in planning the care and support their family member received. Care was delivered in a personalised way and people were supported to make choices. People and their relatives described staff as "kind" and "caring". We observed positive interactions between people and staff. Most staff knew people well and spoke about them respectfully. They engaged in meaningful conversations and encouraged people to remain as independent as possible.

Staff continued to ensure people were well supported to maintain good health and had access to appropriate healthcare services. The staff team ensured that people's health care needs were met. Staff worked closely with the GP and other health consultants to ensure people had access to relevant services. Care plans included clear guidance about how people wished to receive care and support. They were updated regularly, there were some disparities between the information in the care review and in how the person presented. The service had improved provision for people's social care needs. An activities coordinator was employed and people were offered the opportunity to engage in a range of stimulating activities.

Quality assurance systems were in place to monitor both the safety of the environment and the quality of the clinical care provided and these were followed. Some areas of management required further improvement; notifications required by legislation were not made to CQC in a timely manner.

Further work could take place to make the environment more homely, personalised and 'dementia friendly' for the people living on each of the five clusters. It was sometimes difficult to differentiate one area from another with corridors and lounges quite uniform in appearance and lacking 'identity'.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff changes and short term absences had contributed to disruptions but for most of the time staffing levels were maintained to the service levels determined as suitable.

Medicines were administered safely and people received their medicines as required.

Staff received appropriate training to enable them to recognise and report suspected abuse.

Is the service effective?

Requires Improvement

Some aspects of the service were not fully effective. People underwent mental capacity assessments but there were areas relating to specific capacity issues that needed to be more detailed. Further work could take place to make the environment more dementia friendly' for the people living there.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff according to roles and responsibilities. Training needs analysis was completed, gaps in skills and knowledge were identified and relevant and appropriate training was sourced to address any training need.

Communication with health professionals was good. This enabled staff support people to maintain good health and had access to appropriate healthcare services.
People were offered a choice of suitably nutritious meals and received appropriate support to eat and drink.

Is the service caring?

Good

The service was caring. People were treated with respect, and staff approach was caring and compassionate.

People were supported to keep in contact with their loved ones and families could visit at any time.

End of life care plans were in place where people wished to discuss this.

Is the service responsive?

Good

The service was responsive. People's care needs were identified and care plans developed and arranged in response which focused on meeting people's health and social care needs.

Staff demonstrated a good awareness of the individual support needs of people living at the home and arranged care to appropriately meet individual's needs.
A range of stimulating activities was available for people to participate in if they wished.

There was a complaints procedure in place and people felt confident in the process, they knew how to make a complaint if they needed to.

Relatives were involved when appropriate in discussions about how people liked to be supported. Regular reviews of individual needs made sure any changes were identified and addressed.

Is the service well-led?

Requires Improvement

Although there were signs of improvements some aspects of the service were not well-led and needed further improvement. Notifications that are required to be sent to CQC were not sent in a timely manner. We were told by health professionals the manager did not always respond to recommendations made by health professionals in a timely manner and within the timeframes agreed.

People and their relatives were able to feedback on the quality of the service provided. The provider had a number of methods used to monitor and evaluate the service, we saw the management team took appropriate action as a result of the evaluation process to respond to suggestions and drive improvements.

Addington Heights

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 January 2017, day one of the inspection was unannounced.'
The inspection team comprised one adult social care inspector, a clinical specialist advisor, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service and statutory notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care. We reviewed the provider information return (PIR).This form asks providers to give key information about the service, what it does well and improvements they plan to make. We used this information in the planning of the inspection. We also reviewed previous inspection reports and information from professionals and people visiting the service.

We met with all 46 people living at the home. We spoke with 15 people to hear their views about their care. Some people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. In addition, we spoke with the registered manager, deputy manager, and eight members of care staff. We also spoke with five relatives who were visiting, and two members of the housekeeping staff. We gained the views of a number of health professionals involved with people living in the home. The health professionals we spoke with included the visiting GP, the tissue viability nurse, a community psychiatric nurse, and the community infection control lead nurse, end of life nurse facilitator. We spoke with the safeguarding lead and the manager of the monitoring team.

Good

Is the service safe?

Our findings

People appeared well cared for and at ease with staff. People we spoke with were positive about their experiences of the service; People more recently admitted did not find staff changes had affected their service. One person told us, "I always feel safe here." A relative we spoke with said, "I feel that my relative is safe but I am concerned with the constant staff change." A comment we received from another relative was, "When my family member came here first we had some teething issues, these were resolved to our satisfaction and we have not regretted the decision to use this home."

The service had experienced a high turnover of staff in the past twelve months and bank and agency staff were used where necessary to fill vacant posts. The manager told us agencies could not always supply staff at short notice and of incidents when they were operating shifts with the bare minimum of staff. Staff told us of weekends when the staffing levels were not always as good as they could be and felt this impacted on the quality time they could spend with people when delivering care. The majority of staff spoken to felt that there were enough staff on duty to meet individual needs however they would welcome more time to spend with people living at Addington Heights. Comments included "I would like more time to sit with people", "Enough staff, we always cope" and "I think there's enough".

We investigated staff absences and found it took place mostly at weekend. Records showed and the manager told us staff did not inform the person in charge in a timely manner of their planned absences, as a result the short term absences were difficult to fill. The staff rotas for these periods showed occasionally they were short one staff member. The manager shared with us that resources were pooled and staff from other units were redeployed to units where staffing levels were low. The deputy (clinical nurse) manager had worked on the nursing floor on occasions to make sure they had sufficient levels of staff. Staff told us they were happy with staffing levels but additional numbers could enhance the level of care delivered. They felt colleagues who went absent at short notice showed a lack of commitment.
People told us there were usually sufficient numbers of staff to meet people's needs. Some relatives told us staffing levels appeared lower when regular staff were unavailable at weekends. One person using the service told us, "There is always a shortage of staff at weekends." Another person said, "I think there are enough staff, maybe a few less at weekends on occasions."

We saw that work was in progress and management were addressing performance issues with staff such as informing the person in charge in good time and managing more effectively sickness absences. Our observation during meal times were the catering department served the meals alongside care staff. There were sufficient staff present to assist on both days we visited. The majority of people in the residential section could eat independently and required encouragement rather than direct support. On the nursing unit staffing levels were higher; there were sufficient staff present to support people with eating their meals.

The manager and deputy manager were in direct contact with the local authority contracting team about staffing levels. A regular staffing review took place to ensure that the numbers of staff on duty reflected the needs of the people and adjustments were made as appropriate. We saw that actions were taken to increase staffing levels in response to changes to one floor where 20 nursing beds were in use. We saw from

records and staffing arrangements that there was an increase in the number of staff, and this was in direct response to the assessed needs of people. A small number of staff shared concerns that higher staffing levels were provided on one floor and this was not equitable throughout the home. Whistleblowing information we received in the last six months have all alleged low staffing levels in the home, but none of these allegations were substantiated when the safeguarding lead and monitoring officer investigated the concerns. We discussed with the manager the concerns raised by staff about how staffing levels were decided. The manager and deputy manager advised us they shared with staff how staffing levels were determined and coordinated on each unit.

The housing management and the housekeeping responsibilities were contracted with another provider which presented some challenges. The head of this service liaised with the care home manager on all aspects of the contract. The communal areas of the home were clutter free and spacious with grab rails throughout the hallways. The home was clean, well maintained and safe throughout and there were no lingering odours. Waste bins within the communal toilets were emptied regularly to ensure they did not overflow and supplies of protective equipment such as gloves were stored and disposed of appropriately. Concerns were raised by a visiting professional in recent months around the inappropriate storage of equipment and personal clothing and equipment that was no longer in use. Reports we received stated the management team was slow to address the issues but we found these had been resolved. Storage facilities were not good at the home and limited the storage of resources and equipment. We observed that staff followed infection control procedures; they washed their hands before serving food to ensure the risk of cross contamination with food was minimised. Staff wore personal protective clothing such as gloves and aprons.

People were protected from the risk of being cared for by unsuitable staff. There were safe recruitment and selection processes in place to protect people receiving a service. We looked at four staff files, the appropriate checks had been carried out before staff worked with people. This included seeking appropriate references from previous employers relating to the person's past work performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. There was a clear disciplinary procedure in place which was adhered to. The records we viewed and information from the management team showed that the manager had taken appropriate and timely action where concerns had been raised about the suitability and ability of staff in their role. The manager shared with us that further work was needed in this area.

Safe systems of medicine management were in place, and improvements had taken place where any shortfalls were identified. Senior staff who were trained and assessed as competent administered all prescribed medicines. These were administered from a monitored dosage system and staff signed the medicine administration records (MAR) charts to show they had administered the medicine. We examined medicine records for four people and the medicine stock held for people, no gaps were identified. Protocols for medicines to be administered when required gave staff guidance on the circumstances when the medicine was to be administered. Daily reconciliation of medicines and monthly medicine audits were completed. We saw that remedial actions were taken when errors had been identified and a change was made to administering medicines. Two members of staff were assigned to administer the medicines instead of one. Medicines were disposed of safely and appropriately. An annual medicine audit was undertaken by a pharmacist. One of these audits was completed recently and we viewed the result of the medicine audit which included looking at provision for disposing of medicines. We met with a senior member of staff who was responsible for the administration of medicines to people on the residential unit, and for the ordering and disposal of medicines. They told us they had received training in medicines and they undertook a regular assessment to ensure they remained knowledgeable and competent to administer medicines. We

observed people receiving their medicines and this was done in a calm manner. Staff told us none of the people were currently receiving covert medicines. A healthcare professional who visited the home on a regular basis told us the medicines management was very good and the home sought help from the pharmacy and prescription team if they had any queries.

People were safeguarded from abuse by the processes and procedures in place. People told us they felt safe living at the home, both with the staff who supported them and the way their care and support was delivered. Staff attended safeguarding adults training to ensure they were able to identify abuse and received guidance on the procedure for reporting suspected abuse. We spoke with staff who were able to discuss what constituted abuse and their responsibility in reporting such abuse.

The information recorded for handovers showed staff shared information within the team regarding risks to individuals. This included passing on any incidents that were discussed at shift handovers and during staff meetings (brief meetings took place daily with heads of units.) There were also accident and incident records kept and a whistle-blowing procedure. The service had undertaken an assessment of the risks associated with people's care and risk management care plans had been completed when needed. For example, within people's records we saw that risk assessments had been completed in relation to people's risk of choking, falls, nutrition and skin breakdown. Where a risk was identified there was a plan completed that showed staff how to manage the identified risk. For example, one person was at risk of falling if not using the walking stick, they had sustained recent bruising to the cheek as a result of falling. The person had a poor memory. We heard staff remind the person on numerous occasions to use the walking aid when walking about. There were individual risk assessments in place which determine the level of risk and how the risk could be minimised. We saw that staff had involved an occupational therapist on occasions they felt necessary to provide guidance.

Requires Improvement

Is the service effective?

Our findings

We observed that people looked cared for, in that they were wearing clean clothing that was appropriate for the weather and that their individual personal grooming needs were met, such as hair care and nail care. People able to express their views told us they were well looked after by staff who understood their needs, and were happy with the care and support they received. One person told us, "It is okay living here, initially I found things not as I expected. I am well cared for and the food is good and most staff are very pleasant." People were at ease with staff.

During the previous inspection in 2016 we found that the systems in place for managing and overseeing staff training were ineffective and as a result staff were not up to date with training and development, neither did staff receive regular support and supervision. On this inspection we found improvements in these areas. Staff told us there were good opportunities for staff training and development. Staff were positive about their roles and spoke of the job satisfaction experienced in the home. Comments such as "I enjoy my work and the training we get is very good, it inspires me to do a better job", "I've just done my computer training". Staff told us they felt supported; they had one to one supervision from a senior care worker and attended team meetings.

The manager had completed a training needs analysis, and action plans were developed to address the previous shortfalls in training and support arrangements. A matrix was maintained showing the training completed and identifying any gaps such as when refreshers were due. The manager and senior management had an overview of attendance and closely monitored that staff received their necessary training. We saw copies of letters sent to staff instructing them to attend overdue training classes. Carers were receiving mandatory training as due; these included manual handling and health and safety, dementia care, food hygiene and, fire safety. We saw that three days training for certified first aiders for staff was planned over a two week period. Although all staff received dementia training, it was identified that there were some staff that needed further training as they lacked the specialist skills to communicate and respond appropriately to a person with dementia. A relative commented that staff were generally very good, but a small number of staff were not competent at supporting a person with dementia. In response to the need for additional training a community psychiatric nurse was involved with people in the home and worked with the staff group to ensure they understood fully how they should respond to the person appropriately. Three members of staff commented on the positive impact since the appointment of the deputy manager/clinical lead. They said they felt inspired by his sharing of skills and knowledge and were keen to further develop their own skills. Two of the registered nurses told us they had begun preparing for revalidation with the Nursing and Midwifery Council.

We found that people were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Once appointed, staff were required to complete an induction which covered the main policies and procedures of the service and basic training in the essential skills required for their role. Newly appointed staff were required to shadow an experienced staff member and observe care being delivered before they were allowed to work alone with people. Two recently appointed staff told us they were completing the induction programme and this was still underway.

We looked at their records, what training they had completed. We noted the absence of frequent one to one support/supervision from a line manager. We shared with the manager the importance of providing frequent supervision and monitoring for all new staff during probationary period. The manager acknowledged new staff required more support during the probationary period.

We saw that the provider had introduced a new appraisal system for staff, the manager told us these were done bi- annually. We saw records of supervisions and appraisals in progress. We queried the frequencies of these; the manager told us this was in accordance with Care UK policies (four times a year). Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. There were daily meetings held with the manager and the heads of departments.

Staff demonstrated a good awareness and understanding of areas they covered in training they received. Staff were able to share with us they would appropriately care for people living with dementia, how they would support people when they put themselves or others at risk and how they would effectively communicate with people. For example, one staff member said, "One person I support struggles to make choices, so I help them by limiting the options to two items of clothing." The staff member's understanding of the training received was confirmed during our observations of care provision.

During our visit we observed people made decisions about their care and what they wanted to do, although there was a lack of documentation available recording this information. Most staff were aware of people's needs and how to meet them and understood the importance of asking the person's permission before they provided personal care, such as using equipment. New members of staff were learning and getting to know the people by working alongside experienced staff. There was a comfortable, relaxed atmosphere that people enjoyed. People said they made their own decisions about their care and support. Relatives told us they were also able to be involved. People and their relatives said the type of care and support provided by staff was what they needed. One person told us, "A good service despite a turnover of carers, staff ensured my family member settled in well and was made feel part of the process."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff received mandatory training in The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Senior staff such as the manager or the deputy completed needs assessments, mental capacity was assessed as part of the assessment process to help identify, plan and provide for individual needs. The MCA and DoLS required the provider to submit applications to a 'supervisory body' for authorisation. The registered manager had submitted applications for a number of people to the supervisory body for authority to deprive the peoples of their liberty. A social worker came to the home and approved the applications for four people to have their liberty restricted lawfully. The manager informed us they were awaiting a response to a number of other DoLS applications submitted to the local authority.

Staff sought verbal consent from people before providing care and support. Care plans contained information about how staff should support people to make as many choices and decisions as possible. For

example, one person's care record stated: "Support needed with decisions,". We saw staff using the techniques recommended and gaining the person's agreement before supporting them to join in activities. Care records showed that meetings took place with family members to determine the best course of action for people who did not have capacity in specific areas to make decisions for them. Some of the mental capacity assessments we saw were generic and not always decision specific. Internal audit processes had identified the shortfalls and the changes needed. We saw from two people's records that staff had already started to address this and were updating records using the new assessment format introduced.

A relative we spoke with told us of being consulted and involved in discussions with staff about their family member's advance care plans. We met with a nurse from a local hospice who was assigned to facilitate end of life training with staff. They found staff had made good progress as a result of management working with them. This had enabled higher staff numbers attend the training.

The service had developed protocols to ensure people were suitably nourished and hydrated. Individual care records included plans for managing nutrition and hydration. These included the use of a 'Malnutrition Universal Screening Tool (MUST) that was monitored and updated regularly. As required weight charts were kept and staff monitored where necessary how much people had to eat and drink. A nurse told us people's food and fluid intake was monitored where people's nutritional intake was poor and this was supported by the use of individual daily records. Staff told us that when a person had an infection, reduced appetite or unplanned weight loss a food and fluid chart would be put in place to monitor their intake. We looked at a number of food and fluid charts and these records gave a clear picture of what the person had consumed. Staff when spoken with showed a good understanding of the importance of keeping people hydrated and nourished. We observed drinks and light snacks being offered between meals. One carer told us that some were more inclined to drink and eat mid-morning snacks when they were engaged with other people in the communal areas.

There was information regarding the type of support required at meal times. We saw evidence of good practice as staff assisted people at mealtimes. Nutritional advice and guidance was provided and staff involved health care professionals such as dieticians and speech and language as required. The records demonstrated that referrals were made to relevant health services and staff liaised effectively with external professionals. A health professional commented positively on the communication with staff, they found it "very effective". A person told us any concerns they had about a relative were raised promptly by staff and discussed with the person's GP or other relevant health professional such community psychiatric nurse. It was recognised by people and relatives that there were notable improvements in how healthcare was promoted at Addington Heights. A GP surgery was held at the home weekly and the doctor undertook more frequent visits if required. People told us the weekly visits from the GP had contributed to better healthcare provision. A GP informed us the regular weekly visits had contributed to improvements in team working and effective communication with staff at the home.

The feedback on food served was very positive and people told us they enjoyed the meals provided, the majority of people told us the meals had improved. Another organisation was contracted for the catering provision and met with management to discuss meal selection. However, one family member told us they were disappointed the head of catering had not taken up their invitation to attend relative resident meetings to discuss food selection. The head of catering had arranged to attend the next resident/relative meeting. A person using the service said, "The meals are excellent and you have great choice." Another person said, "First class food, I love the meals here, always very seasonal." A relative told us, "I visit often and the food always looks and smells lovely, my parent always finishes the meal." During our visit people chose the meals they wanted. There were three choices available for lunch on both days. The meals were of high quality and special dietary needs were provided for. This information was recorded and shared with

care staff and kitchen staff. The lunch we saw both days was well presented, nutritious and served at correct temperatures.

Since our last inspection the home has provided care for more people living with dementia. Although the premises are divided into five clusters it was sometimes difficult to differentiate one area from another with corridors and lounges being quite uniform in appearance and lacking 'identity'. We shared with the management team our concerns that the current environment did not have a dementia friendly layout. Further work could take place to make the home environment more homely, personalised and 'dementia friendly' for the people living on each of the five clusters. There was no staffing board to inform people about what staff were on duty.

Good

Is the service caring?

Our findings

One person said, "The care is good and the majority of staff are kind and caring." A visiting family member said, "I do find staff are generally pleasant and approachable and most of them have a good attitude to the work." Occasions had arisen when a small number of staff did not follow the codes of conduct. Records we saw and reports from the manager were that individuals were being managed appropriately and disciplinary measures were used to address practice issues.

Despite staff turnover there was a core of staff that were familiar with people, knowing their needs and preferences very well. Although some practices were task focused rather than being totally person centred people were treated with compassion and addressed by their preferred name. Suitable body language was used by staff to communicate messages to people who had hearing or cognitive difficulties. We observed that staff listened to people and acted upon what they were being told. The caring approach of staff was supported by their understanding of the person obtained from their life history and care plans. Staff had made progress in developing life histories for people, work was still in progress to get the additional information from relatives when the person was unable to share this themselves. Staff we spoke with were positive about the care being provided and spoke of improved practices in the home and "getting there." They felt that the staff team worked well together. One senior worker said, "Most staff here are very willing and capable of delivering good care. We do find the occasional one that does not have their heart in it which is not tolerated, we like to really care well for people and have a really nice team here".

People's records included information on race, religion, disability and beliefs. This information enabled staff to respect them, their wishes and meet their needs. Visits were made by religious ministers and people that wished to were supported to attend local church service. In some care records there was information recorded on the person's preferences regarding end of life care. Staff were clearly aware of people's needs, routines and behaviour and were able to explain how they supported different people.

The service had introduced "resident's day." This review process was developed to ensure care needs were reviewed and adequately planned for, it enabled staff to focus on the person and review their care needs with next of kin or relatives invited to the meeting. People were comfortable, well dressed and clean which demonstrated staff took time to assist people with their personal care needs. Staff paid attention to nail care; some people were assisted by staff to paint their nails. We spoke with a hairdresser who had come to provide services to three people, they felt the people were looked after by caring considerate staff. People's preferences regarding showering and bathing were recorded, one person told us they liked that they had a shower a "couple of times" a week.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. Staff were very courteous, discreet and respectful even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. Relatives we spoke with confirmed they visited whenever they wished, were always

made welcome and treated with courtesy.

Good

Is the service responsive?

Our findings

People's care and support needs had been assessed before they started using the service. Pre admission assessments showed people had been involved in discussions about their care, support and any risks that were involved in managing their individual needs.

Care plans were developed in response to needs assessments. When people moved to the home, they and when appropriate their families were involved in assessing, planning and agreeing the care and support they received. Family members told us they were involved in discussions about their relative's care and were kept informed of any changes to their health or well-being. One visiting person told us, "Staff very good and talk to me about my relative's care; they're very conscientious. "
Care plans were held electronically. These contained information on what the person's care needs were and how to meet them. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences. Care plans were in place for routines such as getting up and going to bed, social interaction, health care, nutrition and hydration and mobility. Where risks had been identified there were management and support plans in place for staff to follow to ensure consistent and safe care was delivered.

Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support; which people needed to be encouraged to eat and drink; the support each person needed with their continence; and when people liked to get up and go to bed. Most rooms were personalised with photographs, pictures and other possessions of the person's choosing. We saw evidence that staff responded appropriately to people's changing needs. People's records showed that referrals had been made to additional services when required. These referrals included, the speech and language team (SALT) to assess people with swallowing problems, dieticians for advice about a person's reduced food and fluid intake and the older persons mental health team for assistance in supporting the mental health of a person with cognitive impairment. We saw evidence in the person's records that advice given had been acted upon.

As well as detailed information about the person's care needs in relation to health, personal care support and dietary needs, they also contained information about the person's, likes and dislikes, family and personal history, past jobs and hobbies and interests. Information highlighted in these included, "The person likes to watch sport and listen to their music". When we visited this person in their room it was evident that the information in the care plan had been followed. Another care plan stated 'Use simple and direct questions when communicating with the person'. Another person told us, "My relative likes to pay attention to her appearance, to have their nails manicured and make up are important, staff do that for her."
We discussed the information we had seen in the care plans with the staff who demonstrated that they knew the people they cared for well and understood the ways they wished to receive care. Evidence within the care plans indicated that they were reviewed by the nursing staff monthly or more frequently if individual needs changed. We found that although monthly care reviews took place the care records were not always accurate. For example, we saw that a person recovering well from a fractured arm now required less support and could carry out more tasks themselves. We shared our concerns with the manager about inaccurate care records; he acknowledged the person's current care needs were not reflected accurately following a

recent care review.

Staff were kept up to date on people's needs through a handover meeting when they arrived on shift. This meeting provided the staff with a range of important information about people's conditions and included any special instructions for staff. For example, if anyone needed to be seen by the doctor or district nurse, needed to be weighed or had additional care needs. These handover meetings were supported by written information updating the staff on people's needs.

People told us they had choice over their daily routines and staff knew about and respected their preferences and the way they liked their care and support to be given. At the previous inspection we found the service failed to give people enough opportunities to participate in meaningful social activities, and many spoke of being bored and a need to improve provision in this area. The service had made progress in providing more appropriately for the social care needs of people. There was a range of activities which were available for people to participate in if they wished, each floor had an activity room but we observed most activities took place on the ground floor. The activities coordinator was supported by staff from other floors. A planner of monthly activities was displayed and this informed people and families about events and forthcoming activities. People had attended external events such as local pub restaurants; some went to a knitting club at the library. The provider also arranged external services, such as singers, church services, musicians, dancers, and visits from animals and their handlers. Activities were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. People who remained in their bedrooms by choice or because of their care needs were given the opportunity to receive one to one activities. People and their families were kept informed of forthcoming events and daily activities though the activities notice board and directly from the staff. The manager told us of other changes that could further improve their lifestyle, they were planning to use a minibus available to take people to more events in the community.

People, relatives, staff and professionals who visited the service gave more positive views about people's access to appropriate mental and physical stimulation. There was one full time activities coordinator with plans to hire another person part time to the role. On the day of our visit we saw people engaged in many different pursuits. We saw people, for example, reading, drawing, talking with each other and staff or enjoying music. There was a variety of newspapers and magazines around the home, some completed jigsaws. People were able to sit quietly or take part in what happened around the home and we saw staff respected people's preferences with regards to this. One visitor said, "I think there's much more stimulation for people. The activity coordinator is very good and involves my relative as much as possible." Another person visiting told us, "Activities happen in the activities lounge on the ground floor mostly which my relative can't get to; but staff take her down to events. They have pet dogs brought in to the home for people to stroke; I think they enjoy this very much". One visiting professional who often visited told us, "There seems to be more stimulation. I often see activities going on. "

Relatives told us that they were involved in their family members care where agreed by the person. Staff kept them up to date with the care their loved one received or if there were any concerns these were shared with them. People praised the staff for their hard work which resulted in the positive outcomes experienced by their relatives. A person visiting said, "My parent has become frailer and more dependent, but staff have work tirelessly and she is well looked after."

The service had a complaints procedure in place and this was available to people who used the service. People and relatives told us they were satisfied with the way any concerns or complaints were handled, one person commented "I've never really had to complain but staff would listen if I had a concern, they are always wanting to help us". A relative said " I have never had to raise a concern or make a complaint but I

often speak to the manager and staff when I am here. I am sure if I had concerns staff would listen and act upon a complaint". We reviewed the complaints the home had received. All but one complaint had been responded to and dealt with to the satisfaction of the family. The management team provided evidence to demonstrate they continued to work towards resolving issues raised.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in January 2016 we found that interim management arrangements plus instability and inconsistency contributed to deterioration in the service over a period of time. Staff told us of feeling unsupported and their training needs were not provided for. On this inspection we found the registered manager was now in post for eighteen months and there were signs they had given much needed stability to the service and the service was much improved. However, we found there were still areas requiring further improvement. Notifications required by regulation such as notifications of people where DoLS had been approved were not submitted to CQC in a timely manner. This was a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

A health professional who visited the service in recent months to look at infection control procedures made recommendations regarding the more appropriate storage of equipment and personal care clothing. They said they were disappointed to find on a follow up visit to the home that these recommendations were not responded to within acceptable timescales.

Staff and people using the service told us of the many improvements they experienced so far. Staff felt supported and described "having confidence in the management team" since the new clinical lead/deputy manager came into post. Staff felt the management team worked well together, they were supportive, a training needs analysis was completed and individual training needs were provided for appropriately. Other positive reports we received from staff were that management were addressing staffing issues in relation to attitude, professional boundaries and codes of conduct, and short term absenteeism. One care worker said, "We are getting there, progress is not as fast as we would like but we are all united on making sure good practice is the only practice acceptable." Another care worker told us, "Staff need to make sure they always put into practice training they have learned." One member of staff said, "Staff prefer to work with regular people they get to know well. It is not always the best experience for a person to have many different carers, continuity of care is compromised." Another staff member said, "Morale is so much better among the team now, we attend regular meetings and are kept informed of events, the new manager will always advise you that your training is due for renewal." The manager explained why some routines were changed to effectively manage the service and address staff practice, for example rotating staff on different units.

Communication between staff and external professionals had improved. On each unit there was a diary book held for doctors and professionals appointments, accurate records were maintained of the appointments which led to clarity among staff about practice. A senior staff member (clinical lead) or a nurse undertook the weekly rounds with the health professional visiting. Health professionals commented positively on the working relationship with management and staff, the systems for follow up referrals was managed well . Paper care records such as fluid and food charts were consistent and reports were organised and stored securely making it easy to access important information. Electronic records called Caresay were completed, important information regarding contact with GP and updates, personal care and podiatrist appointments were recorded. Internal audits and governance reviews identified any shortfalls in practice and followed up on any actions set when they next visited the home.

People and relatives told us that there were greater improvements in the management of the service in recent months and were positive about how these had improved people's experiences. Resident relative meetings took place regularly in the home, there were signs that some relatives were strongly committed to raising and discussing issues about aspects of the service they would like to see improved, thus ensuring their loves ones could lead an enjoyable lifestyle and join in events in the local community just as they did before they came to live in the home. The relatives of one person complimented management and staff on the efforts they made to help their elderly parent enjoy a recent family get together. One person visiting spoke of their frustration with minor things that kept reoccurring; they found it frustrating that there was nobody to open the door especially at weekends, or the long delay in getting a response when they telephoned the home. We shared with the manager these issues of concern that people reported.

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards and these had been followed up to drive the improvements required. We saw that action plans were developed for the registered manager to respond to, we saw that some areas for action had not been completed when the follow up governance audit was undertaken. Surveys were conducted annually, resident/relative meetings were held monthly. As a result of the most recent survey we saw that actions had been taken to respond to people's views and suggestions, and these actions were displayed on the noticeboard. These demonstrated that changes were made in response to what people requested in relation to meals.

Relatives told us there was an open door policy that made them feel comfortable in approaching the manager. One person told us, "I would like to see the manager and the deputy present more on the units to observe practice." We saw reports of unannounced visits that the manager and deputy had completed out of hours, there were reports of findings of spot checks undertaken to monitor practice at night and weekends.

There were clear lines of communication within the organisation and specific areas of responsibility and culpability. There was a whistle-blowing procedure that staff said they would be comfortable using.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager did not inform the Commission of relevant events.