Aura Care Living LTD

Kings Lodge

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

Summary of findings

Overall summary

The inspection took place on 26 September 2018 and it was unannounced.

Kings Lodge is a new home providing residential care for older people including those living with dementia. The care home has been opened just over a year. The building is designed to accommodate and care for up to 64 people in four different units. At the time of the inspection there were 19 people living there, 13 of whom were living with dementia.

People in residential care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post at the time of the inspection. 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 registered manager had resigned recently and the provider was taking the necessary steps to recruit to the role. The registered provider was present for the inspection. They had a dual role as they also managed another care home but were spending two days a week at Kings Lodge. There were other staff who were currently taking on addition management tasks who were also present on the day of inspection.

There had been some upheaval recently with the loss of senior staff at the home. The provider was aware of the need to support the workforce, and give clear leadership. Whilst aspects of the care were good, there was a recognition that improvements were still needed and staff needed support to make the necessary changes.

There was some inconsistency in the way that people's consent for care was agreed which was not meeting the legal requirements of the Mental Capacity Act.

Whilst there was sufficient staff on the day we visited, there was some evidence that staffing levels had been stretched in the past. We have made a recommendation about the need for the provider to continually review staffing, based on the needs of the people as the service grows.

Some improvements were needed to ensure the facilities and furniture were always suitable to meet the physical and specialist needs of the people who lived there. Some people were kept waiting to have their lunch served. We have made recommendations to the provider.

People's wishes for the end of their lives were not always documented or clear. Some care plans were not signed off as agreed with the person. Daytime activities for people, and opportunities to access the

community was being improved by the provider. The involvement of people, relatives and staff in the service was still being developed and further engagement was needed.

People were kept safe from harm. The risks to people's safety were assessed and staff knew of the actions they should take. People were protected from the spread of infections through the safe practices of staff.

The environment people lived in was kept very clean. People received their medicines on time and from staff who were trained and understood the medicines administration. Staff were aware of their responsibilities to protect people from abuse.

Accidents and incidents, including any falls that people experienced, were recorded and monitored including trends. Lessons had been learnt from a recent safeguarding incident and processes were updated.

People's physical, psychological and social needs had been assessed before they moved into the service. People had enough to eat and drink throughout the day. Choices were provided and their nutritional needs were being met.

People's health was maintained and they had access to specialist services when needed.

People were treated with kindness, respect, and compassion. They felt they were listened to and their emotional needs were being met. People made day to day decisions about their care. Privacy was always maintained. Staff made sure they spent one to one time with people and engaged with them personally.

There was a complaints process in place, though people said they had no reason to use this.

The service had developed partnerships with other agencies and had an ambition to do more.

The service had experienced a time of uncertainty and the provider was supporting staff during a period of change. There was evidence that the provider was already acting to improve and create a good basis for growth.

During this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made three recommendations to the registered provider.

You can see what action we told the provider to take at the back of the full version of this report.

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.

Staffing levels were adequate. Staff were recruited and managed safely.

People felt safe and staff knew how to identify and report abuse.

People received their medicines safely.

Risk assessments for people were in place and staff were aware of risks.

People were protected from the spread on infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not consistent in meeting the requirements of Mental Capacity Act 2005 (MCA).

The premises met the needs of those who lived there, but some changes have been recommended.

People had enough to eat and drink and their nutritional needs were being met. Some people were kept waiting at lunchtime.

People's needs were assessed to provide effective health and social care.

Staff had access to training and staff supervision was in place.

People had their healthcare needs met and were referred to a specialist if needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and their supported emotionally.

People had a say in their day to day decisions about their care.

People's privacy, dignity and independence was promoted and visitors made welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The involvement of people and their relatives in their care plans was not always clear.

People's wishes for the end of their lives were not always documented.

Improvements were being made to personalise activities for people.

A complaints process was in place and people could complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider was still developing their business.

The registered manager had left and was being replaced.

The involvement of people, relatives and staff needed to be embedded in the service.

Staff were supported through a time of uncertainty.

There was a performance and development plan in place, service improvements were starting and new partnerships were being developed.

Kings Lodge

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 26 September 2018 and was unannounced. This was the first inspection since the service was registered in July 2017.

The inspection was carried out by 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 care service.

Before the inspection, we reviewed the information we held about the service. This included any notifications we had received. Notifications are changes, events and incidents that the service must inform us about. We reviewed the information in the PIR as part of this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people living at the home. We spent time observing interactions between people living with dementia and the staff. We checked how people's medicines were administered. We interviewed three of the care staff, and spoke with the registered provider, the two acting managers, the owner of the company and a director who was also a clinical advisor. We requested some further information after the inspection and this was sent to us promptly.

We looked at the care plans for six people, and the daily notes for two other people. We checked that what was detailed in these plans matched the support and care that people received. We also looked for mental capacity assessments, any applications made to deprive people of their liberty, and whether people had end of life care plans in place.

We checked whether mandatory policies and procedures were up to date and in place. We reviewed the recording of accident and incidents in the home, checked four staff recruitment files, and the evidence of

staff training.

We looked at documentation that showed whether regular tests, monitoring of equipment and of the premises were being done. We reviewed any recent internal audits, improvement plans and responses to complaints and feedback, to understand how well the service was being governed and managed.

We later received some feedback from three professionals who have visited and worked with this home.

Good

Is the service safe?

Our findings

People told us they felt safe living at Kings Lodge. One person said, "I feel very safe and my belongings are safe." Another person, said they felt safe, "Because if anything happens to me they would soon spot it." A third person, told us, "There's always somebody about. And we've got these bells to press, somebody will come."

The staffing levels were adequate and safe on the day of our visit to meet people's needs. People lived in two different units on the same floor level. One was for people living with dementia and there were three care staff looking after 13 people which seemed to work well and there was a calm atmosphere. The people in the other part of the home were more independent, and there was one staff member for six people. People in this unit told us that they sometimes had to wait over five minutes when they called for staff to help them. For example, one person said, "Somebody will come. It could be five to ten minutes but they always come eventually." Another person told us, "They could improve by getting quicker when you press the button." Whilst, we did not see people waiting long, staff had to come across from the other unit to help people on some occasions.

Staff rotas showed that usually there was a minimum of four care staff working in the day and three at night. One staff member said they, "Loved working here when we have the correct staff." We judged there had been times in the past when staff had been stretched. Call bell audits had only recently been started. There was a recognised dependency tool in use and this was completed in each person's care plan. People's needs were assessed and scored against criteria. We asked the provider what they would do to ensure there was always sufficient staff available, especially as more people moved into the home. The provider said they could look at these 'scores' across the home and would be flexible with staffing based on need. Current staff were incentivised to pick up extra shifts at short notice to cover sickness or leave and to reduce the need for agency, with a maximum number of hours worked and 12 hour breaks between shifts. The provider was also taking action to recruit a bank of staff and a regular evening shift as there was local interest in working at that time of day.

We recommend that staffing levels and deployment of staff is kept under review and adjusted, based on people's needs, and as the number of people living at the home increases.

People received their medicines safely and on time. Only staff who had been trained to do so were able to administer medicines. We observed a member of staff giving people their medicines and using an electronic system. This identified what medicines each person should take and when. There was a photo and the person's name on the system to ensure the right person was identified. Any 'as required' (PRN) medicines were also on the system. Once a drug had been given, this was checked off on the system and the colour changed to show this. For specialist drugs and pain patches this was recorded separately in a book and checked by a second staff member. We observed staff applying a pain patch for one person. They followed safe practice and made a record of where it had been placed and signed and dated this. The medicines were stored safely in a locked cupboard, within a locked room. The temperature of the room and cupboard was monitored.

Whilst, the electronic system provided the means of recording all medicines administration, it was dependent on accurate staff input and did not show when stocks were low. For example, one person's medicine had run out on the day on inspection, although this was rectified later the same day. The provider had already decided, as an improvement, to move away from the electronic system and had signed a contract with a local pharmacist and provider. Under the new agreement, the medicines and administration records would be provided by the pharmacist. They would also ensure competency training for the staff was done and undertake external audits of medicines practice. The registered individual told us, "Our medication procedures will be in line with National Institute of Clinical Excellence recommendations."

People's risks were identified and well documented risk assessments were in use and up to date. These were mostly specific to the individual person and their known risks. There were also generic risk assessments, for example if people could use their call bell to get help. Each person also had a Personal Emergency and Evacuation Plan (PEEP) in place so that staff knew about people's physical constraints and what to do in case of a fire or evacuation from the building. Some people had requested and were given a key to their room and a risk assessment was undertaken to ensure any safety issues were considered.

There was clear guidance given to staff about how they should react with people whose behaviour was unpredictable or challenging for the service. This included how staff needed to be aware of the time of day or events that had an impact on the person. We read that, with one person, only one member of staff should speak to them at a time and to answer any questions they had simply to avoid confusion. During the day we observed staff putting this into practice.

People were helped to move about the home safely. Several people were identified as risk of falls. The staff could tell us about people's needs and what measures were in place to protect people from injury. Some people were encouraged and enabled to be independent, using a frame appropriately. Staff supervised those people who were at greater risk of falling when mobilising. The care plans and incident reports also reflected people's current situation and recorded any falls, so the risk to them was monitored. Routine equipment and building maintenance health and safety checks were in place to prevent injury and accidents.

Accidents and incidents were being recorded and reviewed each month. The system allowed each incident to be recorded by person so it was easy to see what reoccurring issues there might be. Most incidents were falls and there was either no injury or a minor injury. There have been two injuries where medical attention was needed in the past four months. The time of day was also monitored as well as the location, but no real trend had emerged where specific action was needed. There was one person who had experienced a fall each month for the past four months, and sustained a bruise on one occasion. Their risk assessment had been updated and staff were aware of the need for close supervision.

People were protected from the spread of infection because they lived in a clean environment. There was a housekeeper and one cleaner employed and we were told another cleaner was being recruited. People's rooms and the communal areas were cleaned daily. There was a monthly schedule for a deep clean of all rooms which was up to date. The house keeper said that the rooms were also deep cleaned after shorter periods of respite care and if the staff requested it due to a person's needs. The laundry room was secure and kept tidy and there was a system for keeping soiled clothes and bedding separate. Monthly water temperature tests also protected people from any harmful legionella bacteria. Staff practiced infection control measures. One person told us, "Staff will wear gloves and aprons for care giving." Another said, "Everything is kept clean."

People felt safe from abuse because of the staff who cared for them. Staff understood their role and

responsibilities to report any potential abuse or unsafe practice. In July 2018, the safeguarding policy and practice was reviewed as part of an audit and as a result some improvements had been made. The policy was shared with us. Staff had received mandatory training in safeguarding vulnerable adults recently. One staff member told us, "I had some training. I know we must report anything and record it." There had been a recent safeguarding incident between two people living at the home. This was reported to the local authority and the CQC and had resulted in learning by staff about when to report. Action had been taken to address the needs of the person, involving their family and relevant professionals.

People were being cared for by staff who had been safely recruited. We looked at the practice and process for recruitment and found evidence of appropriate references, identification and the right to work in the UK. Disclosure and Barring System (DBS) checks had been completed. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who 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 capacity to make decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible. A person can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DOLS).

Whilst we saw that staff asked for people's consent before carrying out tasks, they did not seem confident about when a mental capacity assessment was required. The service was not always clear in their responsibilities to meet the legal requirements of the MCA regarding consent. For example, there were two people where their consent to care had been signed for them by a family member. This was without any mental capacity assessment showing why the person could not make the decision themselves. Neither was there any evidence that the family held the legal powers to consent on their behalf.

There was also a copy of a 'do not attempt resuscitation' form (DNAR) for a person that had been signed by the relative but, again, there was no evidence that the relative had the legal power to do so. Another person had not signed their DNAR form but the care plan stated that the family had been consulted about it. A staff member also told us that this person's family did not want them to have medical tests but the family did not have the legal authority to decide these things for the person. There was no evidence of any mental capacity assessments undertaken for these people.

For two other people, who needed help to make decisions, we saw there was proof of the relative's legal authority and that the relative had been consulted and involved appropriately. Some people who could agree decisions had signed their own consent forms and this included their agreement for staff to record and share information about them with other professionals if needed.

Failure to act in accordance with the Mental Capacity Act 2005 and code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told us that they were addressing the inconsistencies we found and were working with their local authority, "To assist with the future developments around our mental capacity assessments guideline for Kings Lodge staff." We will review any improvements at our next inspection.

The physical environment at the home was tastefully decorated and comfortable. The provider told us they wanted to create a high standard of living for older people, and to "Give people lovely things around them, as they deserve." There was a spacious lounge and bar area where drinks could be served for visitors and this enabled people to meet their relatives away from the communal areas. There was also access to an outside space and some of people's bedrooms had doors that opened onto the gardens. However, these areas were not used or enjoyed by anyone on the day of our inspection.

However, improvements were needed to ensure the facilities were always suitable to meet the physical and specialist needs of the people who lived there. One person, told us it was, "A lovely home, but some of the furniture's not practical." On two occasions on our visit we witnessed people with mobility needs who were unable to get themselves up from a chair that was too low. In one of the units, it took three members of staff to come and assist the person and ensure a safe transfer was made. In the other unit, attempts were made, but staff were not able to get the person up from the chair whilst we were there. We told the provider who agreed they would change some of the furniture, or raise the chairs, and make more suitable to promote people's independence.

Where people were living with dementia, there were memory boxes to help orientate people, which had either a picture of the person or something that was relevant to them and their work of past. However, the internal uniform colour scheme, with all grey doors, meant that rooms did not stand out and it would not have made it easy for people living with dementia to differentiate or find their way.

We recommend the provider ensures that the environment and furniture is made as accessible as possible and meets the needs of the older people who will live there.

People were cared for by staff who had access to training and supervision. One person told us the staff, "Know what they were doing." All new care staff were registered to complete the Care Certificate and they were expected to complete this within 12 weeks old starting. The Care Certificate has been introduced nationally to help social care workers develop the key skills, knowledge, values and behaviours they need to provide people with safe and high-quality care. The provider also gave staff access to mandatory e-learning covering fifteen key areas, which included manual handling, dementia awareness, first aid, infection control, food hygiene, and dignity in care. We were informed that 82% of staff have completed the full set of training and there was a training log in place to evidence this and track progress.

It had been recognised by the registered individual that further investment in staff training was needed, for example to support staff working with people living with dementia, and the de-escalation and management of behaviours that might challenge. Training on continence and catheter care was identified. Sessions were planned with local health services and a health care professional confirmed that they had been asked to deliver training soon.

There was a staff supervision and annual appraisal plan in place. Since the registered manager had left it had emerged there were gaps with the staff supervision and six staff had not had a meeting with their line manager since April 2018. One new care worker said they were "Not sure" if they had supervision. This was discussed with the registered individual. Following the inspection, a new supervision plan was put in place and sent to us. The provider said that "All first supervisions will be completed throughout the month of October. Going forward, there will be regular peer group supervisions and we currently have scheduled appraisals for staff who have completed their first year."

People's needs and individual requirements had been assessed in a thorough way before they moved into the service. This was clearly documented, following clinical guidance and covered different aspects of a person's life. The assessment was holistic as it included whether people had any cultural or religious needs, their communication needs, emotional health, and their social needs and interests as well as their physical, medical and dietary needs.

People had enough to eat and drink throughout the day and their nutritional needs were being met. Where people's weight was a concern a monitoring chart was put in place. People in their rooms all had a drink within easy reach and were offered drinks and fruit during the day. There was a choice of food at lunchtime

and the options all looked appetising. People were given the choice of wine or a soft drink as well. People enjoyed their food and we heard good feedback about the meals. One person said, "The food is very nice, you can have it in your room but I usually come into the dining room." Another person said, "I have a choice of food, you get three choices, one of them is vegetarian, or they will cook you an omelette. They make good omelettes." And we were also told by a third person, "You would never go hungry here."

The dining experience was overall a good one. People were given time to eat and were not rushed in any way. There was some social interaction and the setting was very pleasant and like an ordinary home. However, on one unit some people were kept waiting 20 minutes before their lunch was served and there was only one staff member available to help seat and serve people. A second staff member eventually was able to come to assist.

We recommend the provider deploys the kitchen staff to serve people their food quicker and get direct feedback from people about the food.

People's individual health care needs were met and they received medical support. There was evidence in care records that people could see a chiropodist, their community nurse, GP or social worker on a regular basis. One person's health had deteriorated recently and they had lost weight. Staff had referred them to the GP who had prescribed some medicines and were keeping things under review. There were also evidence of referrals and collaborative working with specialist services such as the community mental health team. Where specific medical and behavioural advice was received or sought this was recorded. We saw correspondence from doctors about people's conditions. We observed that staff followed the advice and guidance in their care giving. A healthcare professional told us, "The staff are generally very good and follow advice."

The right services were accessed when needed. One person told us that they felt unwell on one occasion. They said, "I pressed my bell and someone came to check me. They said I had a high temperature and they called the doctor out then and looked after me." Another person had fallen a few months ago. They said, "The staff arranged for a doctor, who suggested I should be taken to hospital the following day. They gave me a sling there, and I came back okay."

Staff worked together to share information about people's needs. The daily notes were used effectively and gave informative descriptions of people's day to day changes in mood and personal or physical concerns. There was a daily handover meeting between staff on each shift and by email to the whole staff team. One staff member said, "The unit leader keeps us informed so we know what to look for."

Good

Is the service caring?

Our findings

People were treated with kindness, respect, and compassion by staff who knew them well. We observed on both units a calm atmosphere was maintained. Staff responded well when people became anxious or when things got busy. One person told us, "The staff aren't rushed, they are all calm." There were interactions between staff and people that were very positive. We heard from people that staff were, "Friendly and helpful, "Kind", "Cheerful", and "Terrific carers." We also had some feedback from a visiting health professional who said the staff, "Give good care and are patient. They are very careful and respectful in the way they work with and help people." There was a record of several compliments from families which praised the kind and caring nature of staff.

People were given emotional support when it was needed. Staff knew people well, their preferences and any routines that helped them day to day. Staff could tell us about people's moods and the best time of day for them or when they needed emotional support. We observed how staff acted on this knowledge and helped people who were feeling unhappy by talking with them, or checking what they needed if they could tell them. One person said they were feeling "Apprehensive" and a staff member immediately engaged with them, crouching down to and providing some reassurance. A staff member told us they could help a person who got upset at times by asking about their great grandchildren in their family. One person told us, "I've only got to ask and they will help me. They will always sit and listen to me." Another said, "They are so caring, you can talk to them."

People were involved in decisions about their care on a day to day basis. Staff offered to help people, talking to them by their name. They asked people what they wanted before carrying out a task, for example when helping a person to mobilise or whether a person wanted their 'as required' medicines. People were confident that staff would do what they asked. For example, one person asked for their hearing aid to be put in so they could speak with us. They told us, "This place is really good, everything's fine. I have a lie down in the afternoons. … At night, I tell them to shut the door and put the lights out, and they always do." People's choices were respected. Some people chose to stay in bed later in the mornings. Other people said, "They always ask you what you want to wear this morning," and "They give you a choice of shower or a bath every day."

People's privacy and dignity and independence was respected. Staff knocked on people's door and waited for a reply before entering their bedrooms. One person told us, "I usually have help with my bath. They always have towels at the ready. They are very aware that one might be embarrassed." Another person said, "They encourage you to do things for yourself if you can. They are very nice, very friendly, without being intrusive." People living with dementia were encouraged in a gentle persuasive manner to do things and staff were aware of the need for patience. One person with dementia did not want to move from their wheelchair. Staff waited and did something else before returning to encourage the person again.

People were supported to maintain their family and close relationships. One person told us how her family and guests had been made to, "Feel very welcome" and they had lunch together in the visitors lounge and bar area.

Requires Improvement

Is the service responsive?

Our findings

People's care plans provided sufficient information to enable staff to give personalised care. There was a life history map in each person's care plan and their social history and interests were also assessed. This was a quick way of capturing a picture of the person, for example, their occupation, their family, any pets, where they have lived and travel, their interests, favourite things and any strong dislikes, religion, socialising and important dates. We found staff knew people well and could describe their likes and dislikes and preferences. The provider told us that they met with all new potential residents and their families to involve them in the assessment and care planning.

However, such involvement could be improved further by reflecting people's views and using the person's own words in care plans. There was a need to ensure that the person agreed to and signed the plans and consent forms wherever possible. We also found that people's wishes for the end of their lives were either partially or not completed in their care plan. It was not clear whether people had made any advance decisions that needed to be honoured. We drew this to the attention of the provider. The registered individual told us that they would address this in the most appropriate way with people. They also planned to do more work with people living with dementia to develop "Life stories" for individuals and would provide staff with training to do this.

The range and availability of daytime activities for people was an area staff told us they were improving on. The activities co-ordinator had recently left so although there was an activity plan it was not fully implemented at our visit. Some people told us, they watched TV or occupied themselves and they would like to do more or go outside of the home. Action had been taken by the provider and the new activities co-ordinator was starting soon. A mini bus had been purchased and a driver was being recruited. There was a plan to take people out in small groups two times a week to be able to visit a place of interest or enjoy a local activity.

Some people, we were told, had requested a religious service so this had been arranged with the local church and several people benefitted. However, the person who led this activity told us they had recently been asked to hold the service in the lounge of one unit, rather than in a separate room. This precluded some people from coming and meant that other people, who may not have been of the same religion, were affected. They were going to discuss this with the new activities co-ordinator to ensure that this was personalised to those people who wanted and needed to express their faith. The provider told us, after the inspection, " We offer choice of where residents would like to have their religious visits it can be in either in their own room or the quiet room at the end of the hall which was created for this purpose."

People told us that some staff helped them with activities which they enjoyed. One person said, "[staff name] is excellent because she does the quizzes." Another person praised staff for helping with the, "Crossword puzzles, which I love." In the afternoon, we saw a staff member running the group quiz in one unit. On the other unit, some people were engaged in some art work. Visiting healthcare professionals had fed back to us that the home was offering a variety of activities and staff gave one to one attention to people.

People's individual needs were met in other ways. For example, people's rooms were personal to them and adapted to their wishes with their home effects and photos. Whilst the room fixtures and fittings were the same people's bedding was individual. One person spoke highly of the position of the room that they chose and told us." I like it here because I can sit here in my own chair. I can see out of the window."

The service had a complaints policy. Some negative feedback had been received earlier in the year which we were told had been addressed directly with the family. No other formal complaints had been received. People told us that they had no reason to complain.

One person had recently been cared for at the end of their life. The hospital had discharged the person back to the care of home for their last days. The home worked closely with the community nurse to ensure the person had appropriate pain relief and a peaceful death. There was good documentation of their needs and all the actions taken by staff.

Requires Improvement

Is the service well-led?

Our findings

The care provider had been registered for just over a year, and the service had experienced a time of uncertainty. The owners and the clinical director were present on the day on inspection. Although the service had recently lost senior members of staff they wanted to reassure us that action was being taken to find replacements and to sustain and develop the service. The owner said they wanted, "To provide older people with the best possible care environment." The clinical director said that the priorities were, "To support and retain the staff, provide a safe service and build up gradually."

There was a recognition that aspects of the service needed to be improved. The owner told us that the loss of the registered manager had been a "Learning point." They had learned they, "Needed to be more involved." There was a positive attitude to develop and a willingness to support staff. The owner said, "I'm proud of what we have achieved so far."

The registered individual had been coming across from their sister home to lead staff in this interim period. They told us, "We have retained a good core team, a number of them have worked since the opening of the home and are committed to the people and this service." They had already started to look for the right person to be the next registered manager, and had replaced the activities co-ordinator who started the week after the inspection. Following the inspection, we were told of a new appointment and start date for the registered manager post.

People and their relatives had limited formal involvement in the service. In January 2018, a person had been elected as the chair of residents committee. There was an aim that this would, "Enable residents to have a voice." However, there was no record of any subsequent meetings or any actions. The registered individual said they would be talking to people on a one to one basis using the monthly review meetings and there was not sufficient interest in meetings at this stage. As the numbers of people grew this would be looked at. After the inspection, the provider also told us that a relatives meeting was to be held.

There was a user satisfaction survey started recently, which had relevant questions relating to CQC key questions, for example, "Are you treated with dignity and respect," and "Do staff respect your religious and cultural needs." There were also pictures and emoticons to help people complete these. The ones we saw indicated that people and relatives were mostly happy. There were a couple of negative comments on the surveys, about less staff at weekends and response times by staff to the call bell. There were some suggestions about activities and equipment such as getting a DVD player. We did not see any provider response made to this feedback. Following the inspection, the provider told us the negative issues had been addressed and there was a DVD player in the home. The registered individual said they would develop the use of the survey further under a new registered manager.

Staff involvement and engagement was being improved. Staff meetings were being planned as the last meetings had been held in June and July 2018. Staff we spoke with told us they felt well supported now, and that some of the recent changes in personnel were, "For the better." We heard staff felt more valued and their views had been taken seriously. For example, new systems, such as the medicines policy and

agreement, had been put in place. The 'resident of the day' had been re-introduced. This is a recognised method of ensuring each person's care and accommodation is reviewed with them monthly. One staff member said, "We are being listened to and supported to do our job."

There was a performance and development plan in place. The provider has commissioned an external audit in July 2018. This had identified risks and actions across the home, including administration, marketing, staffing care planning, communication and activities. Action had been taken in a good number of tasks, as previously noted, with medicines and safeguarding, the monitoring of accidents and the purchase of mini bus. A further example of key improvements were staff recruitment files, where information had been missing, we found these to be well ordered and the correct paperwork was in place. There was a progress report on actions that were underway or ongoing. This meant that the provider was already aware of the improvements we found on inspection that needed further work, such as staff supervision, activities and care planning.

The provider had a system in place for regulatory checks and to ensure risks to the quality of service are managed. These included a monthly audit of care plans, dignity, dining, housekeeping, kitchen, and medicines. These had been completed but not all had been signed by a manager to show that it had been reviewed and actioned. There was a separate log for the maintenance checks that were completed weekly or monthly. Evidence was sent of the most recent checks. The provider had on-site maintenance working across both of their care homes. They had a facilities contract in place for completing health and safety risk assessment and any related training that was required. The service had recently notified the CQC correctly of a safeguarding incident and were now aware of their responsibilities to do so in the future.

People told us they thought the place was well managed. For example, one person, said, "I'm very happy, I would go straight to the staff on the desk if I had any concerns. It seems to be run well, people are on the ball." Some people seemed unsure about who the manager was now, but we did not hear any negative comments about the leadership.

There was other evidence of service improvement. The service had signed up to the 'Dignity Challenge' a national movement that works individually and collectively, to ensure people have a good experience of care when they need it. The provider and staff pledged to uphold certain values and behaviours, such as to "Treat each person as an individual by offering a personalised service."

The service was developing partnerships with other agencies. The clinical director told us of their plans to make better links with commissioning bodies and local authorities and to market their home. They said, "Growth has been organic. We will assess people's needs as we grow and be flexible with staffing." We heard from a healthcare professional that the service, "Worked well with outside agencies and has built up some useful relationships." The registered individual told us they would also be, "Tapping into the local Care Home Support team going forward for relevant training.

We will review with the provider at our next inspection to see whether the improvements they discussed and identified are made and sustained.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not consistent in meeting the requirements of Mental Capacity Act 2005 (MCA). Consent to care and forms signed by relatives without any mental capacity assessment completed and no evidence that the relative held the legal powers to consent on the person's behalf.