New Century Care (Colchester) Limited

The Oaks Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced, comprehensive inspection on the 10 November 2016 to check that the provider had made the improvements required following our inspection on 15 June 2016.

During an earlier inspection in December 2015 we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was placed into Special Measures and we imposed a condition on their registration to not admit any further people into the service. We told the provider to take urgent action and kept the service under review, with the expectation that significant improvements would have been made within a six month timeframe.

At our inspection in June 2016 we found that robust and sustainable audit and monitoring systems were still not in place to ensure that the quality of care was consistently assessed, monitored and improved. The provider had failed to recognise and identify significant failings impacting on the quality of service provision, and risks to people. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 9 Person centred care, Regulation 10 Dignity and Respect, Regulation 12 Safe care and treatment, Regulation 14 Meeting nutritional and hydration needs, Regulation 16 Receiving and acting on complaints, Regulation 17 Good governance, Regulation 18 Staffing and Regulation 19 Fit and proper person's employed.

You can read the reports from our last comprehensive inspections, by selecting the 'all reports' link for The Oaks Care Home on our website at www.cqc.org.uk.

The provider had acted on our concerns and at this inspection we found that there was a positive, open and inclusive culture in the service. There had been significant progress made in making the required improvements, however there were some aspects of the service provision where further work was needed to ensure that safe and responsive care was delivered at all times.

The Oaks Care Home provides care for up to 61 people who are elderly and frail with complex needs that may include nursing and/or dementia related needs. On the day of our inspection there were 25 people living at the service.

There was currently no registered manager but an interim manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were still needed to protect people from the risk of infection. Some staff were observed providing care without using the appropriate personal protective equipment such as gloves and aprons.

Although significant progress had been made with the care plans we found that records were not always consistent. However, care plans were now person centred and reflected the care and support that each person required and preferred to meet their assessed needs.

People generally felt that there were sufficient numbers of staff to care and support people according to their needs. People and their families were positive about the care they received from staff who respected their privacy, dignity and independence.

Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. Staff were being encouraged and supported to have a greater understanding of how they could ensure a holistic approach to people's care. They had completed additional training to equip them with a greater awareness and understanding with regards to supporting people living with dementia.

There were improvements in the provision of activities. There were times when the opportunities for social interaction were more limited but this was being addressed with the introduction of an additional activities co-ordinator and the provision of further areas where people could meet together once the refurbishment work was complete.

There had been significant improvements in the way the kitchen was managed and monitored. There were also improvements in catheter and pressure care.

People presented as relaxed and at ease in their surroundings and told us that they felt safe. Staff knew how to minimise risks and provide people with safe care. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. People knew how to raise concerns and were confident that any concerns would be listened and responded to.

Suitable arrangements were in place for the management of medicines and staff had been trained to administer medicines safely. However, additional work was needed to ensure that there was clear guidance for staff relating to medicines to be administered 'as required.'

Staff understood the importance of gaining people's consent to the support they were providing. The management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. They were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

At our last two inspections we found widespread and significant shortfalls in the way the service was led. The provider had acted on our concerns and at this inspection we found that there was a positive, open and inclusive culture in the service. A comprehensive improvement plan together with a robust quality assurance system meant that shortfalls were being identified, addressed and used as an opportunity to drive continuous improvement

Although significant progress had been made in improving the service it was not possible for the provider to fully demonstrate the impact of the changes because of the short time they had been implemented for. The provider now needs to demonstrate that the improvements will be sustained and embedded in practice so that people can be confident they are receiving safe, effective and responsive care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were still needed to protect people from the risk of infection.

People generally felt that there were sufficient numbers of staff.

People were provided with their medicines in a safe manner. Additional work was needed to ensure that there was clear guidance for staff relating to medicines to be administered 'as required.'

Procedures were in place to safeguard people from the potential risk of abuse.

There were improvements in the managing and monitoring of the kitchen, pressure care and catheter care.

Is the service effective?

Good

The service was effective.

People received care from staff who had the necessary knowledge and skills to be competent in their role.

Staff understood the importance of gaining people's consent to the support they were providing.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

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

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people. People's independence, privacy and

dignity was promoted and respected.

Staff had a knowledge and understanding of people which meant their individual needs and preferences were being met.

People were supported to have choice, independence and control. They were listened to and supported to express their views and make decisions, which staff acted on.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans reflected the care and support that each person required and preferred to meet their assessed needs and promote their health and wellbeing. However records were not always consistent.

There were improvements in the provision of activities. However, there were times when the opportunities for social interaction were limited.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was well led.

The provider now needs to demonstrate that the improvements will be sustained and embedded in practice

At our last two inspections we found widespread and significant shortfalls in the way the service was led. The provider had acted on our concerns.

A comprehensive improvement plan together with a robust quality assurance system meant that shortfalls were being identified, addressed and used as an opportunity to drive continuous improvement.

The Oaks Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 10 November 2016 and was carried out by two inspectors, one of which was a pharmacy inspector, a specialist advisor who had knowledge and experience in nursing care, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public. We spoke with 12 people who used the service, six relatives and other visitors and received feedback from a health and social care professional who visited the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the interim manager, the clinical lead and the quality support manager. We also spoke with 11 other members of care, housekeeping and kitchen staff.

To help us assess how people's care and support needs were being met we reviewed 11 people's care records and other information, for example their risk assessments and medicine administration records. We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 15 June 2016 we found breaches in regulation about how the provider was protecting people against the risk of unsafe care. At this inspection we found that there had been progress in many areas however there were some practices within the service which needed further improvement.

Improvements were still needed to protect people from the risk of infection. In order to stop spread of infection we saw that staff used personal protective equipment (PPE), including aprons and gloves, when providing care and assistance for two people. There was PPE available outside one person's bedroom, however we saw some staff go in and out without wearing appropriate PPE. Before lunch the box of gloves was empty outside the bedroom of the second person. In addition, we did not always observe handwashing before or after direct contact with people. For example two staff after hoisting a person went on to answer two separate call bells without washing their hands. We also observed that one staff member had a visibly dirty tunic. These practices did not always ensure appropriate actions were taken to prevent the spread of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Oaks was undergoing an extensive redevelopment which meant a significant amount of building work was taking place in the home each day. General environmental risk assessments were in place and regularly reviewed however there had been no specific assessment carried out in relation to the building work. We spoke to the management team about this and they showed us the contractor's risk assessment document but acknowledged that this didn't include details specific to the people in the home and how the work may impact on their health and well-being. On the day of the inspection the management team put a risk assessment together which showed that potential risks had been considered and what control measures were in place to protect people. The management team demonstrated that this would continue to be reviewed by sending us an update in the week following the inspection.

People generally felt that there were sufficient numbers of staff to care and support people according to their needs. However, there were times of the day when call bells were taking longer to answer. We observed that one person had to wait several minutes to be taken out of bed and into the lounge. The same person had a delay in receiving their dessert. They told us, "I asked three different staff including the manager before I got my rice pudding without the jam." A large section in the middle of the service was shut due to the building works. People's rooms were either side of this and although staff could access the main corridor through this section the doors needed to remain closed in order to keep people safe. This made it more difficult for people and staff to move freely about the service and may have meant there were times when it took a little longer to get to people. This was being addressed in the next phase of the building work which was due to start within a month.

The management used a dependency tool to calculate the numbers of staff needed to meet people's assessed needs and this was reviewed each month by the management team. A member of staff said about

the staffing levels, "We are getting there, they are getting agency in more which is good."

Suitable arrangements were in place for the management of medicines. People's medicines were stored safely but available to people when they were needed. Staff had been trained to administer medicines safely and they were observed to ensure that they were competent in this role. Medicines administration records included allergy information, a photograph of the person to make sure they were correctly identified and guidance for staff on how each person preferred to take their medicines. The charts were signed to show that medicines were administered regularly.

Where a separate chart was used, for example for creams or medicines which were only given when needed, these were clearly cross referenced on the main chart. However some of the cream charts we looked at had not always been signed to confirm that the cream had been applied, particularly in the evenings. This meant we could not be certain whether the creams were being applied as prescribed.

Protocols were used to manage medicines to be taken when needed, for example for pain or anxiety, but the protocols did not always have sufficient detail to guide staff. For example one said that a medicine was "to help with pain" but didn't specify what type of pain or how the person would indicate that they needed pain relief. Staff who did not know the person well would not have enough information to assess whether the medicine was needed. This issue had also been raised at our previous inspection, we discussed this with the manager and work was started on this immediately.

There had been significant improvements in the way the kitchen was managed and monitored. A member of the kitchen staff said, "Since last inspection, we've worked really hard to get the kitchen up to standard." We saw that kitchen staff were keeping all relevant records in relation to cleaning schedules and food safety and these were checked daily by the chef on duty. There had been changes in the way the kitchen was staffed and following our last inspection the management team had initially monitored the kitchen daily to ensure acceptable standards of food hygiene were being maintained. This had been reduced to weekly monitoring once the management team were confident that the kitchen staff were taking responsibility for maintaining the new high standards. The local authority environmental health team had re-visited the service and confirmed they were happy with the improvements which had been made. This demonstrated that people were protected from the risks associated with the unsafe management of food and ineffective cleaning systems.

There were improvements in people's catheter care. Catheter care records included the date of insertion and showed that catheters were changed according to guidance. For example one person had recurrent blockages and their catheter changing frequency had been changed every four weeks to avoid blockage.

There were also improvements in people's pressure care. No one in the service had a pressure ulcer. Nurses told us that pressure relieving mattress pressure settings were checked twice a day. We checked three records and found them completed properly and set to ensure that people were getting their recommended pressure relief based on their weight so as to reduce the chance of developing pressure ulcers.

Risk assessments relating to people's care were reviewed regularly. Moving and handling assessments specified people's hoist sling sizes. Staff were aware of these and we found that people had individual slings in their bedrooms. Sling sizes were also on the handover sheets which staff could easily refer to. We checked people's bedrooms and found their slings were clean and the same size recorded within their care records. Staff waited for a second staff member before hoisting people to ensure they were transferred safely. New slings had been purchased and a member of staff told us, "There is now more equipment, more things we can use, slide sheets things like that. It's safer and better."

People presented as relaxed and at ease in their surroundings and with the staff. A relative told us, "I think [person] is safe here now and they look after [person]." A visitor said, "We think [person] is very safe here."

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received training in safeguarding adults from abuse. Staff understood the provider's policies and procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. A member of staff told us, "I'd go to management. At first I used to go to the nurses but now with the new management I'd feel I could go straight to them." They added, "You can also go to CQC."

Equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire and there was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

Employment records confirmed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the vulnerable adults who used the service.

Good

Is the service effective?

Our findings

At our last inspection in June 2016 we found that staff training and development programmes were in progress but had not yet been fully implemented. Training had not been sufficient in some areas to show that people's healthcare conditions were fully understood by staff.

At this inspection we saw that staff were now provided with a range of training to assist them to meet people's needs and preferences. A member of staff said, "I like to look at care plans then find out more, I ask 'can I have a bit more training on that?'" The quality support manager told us about additional training which had been arranged to take place in December 2016 including venepuncture, catheterisation, PEG feed and epilepsy. A member of the kitchen staff told us about a recent diabetes course they had attended and shared how what they had learnt helped them to provide a varied diet for those people who were diabetic. This demonstrated that staff were being supported to understand people's healthcare conditions in order to recognise and meet people's needs effectively and safely.

We had identified at our last inspection that there was a lack of awareness and understanding with regards to supporting people living with dementia. The management team had therefore arranged for all staff to receive additional training in this area with a number of staff also taking part in dementia friends, person-centred dementia care, and dementia virtual tour training. This was helping staff to empathise more fully with people living with dementia and have a greater understanding of their specific needs.

At our last inspection of 15 June 2016 we found that staff did not have easy access to the care plans and rarely read them. We found that significant progress had been made in relation to this. A member of staff told us, "We are being given new things to do, like reading the care plans. [Quality support manager] has given us a folder and we have to write down the resident's name, date and what we feel we've learnt. It's a massive help and will give everyone some knowledge." The interim manager explained how previously, "It had been very process orientated rather than thinking about outcomes. We are encouraging staff to think things through." They added, "Staff are proud to do it better now. Their sense of achievement when they recognise things about people, like someone likes green…it's beautiful." This demonstrated that staff were being encouraged and supported to have a greater understanding of how they could ensure a holistic approach to people's care.

Staff were receiving one to one supervision but these meetings were mostly only taking place in response to concerns. The management team explained how initially there had been a need to concentrate on supervisions taking place where poor performance had been identified but they were now working on putting a regular supervision programme in place. The quality support manager said, "We've been reactive now we are starting to be proactive." It was recognised that staff supervisions were important so that staff were supported in their role and given the opportunity to talk through any issues, seek advice and receive feedback about their work practice. This demonstrated that the provider was working to provide a support system for staff that developed their knowledge and skills, and which motivated them to provide a quality service.

The provider now needs to demonstrate that their staff training and supervision programmes are embedded and that this continues to be reflected in the positive way staff provide people with care and support.

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

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

Care plans contained a DoLS checklist for each person in order to establish whether an assessment and application were needed. Staff were aware of people subject to a DoLS and we saw that appropriate documentation had been completed in order to ensure that people were only deprived of their liberty when it was in their best interest to do so. Staff told us they always asked for consent before delivering care and we observed this in practice. One member of staff said, "We always ask, and if people refuse to have a wash or eat, we never force but go back at a later time and try and encourage them."

Staff had an understanding of what capacity meant. We saw comprehensive capacity assessments in place for specific decisions such as nutrition, continence and use of call bells. We observed that staff sought people's consent and acted in accordance with their wishes. For example, we heard one member of staff say, "[Person], the GP is here to see you. Do you mind if we go to your room then we can come back?"

There was an improvement in the way that people were supported with their nutritional needs. People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Records showed that guidance and support had been sought from relevant professionals to ensure that all people's dietary needs were being met. We reviewed records for one person who required specific assistance with their nutrition and found that the support was given as advised by the dietician. People's weights were regularly monitored to ensure that people were not at risk of malnutrition. Nutritional risk assessments were completed and people at high risk of malnutrition were referred to professionals for further advice and intervention. Fluid balance charts now had the recommended fluid intake for the day stated at the top and were totalled daily and signed by the nurse in charge to confirm that people had received their recommended fluid intake. This demonstrated that people could be assured that changes in their nutritional needs were monitored and appropriate action would be taken if necessary.

Lunch time was a positive experience for those using the dining room, there was a vibrant and happy atmosphere as people chatted together. Staff were available to support those who needed assistance. One person was having difficulties with their meal and a staff member noticed this, had a quiet word with them, then sat beside them and helped them to eat. Another member of staff noticed that a person's plate was too far away from them so pushed it closer so they could manage more easily. People were complimentary about the food on offer. The menus had been changed so that all food was fresh rather than processed. A relative said the food was, "Totally and utterly fantastic. There is a massive difference."

People were involved in deciding what they would like to eat and drink. The head chef had carried out a food survey to get people's views. A relative told us, "[Chef] had a meeting with me and [person] about [their]

requirements, [chef] went through it all. [Chef] checks with [person] and often brings [their] lunch to check it's ok. [Chef] has spoken to [interim manager] about it. That's important." There was a large board in the kitchen which displayed people's specific dietary requirements such as diabetic, pureed and fortified diets. It was also recorded that one person didn't like ham or cheese and another person liked a bigger portion. This showed that people's preferences were being considered and acted on.

People had access to health care services and received ongoing health care support where required. People were referred to appropriate health professionals such as speech and language therapists, dieticians and GPs. In one person's care plan we saw that blood pressure, temperature and pulse were repeated three times one afternoon for a person who was unwell and the GP informed.

Good

Is the service caring?

Our findings

The atmosphere within the service was relaxed and welcoming. One person told us "When I heard you were here, I've been thinking about what to say to you, and I can honestly say I can't think of anything I'd change, I'm alright here, and they look after me alright. All the staff are lovely."

People and their families were positive and complimentary about the care they received. A person told us, "They treat me well and are always smiling." A relative commented, "On the whole, [staff] are very attentive." Another relative said, "They always keep [person] lovely and clean and the rooms are lovely and clean."

Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. A person commented, "Staff are very good to me and listen." Staff had built a rapport with people and this was demonstrated in the warmth they displayed when engaging with them. We observed friendly banter between a person and a member of staff and the person told us, "We always have a laugh together."

People and their relatives had been involved with discussing their care and support needs. We saw in one person's care plan that it had been updated following a discussion with them and their family. People were encouraged to make their own decisions relating to their daily routines, where they would like to be and what they would like to do. We heard a member of staff ask a person, "Where would you like to sit?" A member of staff told us, "I've always said, someone tells me when they want to go to bed, they can say no, they can stay up until they want. Management are getting on top of that, everyone was going to bed the same time." They explained how this practice was no longer considered acceptable. Another staff member commented, "[People] tell us what they would like to do." This demonstrated that staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

People were encouraged to be independent. For example, we saw during meal times people had special crockery that enabled them to eat independently. One person said, "I go up and down as I please in my electric chair. All I need is a hand out of bed and then I can go about my business." A member of staff told us how they encouraged people to maintain their independence by getting involved in tasks around the service, "Sometimes residents come along and sit with me in reception, and I ask them to open the door when the bell goes and let people in, residents like to have a job, and they seem to like doing it."

Staff respected people's privacy and dignity. They knocked and waited for a response before they entered people's bedrooms and closed doors during personal care, and whilst hoisting people. Staff spoke with people in a polite manner and promoted their dignity by engaging with them at every opportunity. A relative told us, "Every single [member of staff] speaks to [people]. They don't ignore [people]."

In the part of the building where refurbishment work was almost complete we noted that people's daily care notes were kept outside the door of people's bedrooms. We were concerned that this was a breach of confidentiality and did not respect people's privacy. We discussed this with the management team who told us that this was a temporary measure and new holders for the records were being fitted in people's

bedrooms. They acknowledged that keeping records in a communal corridor was not best practice and agreed to move them into people's bedrooms.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that improvements were needed to ensure that care plans reflected all of people's current physical, psychological an emotional needs.

Although significant progress had been made with the care plans we found that records were not always consistent. For example, one person's 'This is me' document was undated and said they wanted to go to bed at 4.30pm whereas their care plan said they went to bed between 6pm and 7pm. Another person's night time care plan documented the person liked to talk to their relative before bed. However, this was no longer correct as their relative had recently passed away. Staff had been inconsistent in the way they had completed some records such as those recording the delivery of personal care. The form asked that staff initial when care had been given but the majority were only ticking. This meant it was unclear who had provided the person with the care and support which meant it would be difficult to check with them should any concerns arise regarding the person's health and well-being. We discussed this with the management team who acknowledged that now they had made improvements to people's care records these needed to be checked for consistency to ensure people were receiving care according to their current needs and preferences.

Personal care profiles which included a summary of people's support needs in daily record files were not completed in three of the six we looked at. We also discussed this with the management team who told us that these were new documents which had only been put in place that week and they planned for all of these to be completed as soon as possible.

Care plans were now person centred and reflected the care and support that each person required and preferred to meet their assessed needs. For people living with dementia additional details had been included in their care plans such as how dementia was affecting the person, what was usual for them and what could alert staff that something was wrong and they needed additional support. This helped staff to understand the specific needs of people living with dementia.

Information was also provided to guide staff regarding other specific health conditions such as epilepsy or diabetes. Staff were able to tell us how they managed these conditions to keep people safe and well, for example they were clear on the action they would take should someone have a seizure due to their epilepsy. Care records showed that blood glucose levels were monitored for people living with diabetes and included specific instructions of what staff should do should the result be too high or too low. A member of staff confirmed, "We give a sugary drink and recheck the blood sugar if it's too low and withhold diabetic medicines. We also let the GP know and they may review medicine if required." This demonstrated that people's care plans provided staff with the information they needed to provide safe and effective care. Staff were aware of this guidance and used it to help them respond to changes in people's needs.

Care plans reflected people's preferences such as whether people preferred care to be delivered by staff of particular gender. Sexuality and religious and cultural preferences were also addressed in the care plans we reviewed. 'This is me' documents recorded people's history, likes and dislikes and things which were

important to them. Care plans could be further strengthened with the addition of further details regarding people's goals and aspirations to guide staff in promoting independence, choice and control.

People and their families told us they received personalised care which was responsive to their needs and their views were listened to and acted on. A person expressed how they were happy with the support they received and told us how they had recently been asked to be involved with writing an advertisement to recruit new staff. They had suggested that the advertisement read, "Angels wanted to join those already working at The Oaks care home."

At our last inspection we found that there were limited resources to assist in the delivery of meaningful activities for people who were living with dementia. At this inspection we noted that in one corner of the main communal area was a large selection of new activity materials such as puzzles and painting. We asked the relative of one person whether these were used and they told us, "I think they use the stuff." They added, "[Activities co-ordinator] involves everyone. The other day [activities co-ordinator] had a bowl of Christmas cake mix. [They] let everyone have a stir and make a wish."

There were a range of activities taking place throughout the week. There was a vibrant atmosphere in the main dining area when activities were taking place during the afternoon. A group of people joined together with the activities co-ordinator to take part in a beetle drive and we saw that they were enjoying their time together. The activities co-ordinator generated conversations with different people around the table and they chatted to each other as they played the game and sung along to the music which was playing. One person was brought into the dining area by staff on their bed so they could also join in. Another person preferred not to take part but instead sat at a nearby table painting. We asked a relative whether there was a similar atmosphere each day and they confirmed, "In the afternoons. Oh yes, it's brilliant."

People were able to choose what activities they took part in. One person said, "I can do my own thing here. I like to read, and have lots of books. I also come outside into the garden for a smoke when I want to." Another person told us, "I enjoy going to the main room. There is usually something on in the afternoon. Sometimes I join in other times I just watch."

A member of staff told us, "We had a great Halloween night, when the staff dressed up and we had various games and things to eat. It was great fun for the residents. We're all looking forward to Christmas now and we have arranged the Christmas decorating Sunday on 4th December when we decorate the home and make decorations for Christmas." A person confirmed that Halloween was a, "Great night."

Some people demonstrated that they felt there were times in the day when there was a lack of stimulation for people in the communal areas of the service. During the morning one person remained on their own for much of the time in the lounge area. They appeared restless and we heard them say to others at lunchtime, "They put me downstairs and all I've done is watch the television." They repeated this again a short while later. We discussed this with staff who told us that during the quieter times of the day the activities co-ordinator spent time with people on a one to one basis. A member of staff told us, "[Activities co-ordinator] will go in [to people's bedrooms], [staff] will go in and have a chat." They added that at tea time "A lot do prefer to stay in their room, they've got the option. After activities they like to get back to their rooms." The activities co-ordinator told us, "We do lots of one to one activities here, like take people out for walks in their wheelchairs." Activity records showed that a person who preferred to stay in their bedroom had been involved in one to one sessions at least four times a week.

Due to the refurbishment work there were less communal areas available than usual where people could meet together throughout the day. We discussed this with the management team and they shared with us

the plans for improved facilities as the refurbishment work was completed. A new lounge area with a small kitchen attached was already available for people to use to do cooking activities and a further additional lounge area was to be provided. An additional activities co-ordinator had been employed and a member of staff confirmed, "[New activities co-ordinator] is going to start doing things at weekends…like cooking." The activities co-ordinator on duty told us, "I have a budget for activities, and the manager lets me do whatever I like. I'm looking forward to when the building work is completed and we can use the new recreation areas. I think the new cinema room will be used, as they all like a nice film."

The refurbishment work was also providing some disruption to other areas of the service's operation. For example, a relative told us how some clothes seemed to take a long time to come back from the laundry. There was a large box of this person's clothes in the laundry room waiting to be returned to them. A member of staff commented, "It's a long way down the corridor to the resident's rooms, it's quite a trek and the baskets are quite heavy." There were also some on-going problems with the heating in some areas. One person told us, "The [staff] look after me OK, but I've been cold here today, the radiators aren't working again." The person's relative said, "I've mentioned it and they're sorting it out." However they also added that, "It's a regular problem." We asked staff about the issue and they confirmed that there had been issues caused by the building work and they were doing their best to resolve these. We saw that staff were releasing air from the radiators in order to alleviate the problem however the provider needs to make certain that people are kept warm and comfortable at all times and additional work may be needed to ensure this.

At our last inspection we found that concerns and complaints were not always responded to in a timely manner. At this inspection people and their relatives told us there were improvements in the way that concerns and complaints were managed and responded to. One person said, "I don't hesitate to say if I have any concerns. They deal with them straight away." A relative told us, "Complaints or issues are listened to. They do take on board what I have said in the past."

There was a complaints procedure in place which explained how people could raise a complaint. Records of complaints showed that they had been responded to appropriately and in a timely manner. For example, records of one complaint showed that a number of actions had taken place as a result including a meeting with the relative making the complaint, a discussion with the person involved to clarify their thoughts and preferences, care plans and documents had been updated and discussions had taken place with staff to address the issues raised. A relative commented, "Now they follow up on them [concerns], you see [interim manager] around, you see [quality manager] and [area manager] when [they] are here." This demonstrated that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right. The management team also used these concerns as an opportunity to learn how things could be done better in the future and shared what they had learnt with the staff in order to continually improve the standard of care provided.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections in December 2015 and June 2016 we found widespread and significant shortfalls in the way the service was led. There had been a lack of managerial oversight at all levels and a failure to recognise and identify significant failings impacting on the quality of service provision.
The provider had acted on our concerns and at this inspection we found that there was a positive, open and inclusive culture in the service. A relative commented, "It feels a happy environment, a happy place." They added, "I've seen such a difference. I wasn't surprised at the rating before. It's better now, I know it is because I see it."

People and staff told us the management team was approachable and had implemented a lot of positive changes. One person said, "[Interim manager] is very good and leads by example." Another person said, "[Interim manager] is around most times and sometimes very early in the morning." A staff member said, "I have been here for 10 years and this is the best it's ever been in terms of management." Another staff member said, "Yes management are very supportive. The manager is in early in the morning and joins in the handover." There was a newly appointed clinical lead who told us they were supported by the current interim manager and the quality support manager.

Staff felt that they were now being supported in their role and their opinions were valued. One member of staff told us, "[Management team] are definitely getting on top of things now. It's a big change. New management is pulling things together, you feel there is always someone to go to, [management team] are really good. Staff morale is much better, we are working better, teamwork is much, much, better." Another staff member said, "It's so different here now, it's a nice place to work." They added, "I've been here for 12 years now, and I can honestly say it's the best group of people to work with now."

The interim manager told us how they had been working with the staff team to encourage them through the changes. They said, "I come in to handle handovers six days a week. When I started here, the staff were quiet and sat in two groups, nurses one side, carers the other, but I've mixed them up a bit and now everybody is involved and speaks up. It's no longer a quiet meeting, staff are involved. I've worked hard to empower the team into making decisions for themselves."

The management team monitored accidents and incidents which occurred in the service to ensure they were investigated and appropriate actions taken. For example, one person had fallen three times and records showed that they had been closely monitored after each fall. In addition, actions had been taken to reduce the risk of the person falling again such as a referral to the falls team and appropriate equipment put into place following assessment. A relative told us they were confident that the management team had taken appropriate action following a specific incident. This had included the involvement of the local authority safeguarding team, internal investigations and disciplinary action being taken. They had been kept informed throughout the process and told us, "[Quality service manager] is completely transparent. I'm very impressed."

The provider's action plan in response to the inspection in December 2015 had stated that daily meetings

were to be held with heads of departments to highlight people with changes in need and to inform work for the day. However, at our inspection in June 2016 we found that these had not been occurring with any regularity and so the management team had missed opportunities to improve on the service provided. At this inspection we saw that these meeting were now taking place five days a week which was aiding in communication and assisting staff to be aware of people's current support needs. The interim manager also carried out weekly walkabouts where they could observe and share best practice with the staff. A member of staff confirmed, "There have been lots of improvements in the way we do things."

The provider had put together a comprehensive improvement plan which was regularly updated as changes were being made within the service and as other areas requiring improvement were identified. This was a working document which the management team frequently consulted and actions were taken as a result of it.

To supplement the improvement plan, robust quality assurance systems had been put in place to identify shortfalls and to drive continuous improvement. These included daily and weekly monitoring by the interim manager as well as monthly monitoring of all areas of the service's operation by the quality support manager. Quality performance indicators were produced and analysed each month to review any trends of concern. Areas monitored included, occurrence of infections, falls, dependency trackers for each person to assess staffing levels, medicines errors and monitoring of people's weights. Where concerns had been identified appropriate action had been taken. For example, it was noted that one person's weight was falling so this was being observed so that a referral to the appropriate healthcare professionals could be made.

Audits of care plans had resulted in changes being made to ensure that people were receiving continuity of care and were not at risk. For one person the audit had identified that they needed a specific prevention of pressure ulcers care plan. We saw that this was now in place.

Where areas requiring further improvements were still needed, the management team were open and transparent throughout the inspection and responded immediately to the concerns we raised. The refurbishment work was providing challenges however the management team were confident that the improvements which were being made would have further benefits for the people using the service. A relative commented, "The new decoration is lovely, and it's all very fresh for [person]." A member of staff said, "The refurb is making everyone happier. It lifts everything."

The management team were continuing to work with the staff team to help them to understand and share the culture, vision and values of the service in its main objective to provide high quality care and continued positive life experiences to those who used it. Although significant progress had been made in improving the service it was not possible for the provider to fully demonstrate the impact of the changes because of the short time they had been implemented for. The provider now needs to demonstrate that the improvements will be sustained and embedded in practice so that people can be confident they are receiving safe, effective and responsive care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Improvements were needed to protect people from the risk of infection. Regulation 12 (2)(h)