Defiant Enterprises Limited

The Laurels Care Home

Inspection report

The Laurels
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Date of inspection visit:
23 July 2018
24 July 2018

Date of publication:
15 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 and 24 July 2018. The first day was unannounced.

Our last full comprehensive inspection of this service was in July 2017. At that inspection we rated the home overall as Requires Improvement. At that inspection there were three breaches of legal requirements within the Safe and Well Led areas.

Following that inspection we received a number of concerns regarding the quality of care being provided to people. Therefore, we conducted a focused inspection in November 2017 that concentrated on the Safe and Well Led areas only where we found breaches of five regulations. This was because the provider had failed to ensure that: risks to people's safety had been adequately managed and that people received their medicines correctly; staff had the appropriate skills and knowledge to provide people with safe care; the home and some equipment that people used was clean; robust systems were in place to assess and monitor the quality and safety of care provided to people and that certain incidents had been reported to the Care Quality Commission (CQC) as required by law. The home was therefore rated as Inadequate and placed in special measures. Services that are in special measures are kept under review and inspected again within six months from the publication of the report. We expect services to make significant improvements within this timeframe.

During this latest inspection the manager and provider demonstrated to us that improvements had been made and the home is no longer rated as inadequate overall or in any of the key questions. Therefore, this home is now out of special measures. The provider is no longer in breach of any of the regulations that we found at our inspection in November 2017. However, further improvements are needed in some areas as detailed further below.

The Laurels Care Home is a 'care home'. The provider advertises themselves as providing specialist care to people living with dementia and who are frail. It is registered to provide care for up to 52 people and care is provided on one floor. At the time of the inspection there were 26 people living in the 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.

There was a manager at the home and they have applied to register with the CQC. 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 home is run.

People felt safe living in the home and systems were in place to protect them from the risk of abuse. Risks to people's safety and individual needs and preferences in the main, were managed well. However, the guidance provided to staff on how to manage these risks and meet people's individual needs and

preferences was variable in its quality. This included at the end of their life.

Most people had received their medicines correctly although some had not for a short period of time which had not been identified in a timely fashion by the provider. Therefore, this requires an improvement to the provider's current quality monitoring systems so they are more robust to identify such issues to enable the necessary action and improvement to be made. The manager told us during the inspection visit that these would be implemented immediately.

There were enough staff to keep people safe and to meet their needs. New staff working at the home had been subject to the appropriate checks before their employment began designed to check they were safe to work within care. Most of the communal areas within the home, people's rooms and the equipment that people used was although there were some offensive odours in two areas that the manager was actively trying to reduce.

Any incidents or accidents that had occurred had been reported, investigated and learnt from. People who lived in the home, those who were close to them and the staff were involved in improving the quality of care that was provided by providing regular feedback to the manager and provider.

Staff had received training in a number of different areas to provide them with the skills and knowledge to support people effectively. Further training was to be provided to staff regarding dementia care to help them develop their skills further and gain confidence on how to assist people who may regularly become upset or distressed. Staff also received adequate support and guidance in their roles.

People received enough to eat and drink to meet their individual needs. Religious and cultural aspects of their care were respected. Consent was obtained from people before any care was given. Where people could not consent, staff acted in line with the relevant legislation and only made decisions on people's behalf in their best interests.

People received stimulation from a range of activities that were on offer. This included one to one chats within people's rooms. This was being developed further in conjunction with the people living in the home and their relatives.

People were offered choice and were involved in making decisions about their own care. The staff were kind and caring and treated people with dignity and respect. People and staff were able to raise concerns or complaints without fear which demonstrated an open culture. Any complaints or concerns raised had been appropriately investigated and dealt with.

People's healthcare was monitored and any needs met. Relationships had been developed with outside healthcare professionals who visited the home regularly in response to any concerns raised.

Governance and quality monitoring had improved, but still required further amendments to ensure it was robust. Audits and checks in place to monitor the quality of the service had not found some of issues that were present during our inspection. The manager and provider were open to suggestions for improvement and had a plan in place to drive up the quality of the service provided.

The staff were happy working at the service, felt very supported by the manager and provider and worked well as a team to deliver care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements had been made to the assessments of risks to people, however guidance to staff in the management of this needed to be clearer in some records.

Audits of people's medicines needed to be more robust to ensure that any issues where identified at the earliest opportunity.

The service was clean and staff demonstrated good infection control practices.

Safe practices where undertaken in the recruitment of staff. There were enough staff to keep people safe, although people reported that care provided by staff was rushed on occasions.

Is the service effective?

Good

The service was effective.

Staff were provided with training, supervision and a yearly appraisal to maintain and develop their skills.

People's rights were respected and care was provided with consent or in people's best interests. Staff understood the principles of the Mental Capacity Act 2005.

People had access to enough food and drink to meet their needs. They were able to see healthcare professionals when needed to help them maintain their health.

Is the service caring?

Good

The service was caring.

People confirmed staff were caring and kind.

Staff provided caring support to people and their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people's care records still lacked important information about how staff were to support them, which may lead to some people not receiving the right care and support.

A complaints policy and procedure was in place. Issues raised were acted upon to improve the service.

Staff required training and development in ensuring they could consider the needs of people at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Governance and quality monitoring had improved, but still required further amendments to ensure it was robust. Audits and checks in place to monitor the quality of the service had not found some of issues that were present during our inspection.

People using the service, relatives and staff had their views asked for and their feedback was acted upon.

The recruitment of a new manager had an immediate and positive impact, people and their relatives had found the service was improving.

The Laurels 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.

We inspected this service in line with our methodology where we return to re-inspect services rated as Inadequate within six months of the report being published on our website. The inspection took place on 23 and 24 July 2018. The first day was unannounced which meant the provider did not know we were planning to inspect the service.

On 23 July 2018, the inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 24 July 2018, two inspectors and an inspector who specialised in medicines management visited the service.

Prior to the inspection, we reviewed information we held about the service to inform our planning of the inspection. This included notifications that the provider has to send us by law and any concerns and/or positive feedback received about the quality of care provided at The Laurels. We also gained feedback from the local authority quality assurance team and two healthcare professionals.

During the inspection, we spoke with six people and three of their relatives to gain their views about the quality of care received. Some people living at The Laurels were not able to provide us with verbal feedback regarding this, therefore we spent some time observing the care that these people received. We also spoke with six staff that included care, activities and kitchen staff. We also spoke with the manager and a director who represented the provider, Defiant Enterprises Ltd.

We looked at a number of records that were kept in relation to the care that people received. This included five people's care records and a number of people's medicine records. We also looked at staff training, recruitment and supervision records and paperwork in relation to how the provider monitored the quality of care provided to people living in The Laurels.

Requires Improvement

Is the service safe?

Our findings

Following our last inspection of this domain in November 2017, we rated Safe as Inadequate. At this inspection we have rated Safe as Requires Improvement.

At our last inspection in November 2017, we found that the provider was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not taken appropriate action to manage risks to people's safety or to ensure they received their medicines correctly. At this inspection we found that improvements had been made and therefore, the provider is no longer in breach of this regulation. However, further improvements are required to medicines management to ensure that people receive their medicines correctly.

People and told us that they received their medicines regularly and on time. Relatives we spoke to confirmed this. Records showed overall that most people living in the home had received their medicines as prescribed. However, we noted that medicines for some people had not been delivered by the pharmacy when needed. Staff had contacted the pharmacy about this to try to obtain the medicines but we saw that they had not done this for two days after the delivery due. This had been due to a breakdown in communication. This meant that some people had not received their medicines for a short amount of time. Also, one person had received an incorrect dose of Warfarin. This had not been identified through any current audits undertaken by the provider because they were being conducted on a monthly basis. When we fed this back to the manager they immediately put a new system in place to audit these types of medicines weekly. We concluded that people would not have come to harm in relation to these errors.

Medicines were stored securely for the protection of people living in the home. Medicines requiring refrigeration were stored within the appropriate temperature range to ensure they were safe to use. However, we noted that at the time of inspection the temperature of the room in which oral medicines were stored, exceeded the upper limit recommended. During the inspection, the manager arranged for an air conditioning unit to be fitted within the room to reduce the temperature.

When people were prescribed medicines on a when-required basis, there was written information available for medicines prescribed in this way to show staff how to give them consistently and appropriately. However, when more than one pain-relief medicine was prescribed in this way, more detail was needed about the person's overall pain-relief strategy. In addition, there were no pain assessment tools in use for people who were unable to tell staff about their pain levels. This is important to help staff identify when people are in pain so they can give them the appropriate medicine. We discussed this with the manager who agreed to implement these systems.

There were additional records in place for people who were prescribed medicated skin patches to show that they were applied to different parts of the body each time to reduce skin effects and also to show their removal to ensure safety. Body maps were in place for medicines prescribed for external application such as creams to show where on people's bodies they should be applied, however we noted some gaps in the daily records of their application.

There was supporting information available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities and notes about how people prefer to have their medicines given to them.

We observed the latter part of the morning medicine round and noted that medicines were given to people by staff who followed safe medicine administration procedures. Staff who handled and gave people their medicines had received training and had their competence assessed regularly to ensure they managed people's medicines safely.

People and their relatives told us that they felt safe living at The Laurels. Most risks to people's safety had been managed well. These included risks in relation to falls, choking and malnutrition. For example, some people had equipment in place to reduce the risk of injury should they fall out of bed such as a crash mat and a bed that could be lowered to the floor. We observed staff ensured that people who may forget to use their walking frame had this near them and prompted them to use it where needed to reduce the risk of them falling. People who were at risk of choking received their food in line with specialist advice. Staff ensured that people were sat up before they ate to help prevent them from choking.

Staff told us they re-positioned people regularly who were at risk of developing a pressure ulcer to help reduce the risk of them developing one. Specialist equipment was in place such as mattresses and cushions and we observed people to be laying or sitting on these where it was indicated they were required. However, for one person the records we viewed did not always support that people had been re-positioned as frequently as deemed required by the manager to manage this risk. We also noted that another person's specialist air mattress was set at an incorrect setting for their weight. This meant that it may not have been as effective as it could have been. The manager immediately put new systems in place to monitor these areas more robustly.

The information within people's care records to guide staff on how to manage risks to people's safety was variable. Some had very clear information to tell staff what they needed to do to reduce the risk whilst others did not contain all relevant information. For example, one person's care record guided staff clearly on what action they needed to take to support a person when they became distressed. However, another person's care record did not specify how often staff needed to offer them a drink to reduce the risk of them becoming dehydrated. The manager told us they were currently working on updating care records and that relevant information would be added so that all contained sufficient information. This would reduce the risk of staff providing people with unsafe care.

The manager had completed risk assessments in relation to any items that could be hazardous to people such as toiletries and razors and where appropriate, these were kept secure in a locked cabinet for the safety of the people living in the home.

Risks to the premises had been managed well. Fire exits were clear to aide any evacuation from the premises that was required. Any hot surfaces such as exposed pipes that had been deemed as a hazard had been covered to reduce the risk of people acquiring burns. A fire safety officer had recently visited the home and concluded that fire safety within the home was adequate. They had made three recommendations to the provider which were being worked on during our inspection. The manager made regular checks around the home in respect of fire safety. Lifting equipment such as hoists had been serviced in line with relevant legislation. Checks of water temperatures were in place to help reduce the risk of legionella.

The home had been visited recently by the local authority to review their procedures regarding food safety. The manager told us that the home had again been awarded the top mark of five stars.

At our last inspection in November 2017, we found that the provider was in continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not taken appropriate action to ensure that some areas of the home or equipment that people used was clean. At this inspection we found that the required improvements had been made and therefore, the provider is no longer in breach of this regulation.

A relative we spoke to told us that, "The care home is clean." We found most areas of the home were clean and we saw the equipment that people used was also clean. There was an odour of urine within two areas of the home. The manager told us they had identified this and plans were in place to replace a carpet in a communal area and to steam clean the other communal corridor. We observed that the kitchen was clean.

Staff used good infection control practice. They were able to tell us what precautions they took to reduce the spread of infection and we saw this in their practice where they wore gloves and aprons when assisting people with personal care.

At our last inspection in November 2017, we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not taken appropriate action to ensure that staff employed in the home had the necessary skills and knowledge in place before they provided care to people. At this inspection we found that the required improvements had been made and therefore, the provider is no longer in breach of this regulation.

The provider and manager had made the required checks on new staff before they allowed them to work at the service. This included a check to ensure they had not been barred from providing care within a care home setting and references from past employers so they could assess these staffs character. Where staff had said they had a qualification in social care, the provider had checked that this was the case.

People and their relatives told us that there were enough staff on duty to keep them safe. We received mixed feedback about whether staffing levels meant that staff had the time to provide care that was not rushed. One person told us, "I know the staff but there's been lots of changes." This related to the employment of several new staff at the home. Another person told us, "Staff respond fairly quick at night." Another person told us, "I use the call bell when I need to, mostly they are kind but sometimes when they are busy, they say you are not the only one here."

Two relatives that we spoke with told us that they had seen a reduction in the number of agency staff used due to recent recruitment. They went on to tell us that they felt this was an improvement in the continuity in care for people.

All of the staff told us that there were enough staff to keep people safe and to meet their needs. They told us that this had significantly improved since our last inspection. A staff member we spoke with told us, "Yes there is enough staff now. [Manager] has also changed how we are allocated which is much better now. There was no structure before but there is now." Another staff member told us, "There didn't used to be enough staff before, people left and new staff didn't stay, but they do now." We observed there were enough staff to keep people safe and to meet their needs. However, in the morning people's calls for assistance were frequent and staff were seen to be very busy. At this time, most of their practice was task based and the staff did not have time to spend engaging with people, particularly those who chose to spend their time in their rooms. This improved in the afternoon where we saw some staff had more time to engage with people.

We spoke to the manager about staffing levels. They told us they calculated these based on people's individual needs. Following a recent analysis of incidents, they had increased the number of staff working in

the afternoon. This had only recently been implemented and they were still reviewing this to ensure the times for this extra staff member were correct.

At our last inspection the provider had a high usage of agency staff to cover shifts. This had now reduced and the majority of shifts were covered by existing staff. However, the provider told us that agency staff could still be used as a contingency to provide cover if needed to ensure that people's needs could be met.

The manager had reported any incidents of alleged abuse to the local authority safeguarding team, and had notified the Care Quality Commission (CQC). Staff we spoke with knew how to keep people safe and were aware of their roles and responsibilities in reporting any concerns or incidents. They told us this could be to their manager or to external safeguarding agencies such as the police or the local safeguarding authority. Staff had undertaken training in the safeguarding of adults, and could tell us how to recognise indicators of abuse.

The staff we spoke with were clear that they needed to report any incidents or accidents that occurred to a senior member of staff such as falls or medicine errors. Records showed that the manager had then reviewed these to ascertain if they needed to take any action such as requesting specialist advice in relation to falls. Lessons had been learnt from incidents. For example, the manager had re-assessed risks to people's safety in relation to ingesting liquid soap following a recent incident. This had resulted in some people having this removed from their room where it was felt a risk to their safety.

Good

Is the service effective?

Our findings

Following our last inspection of this area in July 2017, we rated Effective as Requires Improvement. At this inspection we have rated Effective as Good.

During our last inspection of this area in July 2017 we found that the competency of staff had not been assessed to ensure that their care practice was safe. This had resulted in some staff providing people with unsafe practice. At this inspection we found the required improvements had been made.

The manager had assessed the competency of new staff before they started working with people on their own. The staff told us that the manager had regularly worked alongside them to provide support and guidance in relation to their practice. Staff were able to explain to us how their competency was checked, and reported that these checks had increased since the arrival of the new manager. Staff also told us that they received regular supervision sessions, where they discussed their performance and planned their skills development with the manager.

All of the staff we spoke with told us they felt the training they received was good and provided them with the skills and knowledge they needed to provide good quality care. One staff member told us, "Since the last inspection, we've had lots of training." Staff told us that they had also completed face to face training in some areas, which they felt was more beneficial than on line based training. For the majority of the inspection we observed staff using safe practice. There was one instance where two staff members assisted one person to stand from a chair using an unsafe technique. However, a senior member of staff was present and intervened to ensure the manoeuvre was safe.

Staff who were new to the home completed induction training that was based on the Care Certificate. This is a recognised qualification within the social care industry. Staff also told us they were supported to complete other qualifications in health and social care if they wished to do this.

Records we checked in relation to staff training showed that the majority of staff had up to date training in a number of areas including but not limited to fire safety, food hygiene, safeguarding adults and moving and handling. Staff received their training either face to face or via a DVD and then completed a workbook on each subject that was assessed externally. Once completed satisfactorily, the staff member received a certificate to demonstrate the training. We ascertained that the training staff received in respect of dementia was also delivered in this manner.

We spoke with the provider and manager about this method of delivery in respect of dementia as we were aware that they intended to provide care to people with advanced dementia. The provider told us they were aware that staff required further training in this area to give them the skills and confidence to support people who may regularly become upset and distressed. Therefore, they had booked further training with an outside trainer with knowledge within this area. The manager told us they had received training in dementia from dementia specialists and could therefore guide and support staff whilst they were working with people.

Before moving into the home, a holistic assessment of people's needs had been completed covering their physical, mental and social needs. The manager had some awareness of best practice in relation to providing care for people living with dementia although these had not yet been implemented. The manager was in the process of issuing new policies and procedures for the service and they told us that these would be reflecting best practice guidelines issued by professional bodies such as the National Institute for Health and Care Excellence.

People and their relatives told us that they were satisfied with the food and drink provided. One relative told us, "The food is good, like you get at a good restaurant." All the staff we spoke with had a good knowledge of people's food likes and dislikes and any cultural needs they had in relation to food. They also expressed to us the importance of ensuring that people had enough food and drink to meet their needs.

We observed the lunchtime meal in the main dining room. This was a pleasant and social experience for people. A choice of two main meals was on offer. Alternatives were given and provided to people if they did not like the main meals. For example, one person who had declined both of the choices provided said that they did not feel like eating due to the hot weather. A staff member asked them if they would like a chilled homemade blackcurrant milkshake instead, which the person readily accepted and enjoyed. Where people could not make a decision about what to eat, the staff showed them both meals to help them make their own choice.

People received assistance to eat when required. Staff did not rush people and regularly checked with them as to whether they were enjoying the meal, and if the temperature of food was suitable. We saw a staff member supporting a person to eat ask them after the first mouthful, "How does it taste?" The person replied, "Lovely". We observed that staff had noted that a person being supported to eat appeared to not want the company of the staff member with them. Staff discussed this discreetly and changed the person supporting them to see if this was more suitable for the person, but checked with the person first that this was okay.

People who chose to eat their meals in their rooms received this in a timely manner. One person decided to move from eating in the lounge area to the dining room as they felt hot. This was facilitated by staff without delay or fuss. Where people did not eat much, staff prompted them to eat as much as they wanted to. Staff were attentive to when people slowed down their pace of eating, or had become confused due to living with dementia. For example, one person was using their table knife to eat rather than a fork. Staff spotted this quickly and discreetly supported the person to use a fork.

People had access to a choice of drinks which were regularly topped up. One person who resided in their room was offered an alcoholic beverage that they enjoyed. During our inspection both days were very hot. In response to this we saw that staff offered people ice lollies and/or ice-cream to help them cool down.

The kitchen staff were aware of which people required their foods to contain extra calories to help them build up or maintain their weight. They explained they would add extra calories in the form or cream or butter to certain foods. Milky drinks and milkshakes were also provided to some people. Snacks such as biscuits, cakes and fruit were available as part of the regular drinks trolley that went around the home several times per day.

Where people were at risk of not drinking much, their intake had been recorded. Some people's records did not reflect that they were being offered drinks as frequently as they required. For example, one person had been assessed as needing to have drinks offered every two hours but the records showed that sometimes these had not been given for between three and four hours. However, staff told us they regularly offered

people drinks and we observed this to be the case. We have therefore concluded this is a records issue rather than people not receiving suitable assistance to drink.

The staff told us they worked well as a team to deliver effective care to people. They also worked well with other healthcare professionals when required. Records showed they followed healthcare professional's guidance when given. When people came to live in the home, the manager visited them in their current place of residence to find out their requirements and assess their needs. This meant they worked closely with organisations such as hospitals and local authorities to ensure the person's move in to the home was as smooth as possible.

People and their relatives said they had access to healthcare professionals as and when required. They also said staff were proactive in seeking medical attention should a person feel unwell. One person told us, "I have seen the doctor, district nurse, I have also seen a chiropodist."

During our inspection visit, we observed a nurse visit the home to provide people with diabetes care. The manager told us that the GP visited regularly to check on people's healthcare needs. Staff told us that they understood the importance of ensuring people received good healthcare, and described how they would report any concerns to the senior staff on duty. Records showed that staff requested assistance from specialist healthcare professionals when needed such as physiotherapists, dieticians or the speech and language therapist. An optician had visited some people to have their eyes checked and dentists had seen others. The manager told us that people saw the dentist when needed but that not all had been offered an annual dental check as recommended by the National Institute of Health and Care Excellence. The manager said they would immediately implement this to ensure that people's oral care was monitored as they wished or that was in their best interests.

During the inspection we viewed the premises to judge whether it was suitable for the people who live there. The home had a number of spacious lounge areas for people to use. One lounge was used for activities but the others were quiet areas where people could spend time if they wished. There was one dining room in use and another available. The one that was used was bright and airy. People's bedrooms looked comfortable and well equipped with storage for clothes and a television if they wanted this. People were able to freely access a pleasant outside garden area. The manager told us that plans were in place to develop this garden into a sensory area for people and to enclose another garden for people so they could use this freely whilst remaining safe.

Hand rails were in place for people to use whilst they were walking around the home. Some signage was strategically placed to help direct people to certain areas within the home. Pictures were on some people's doors that were meaningful to them which is good practice in dementia care. However, this was not in place for everyone living with dementia which may help them orientate themselves to their own room. There were some pictures on the walls that people could look at for interest. There were also some rummage items for people to pick up to provide them with sensory stimulation, although these were not all over the home and therefore, not available to everyone. The use of colour could be improved in some areas to help people be more independent such as colour contrasted toilet seats, plates or doors.

The manager told us they had plans to improve the environment further and we recommend that the provider consults some best practice in relation to developing the environment further for people living with dementia.

Some people living in the home lacked capacity to consent to and make decisions about their own care. Therefore the staff had to comply with the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA)

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People and their relatives told us that staff always sought consent before providing care. One person's relative told us, "The staff know him well, they talk to him to tell him they need to do something and ask, 'Is that okay with you'." All of the staff we spoke with had a good knowledge about the MCA and DoLS. We observed them regularly asking people's consent. Where people could not make a decision, staff offered them choices such as what to wear or eat to help the person make a decision for themselves.

Where it was in doubt, the manager had assessed people's ability to make certain decisions about their own care. This included areas such as medicines management, the provision of personal care and if people had pressure call mats in place. Where the person lacked the capacity to consent to the care being offered, a best interest decision had been made. This involved relevant parties such as a healthcare professional and relative. The manager was aware if a person had a Power of Attorney in place and ensured they were contacted for their consent on decisions as required.

The manager had assessed if anyone living in the home was being deprived of their liberty. Where they were, an application had been made to the local authority for this to be authorised. The manager ensured that where people were being deprived of their liberty, the least restrictive option was being used.

Good

Is the service caring?

Our findings

Following our last inspection of this area in July 2017, we rated Caring as Requires Improvement. At this inspection we have rated Caring as Good.

During our last inspection of this area in July 2017 we found that the provider had not ensured that people received a service that was consistently caring. At this inspection we found the required improvements had been made.

During the inspection we observed staff being consistently kind and caring to people and treating them with dignity and respect. A relative told us that they were kept up to date with their family members welfare, and that this was a strong point of the service. They also told us, "[Relative] is always clean and comfortable." A person living at the home told us, "I like the carers, they will do anything for you."

People were spoken with by the staff in caring tones and staff were attentive to their emotional needs. On one occasion we saw a person become upset. A staff member immediately offered them comfort which made the person happier. The staff were polite and always offered to help people or assist them if they required this. One person had recently been through a period of severe illness and was recovering slowly. They were reluctant to eat, but the manager had purchased the persons favourite ice cream on the way to work that morning. They asked the person if they would like some, to which they enthusiastically replied, "Oh yes please." We observed the person enjoying this and when they finished told us, "That was lovely." The same person had spent a considerable amount of time in their room due to this ill health, but had decided to spend some time in the communal lounge. Staff who had not seen the person for a while stopped to speak to them, saying how nice it was to see them and how much better they looked. This pleased the person who was smiling and talking to them.

Staff ensured that items such as TV remote controls, drinks and food were placed within people's reach so they could access them easily. During lunchtime, staff sat with some people who required assistance to eat their meals. The staff engaged with them, making sure the person had plenty of time to eat each mouthful before offering more. Gentle encouragement and prompting was given to people. People were observed to respond to this manner of care with smiles and looks of contentment.

Staff knew people's preferences and personal histories well. One staff member we spoke with could tell us a person's work history. This meant they could have discussions about things that mattered to the person from their past. We saw another member of staff who was supporting a person to eat, talk about favourite foods from their child hood, and the food their mother used to make. Staff knew that the person liked to reminisce about memories from their childhood.

People and where appropriate relatives or someone close to the person, had been involved in the initial assessment of care so the provider could ascertain what level of support was required. People and relatives were also asked for their opinions regarding the care in the form of an annual survey so they could express their views about the care they received.

Throughout the inspection we observed staff actively involving them in making decisions about their care. This included areas such as where to reside within the home, what to eat and drink and what activities they wanted to be involved in.

One person who wanted to stay in their bed in their underclothes due to the heat was provided with a screen to protect their dignity. Doors were also closed when providing people with personal care and conversations with people were held quietly so that their privacy was respected.

Staff ensured that people were supported to remain as independent as they could be. People were encouraged to get involved in tasks around the home. We saw that the activities co-ordinator included people in setting out menus, activities notices and update weather boards. They also involved the same person in calling out the numbers during a game of bingo. The person enjoyed doing this. We saw staff act quickly to find them tasks to do when the person, who was living with dementia, become restless and anxious during the afternoon. This was a time of day that the person regularly become upset, staff knew and pre-empted this by offering a range of things for them to do to increase their independence.

Requires Improvement

Is the service responsive?

Our findings

Following our last inspection of this area in July 2017, we rated Responsive as Requires Improvement. At this inspection we have continued to rate Responsive as Requires Improvement.

During our last inspection of this area in July 2017 we found that the provider had not ensured that staff consistently provided care to meet people's individual needs and preferences. Also people's care records were not fully complete. At this inspection we found that some improvements had been made but that further improvements are required to people's care records. This includes for people who were at their end of their life. This is to ensure that staff had adequate guidance on how to provide people with the care they want and need.

People's needs had been assessed. Preferences had also been captured for some people although this was variable. Some contained good information regarding people's preferences such as times to get up, how they wanted their door at night, whether they wanted a male or female carer but others did not contain all of this information. Care plans were in place to guide staff on how to meet people's needs but again as with risk assessments, these were variable in the information they contained. For example, one person's care plan contained very clear guidance on how to support them when they became upset or distressed and another on how to meet a person's needs in respect of diabetes. However, for one person who was noted to have depression there was no information on how the staff were to support the person with this. Also there was no guidance on what staff needed to do to support the person to reach their goals, although the person told us they were receiving this care from the staff. The manager told us they had identified that some information within care records required improving and they were currently working on this.

Staff had recently received some compliments from relatives regarding the care that had been provided at the end of some people's lives. We saw thank you cards that had been sent to the home from family members of people who had passed away. These included comments that staff were kind, caring and attentive.

Staff were aware of people who were at the end of their life and could tell us what support they required. One person had been bought their favourite dessert which we saw them enjoy. The manager told us that extra staff were asked to work when needed so they could spend time with a person who was reaching the end of their life. People who were at the end of their life had the relevant healthcare professionals involved in their care such as GPs and district nurses.

People's choices and preferences at the end of their life in some circumstances had been assessed however, this was not always the case. The manager told us of one person who was reaching the end of their life but the information about their wishes had not been assessed since 2011. There was no plan of care in place for this person or another person about how staff needed to provide them with the care they required. The manager told us they would address this immediately so staff had sufficient guidance within this area. Staff had also not received training in end of life care. The manager told us they had started an accredited training programme in this subject and had plans to roll this out to the staff.

Our conversations with staff demonstrated they knew the people they provided care to well. They were able to tell us about people's personalities, their likes and dislikes and what their occupation had been. During our inspection visit a new person had arrived in the home. We saw that staff took time to get to know this person. They found out their past occupation and plans were put in place to utilise this to help the person to settle into the home.

We observed staff being responsive to people's needs. The days of our inspection visit were very hot and staff responded to this. People had access to fans to keep them cool both in their rooms and in communal areas. People were prompted to stay out of the sun in the middle of the day and ice creams and cool drinks were made available. Staff ensured the people were kept comfortable by offering them cushions or pillows and re-positioned them when required. Some people were observed to have a 'lay in' in the morning if they wished to whilst others were supported to get up at a time of their choosing. One person had not eaten their breakfast as they had fallen asleep on their bed. Staff asked them if they wanted a new hot bowl of porridge which the person said they did and we later saw them enjoying this.

The provider employed an activities co-ordinator to provide people with activities. We observed this member of staff regularly visiting those people who preferred to stay in their rooms to have a chat and check how they were. People were told of what activities were on offer and asked if they wanted to participate. In one area of the home, activity 'stations' had been set up for people to explore and take part in if they wanted to. Some people were seen to enjoy doing word searches and puzzles whilst others enjoyed colouring in pictures and using building blocks. One person told us, "I really like doing this, lots of us here do."

After people had eaten their breakfast, the activities co-ordinator led a session of 'Shake and Wake' which encouraged people to exercise and stretch. We saw that people enjoyed this and participated with energy. Some people had their own set of exercises which focussed on their abilities to ensure they could participate. For example, people who were not mobile were encouraged to stretch and move their arms and hands. In the afternoon, a group of people enjoyed bingo and we heard them talking enthusiastically that they were looking forward to doing this.

There was a programme of activities in place. The activities co-ordinator, who has been working in the home for approximately one month, told us this was being developed in line with people's preferences which they were currently gathering. People told us that they had been asked what activities they would like to do. One person told us that they felt more activities could be provided at the home.

People and their relatives told us that they knew how to complain, and that any complaints had been dealt with to their satisfaction. One relative that we spoke with told us, "We have had no cause to complain here. We do know the complaints procedure, the home has always let us know the procedure."

Since the last inspection the provider had received four complaints regarding the care being provided to people. Each of these complaints had been replied to, fully investigated and the outcome communicated to the complainant.

The provider's complaint procedure was advertised on the back of the doors to people's rooms if they were happy with this to increase their and their relative's awareness of this process. This gave details of who to contact when making a complaint however, we noted that the Local Government Ombudsman information was not detailed. This is the body to whom complaints need to be escalated to if people are unhappy with the provider's response to their complaint.

Requires Improvement

Is the service well-led?

Our findings

Following our last inspection of this area in November 2017, we rated Responsive as Inadequate. At this inspection we have rated Well-led as Requires Improvement.

During our last inspection of this area in November 2017, we found that the provider had not ensured that there were robust quality assurance in place to assess, monitor and improve the quality and safety of care that people received. This resulted in a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that most areas of care were robustly monitored and therefore, the provider was no longer in breach of this regulation. However, some issues we found had not been identified by these current systems. Therefore, further improvements are required.

For example, the manager conducted a monthly audit of equipment that was in place in respect of people's pressure care needs. Also, a daily and monthly check were in place in respect of air mattresses. However, although these had been completed when required, they had not identified that one mattress was set at an incorrect setting for the person's weight. The audits of medicines to ensure that people received their medicines correctly had been completed on a monthly basis. No consideration had been given to checking high-risk medicines such as Warfarin more frequently to ensure people had received these correctly. It had not been identified by the provider or the manager that the temperature of the room where the medicines were stored were likely to exceed required levels due to the very high external temperatures. The manager immediately implemented changes to the existing systems to monitor these areas to make them more robust at identifying such issues.

The manager told us that senior staff checked people's fluid charts daily to ensure they had been completed correctly. However, although staff told us they offered people drinks in line with their needs the records did not reflect this. The manager had identified this as an issue and told us they were working closely with senior staff to improve this. The staff we spoke with told us that they felt record keeping had improved within the home since our last inspection but that further coaching was required for some staff. The manager assured us that this was being regularly monitored and addressed.

Other systems in place were effective at monitoring and improving the quality of care people received. Regular audits of people's weight and nutritional intake had been conducted to monitor that action was being taken in these areas. The manager conducted daily walk around's in the home to assess staffing levels, cleanliness and people's experiences. In response to one of these audits, the manager and staff had reviewed and changed the dining experience to make it more pleasant for people. The manager had also conducted night visits to ensure that people were receiving the care they required.

An audit of the kitchen had recently been completed that had identified it required further cleaning and we saw this had been completed. A schedule had been set up to ensure this occurred on a regular basis. Health and safety audits were also completed monthly and again we saw that where improvements had been identified as being required that these had been completed. For example, the provider had identified that a Legionella risk assessment was required and this had been completed.

A weekly report was sent to the provider so they could monitor the quality of care provided. This included any incidents that had occurred, complaints made and staffing levels. The provider also visited the home at least three days per week where they conducted a walk around of the home to check on cleanliness, staff interaction with people and the quality of care being provided to people. Both the provider and manager were supported by an external consultant who visited the home regularly to conduct audits and fed back their findings which were acted upon.

An overall action plan was in place to enable the manager to monitor progress against any issues that had been identified. New issues were added to this action plan when identified to help drive improvement within the home.

During our last inspection of this area in November 2017, we found that the provider had not notified us of serious incidents that they should tell us about by law. This resulted in a breach of Regulation 18 of the Care Quality Commission Regulations 2009. At this inspection we found that improvements had been made and that we had received the relevant notifications. Therefore the provider was no longer in breach of this regulation.

The manager presently working in the home had been employed by the provider for approximately three months. The director of the provider who was present during the inspection had been the sole director of the company for three months. They had previously had minor input into the home but they were now taking a much more active role in the running of the home. Both the manager and providers director told us they had made a number of changes since these changes had come into place which included increasing staffing levels, recruiting new staff, ensuring staff had received regular supervision and training as well as stabilising the current staff team. They told us that they felt progress had been made but were candid and transparent about how they felt that further improvements were needed.

The new manager had experience of working with people who lived with dementia and therefore had a number of ideas for continuous improvement in this area. This included improving the environment, the information within people's care records and activities that were offered to people. Best practice guidance was to be consulted to make these improvements.

People and their relatives told us that the arrival of the new manager had been positive. One person said, "There is a new manager around which I am getting on very well with. " A relative told us that the new manager was always around and very visible. They went on to say, "When I get older, and if I have dementia, I would hope that I end up in a care home like this."

People's feedback and their relatives where appropriate had been sought to improve the quality of care they received. We saw that the minutes of a recent relatives meeting detailed positive feedback. We reviewed the results of a recent satisfaction survey of relatives. All respondents stated that the quality of care had either improved or was satisfactory. No respondents had said the quality of care had declined.

All of the staff we spoke with told us the quality of care people received had improved since our last inspection. They added that arrival of the new manager and visibility of the director of the provider had had a positive effect. They told us that their morale was high and that they felt supported and valued. One staff member told us, "You can't fault [manager], they are absolutely brilliant, they have lifted the place, good morale now, and they are approachable." Another staff member told us, "You can tell she knows what she is doing." `There was no fear of recriminations if they needed to raise concerns and they told us they were always listened to and respected. Staff said they now had a structure and understood what their responsibilities were. This they said, meant they worked better as a team to deliver care to people.

The manager and director were seen to be visible to staff and the people living in the home which demonstrated an open culture. Both knew the people and staff very well and were seen chatting and engaging with them and assisting staff where necessary. Good relationships had been developed with local healthcare professionals and some community services. This included a local supermarket who provided flowers for the home for people to enjoy. Training and support had been provided by the local Clinical Commission Group in some areas and further training in areas such as end of life care was being sourced.