Elmcroft Care Home Limited

Elmcroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Inspection took place on 19 and 23 October 2017.

Elmcroft Care Home provides accommodation, personal care and nursing care for up to 54 people. Some people have dementia related needs and require nursing care. The service consists of two units: the General Nursing Unit (GNU) and Blythe unit. At the time of our inspection there were 42 people living at the service.

A registered manager was in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last visited the service in April 2017, we had found the care being provided was not consistently good. Whilst people in the GNU received good quality care, in the Blythe unit, care was not person-centred and people were not supported to engage in meaningful activities. We were also concerned that the manager had not put adequate processes in place to monitor people's wellbeing.

At this inspection, we found the care people received had improved and was now consistent across the two units. A new activity coordinator had been appointed and people in the Blythe unit were receiving more personalised care.

In the period between the two inspections, a number of concerns had been raised following a specific complaint and a visit from an Environmental Health officer. These concerns had been acted on by the manager and improvements had been made, such as safer care for people using catheters and new kitchen equipment.

However, we were concerned however that the manager and provider had failed to put measures in place to pick up these issues in a pro-active manner. During our inspection we saw a number of tools to check the quality of the service had been recently been introduced and another set of measures were due to be implemented before the end of the year. Whilst these were positive, they had not been implemented in a timely manner after our last inspection and we were not able to measure how effective they were and whether any improvements were sustainable.

Staff, people and families were extremely positive about the registered manager. The manager promoted an open culture throughout the service and was now more visible in the Blythe unit. There was good communication at the service, and this was improving with the introduction of additional meetings with staff and families.

There was no longer a dedicated clinical lead at the service and the provider was recruiting for a new deputy manager. The manager was covering both posts and so their time was stretched. Nursing and care staff were

focused on meeting people's daily needs; however there was insufficient oversight and coordination of the care and domestic tasks being carried out. As a result the manager had not always picked up where there were gaps in staff skills.

People were supported to maintain good physical health. Staff ensured people had enough to eat and drink, and the dining experience had improved in the Blythe unit. At our last inspection we made recommendations around developing staff skills when supporting people with dementia and mental health issues. This was an area which required on-going improvement.

The manager was open and pro-active when safeguarding concerns were raised. There were effective plans in place to manage risk. There were sufficient, safely recruited staff to meet people's needs, and there had been a focus on reducing the dependence on agency staff. Experienced staff were now working across both units so people were consistently cared for by staff who knew them. Medicines were administered safely by well qualified staff.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made diligently to the relevant local authority. Assessments and care plans had been improved in the Blythe unit and better reflected people's needs and preferences. Staff developed good relationships with people and families. People were treated with dignity and respect.

Whilst there had been some setbacks since our last inspection, there was a positive culture within the service. The manager and staff demonstrated a commitment to the needs of the people they supported and had worked hard to make improvements since our last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff focused on keeping people safe and there were personalised assessments of risk in place.

There were enough safely recruited staff on duty to meet people's needs.

Medicines were administered safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Observations of staff competence were not sufficiently robust. Staff were not consistently skilled when supporting people with dementia or complex mental health needs.

People were supported to maintain good nutrition and hydration. The dining experience had improved, though there was still scope to continue developing this area further.

People were enabled to make their own choices about their care. Decisions made on people's behalf were done in their best interest and in line with legislation.

Staff worked well with other professionals to promote people's health.

Is the service caring?

Good

The service was caring.

Staff showed compassion towards people and took time to get to know them well.

Staff treated people with respect and put measures in place to promote their privacy.

Is the service responsive?

Good

The service was responsive.

A new activity coordinator had been appointed who was developing person centred activity and developing staff skills to enable them to meet enhance people's quality of life.

People's needs were now met in a consistent and personalised way across both units of the service.

Complaints and concerns were well investigated and responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider and manager had started to address our concerns regarding the lack of checks on people's wellbeing but this had not been done in a timely manner. As a result, concerns were still not being addressed in pro-active way.

The manager had increased their visibility in the Blythe Unit. The lack of a deputy manager and a clinical lead had affected the service negatively, though this was being addressed.

There was an open culture where people, families and staff were listened to and communicated with well. The manager and staff were committed to the care of the people at the service.

Elmcroft 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 the 19 and 23 October 2017 and was unannounced.

The inspection team consisted of two inspectors, a specialist nursing advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this instance they had experience of caring for an older person. The nursing advisor was used to check that people's health and care needs were met in a safe and effective way. Before the inspection we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We also reviewed safeguarding alerts and information received from a local authority.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service.

During our inspection we spoke with 12 people and four relatives. We also spoke with the registered manager, regional manager, six care staff and other office staff. We reviewed 11care files, six staff recruitment files and other records relating to the management of the service. We also spoke with two health professionals to find out their views of the service.

Good

Is the service safe?

Our findings

At our inspection in April 2017, people were safe and during this visit we found people continued to be supported safely. We found people and families were overwhelmingly positive about how safe people were. One person said, "I am happy here, I feel safe and secure." There were some concerns about people with dementia wandering into people's rooms; however family members told us they felt able to discuss this with the manager to find a solution. Prior to our inspection we had concerns raised by one family member regarding the safety of people at the service. The manager and outside professionals told us about the actions taken in response to the concerns which had been raised.

There were enough staff to meet people's needs. Staff told us, "Yes, I think there are enough staff there is always someone to help if need be for example if someone needs 2:1" and "We do have agency staff but they have been working here for ages so they know everyone."

The environment within the service was calm. Staff did not appear to be rushed and took time to talk to people. We observed buzzers being responded to promptly. We were with a person who pressed their call bell and we observed this was responded to swiftly by staff.

Generally, people and their families told us there were enough staff on duty; though some felt they had to wait longer for their needs to be met at weekends. We were not made aware of any serious impact resulting from people having to wait for staff to attend them. We discussed staffing with the manager and looked at rotas for two weekends prior to our inspection, which showed care staff numbers were adequate. The manager was not able to show us how they could be assured people's needs were being met and they agreed increased monitoring and checks were needed, especially at weekends. We also discussed with the manager about how they organised staff time in order to minimise disruption to people, such as ensuring staff breaks were taken in a structured way.

We looked at the recruitment files of six staff members and saw that the service had a robust recruitment policy in place to ensure that staff were recruited safely. Each staff member had to attend a face to face interview and all the required employment background checks, security checks and references were reviewed before they began to work for the organisation. This process ensured that the provider made safe recruitment choices. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

To manage the challenges in recruiting staff, the provider had arranged for staff to be brought over from a service in East London. This provided some continuity for people by promoting more consistent staffing at the service. There was still some reliance on agency staff but the provider demonstrated a commitment to developing a more settled team by enhancing care staff conditions and focusing on recruiting staff from the local area.

People's care plans detailed the level of staffing they needed to meet their needs, for instance, one person's

plan stated that they needed to be kept "within eyesight" of staff. We observed there was always a member of staff in the lounge providing supervision when that person was in there. Another person needed to be checked every 15 minutes and we saw this being carried out and recorded effectively.

During our inspection we saw that the kitchen was not cleaned and organised to a high level and whilst we observed domestic staff carrying out cleaning we noted some furniture was worn and marked. We did not have any concerns raised with us regarding the cleanliness of the service or that people had developed infections, for example from poor hygiene. The manager told us that prior to the inspection their food hygiene level had dropped to three. They then outlined the improvements made in response, such as the purchase of new equipment and redecoration of the kitchen. As a result of these improvements, on the day of the inspection we did not have evidence of serious impact due to lack of infection control. Shortly after the inspection the food hygiene level was reviewed and achieved a rating of five.

The manager promoted a culture where staff were committed to the care of the people they supported and were focused on their safety as a priority. Staff had completed training which provided them with the knowledge about how to recognise signs of abuse and they understood their responsibility to report any concerns to senior staff and, if necessary, to the relevant external agencies. The manager worked openly and well with outside professionals when concerns were raised about people's safety. Alerts and notifications were raised with outside organisations, as required.

Individual risk had been assessed effectively. Risk assessments had been completed in areas including; managing anxiety; eating and drinking and manual handling. Each assessment provided staff with the necessary information to support people in accordance with their expressed preferences and to minimise the risk of harm to the person. The daily record files which were used to highlight potential risk such as food and fluid intake charts and movement charts were all filled out well and in a timely manner.

Plans were in place to advice staff about what action to take if an emergency situation arose and staff told us that they felt confident in the on-call system that was in place to support them over night and at the weekends. Each person had a personalised evacuation plan, should they need to leave the building in an emergency. The plans made it clear what support a person would need. For instance, one person's plan stated they could walk independently if they needed to leave the building in an emergency but would need guidance and reassurance.

People received support to take their medicines safely and as prescribed. Guidance on medicines was clear and personalised. Staff were knowledgeable about medicines and the importance of their responsibility in this area. We spent time with an agency nurse and found they understood the system for administering medicines well as they had been many times to the service. We looked at a selection of medicines and medicine records and noted there were no omissions or inaccuracies. There was a policy for giving out as and when required medicine and it was being followed safely by staff.

There were safe process in place for giving out 'as and when', for example, when pain relief was required. Medicines were securely stored and disposed of safely. Nurse staff checked all the medicine charts and controlled drugs at every shift handover. We were shown a new medicine audit tool, which checked how well medicines were administered. We saw this tool had already picked up where a member of staff had failed to record the administration of prescribed cream. The manager was also then able to check the person was now receiving their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found staff were effective and at this visit we observed the staff team worked well together to meet people's needs. A staff member told us, "I really enjoy working here we all work as part of a team." We received positive feedback about staff from people and families. One person said, "The staff look after me well." There was improved use of skilled staff since our last visit as permanent and more experienced staff now worked across the service, including in the Blythe unit.

Prior to our inspection we had concerns raised with us that staff did not always have the correct skills in relation to catheter care. During inspection, the manager told us that following this concern, staff had immediately received a refresher session on catheter care and a new training pack was being put together. Staff were also receiving input from outside health professionals to improve their skills in this area. We found the concerns had been addressed by the manager. However, improvements in staff skills had primarily come about following a complaint from a family member, rather than from internal quality checks on people's wellbeing. We were therefore not assured that the existing staff training and observations of competence were sufficiently robust.

Competency assessments of staff skills were not consistently recorded and reviewed so it was difficult for the manager to assure themselves that staff had understood the training and were putting it into practice. The management team told us they were in the process of improving observations of staff practice, but there had not been time to measure whether these were resulting in sustainable improvements in staff competence.

All new members of staff completed an induction programme. The induction programme included training sessions on health and safety, safeguarding and whistleblowing as well as completing shadow shifts with more experienced staff members before being included onto the rota. Before working independently observations of practice on new staff were carried out to ensure that they had the necessary skills to care for people.

Most of the training was done online although there were some face to face training such as First Aid and Fire Safety. Staff were largely positive about the training they received. One member of staff said, "We have loads of training."

Staff told us they needed more training in managing more complex emotional and mental health needs. We observed some staff were not confident in working with people with communication or behavioural challenges. This was an issue we had already raised with the manager at the last inspection and we discussed the delay in addressing this gap concern. They told us staff were being booked onto dementia training, however there was a continued need to developing staff skills in this area.
All of the staff members that we spoke with told us that they felt well supported and confirmed that they had regular planned supervision sessions and an up to date annual appraisal. The supervision schedule demonstrated that some staff had not had a 1:1 supervision for some time however, when speaking with staff they told us, "I feel fully supported, the manager's door is always open and they are really approachable

you can talk to them about anything."

We checked whether the service was meeting their responsibilities within Mental Capacity Act 2005 (MCA). The 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).

Staff asked for people's consent before carrying out any tasks. For example, asking we observed member of staff check before supporting a person put on their slippers or go to lunch. People had been assessed when there was a query over whether they had capacity to make decisions. Care plans had then been written with clear guidance to staff, for example, one person's care plan stated, "I can make very simple choices; staff must always speak clearly." Where a person was unable to make a decision then best interest assessments had been carried out. Where it had been assessed it was in their best interest for them to have their liberty restricted the manager had fulfilled their legal requirements. For instance, a person who could not leave the service unescorted due to their need for supervision had DoLS in place.

Applications to deprive people of their liberty had been made the local authority and were completed in great detail by the manager, demonstrating a good understanding of their legal responsibilities. These applications were logged and reviewed well.

People were free to walk unrestricted round the unit where they lived. There was a key code pad which locked off a far end bedroom corridor which meant the people in the corridor had to ask each time they wanted to access their bedrooms. We found this to be unnecessarily restrictive and discussed this with the manager who immediately arranged for the lock to be disabled.

At our last inspection we found staff did not pro-actively support choice at meal times, in line with best practice. Whilst we observed improvements at this visit, staff did not consistently use any tools to communicate with people with memory issues. For instance, they were not shown a selection of meals or a picture menu to help them better make a choice. We discussed this with the area manager and the registered manager who told us the improved dementia training was aimed at improving skills in this area. We were also shown a new audit tool, due to be introduced imminently to help senior staff check the dining experience. This included considering whether, "Visual choices are offered to those who are finding it difficult to express their choice or who may have difficulty recognising written word or spoken instructions."

Although all staff had not been enabled to adopt best practice, staff supported people to eat and drink in line with their preferences and needs. The chef told us, "People can always ask for something different and we will accommodate them it is never a problem" and "Some people choose an omelette or sandwich and can always have snacks in between meals if they need to." We observed a member of staff saw a person was not enjoying their meal and said to them, "You asked for lasagne, but let me show you the chicken instead." They returned with a plate of chicken which the person ate and appeared to enjoy. Another member of staff went around the tables asking people who would like some gravy.

The dining experience had improved in the Blythe unit since our last inspection so that people had a more consistent mealtime experience across the service. The dining room had been re-decorated and the

atmosphere was more pleasant. All staff from across the service worked together to support people during meal times.
People's specialist nutritional and hydration needs were met well. The chef was knowledgeable about individual dietary needs and told us communication about people's nutritional requirements was excellent. The chef attended the morning meeting in order to be kept up to date with any additional needs or changes in people's health which could affect their appetite or food preparation.

Staff helped minimise the risk of dehydration. A choice of tea and coffee was served regularly and people had drinks available at all times. Squash was served with lunch and we observed they were encouraged to drink before leaving the table. Staff kept detailed records about the drinks people were drinking which helped monitor the amount of fluids they were receiving. These records were personalised, for example we saw one person's fluid charts recorded when they had drunk hot chocolate.

Staff worked well with other professionals to support people's health needs. Care plans and discussions with staff demonstrated involvement from external health care professionals, such as mental health teams, opticians, the falls prevention team and dieticians. Speech and language therapists had been involved with advising on a person's care, to ensure they were safe when eating. As a result this person now received a soft diet and had thickener in their drinks to minimise the risk of choking.

Advice from specialists was incorporated into detailed health care plans. For example, a treatment plan had been drawn up by a visiting tissue viability nurse specialist for a person with who needed support with a pressure sore. This plan had been further developed in detail by the nurse in the unit and included guidance such as how to re-position the person and how to apply dressings. Staff also had access to photos to advise them on best to support the person.

Good

Is the service caring?

Our findings

Feedback from people at the service was very positive about how caring staff were. They told us, "Staff have been very good to me", "I am really happy living here" and "The staff are super". Staff spoke about people warmly for instance, "People are all so different it is nice to sit and chat with them." All the relatives we spoke to during our visit were positive about staff attitude and said they felt welcome to visit at any time.

We observed staff interacting positively with people. For instance, we observed a member of staff who was supporting a person who was unwell. The member of staff came down to the level of the person and spoke kindly to them, saying their name and stroking their face. The member of staff demonstrated a compassion for the person and knew them well.

Staff who knew people communicated very well with them. We observed some staff that did not know people as well and did not have the same level of communication. When we investigated, further we were told these staff were agency or new staff. The manager had highlighted a commitment to employing permanent staff to help promote meaningful and positive relationships over time. This was a situation which was improving. One family member raised a concern that staff did not take the time to wait for their relative to answer. This was also being addressed by the manager with increased dementia training which was due to take place shortly after our inspection.

Care plans were written in a personalised way to highlight people's preferences and ensure they had a choice about the type of care they received. One person's care plan stated they liked a back rub, which helped them relaxed. When we spoke with a member of staff later, they knew about this request and said they supported the person in this way. Staff had advice on people who needed support to maximise their independence. We observed people going into the dining room for their lunch and saw this was done with positive interaction from staff and involved praise and encouragement. Staff supported one person by walking alongside them and encouraging them to put their whole foot to the ground as they were walking on tiptoes.

We asked a member of staff about a person who liked to have a bath but could be very anxious about the process. The member of staff told us, "We try to use permanent staff and cajole them as we know they enjoy it when they get in the bath." The member of staff demonstrated a compassion for the person and a commitment to make an extra effort to ensure care was provided in line with choices and preferences.

People's dignity and privacy was maintained. We heard one person being asked discreetly if they needed the toilet before entering the dining room and observed staff knocking on people's bedroom doors before entering. During meals, we saw staff wiping off food when people had spilt it on themselves and tactfully gave people a napkin to use.

A number of people told us they did not feel comfortable because people walked into their room, for example if they became confused. One person told us they had been supported to maintain their privacy after they had discussed it with the manager. They said, 'I have had lock put on my room to stop people

wandering in and out."

We noticed that there were memory boxes attached to the side of people's bedroom doors. They were largely empty and had not been used to personalise the entrance to people's rooms. The manager said they were going to remove these boxes as they were not in use, however acknowledged they could be used in a personalised way to support people who became confused as they walked around the service and struggled to find their room. Making entrances to people's bedrooms more personalised would also help minimise the risk of people going into the wrong room.

Good

Is the service responsive?

Our findings

At our last inspection in April 2017, we found the service was not always responsive. Improvements were needed as people did not receive consistent care across the service. In particular, we found that support was not person centred in the newly opened Blythe unit. On our return, we found the manager and staff had worked hard to transform the unit. The environment felt warmer, more homely and a member of staff had decorated the dining room to make it more attractive and welcoming.

When there was an agency nurse on duty, the manager ensured they worked in the main unit, which was near the main offices and so more visible. As a result the Blythe unit was staffed by a more consistent staff team who knew people well. We observed a very experienced nurse on duty in the Blythe Unit who lead by example and promoted good practice. For example, we observed at lunchtime the nurse ensured staff provided the necessary support to people during meal times.

At our last inspection we found the care plans in the Blythe unit had not been completed in sufficient detail to ensure staff knew what people's preferences were. The care plans had been reviewed and improved and staff in both units had access to consistent levels of care. Care plans were now more person centred, contained information and guidelines which enabled staff to provide care in accordance with people's expressed wishes and preferences. Improvements were still being made to care plans, in particular to provide more information about people's mental health needs.

Each person had a summary of their care needs at the front of their care plan. This provided all staff, especially new or agency staff with a quick reference about their needs. The snapshot forms could go with a person, if, for example they were admitted to hospital or for information for any visiting health or social care professional.

Prior to our visit, concerns had been raised about the support given to people who used a catheter. At this inspection we looked at the care plan for a person who used a catheter and saw the nurse had developed detailed and personalised plan to meet their needs. People with a catheter had a 'catheter care' booklet in the care plans which also recorded how often the catheter was changed, by whom and why. On several occasions we heard nursing staff ask for urine tests to be carried out to check for potential infections.

At the last inspection we found mental health and challenging behaviour care plans were weaker than the plans to support people's physical needs. Whilst there was still scope to improve the written plans; there were improvements in the actual care people received in this area as staff knew people better, particularly in the Blythe Unit.

A member of staff described how they supported a person who became anxious near water and demonstrated they knew how to provide them with personalised support in this situation. Although the person's care plan did not provide detailed advice about how best to support them, communication had improved in the unit and people were being supported by a more consistent staff team. Staff told us they had a handover at the end of each shift with senior staff to plan people's care and discuss any changing

needs. These measures helped ensure people received consistent care, despite some of the gaps in their care plans.

Care plans were reviewed at least monthly and necessary changes were made to the support received were required. For example, when a person was losing weight, staff started to weigh them weekly, rather than monthly.

Since our last inspection, a new activity coordinator had been recruited. Although they had only recently started in their post we spent time talking to them and found them to be enthusiastic and creative. They explained that part of their role was to support other care staff to engage with people in a more meaningful way, in line with individual interests. They showed us a well-resourced activities room which was well laid and pleasant out environment to be in.

The coordinator was putting together small boxes which care staff could use to enable people to engage in activities of their choice, such as a sewing or craft box. During our inspection we observed two incidents where care staff were supervising people in the lounge, and did not engage with the people around them. However, the introduction of these boxes was an innovative idea with the potential to promote good practice across the service.

Throughout our discussion, the activity coordinator demonstrated a good knowledge of people's needs and interest. They knew the people at the service who were being cared for in bed and made sure they spent time with them regularly. The activity coordinator told us one of the people at the service had done flower arranging and activities were being arranged which made use of their expertise.

People were supported to take part in flower decorating for Halloween on the day of our inspection. The activity was enjoyed by a number of people and was well planned as was taken round the service to people who did not want to join the group activity. People also took part in a movement to music and singing session and we observed two people who were keen gardeners accompanying the gardener who was potting winter flowers. As well as more formal activities, staff were observed having a chat with people in their rooms.

Complaints were responded to openly and fully. Prior to our inspection we were aware of a specific complaint which the manager had responded to in great detail. Comprehensive action plans were developed as a result of the complaint and there was on-going courteous communication with the family member who was raised concerns. As a result of the complaint, improvements were made. When we asked people about the service they were largely positive. One person said, "I have no complaints at all."

Family members we spoke with told us they did not have any formal complaints but gave us details of when they had raised minor concerns with the manager. They told us they found the manager was open and responsive to any complaints which were raised. The manager developed varied opportunities, such as surveys to gather feedback, however most significant was their exceptional skill at creating an atmosphere where people and families felt able to speak out freely.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found there were inadequate checks on people's wellbeing, which meant the manager could not be assured people were receiving consistently good quality care. When we gave feedback at our inspection in April 2017 we were shown an auditing tool which was due to be introduced to monitor people's wellbeing. We spoke with a professional who visited the service regularly between the two inspections and they told us they had not seen the tool used. When we discussed this with the manager they told us the monitoring tool had been introduced in October 2017, and showed us a small number of completed checks.

There had been a specific complaint by a relative prior to our inspection raising concerns about the wellbeing of their family member. As a result, there had been referrals and input from outside professionals who had also raised concerns. There were a number of issues regarding the person's care which had not been identified by the manager and staff through internal checks and reviews. We found the new tool checking on people's wellbeing had not been in place at the time when the family member raised concerns.

We were satisfied improvements in the monitoring of people's wellbeing were now being introduced. However, we were not assured these had been implemented in a timely manner and that checks on people's wellbeing had been sufficiently robust in the period between the two inspections.

The regional and registered manager described other checks which were being introduced to improve monitoring of the quality of care and safety at the service. Whilst some tools, such as the wellbeing tool and competency checks had been introduced in the month before our inspection, others quality checks, such as improved health and safety audits were not yet in place. As a result, we were not able to measure the effectiveness of the new and planned changes and determine how sustainable any improvements were.

We saw that some senior staff were still getting used to using the new tools. For example, an audit of medicine records had highlighted a number of missing photos, but there was no information about who was going to sort this out and whether this had happened. The photos helped to minimise the risk of the medicines being given to the wrong person, which was especially important given the continued use of agency staff. The manager agreed to continue to improve the roll out of the audit tools to ensure they could track any actions needed as a result of the checks.

The manager had introduced a new task list for nurses to ensure no areas of care were missed and to clarify roles and responsibilities. This included the number of checks to be carried out, such as on medication and dining experience. Whilst this was not fully in place yet it had the potential to be a useful tool.

Although some of the new streamlined audits had not yet been introduced, regular visits by the regional manager already took place which included checks on the quality of care. These were quite detailed and highlighted areas which needed improvement; however the manager and provider were not able to demonstrate how they were tracking that required actions had been carried out following the regional manager's visit. Action plans were set up following concerns raised by outside agencies, such as the local

authority; however these were in response to issues raised and were not on-going internal systems to monitor improvements at the service.

Following an audit by the regional manager in May 2017, the regional manager asked the manager to increase one of the infection control checks from annually to monthly. At our inspection, the manager told us this change in audits was still being implemented and was not yet in place. Therefore despite the concerns which had been raised by the environmental health officer about food hygiene standards, there was still a lack of robust checks on the cleanliness of the kitchen at the time of our inspection.

Shortly after our visit, we were told the environmental health officer had re-inspected the service and determined the manager had made the necessary improvements as a response to the concerns raised. However, we found the improved checks of the environment not been put in place in promptly to ensure the manager and provider were pro-actively identifying concerns.

When we arrived unannounced on the morning of our visit to the service, the manager and administrator were not yet at the service. The unit at the front of the service was being run by an agency nurse, who was occupied with supporting people and staff. The nurse on duty in the separate Blythe unit was in charge of the service. This nurse was also occupied with supporting people to get up and take their medicines and so we asked for them not to be disturbed. Staff were welcoming however they did not seem clear about who should formally oversee an unexpected event, such as an unannounced inspection, in the absence of the manager and administrator. Both the manager and administrator arrived at the service shortly after our arrival and supported the inspection in a positive manner.

This incident highlighted that the nurses on each unit were involved in supporting people's health needs and administering medicine and did not have sufficient time to provide the necessary oversight of the service. This was a theme we found throughout our inspection. The manager committed and knowledgeable however arrangements in their absence were not robust. In addition, when they were at the service their time was spread thinly as they were acting as the clinical lead as well as overall manager of the service.

Two external professionals told us they had observed a lack of supervision and coordination in how the staff team was deployed. One of the professionals told us this issue had been raised a number of times but they were still not clear who was providing overall coordination of staff across the service. At one point, during our visit to the service, there were five staff having a cigarette break in the courtyard. When we discussed this with the manager they told us the staff taking breaks were a combination of care, domiciliary, kitchen and office staff. Staff worked effectively as a team and people were not left unattended as a result of the timings of the breaks, however there was scope for improved coordination in this area.

Since our last inspection, a new deputy manager had been appointed, however they had left the service after a short time. The area manager advised us they were now in the process of recruiting a new deputy, and would ensure they had a clinical background and could supervise both health and care staff. We were also told the manager was developing further the role of the senior care staff to run each unit and free the nurses up to focus on clinical needs. Both these improvements aimed to enhance staff coordination; however they were not in place in time for our inspection and so we could not measure their impact.

In the past, the numbers of people living at the service had dropped and the regional manager told us they had not reduced staffing during this period. However, the number of people at the service had now increased so that the same numbers of staff were expected to carry out more tasks than before. Efficient coordination of staff was therefore increasingly important at the service.

At our last inspection we found the care provided at the Blythe Unit was not of the same standard as that provided in the main building, in part because the unit was physically separate from the main part of the building. At this inspection, we found oversight of the Blythe Unit had been improved, partly through the addition of Wi-Fi, which meant the manager was able to spend time working there and generally being more visible. The unit was staffed with more experienced members of staff which had improved the consistency in care across the service.

Although we had received negative feedback from one family member prior to our inspection, feedback about the manager from people, other families and staff was overwhelmingly positive. In a recent questionnaire, the manager scored extremely highly. The manager told us the last relatives meeting was only attended by three relatives so they had set up individual meetings with relatives every three months, involving the person being care for where appropriate.

Staff were particularly positive about the level of support they received from the manager and other senior staff. Comments from staff included, "I like working here; you get a lot of support", "There's never a time when you are not supported" and "We always get support, their door is always open." The manager had promoted an exceptionally committed staff team although one member of staff told us, "The manager is the best but is quite soft and needs to put their foot down." We noted, however, despite their gentle approach, the manager had dealt well with concerns raised about poor practice and disciplined staff when necessary.

Senior staff and care staff communicated well and this continued to improve. Since our last inspection a new meeting was held every morning with representatives from laundry, housekeeping, catering, activities, maintenance and nursing. The meeting was a very effective way of sharing daily information and any risk issues between all areas. This was confirmed by a member of staff who told us, "Communication in this house is really good."

Despite a challenging time since our last inspection the manager and staff had remained committed and passionate about providing good care to people at the service. Many areas had improved, most notably the improvements in the Blythe Unit and the introduction of a new activities coordinator. The manager and staff had worked with outside health professionals who had spent a significant amount of time supporting the service to improve. The manager had also improved links with the local authority, focusing on specific key areas such as falls management and infection control.

However, we found that improvements, such as catheter care and kitchen cleanliness had primarily been introduced in reaction to concerns raised. The manager and provider had taken on board our feedback about the lack of checks on people's wellbeing and on the overall quality of the service at our last inspection, and new processes were being introduced. Nevertheless, this had not been done in a timely manner and so we remained concerned about the lack of urgency in putting robust measures in place to ensure people were receiving the care they needed in a safe and consistent manner.