Care UK Community Partnerships Ltd

Ellesmere House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

We conducted an inspection of Ellesmere House on 21, 22, 26 and 29 June 2018. The first day of the inspection was unannounced. We told the provider we would be returning for the remaining days.

At the last inspection on 6, 7 and 10 July 2017, we asked the provider to take action to make improvements in relation to medicines management and this action has been completed.

Ellesmere House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ellesmere House provides care and support for up to 70 people who require nursing and personal care. There were 62 people using the service when we visited. The home is divided into four units. Two 15 bed units located on upper floors provide accommodation for people with nursing needs. A 20 bed unit on the first floor is allocated to frail older adults requiring nursing care and the lower ground floor provides residential care for people living with dementia.

There was no registered manager at the service, however the manager had applied to register with the Commission and their application was being processed. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider ensured there were enough suitably trained staff to care for people.

Care staff received an induction and ongoing support through supervisions and appraisals to ensure they were competent in their roles.

Risks to people's care were investigated and risk management guidelines were put in place. Care staff were aware of the risks to people's care and had a good understanding of how to mitigate these.

There was a safeguarding policy and procedure in place which was understood and implemented by care staff. Care staff were aware of the need to report concerns.

The provider followed good infection control practices and the home was clean and odour free throughout our inspection.

People were given appropriate nutritional support. People's care records included detailed information about their needs and kitchen staff were aware of these.

People's care records contained a good level of information about their healthcare needs and care staff had

a good understanding of how to support people with these.

People using the service and their relatives were involved in decisions about their care and how their needs were met.

The organisation had good systems in place to monitor the quality of the service. Audits were conducted by the manager on a monthly basis and further monitoring was conducted by the regional manager.

The provider followed safe medicines practices although guidance in relation to 'when required' medicines was not always clear. We recommend that the provider seeks further advice in relation to this area of their practise.

Staff a good understanding of their responsibilities under the Mental Capacity Act 2005. People were provided with care in line with their valid consent and this included implementing best interest decisions where needed, in accordance with legislation.

People gave good feedback about their care workers and told us they were caring. Care workers had a good understanding of the people they were supporting and we observed people being treated in a kind and dignified way. People confirmed their privacy and dignity was respected and care staff gave us examples of how they ensured this.

People knew how to make complaints and there was an appropriate complaints policy and procedure in place.

The provider conducted a varied activities programme and monitored people's involvement in these.

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.

The provider ensured there was a sufficient number of suitable staff working to provide people with care.

Risks to people's care were assessed and plans were put in place to mitigate these.

There were procedures in place to investigate and learn from incidents that occurred.

Medicines were managed safely, however PRN protocols did not always contain robust advice for care workers. The provider followed good infection control practices.

The provider operated safer recruitment procedures to help ensure only suitable people were recruited to care for people.

There were appropriate procedures in place to minimise the risk of abuse and to investigate allegations of abuse.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service was responsive.

Complaints were responded to appropriately in accordance with the provider's complaints procedure.

The provider offered a varied activities programme of both planned and ad hoc activities both inside and outside the building.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Notifications were not always sent to the Care Quality Commission as required.

Care staff told us they were well supported by the management team.

The provider had effective quality assurance systems in place. The provider sought and acted appropriately on feedback from people using the service.

Ellesmere House

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.

The inspection was prompted in part by notifications of incidents that gave rise to concerns that people may have been at risk of psychological abuse or neglect. Information shared with the Care Quality Commission (CQC) also indicated potential concerns around staff morale and staffing numbers. At our previous inspection we found a breach of regulations in relation to the safe management of medicines. After our previous inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to this area. We conducted this inspection to check the provider had followed their plan and to confirm that they now met legal requirements in relation to the breach found. We found improvements had been made in line with the provider's plan and we did not identify any concerns in relation to the information of concern.

The inspection took place on 21, 22, 26 and 29 June 2018. The inspection team consisted of three inspectors and a pharmacy inspector. The first day of our inspection was unannounced, but we told the provider we would be returning for the remaining days.

Before the inspection took place we looked at information the CQC holds about the service including notifications of significant incidents reported to CQC since our last visit in July 2017.

During the inspection we spoke with 10 people using the service and three of their relatives. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with six care workers, four team leaders one activities coordinator and the lead activities coordinator, a nurse, the regional clinical lead, the regional head chef, the manager of the service and regional manager for the provider. We looked at a sample of 10 people's care records, four staff records and

records related to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. Their comments included "I feel safe here. There's no problems" and "It is secure."

At our previous inspection we found instances where recording charts were not always being completed. At this inspection we found the provider assessed risks to people's safety and took appropriate action to mitigate these, including the completion of contemporaneous records such as turning charts. People's care records included numerous risk assessments that identified areas of risk, signs of the risk materialising as well as actions to take to mitigate the risk. Risk assessments covered areas such as falls and mobility, urinary tract infections (UTIs) and pressure ulcers. These were reviewed monthly or sooner if the person's needs changed. For example, we saw one person's pressure ulcer risk assessment stated that they were at risk of developing a pressure ulcer, although their skin was currently intact. Advice for care workers included monitoring the person's skin on a daily basis, making sure their skin was properly washed and dried as part of their personal care routine and that their medicated creams were applied as required. There were also instructions for care staff to notify the Tissue Viability Nurse if the person's skin was to break down. In another person's care record we saw the person was at risk of falls as they mobilised independently with the use of a walking stick. Care staff were instructed to conduct hourly checks of the person to ensure they were safe and to ensure they had their walking aid within reach at all times.

Care workers had a good understanding of the risks to people's safety and demonstrated that they knew what actions they were required to take to mitigate these. For example, one care worker told us, "Some people have moving and handling needs, lots of people use the zimmer frame. We keep an eye on people, we check that there's nothing on the floor that can be tripped on" and another care worker confirmed this and told us "The main risk to people on this floor is with their moving and handling. People are very mobile here and you have to make sure that people are safe."

People's care records contained contingency plans in the event of an emergency. Each person had a personal emergency evacuation plans (PEEPs) within their care record. A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. These documents were detailed and showed the number of staff and type of equipment required for the safe evacuation of each person.

Prior to our inspection we received information of concern that people's call bells were not responded to in a timely manner when needed. At our inspection people gave us mixed feedback about whether care staff attended to them when they pressed their bell. People's comments included "I hardly ever use the call bell, but if I ever ask for anything they do come" and another person told us "sometimes it takes 15- 20 minutes before someone answers." We observed that people cared for in bed had call bells within reach. Care staff had completed a risk assessment to identify potential risks where people had been assessed as being unable to use their call bell. We found that control measures were put in place and were carried out by staff and documented, for example hourly checks on the person by care staff. However, we found there was a lack of objective analysis on the time taken for care staff to respond to call bells. The provider had an

electronic logging system for the recording of calls bell response times, but due to technical difficulties, this had not been in operation for some time. The manager explained that she was taking action to rectify this issue as soon as possible, and we will check this has occurred.

Care workers told us they had received appropriate training in how to manage emergency situations and this included fire safety training and basic life support training. Care workers had a good understanding of how they were expected to respond in an emergency situation and confirmed that if a person was in distress they would take initial action to ensure they were comfortable and safe from obstacles before requesting the attendance of a nurse within the building or calling an ambulance. One care worker told us, "If there is an emergency, we would call a nurse or we would call 999." Care workers were aware of whether people required resuscitation and we found people's care files were clearly marked to indicate whether they required to be resuscitated or not.

Appropriate investigations were conducted into accidents and incidents and plans were put in place to learn from these. We found accidents and incidents were clearly documented with details of what had occurred, what immediate actions had been taken as well as further plans to prevent a reoccurrence. For example, we saw one record about an incident that had occurred where a person with behaviours that had challenged the service had threatened another person with a butter knife. Records indicated that the provider had contacted the person's psychologist to determine the cause of their behaviours and the psychologist had given written instructions as well as face to face training with care staff about how they were to manage the person's behaviour. The advice was incorporated into the person's care plan and as a result there had been no repetition of incidents in approximately two years since the incident. Care staff had also implemented other practical measures such as handing out cutlery to people directly instead of leaving it on the table prior to people eating their meals.

Prior to our inspection we received a concern that people were at risk of psychological abuse. At this inspection we found the provider had appropriate safeguarding systems in place to investigate and manage safeguarding concerns. Care staff told us they had received safeguarding training within the last year and records confirmed this. Care staff had a good understanding of different types of abuse including psychological abuse and what they were expected to do if they thought someone was being abused. One care worker told us "We love our residents. If there was something wrong we would report this right away."

Records of safeguarding incidents demonstrated that appropriate investigations were conducted when concerns were raised and this information was relayed to both the local authority and the Care Quality Commission. The provider had a safeguarding policy and procedure which stipulated the process that was supposed to be followed in the event of a safeguarding concern and care workers were aware of this. Care staff referred to the organisation's whistleblowing procedure. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

Prior to our inspection we received a concern that some people may have been at risk of discrimination. During our inspection we found the provider had taken reasonable action to prevent people from being discriminated against. Care staff received training in equality and diversity and records confirmed this. Care workers told us they did not have any concerns about people being discriminated against and demonstrated an open attitude to different types of people. Relatives spoke positively about care workers and confirmed they did not have any concerns.

At our previous inspection we had concerns that people's medicines were not being managed appropriately as nurses did not always ensure that people had taken their medicine before recording this on their

medicine administration records (MAR) charts. We also found that not all staff administering medicine wore 'do not disturb' tabards or secured medicines trolleys when they had completed the administration of medicines. At this inspection we found the provider managed people's medicines safely. Nurses ensured that people had taken their medicine before recording administration on people's MAR charts and we observed this happening. Staff administering medicine wore 'do not disturb' tabards and secured medicines trolleys after administering medicine to people.

We looked at MAR charts and care plans for ten people. The provider had recorded relevant information such as the person's name, their photograph for identification purposes and their medicine sensitivities to help care staff give people their medicines safely. We found that not all care plans had an up to date medicines list and when there was a list of medicines, there was little or no information about what the medicine was for and its side effects. However, medicines listed on people's administration record were always accurate and care staff confirmed they followed this when administering medicines to people.

Some people were prescribed medicines on a 'when required' basis. There was guidance in place to advise care staff about these medicines and this was kept with people's MARs. However, we found this guidance was not always person specific. For example, we saw four people who were prescribed two different medicines to treat the same condition but it was not clear which one should be used first. We also found that when these medicines were being routinely given, care staff were unable to confirm when they would refer people to a GP for review. Although the home had a policy in place for 'when required' medicines it was not robust enough to guide staff in this area. We recommend the provider seeks advice from a reliable source in this area of its medicines practice.

Some people were prescribed creams and ointments to be applied to their body. These were stored in people's own rooms and recorded when applied by staff on separate charts. Medicines were stored safely and securely at the home.

Some people were given their medicines disguised in food or drink (covert administration). We found this was carried out in their best interest following assessment under the Mental Capacity Act 2005 and a documented best interest review, which included an advocate for the person. We saw staff members were caring when administering these medicines to people and they tried to gain permission from the person to give the medicines. Only when this failed would the staff member follow the agreed covert protocol. We saw care staff signing for each medicine immediately after giving it to people on their MAR chart.

We saw evidence that people's medicines had been periodically reviewed by their GP. This meant people were being prescribed medicines appropriate for their health condition. People who were on medicines for diabetes had blood glucose tests at regular intervals. This meant that people were getting the correct doses of medicines for their condition.

Care staff received annual medicines training and the provider assessed the competency of staff to ensure they handled medicines safely. There was a process in place to report and investigate medicine errors. Medicines systems were regularly audited for service improvement.

Prior to our inspection we received a concern that staffing levels were not adequate to meet people's needs. At this inspection we found the provider ensured there were sufficient numbers of suitable staff to support people safely. Care workers told us they felt there were enough staff scheduled to work in each shift. Their comments included "there are enough staff even at night" and another care worker told us "this is a normal amount of staff. I think we are ok." People also confirmed they felt there was enough staff to meet their needs. People's comments included "You can find someone if you need some help. Just look out the

windows and you'll see someone" and another person told us "I think there's enough staff."

We spoke with the manager about staffing levels. She told us that people's dependency was assessed upon their arrival and this was balanced with the needs of other people on the unit within which they were staying. As a result of assessing both the individual's needs and the needs of other people on the unit, the required number of staff was determined and consequently scheduled. We reviewed the staffing rota for the week of our inspection. We found an appropriate number of care staff had been scheduled to work and this reflected our observations during the inspection. Care staff did not seem to be rushed in the completion of their duties and had time to speak with people.

The provider followed good infection control practices. Domestic staff were working every day during our inspection and we found all areas of the building were clean and free from odour. Each unit had a sluice, containing wash facilities for bedpans. Care staff told us they were given personal protective equipment (PPE) such as gloves and aprons for use when providing personal care and had received training in infection control procedures. We saw care staff wearing PPE and records indicated that staff had received appropriate training within the last year. People confirmed that the building was usually clean and tidy. One person told "They're always cleaning around here. You have to though."

Care workers gave us examples of how they practised good infection control and emphasised the importance of hand hygiene. We noted that hand wash facilities were available in each bedroom as well as in shared facilities such as bathrooms and toilets. There were hand sanitiser pump dispensers located at certain points within the home, although the provider agreed that there were some areas without these. The manager agreed to look into this.

Safety was promoted in recruitment practices as appropriate pre- employment checks were conducted of candidates. We reviewed the staff files of four care staff. We saw these included evidence of criminal record checks, at least two references (including one from the person's previous employer), application forms which detailed people's previous employment history as well as photographic identification and proof of people's right to work in the UK. We also found nurses were checked to ensure their registration with the Nursing and Midwifery Council was current.

Good

Is the service effective?

Our findings

Prior to our inspection we received a concern that one person's fluid intake was not being managed appropriately. At this inspection we found people were given appropriate support to maintain a balanced diet and their fluids were managed appropriately. People were given regular fluids and where needed, this was recorded. We found provisions were in place to keep people appropriately hydrated included chilled drinks within communal areas and care staff were asking people regularly whether they could provide people with drinks.

People's care records included a good level of information about their likes and dislikes in relation to food as well as whether they were subject to any nutritional risks. For example, we saw one person's Malnutrition Universal Screening Tool (MUST) determined that they were at medium risk of malnutrition. The MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. The person's care plan contained specific instructions for care workers to record everything the person ate and drank onto a fluid and nutritional chart and to ensure that the person was weighed on a weekly basis. The person was seen by their GP regularly and care staff had specific instructions from the person's dietitian about what food they were required to eat. We also found other people with specific conditions had advice within their nutritional care plans about what food they were required to eat to manage their conditions. For example, we saw another person with diabetes also had detailed recorded advice for care workers about what food they should eat for optimal health.

Kitchen staff were aware of what food people should eat and whether they had any allergies or conditions. For example, we saw they had been provided with diet logs from care staff that detailed whether people had any particular allergies or required their food to be fortified. These details were also displayed on a white board within the kitchen area so the information was easily accessed.

People gave good feedback about the food available. One person said, "I think the food is nice" and another person said, "The food's good." We spoke with both the acting chef and the regional head chef who was providing them with senior support. They explained that people's feedback was sought in relation to their meals and this was implemented depending on whether people liked the food. We observed the lunchtime period on the second day of our inspection and sampled the food. We found people were given a choice between two food options and a vegetarian option was also available. The food was appetising, of a good portion and served at the right temperature.

People's care was delivered in line with current legislation and evidence based guidance to help achieve effective outcomes. The manager explained that she reviewed the training being given to care staff to ensure that it was up to date and met required standards as well as people's needs. Policies and procedures were also reviewed internally by the provider annually to ensure that the right standards were being set within the service. We reviewed the provider's policies and procedures and found these referred to up to date guidance and legislation. For example we found the provider's Equality and Diversity policy contained appropriate reference to The Equality Act 2010 along with suitable explanations and examples.

Care staff told us they received a wide range of training courses on a mandatory and developmental basis. One staff member said, "We get lots of training here". Training modules included moving and positioning including the use of specific equipment such as hoists and wheelchairs, and infection control. Specialised training topics were also provided depending on people's specific care needs and this included topics such as catheter management where the need arose. We looked at the provider's training records and saw care staff were up to date in their completion of mandatory training.

Care staff received an appropriate induction and had ongoing supervision and appraisal meetings to perform their jobs well. Care staff were required to complete an induction which included completion of mandatory training subjects such as safeguarding adults and infection control and also shadowed experienced staff before working independently.

Care workers confirmed there was a regular system of supervision which took place approximately every three months. Records demonstrated that these were taking place and care workers told us they found these useful to their work. One care worker told us they found supervisions were "very good. If you make a mistake, they will tell us."

Care staff received an annual appraisal once they had worked for the service for a year. Records indicated that these were taking place as required and care workers told us they found these useful. One care worker told us, "The appraisal was good because I could really think about my development and look ahead."

People who used the service were supported to access healthcare services and receive ongoing healthcare and support as required. People's care records included details about their medical histories and whether they had any ongoing healthcare needs. For example, we saw recorded details of one person having Alzheimer's. Their record contained details of how long they had the condition, how it developed and advice for care workers in how they should care for the person. People's care records also contained other details about people's ongoing healthcare needs. This included their oral and eye care needs, whether they required any appointments and how care staff could assist them. For example, we saw in one person's records that care staff were required to assist one person with their oral care needs by reminding them to brush their teeth both in the morning and evening.

Care staff had a good level of knowledge about people's healthcare needs. For example, one care worker gave us details of one person's diabetes and how they were required to manage this. For example, care staff were required to check the person's blood sugar levels every month, to record this and to report any issues to their GP.

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

Care staff understood the requirements of the DoLS and knew who was subject to this and required restrictions on their movements. There was restricted entry and exit to and from all the units, via use of keypad codes. Care staff told us that people were reminded of these codes provided their movement was not restricted by a DoLS authorisation. We observed some people using these codes in order to leave their

unit.

Documentation indicated that appropriate procedures had been followed in restricting people's liberty where needed. We saw applications had been made to the local authority and authorisations had been made in people's best interest. We also saw that mental capacity assessments had been conducted where needed to ensure that people were able to consent to their care. Records showed that these were conducted appropriately and included the involvement of the person's next of kin or advocate, as well as their doctor or healthcare professional.

Good

Is the service caring?

Our findings

Prior to our inspection we received a concern that people were not treated with dignity. At this inspection people told us they were treated with respect and their dignity was maintained. One person told us, "They respect you and knock on the door" and another person said, "I think they respect me." We observed care staff knocking on people's doors before they entered their rooms. Care staff gave us examples of how they maintained people's dignity, in particular when they were supporting people with personal care. One care worker told us, "We try to ensure people are receiving personal care to have a dignified and hygienic appearance. We do this in private", and another care worker told us they will "ask relatives to come out of [people's] room when giving personal care, unless the resident asks them to stay."

People gave good feedback about the care workers and other staff and told us they were treated in a caring way. People's comments included "The staff are nice" and "They are very kind."

We observed people interacting with care staff throughout our inspection and found people were treated with warmth, familiarity and kindness. We observed care staff chatting to people, laughing together and sharing conversations based on people's individual interests. For example, we heard one care worker speaking to a person about a holiday they had previously taken and another care worker spoke with a person about a sport they enjoyed watching on television. We also saw care staff responding to people's immediate needs quickly. For example, we saw one person had a spilled a drink and was upset at having done so. Care staff approached the person calmly and quickly. They cleared their table very quickly and took them to change their outfit, speaking to them reassuringly as they did so.

Care staff demonstrated that they knew the people they were caring for. We spoke with care workers about specific people and they demonstrated a knowledge of their care needs as written in their care plans, but also had knowledge of people's personal histories and their preferences in relation to their care. For example, one care worker explained the importance of one person's family visiting them as frequently as possible. They told us the person looked forward to these visits very much and when they were unable to attend, care staff tried to involve the person in activities to keep them occupied and happy. Another care worker told us about the career of another person and used this information to speak with them about subjects that would interest them. The care worker told us they could see a change in the person's mood when they spoke about matters related to their former occupation.

Care staff made attempts to communicate with people in a way they could understand and care records confirmed this. For example, we saw one person struggled to communicate in English. The provider had therefore employed a care worker who spoke the same language, but on occasions where a care worker speaking the same language was not available, care staff knew common phrases that the person could understand. For example, one care worker told us the words they used to ascertain the person's needs in relation to their food or whether they needed to use the toilet.

Care records included details of people's cultural and religious requirements. This included whether they attended a religious service or whether they had any particular requirements which emanated from their

religion. For example, we saw one person's care record stipulated that they were a Muslim and as a result required Halal meat to be provided. Care workers and the catering staff were aware of this.

Good

Is the service responsive?

Our findings

People told us they were involved in the assessment of their care needs. People's comments included "They asked me questions when I first moved in" and "I have a care plan… they spoke with me and my [relative] about this."

At our previous inspection we identified some concerns with activities provision. We found there were limited activities on offer and those taking place did not reflect what was advertised on the activities timetable. At this inspection we found activities were taking place as scheduled and there was a wide variety of activities on offer both inside and outside the building. The provider employed three activities coordinators, one of whom worked at the service on a full- time basis. They delivered a programme of activities which included games, singing and dancing and flower arranging. The provider worked in collaboration with external partners in delivering some joint activities. For example, they were delivering a sculpting activity in conjunction with a local school that people enjoyed. Some activities were also delivered by volunteers who were appropriately trained and inducted into the service. For example, we spoke with a singer who had attended the service on the second day of our inspection. We found people enjoyed this activity very much as they sang along to the songs, danced and engaged positively with the volunteer.

Further activities on offer included outdoor visits, such as trips to museums or the local gardens and organised parties such as a recent black- tie event which relatives commented positively on. We also found there were one to one activities available for people who could not or did not want to leave their rooms. For example, we heard someone being sang to in their room during our inspection and we saw people were delivered their choice of newspaper and assisted to read this by care staff.

We spoke with the lead activities coordinator on the final day of our inspection. They told us people's involvement in activities was monitored and recorded on the online system. We looked at a sample of records and found people's involvement in activities were recorded along with their involvement and feedback. The activities coordinator explained that people sometimes refused to participate in activities depending on their mood and whether they were interested in the activity on offer, but that they monitored the number of times they refused in order to determine whether they should take further action to ensure they were not socially isolated. For example, the activities coordinator expressed concern about one person they had noticed who had not participated in activities for a period of four days. They told us they were aware that the person did participate in some activities and knew they had left their room to interact with people. The activities coordinator told us they intended to speak with this person later in the day to determine their needs and take further action if needed.

At our previous inspection we found complaints were not always responded to in a timely manner. At this inspection we found complaints were responded to in time and the provider had an effective complaints policy and procedure in place which was displayed on notice boards within the building. People told us they would feel comfortable complaining about any aspect of the service if they needed to. For example, one person told us, "I haven't had to make a complaint. I would ask one of the staff if I had a problem with anything." One relative also told us their other family members "notice everything and they would be on the

nurses like a tonne of bricks" if they experienced any problems with the care. They went to tell us they "would give them 9.5 out of 10. I've had one issue, but that was sorted out. I have no problems."

The provider's complaints policy stated the manner in which complaints were to be dealt with, and this included the necessity to record complaints and promptly respond to the complainant. We looked at complaints records that were kept by the management team within the service. These demonstrated that complaints were logged and details were monitored within a dedicated 'complaints tracker' audit. We saw complaints were responded to promptly, to the satisfaction of the complainant and where necessary, appropriate changes were made to deal with these.

Care plans reflected different aspects of people's needs including their physical and mental health as well as their social needs. Care records included details about people's physical heath including their moving and handling needs, whether they were taking any medicines and their skin integrity among other matters. There was also an assessment of people's risk of social isolation and whether people had any challenging behaviours. People's paper care records included a summary of the care plan which was written in relation to each area of the person's needs and their full care plan was on the computer system for care workers to refer to if needed. Care records were reviewed monthly on 'the resident of the day'. This was a scheme which was designed to ensure that people had personalised attention on one day in the month. On this day, people's care records were reviewed and updated, their rooms were checked to ensure they did not require any changes to be made and they were given a specially prepared meal of their choice. We found people's care plans were personalised and included individual details about people's needs, their routines and their preferences. For example, we saw written information including details of one person's favourite classical music composers as well as the pieces of music they liked to listen to when in their room.

The provider worked in partnership with other professionals such as social workers, occupational therapists and people's GPs. We saw examples of written communications about people's needs and where changes were made to their care, these were recorded within people's records. For example, we saw one person's mental health care record included advice from their psychiatrist which had been effectively implemented.

Requires Improvement

Is the service well-led?

Our findings

The law requires that providers of care services send notifications of changes, events or incidents that occur within their services to the Care Quality Commission. The provider was aware of their obligation to submit notifications of significant incidents, but not all notifications had been sent to the Care Quality Commission (CQC) as required.

This was a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

At our previous inspection we found quality monitoring systems were not always effective. At this inspection we found the provider had good quality assurance systems in place to monitor and improve care. The manager or team leader of the unit competed audits which included a health and safety audit, a monthly review of three care records per unit and a monthly medicines audit. Further monthly checks were conducted by the manager which included a check on accidents and incidents and complaints within the home and whether these had been appropriately investigated and dealt with. Where issues were identified, we found action plans were in place to address these. Further auditing was conducted by the regional manager who the manager reported to. This involved a monthly check that all audits were being conducted as required as well as obtaining feedback from care workers and testing their knowledge of procedures, such as the need to report incidents and safeguarding concerns.

Prior to our inspection we received a concern that there was low morale among care staff and this had been exacerbated by a lack of consistent leadership within the home. Our conversations with care workers demonstrated a concern that there had been inconsistent leadership for approximately one year. Care worker's comments included "The change of managers has really had an effect.", "It has been very hard to have different managers, but we stick with what we are doing" and "At the beginning it was great and then after the first manager [left] people [managers] were coming in and out. You didn't know who to go to for support… Recently I have felt …more supported."

The manager and regional manager accepted that the change of managers had been disruptive for care staff and told us they had been aware of this for some time. They were honest and clear about improvements they were trying to make to restore staff confidence and demonstrated they had begun to take action to manage this appropriately. For example, the manager had applied to become the registered manager of the service in order to stabilise the management team. The provider was also conducting monthly human resources (HR) meetings with staff in order to discuss their concerns and provide additional support. Both the manager and the regional manager told us they considered repairing staff morale a priority and were also implementing further initiatives to do so. For example, they were reintroducing a scheme known as the 'gem awards'. This was for care staff to nominate a colleague who they considered had gone above and beyond in their role. The manager and regional manager explained that this was to provide encouragement and appreciation to care staff who were delivering excellent care.

Care workers, relatives and people using the service gave good feedback about the manager and told us they hoped she would stay with the service. One care worker told us, "She is so calm. She talks to you in a

human way. She's lovely" and one relative told us the manager was "very helpful." We observed the manager interacting with both care staff and people using the service throughout our inspection. Despite only having worked at the service for six months, the manager demonstrated a good knowledge of people using the service. Her conversations with people demonstrated familiarity. We observed her to approach one person who was struggling to communicate with care staff. She quickly approached the person and reverted to their language which they responded well to.

The provider had a clear governance framework which ensured that roles were identified and understood. We met both the manager and the regional manager every day of our inspection. The manager was clear about her responsibilities within the organisation, but also received support from the regional manager. This ensured that higher levels of the management team were aware of what was happening within the service and that the manager had direct, senior management support to manage known issues.

Care staff also had a good understanding of their roles and responsibilities. They confirmed they had received a job description prior to starting work at the service and that their roles had met their expectations. One care worker told us "The main purpose of my job is to care for people… to actually care. I care for people's families too. You have to be a caring person."

The provider had effective systems in place to ensure confidential data was protected. People's care records and daily notes were on the provider's computer system, which only authorised personnel could access. There were also paper records available of people's care records and these were safely stored on each unit of the building.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider did not always notify the Commission without delay of the death of service users whilst services were being provided in the carrying on of a regulated activity. 16(1)(a).