Bupa Care Homes (CFHCare) Limited

Chilton Meadows 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Chilton Meadows Care Home provides accommodation, nursing and personal care for up to 120 older people some of whom may be living with dementia and/or have complex nursing needs. People were accommodated across four houses named Beech House, Munnings House, Gainsborough House and Constable House. At the time of our inspection there were 84 people using the service. The service is situated on the periphery of the town of Stowmarket in Suffolk.

Chilton Meadows Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. This inspection took place on 6 and 13 February 2018 and was unannounced.

The registered manager had already left the service in August 2017 and was working at another location for the provider company. The replacement manager had commenced their role at Chilton Meadows in August 2017 but had not yet registered. They had only just started the process to apply to do so. We have referred to this person as the home manager throughout this report. A registered manager is a person who has registered with CQC 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.

At our last comprehensive inspection in January 2017, we found that improvements were needed to the safe management of medicines. We found improvements were also needed to ensure that all staff received medication training and their competency in this area was assessed. Suitable arrangements were needed to ensure that all staff received regular formal supervision and an annual appraisal of their overall performance. Minor improvements were required to ensure particular decisions which had been made in people's best interests were recorded. Work was required to ensure that people's care plan documentation was accurate and up-to-date and that people had opportunities to lead meaningful lives and to participate in social activities of their choice. We also found that work was required to ensure that appropriate infection control practices, policies and procedures were applied and also that auditing arrangements demonstrated where actions required had been addressed.

We received an action plan from the provider telling us the improvements they were making to meet regulatory requirements. We rated the service 'Requires Improvement' overall and in all of the key questions we ask. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chilton Meadows Care Home on our website at www.cqc.org.uk

At this inspection in February 2018, we found that whilst there was progress at the service, there was still further work to be completed. Improvements continued to be needed to the safe management of people's medicines. Notifications of events and incidents were not always submitted in accordance with statutory regulations. Registered managers and providers are required to submit to CQC statutory notifications in

accordance with regulatory requirements however we found a number of serious injuries and potential safeguarding incidents that had occurred at the home which we had not been notified of. We also found whilst risk assessments were in place, improvements were needed to how staff responded to emergency situations such as falls, to ensure they followed the guidance within people's care plans.

Staff were able to recognise signs of abuse should they occur and knew how to report concerns if they suspected a person was at risk of harm. There was a complaints procedure available in the service for people and relatives to raise concerns.

People received effective care from staff who had the skills and knowledge to meet their needs. Staff monitored people's health and well-being. People had access to healthcare professionals according to their needs.

People were cared for by staff who were observant and ensured people were comfortable. People told us, and we saw, that staff were kind and caring.

Staff knew the needs and preferences of the people they cared for and people were given reassurance and encouragement when they needed it. People's rights to privacy, dignity and independence were taken into account by staff in the way they cared for them.

People and their relatives felt the service was well managed and acknowledged the improvements that had been made to date. There were clear lines of accountability. Each of the individual houses had managers in post who were supported by the overall management team on site. There were quality assurance audits in place. However the system was not always effective because issues identified at the inspection had not been recognised during the monitoring and auditing process.

We found the service was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

Improvements were needed to the management of medicines.

Improvements were needed to way staff responded to any accidents or incidents.

Staff were aware of safeguarding procedures and were able to describe what to do if they felt people were unsafe.

Staff observed safe infection control practices.

Is the service effective?

Good

The service was effective.

People received effective care from staff who had the skills and knowledge to meet their needs.

People received sufficient food and drink to meet their needs.

People had access to a range of healthcare professionals, as needed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

People's care was planned with them

People's rights to independence, privacy and dignity were valued and respected.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and provided staff with sufficient information to enable them to meet people's needs.

There was a system in place for acting on complaints and feedback.

Staff recorded people's wishes about their end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications of events and incidents that occurred were not always submitted in accordance with statutory regulations.

The quality monitoring arrangements were not fully effective. They had not identified the concerns and shortfalls that we identified at this inspection.

Regular meetings took place to involve people, relatives and staff in the running of the service.

Chilton Meadows 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 inspection took place on 6 and 13 February 2018 and was unannounced. The inspection team consisted of two inspectors on both days of the inspection. On 6 February 2018, the inspectors were accompanied by two 'experts 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. On 6 February 2018, the inspectors were also accompanied by a member of the Care Quality Commission's medicines team and a specialist advisor. The medicines inspector's role was to specifically look at the safe management of people's medicines. The specialist advisor, who was a trained nurse, looked at people's nursing care needs.

Before the inspection, we requested that the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider.

We also reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We also sought views from commissioners who funded the care for some people and the local authority's Provider Support Team.

We looked at the care records of 10 people in detail to check they were receiving their care as planned. We also looked at other records including staff recruitment files, training records, meeting minutes, medication records and quality assurance records. We spoke with 21 people who live at the service, 23 members of care staff, three nurses, the activities co-ordinator, the chef, the head housekeeper, the clinical services manager

and the home manager. The provider's regional director was also present on both days of our visit. We spoke with relatives of 18 people currently living in the service. We also spoke with two healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in January 2017, we were concerned that although staff followed safe procedures when helping people with their medicines, the morning medication rounds did not complete until late morning on two out of four houses. At that inspection, we advised the management team of this who gave us assurances that the time taken for staff to administer people's medication would be reviewed for the future.

At our last inspection, we were concerned that medicines were sometimes not administered in a timely way. We were also concerned that staff training in medicines management was not up to date and they had not had their competence assessed. At this inspection, we found that the safety of systems for managing medicines had improved but further work was needed. We found at this inspection that this area still needed improvement.

During our visit we observed a member of staff who followed safe procedures when giving people their medicines. However, we noted the morning medicine round, particularly on Constable House continued to be lengthy so people did not always get their medicines at the times scheduled and intended by the prescribers. This meant that some medicines scheduled with multiple daily doses may not have been administered at safe and appropriate intervals. On another unit, we found a capsule in a person's room that had not been taken and were concerned that staff may not have followed safe procedures to ensure it had been ingested by the person.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. There were internal audits in place to enable staff to check records and monitor and account for medicines. Recent errors had been identified and reported to the manager; however, we found further gaps in records, including some related to the first day of our visit, where records did not always confirm that people were receiving their medicines as prescribed.

Some supporting information was available to staff to enable them to give people their medicines safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on people's preferences about having their medicines given to them. Additional charts were in place to record the application and removal of prescribed skin patches and these had been completed by staff. There were care plans in place about people's medicines. However, when people were prescribed medicines on a when-required basis, written information was available for some but not all medicines prescribed in this way. We also noted that further work was needed to ensure more detail was supplied for medicines prescribed to be given 'when required'. This included those that were used to treat people's psychological anxiety and distress and for pain-relief medicines particularly when more than one was prescribed in this way. This is to ensure they were used consistently and appropriately.

For people who had limited mental capacity to make decisions about their own care or treatment and who refused their medicines there were records of assessments showing they lacked mental capacity. There were also records of wider consultation with their doctor and advocates to give them their medicines given to

them crushed in food or drink (covertly). However, for one person their written plan about this was in need of review and for another person an agency member of staff who was on duty was unable to clarify to us if the person was to have their medicines covertly.

The concerns with safe medicine management that we found at this inspection were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were seen around the assessing of staff competence to administer people's medicines safely. Members of staff employed at the service who were handling people's medicines had received training and had their competence regularly assessed since our last inspection.

Each person's care plan contained information about their support needs and any associated risks to their safety. Guidance was in place about any action staff needed to take to make sure people were protected from harm. Risk assessments were completed in areas such as moving and handling, nutrition and skin pressure care. Whilst we found that, in the main, the risk assessments in place were followed by several staff, there was one occasion during the first day of our visit when the risk assessment for a person was not followed by staff. The falls risk assessment stated that if the person were to fall, after initial checks and if safe to move, they should be assisted to get up from their fall using a hoist. During our first visit, the person had a fall and was moved back to their bed by staff without using the hoist. This person had been injured by their fall and it was later established they had sustained a fractured bone. Whilst the actions of the staff did not cause the fall or fracture there was a failure by staff to follow the correct procedures in place. We asked the service manager to investigate our concerns. After our visit they informed us they had reviewed the practice of staff and had established that the correct action had not been taken and in hindsight the staff involved stated they would take different action if faced with the same situation again.

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

People told us they felt safe living at the service. One person said, "Yes I do feel safe, everybody is kind – they're (staff) always there when I need them." Another person told us, "They keep the door ajar [as I like] and they check me regularly at night and in the day time." A third person said, "I feel safe, there is always someone you can call and when in bed I have a bell to use."

Staff were aware of how to identify potential safeguarding concerns and had attended training in safeguarding vulnerable people. Staff we spoke with were aware of types and signs of possible abuse and their responsibility to report. Staff knew who to report any concerns to and had access to the provider's safeguarding and whistleblowing policy.

On the whole, people were positive that there were sufficient staff to meet their needs in a timely manner. We did receive some comments from some people that they had to wait at times for staff to come to them; however these comments were in the minority. One person told us, "As far as I'm concerned there are [enough staff]." Another person told us, "They're [staff] always looking about, if anyone's looking a bit distressed they go over to them straight away." A third person said, "They [staff] come quite quickly, breakfast and lunchtime when people want the toilet you can wait, but they say 'can you wait a minute?' and they come back. Weekends they have different staff, they seem okay and are nice [staff], nights you don't wait too long, the waiting time is about right." Relatives were also mainly positive about the staffing levels. One relative told us," Always got enough staff, really nice and friendly here and everyone sings along to the music (playing at lunchtime) it is nice and jolly."

We saw that across all of the houses staff were busy but were available in the communal areas and they responded to people's requests and had time to talk with people. We found medicine rounds were lengthy particularly on Constable House. The nurse on this house was busy assisting people with their medicines and was carrying out this task for long periods of time. This reduced the number of staff available to help people with other tasks including their morning personal care. The feedback that we received from staff working on Constable House confirmed our observations. One member of staff told us, "Often they [people] are not all up until late. Yesterday it was 11.30am and today they're still not quite all up at 11am."

We raised the variable feedback we received about the staffing levels with the home manager who told us they were actively trying to recruit new staff to the service. They told us about plans they had for recruitment open days in an attempt to attract new care staff. The home manager also told us they had recognised some of the staffing challenges and were in the process of recruiting additional nursing staff to be on shift on Constable House. The home manager also told us that they had taken a decision not to admit any more people during the week to enable them to be sure staff could meet the needs of the people already living at the service.

Staff records confirmed the provider had undertaken pre-employment checks to ensure potential staff recruited to work with people were suitable. The provider requested references from previous employers, asked the staff for proof of identity and eligibility to work in the United Kingdom. A full employment history was obtained and each employee consented to having checks on them for any criminal records from the Disclosure and Barring Service (DBS). The DBS helps employers ensure people they recruit are suitable to work with vulnerable people who use care and support services.

Staff received infection control training and understood their responsibilities in relation to infection control and hygiene. Staff across all houses that we spoke with were clear on the infection control protocols and practices in place. Staff we saw used protective equipment, such as gloves and aprons and we observed frequent hand washing. Cleaning schedules were in place and housekeeping staff were aware of their responsibilities around infection control. There was a head housekeeper in place who managed a team of eight housekeeping staff. We spoke with the head housekeeper who told us about the cleaning schedules that were completed on a daily and weekly basis. We observed cleaning trolleys were not left unattended and chemicals used were not left exposed. One relative told us, "[Service] looks alright to us, [person] is in bed the whole time, their room is clean and tidy, no smells." A visiting healthcare professional commented, "[Service] seems very clean and smells fresh."

The home manager told us they learnt from incidents and if things went wrong and made improvements following these. All accidents and incidents were recorded and analysed. The system that the provider used meant that any incidents were entered onto a computer system which was accessible and monitored by the provider health and safety team. The analysis considered whether things could have been done differently to prevent the accident or incident and feedback provided to the management team at the service.

Good

Is the service effective?

Our findings

At our last comprehensive inspection in January 2017, we found that improvements were needed to ensure staff had the training they needed. Agency staff were not fully inducted to the service and the frequency of staff supervision needed reviewing. We were also concerned that decisions being made were not always discussed with the person or those with legal authority acting on their behalf. The provider was unable to demonstrate that actions were being taken in the person's best interest and the least restrictive option available. We rated this key question 'Requires Improvement' at that inspection.

At this inspection we found that improvements had been made and as a result we have rated this key question 'Good'.

People received effective care and support from staff who had the skills and knowledge to meet their needs. People's relatives were positive about the knowledge of staff and their ability and skills to meet their needs. One relative we spoke with told us, "Staff answered everything I wanted to know [about family members care]." Another person's relative said, "I can speak to the staff and they answer my questions." A visiting healthcare professional told us, "Seems fine [staff knowledge], I phone up and they [staff] know who I am talking about, family seem happy with the care and staff. Staff are approachable and friendly. Receptionist knew immediately who I was talking about; they were friendly, approachable and wanting to help."

New staff and agency staff received an induction into the service to make sure they understood about people's needs and the provider's policies and procedures. One member of staff who had recently commenced employment at the service told us, "Everyone has been great. I've been really welcomed." They also told us they had a detailed induction programme which included a dedicated week for training covering all the essentials they need to know. They added, "It was really good."

Staff told us they received regular supervision. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff or manager. A staff member we spoke with said, "Yes I get supervision regularly with the person in charge of the house I work on and records are kept."

Staff told us and records confirmed that they attended training including, medicines management, fire safety, moving and handling and safeguarding. Staff we spoke with told us they found the training helpful and informative. One member of staff said, "We had fire training refresher yesterday. They make it fun, but you learn at the same time." They also told us about some training they had undertaken to help staff experience and understand what it like is to live with dementia.

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 so that they can 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 in line with the MCA.

At our last inspection, we were concerned that decisions being made were not always discussed with the person or those with legal authority acting on their behalf. The provider was unable to demonstrate that actions were being taken in the person's best interest and the least restrictive option available. We found at this inspection, that improvements had been made.

The registered manager had an understanding of the Mental Capacity Act and worked in partnership with relevant authorities to make sure people's rights were protected. The provider had made applications to the local authority for DoLS when needed. Where people lacked capacity the service followed the principles of the MCA and made sure that any decision was only made in the person's best interests. When a person was unable to make a decision then relatives, health professionals were involved to make sure decisions were made in the person's best interest.

Whilst they didn't all have a good understanding of the MCA legislation, overall staff had a good understanding about the importance of getting consent before assisting people with daily care and were able to explain how they communicated with people when they lacked capacity or were unable to verbalise. Staff supported people to make their own decisions and respected them wherever it was safe and possible to do so. One person's relative told us, "Yesterday [person] dressed themselves; they had two sets of clothes on. They [staff] said they were going to keep an eye on them, and help them to change [if they got too warm]." Another person's relative told us, "They're [staff] good to [person], talk to them nicely, if [person] says they don't want to get up they give them breakfast in bed and then get them up when they want to – they talk to them."

We found that in some instances, staff were told by people's relatives that they had a 'lasting power of attorney' (LPA) in place for their family member and therefore the legal authority to make certain decisions on behalf of their family member. For some this was correct. However other relatives did not. Staff however did not have access to this information to establish if the relatives' claims were correct. An LPA is a legal tool that gives another adult the legal authority to make certain decisions for a person, if they become unable to make them for themselves. This information should be readily available to staff so they can confirm legal rights.

People's needs and choices had been assessed in line with current legislation and good practice guidance. The home manager or senior staff such as the clinical lead or registered nurses met with people before they moved to the service to review and discuss their needs and determine whether these could be met by the service. The assessments were clearly recorded and incorporated information about their preferences and wishes.

People's nutrition and hydration needs had been met and effective monitoring was in place to sustain good health. People were offered choices of food according to their needs. In communal areas of the individual houses there were baskets of snacks that people could help themselves to whenever they wanted. We saw staff offered people snacks throughout the day. One person told us, "I enjoy a little snack like that [small muffin], it's easy to eat." We observed throughout our visits people being offered drinks and having access to fluids. People who required assistance with drinking also received this frequently.

We observed lunch being served in a selection of dining rooms across the four houses and found that the

meal times were relaxed and people who required assistance with eating and drinking were assisted so in a respectful and sensitive manner. People were complimentary about the food and the choices available to them which were based on their preferences and requests. One person told us, "It is very good here, the menu is good, a good service. I like a boiled egg for tea and said I wanted it soft and I got two. They were soft and my bread was cut up into fingers, they were very good." Another person told us, "I like the breakfasts best; you can have eggs, bacon which I mainly do. At tea time there is sandwiches, soups and a little special dish like quiche or cauliflower cheese."

We spoke with one of the chefs at the service. We found that they knew about people's dietary preferences and were knowledgeable about how good nutrition could help people's overall health. Details were kept in the kitchen of any specialised diets that people required which enabled the kitchen staff to ensure they were providing specific foods that people required or requested. The chef told us that special occasions and events were also marked. The first day of our visit was Shrove Tuesday and so the chef had cooked 84 pancakes to ensure there were sufficient for everyone. They told us that on the 14 February they were preparing a special Valentine's menu for people and their guests. They told us they were offering a menu consisting of home baked bread rolls, soup, and steak marinated in red wine or chicken in white wine and a dessert of white chocolate cheesecake. As a result the kitchen staff were catering for an additional 23 guests that people had invited themselves.

People's healthcare needs were met and staff supported people to access healthcare professionals as needed. Joint working between healthcare professionals and staff was evident through the effective record keeping of healthcare professional's recommendations and follow up actions. One person told us, "I can see a doctor when I want one, optician comes here sometimes and I see a chiropodist here." People's relatives were confident that appropriate healthcare referrals and contact was made when needed to ensure their family member was supported to maintain good health. One relative told us, "Doctors seem to be here regularly, three times a week, we always get a response back [after GP visit], we always get a phone call to keep us up to date." Another person's relative told us, "Yes, they [staff] understand, if [person] has an infection and I know straight away. I tell the nurse and she gets a doctor in straight away."

We looked at the design of the premises. Chilton Meadows is set out over four individual houses supported by a central building where the catering and facilities management functions took place. Individual houses were in the main well decorated and maintained. Houses primarily caring for people living with dementia contained lots of visual items of interest such as murals and objects to look at and feel secured to the walls. People had private rooms that were generally of good proportions and benefited from good natural light. Whilst not all people had en suite facilities there were adequate communal bathroom facilities that were well maintained. Large visual signs were present on all doors leading to toilets and bathrooms in the communal areas. Some of the carpeting in some houses required replacement due to sun fading and staining. However, the home manager told us that there were already plans in place to address this. We saw walkways in the communal areas were free of obstruction and there were no steps or slopes for people to contend with. The service would benefit from further improvements to personalise signage and people's rooms. We recommend the provider consider best practice guidance on dementia friendly environments in these areas.

Good

Is the service caring?

Our findings

At our last comprehensive inspection in January 2017, we found that improvements were needed to ensure that staff interactions on two out of the four houses at the service were person centred and not task and routine led. As a result we rated this key question 'Requires Improvement'. We found at this inspection that improvements had been made and have rated this key question 'Good'.

People told us they liked living in the home and that staff were kind towards them. One person told us, "The staff are very, very nice, they make me very happy." Another person told us, "The [staff] are lovely, [they] join in, laugh with me." Relatives also spoke about the caring nature of the staff and their approach. One relative said, "They are [staff] excellent, they just can't do enough, for us too – they're all lovely, we can't fault it at all. The level of the care is excellent, over and above most of the time."

Staff spoke affectionately about the people they cared for and supported at the home. People were cared for by staff who were very kind and caring. We observed numerous occasions throughout our visit of staff displaying warmth and consideration towards people. On one occasion, we saw a person becoming distressed. A member off staff went straight over to the person and knelt down so their face was level with the person's. The member of staff gently put their hand on the person's arm and spoke kindly. In response the person calmed down and became settled. Many staff told us how much they cared for the people they were supporting. One staff member told us, "I love working on Munnings House, I love [people] and I really do enjoy coming to work." Another member of staff said, "'I'm here for the people. I love them to bits."

People using the service and their relatives told us that they had been involved in making decisions about their care. They explained that they had discussed their needs and preferences with the previous registered manager or care staff and nurses when they first moved to the home. One person told us they chose how they wanted their care delivered. They said, "Staff are very cooperative. I have my bath in the morning, you have it when you like." Relatives told us that the staff continued to keep them informed about their family member's care. One relative said, "They'll update us, tell us how [person's] been."

There were meetings for people and their relatives. We saw from previous meeting minutes that people who attended the meeting were kept informed of any changes happening at the home and also had the opportunity to ask questions and make decisions. People's relatives told us that they were able to visit their family member at any time and they were always made to feel welcome

People were supported to maintain independence where they were able. Care plans described when people had the skills and abilities to do something for themselves. One person told us, "The carer washes me, I can do some myself – I have a shower now and again, I don't like baths. I'm happy." One relative said, "When they're [staff] helping [person] up they support them without leading them, [they are just] an arm to hold on to." Another relative told us, "Last year [person] wasn't walking; now they're walking with a frame."

Systems were in place to ensure people's privacy and dignity was upheld. For example, people had their own rooms and doors were closed when personal care was being delivered. People also confirmed they

were treated with dignity and respect and that their privacy was maintained. One person told us, "Yesterday morning I had a bath, mixed [gender] carers but does not matter to me, they always shut the door." A second person told us they received their care with dignity and had their choice of carer gender respected. They said, "Bath as often as you like, female carer and I like that, they are definitely respectful."

Good

Is the service responsive?

Our findings

At our last comprehensive inspection in January 2017, we found that improvements were needed to ensure care provided by staff was responsive to people's needs. We also found that improvements were required to ensure that all people living at the service received appropriate social activities to meet their needs Additionally we also were concerned that some people's care plans did not provide sufficient detail and were not a fully reflective or accurate picture of people's care needs We rated this key question 'Requires Improvement' at that inspection. We found at this inspection that improvements had been made and have rated this key question 'Good'.

People and their relatives told us that they received care that was responsive to their needs and enabled people to make choices that were respected. One person told us, "[I've] got no complaints, no restrictions, do what you like, visitors at any time." A second person said, "They showed me around, I asked lots of questions and am very pleased as I was lucky enough to choose this place." A person's relative told us, "It is lovely, [family member] is a different person, brighter, talks a lot better, the place and the staff have made a difference. [Family member] is not getting agitated like they used to be."

Prior to admission, the home manager or nurse completed an assessment to ensure the service could meet people's needs. Following their assessment, the information about the person was used to develop a care plan that gave staff detailed information regarding the care the person required and how it should be delivered. People's care plans had improved since our last inspection and were more person focused. All care plans we viewed were person centred with information on people's family background, preferences and routines such as how people preferred to spend their time. Care plans also included people's personal care wishes, food preferences as well as other individual preferences relating to their care. There was evidence within care plans that people and their relatives had been consulted and involved in the planning of their care.

Staff made daily notes of the care they delivered to people. These records included information about people's wellbeing, what they had done each day and the care and support they had been provided with. These records demonstrated that care was provided as identified in people's care plans. Regular reviews of care plans took place to ensure that the information within them was current and reflected people's care needs and preferences.

The opportunity to take part in activities and hobbies varied across the four houses during our two day visit. There were four activities co-ordinators in post but they often worked on their own so there was only one on duty across the site. A weekly activity planner was developed which covered all four houses across the site. We were told that these included general activities such as bingo, which were held in one house and people from other houses, attended and joined in.

People told us that there were social events that they could participate in. One person said, "There's usually something on the afternoon, mornings there are board games and quizzes." Another person commented, "I like gardening and this garden magazine was laying here on the table. There is enough for me to do, I join in

most things, play games, cards, quizzes, usually plenty to do, you join in if you want to." Another person's relative told us, "Yes, definitely [enough activities], people are involved and brought into the lounge. I think the activities are great here. They had a local historian in to talk, they knew [family member] was a local person and involved them." A second relative told us, "Saturday afternoon I came and the carers were doing [people's] nails, it was really nice."

Some relatives were not as positive about the opportunities their family member had to take part in activities. We were told, "They [people] just sit there, they need something to do. The entertainers do spend time with people, but only a few at a time, the rest fall asleep. There is not enough entertainment for them."

We observed on some houses there was little activity however on others people were more engaged. We spoke with one of the activities co-ordinators who was on duty during our visit. They told us, "I'm spending this morning on Beech House and this afternoon on Gainsborough House. We're doing knitting and making a bag of sugar which I will wear next week for pancake day – someone else is a lemon." They also told us, "This afternoon on Gainsborough House we have an [entertainer] who goes from room to room and plays the organ and sings to people. People may miss out by staying in their rooms so the music goes to them." We observed this taking place; people were asked, "What is your favourite song or hymn and I will play it for you?" The entertainer was accompanied by the activities co-ordinator who introduced people and encouraged them to think of something from their past they would like to hear played. This meant that people who were cared for in their bedrooms were not isolated from the activities.

During the morning on Beech House we observed some knitting activities taking place. There was lots of friendly and inclusive chat and involvement that meant that people who were unable to physically take part were still involved.

The home manager told us about an initiative they had introduced which was referred to as '20 minute carer led activities'. They told us that they were in the process of implementing this across all four houses. The purpose was for staff to spend 20 minutes moving away from the focus of personal care and to an activity or engagement with a person. They told us that this concept had been embraced by staff working on Munnings House and Constable House and was still being developed on the other two houses in conjunction with the house managers.

The provider had a clear complaints policy which made sure all complaints and concerns were fully investigated and responded to. Relatives we spoke with told us they would speak with the manager if they had any complaints or concerns. They told us they felt confident that the manager would listen and take appropriate action to address their concerns. One relative told us, "We would speak to any of the [staff], they always pass it on to [manager], she always records it and they let us know." The records showed that complaints were dealt with in line with the provider's policy.

People's care plans contained an 'end of life awareness book' and some people had a 'my life my future' living will in place both of which documented wishes in relation to death and dying. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were in place where requested by the person or where a formal best interest's decision had been made. Throughout the documentation people's end of life wishes and preferences were very clear.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2017, we found that the service was not consistently well-led. Whilst we noted significant improvements at that inspection compared to the previous one in May 2016 where the service was rated inadequate in all key questions and overall, we found that the provider's systems to check the quality and safety of the service required minor improvements. At this inspection we continued to note that improvements were needed. The provider was not notifying us of specific incidents as set out in the regulations. As a result this key question has been rated 'Requires Improvement' again. It is however worthy to note that over the past two years significant changes have been made at the service resulting in a lot of progress overall.

Providers are required to submit to the Care Quality Commission (CQC) statutory notifications in accordance with regulatory requirements. Statutory notifications are documents which inform the CQC of the incidents/events which affect the safety and wellbeing of people who are living in care homes. Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. We found that, whilst we had been notified of some incidents at the service, we were not always identified of serious injuries. We spoke with the home manager who on reflection agreed and recognised they had not been accurately reporting.

The failure to submit notifications required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 service had a manager who was registered with CQC but no longer working at the service having left in August 2017. The current home manager commenced employment at the service on 4 August 2018 was just beginning the process of submitting their application to register with CQC.

People and their relatives were positive about the management of the service. They told us the home manager, management team and house managers were approachable and helpful. People were also positive about living at the service. One person said, "They [home manager] do a fine job, they are respectful to me and I think it is a good home." Another person told us, "Lovely. It's smashing here, I like the freedom and I know I am well looked after." A third person commented, "I just love it here. I have never regretted coming here, you are looked after."

Relatives were generally positive that the service was moving in the right direction following two years of challenges and change. One person's relative told us, "I think it is going in the right direction." Another relative commented, "I would give it nine out of ten. There are no smells and staff are friendly and from what I have seen they respect [family member] and their feelings."

Overall staff we spoke with were positive about working at the service and the culture and team work present. There had been a number of changes in nurses managing the individual houses and a change in

culture across the service. Some staff found the changes challenging, however overall most were embracing it. One member of staff told us, "We [staff] work as a team and we help each other out. We work together well." Another staff member said, "On this house you have got good teamwork, lots of support from all the staff and you are not afraid to ask questions. The house manager is very supportive and everyone seems happy and work gets done as everyone mucks in together."

Quality assurance systems were in place. A member of the management team carried out audits across all areas of the service including training, care planning, staff files and general health and safety. We saw that any areas for improvement were clearly identified and acted upon, with the exception of medicines audits. We found that they had not identified or fully addressed all of the medicines issues that we found during our visit.

Regular reviews by the regional director were undertaken. On the first day of our visit the regional director was auditing the service along with support from the regional support assistant. In looking at progress made and driving improvements a 'home improvement plan' was in place. This plan reviewed progress in all areas of the service management and delivery and clearly highlighted actions where needed.

Meetings were held each morning, locally referred to as 'take 10' meetings. These were a chance for the management team and managers of each of the houses to come together and review quality of care, specific challenges and needs on each of the houses. We observed these meetings on both days of our visit and found they were in-depth and all areas of the service were discussed.

The provider actively sought feedback from people and their relatives. Meetings were advertised and held across the four houses, we were told timings and days of the week had been changes in order to enable more relatives to attend. At the time of our visit there had been a recent meeting held on one of the houses and some feedback about the choice of food offered to people had been raised by a family member who was concerned spicy foods on the menu were not appropriate for people. As a result the management team were consulting with people again about the menu choices and were planning to invite relatives to share a meal with their family member.

People benefited from staff that understood and were confident about using the provider's whistleblowing procedure. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. They can do this anonymously if they choose to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us about all significant events within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always well managed. Appropriate action following accidents or incidents was not always taken by staff.