Acer Healthcare Operations Limited

Cedar Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 28 July 2017 and was unannounced. Cedar Court Care Home provides residential, nursing and respite care for older people who are physically frail. It also provides care for people living with dementia. It is registered to accommodate up to 75 people. At the time of our inspection 62 people were living at the service.

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

People's human rights were not always protected because the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) were not being followed. MCA assessments were not always completed where needed. Staff did not always understand MCA or why it was important to understand if people had capacity to make decisions. There were some staff that did have an understanding of MCA and its principles. Where restrictions were in place this was not always supported by a MCA.

There were aspects to the care that people received that was not always dignified. Some areas of the service smelled strongly of urine and people did not always look clean and well presented. People were not always able to communicate with staff whose first language was not English. Other aspects of care to people was kind and considerate to people's needs. People and relatives said that staff were caring and kind to them and treated them with respect. People and relatives were involved in their care planning and the care that was provided was person centred.

The provider did not always have robust systems in place to regularly assess and monitor the quality of the care provided. Concerns we identified were not always picked up on the providers audits. Where concerns were picked up on audits these were not always addressed. Records kept for people were not always up to date and did not always reflect the most appropriate care.

There were enough staff to support the needs of people at the service. When people required support this was provided quickly by staff. We did raise with the registered manager that staff were not always visible on the dementia unit which was a risk. The registered manager told us that this would be addressed.

People were protected from the risk of abuse and staff understood their roles and responsibilities. People told us that they felt safe. One relative told us, "The care is really good and my relative feels safe and happy here."

Staff understood the risks to people. Staff encouraged and supported people to lead their lives as independently as possible whilst ensuring they were kept safe. People's medicines were managed in a safe

way. In the event of an emergency plans were in place to keep people safe. Accidents and incidents were monitored and action taken to reduce the risks.

Staff received appropriate training and supervision to provide effective care to people. People felt that they were being supported by staff that were effective in their role. Staff felt that they had sufficient training and support. Staff that worked at the service had appropriate recruitment checks before they started work.

People enjoyed the food at the service. Staff supported peoples nutritional and hydration needs and people accessed health care professionals when needed.

Care plans detailed and had specific guidance to staff on how best to support people. Staff communicated with each other the changes to people care. People were able to participate in a range of activities both inside and outside of the service.

Systems were in place if complaints, concerns and compliments were received. The provider actively sought, encouraged and supported people's involvement in the improvement of the service.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the service. Staff told us they would report any concerns to their manager. Staff felt that management were very supportive and staff felt valued.

The registered manager had informed the CQC of significant events.

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 not consistently safe.

Medicines were administered, stored and disposed of safely.

There were enough staff at the service to support people's needs.

People had risk assessments based on their individual care and support needs. Staff understood the risks to people.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always understand the principles of MCA. There were not always MCAs in place to ensure consent to treatment was obtained. Where restrictions were in place this was not always supported by a MCA.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs. Staff received supervisions to ensure best practice.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of their health.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Requires Improvement

There were aspects of the service that was not caring.

People were not always treated in a dignified way and people were not always able to communicate with staff.

Staff treated people with kindness and respect.

People's privacy were respected and promoted.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Good

The service was responsive.

Information regarding people's treatment, care and support was up to date.
People's needs were assessed when they entered the service and on a continuous basis.

People had access to activities and people were protected from social isolation. There were a range of activities available within the service.

People were encouraged to voice their concerns or complaints. Complaints were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well- led.

The provider did not always have effective systems in place to regularly assess and monitor the quality of the service provided. Records were not always maintained.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

Staff were encouraged to contribute to the improvement of the service and staff felt valued.

The management and leadership of the home were described as good and very supportive.

Notifications were sent to the CQC when needed.

Cedar Court Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 28 July 2017. The inspection team consisted of three inspectors, a nurse specialist 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 service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. As we were inspecting earlier than expected we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We will review the PIR at our next inspection.

During the visit we spoke with the registered manager, 11 people, five relatives, 10 members of staff and two visiting health care professionals. We looked at a sample of 11 care records of people who used the service, medicine administration records, training and supervision records for staff. After the inspection we looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

This was the first inspection of this service with the new provider.

Good

Is the service safe?

Our findings

People told us that they felt safe at the service. Comments included, "Yes, they look after us very well", "We are very safe here, no complaints" and, "I do feel safe. There's always someone around. I don't need that much care but they are there if I need them". A visiting relative said, "The care is really good and my relative feels safe and happy here." One health care professional told us, "I'm in every week and haven't noticed anything that would give me concern in people's general care."

People told us that they understood what medicines they were receiving and were involved in the review of their medicines. One person told us, "I take medication for high blood pressure and epilepsy" whilst another said, "I take some for sleeping and for blood pressure."

People's medicines were managed appropriately. We examined the Medicines Administration Records (MAR) for people. Staff told us and we confirmed that regular medicine training updates were offered by the provider and the service dispensing pharmacist. The service's visiting GP had also worked closely with the provider to ensure the safe management of medicines, particularly in the area of ordering medicines. A guide on ordering medicines had been devised, which contained a flow chart describing the process of ensuring the safe and efficient management of this process. Formal competency checks were undertaken with staff as part of the training process and informally after that.

All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective, in line with the provider's policy. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Medicines were safely stored in locked cupboards or lockable fridges if required. The temperature of the fridges and the rooms in which they were housed were monitored regularly to ensure the safety of medicines. Medicine trollies were not left unattended when unlocked and medicines were not signed as given until the person had been observed taking them.

We looked at how medicines given on an 'as needed' basis (PRN) were managed. PRN protocols were in place for people taking medicines in this way; they outlined how, when and why they should be taken and included maximum doses over a 24 hour period. We noted where a person could be given varying numbers of tablets, for example one or two, that this was clearly recorded on MARs. We also noted that 'time-critical' medicines were given at the appropriate time and the management of oxygen therapy was safe and effective.

There were appropriate numbers of staff to ensure that people's needs were met. People we spoke with felt there were enough staff on duty to provide safe and effective care. One person told us, "I don't wait for them (staff) if I need something. They come straight away." During the inspection there were times where people living on the dementia unit were left on their own in the lounge. There were people who were at high risk of falls and we saw that on at least two occasions staff were not present in the lounge for more than 10 minutes. We raised this with the registered manager who told us that they would speak to the senior on the floor to ensure that staff were more appropriately deployed throughout the day. In other parts of the service we found that staff were present at all times. We asked staff if they thought there were enough staff on duty

to care for people safely day to day. One member of staff said, "Yes there are enough, there are safe numbers. We have a good team and help each other out. All the agency is planned and regular. I wouldn't work here if there weren't enough staff." Another told us, "The unit isn't full so we have more time. It's not a problem." A third said, "It's better than it was here. The carers work well together and there's a lot less agency staff." A fourth told us, "According to people's needs we have enough. Everyone (staff) knows what to do. I feel people get care in the time they need it." We confirmed this with our observations.

Risks to people were assessed regularly to ensure that people were kept safe. People we spoke with did not feel there were any restrictions placed on their actions or movements. One person said, "My family takes me out every day. As long as I let the staff know I'm going, it's no problem." Another person told us, "I spend a lot of time in my room but that's my choice. I come and go as I want." Care plans contained up to date and relevant information concerning the risks associated with independent movement, including bed rails risk assessments and those requiring positional change to reduce the risk of pressure sores. These were regularly reviewed and updated as required. We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member said, "We need to keep them (people) safe. If someone (with mental capacity) wants to do something risky, then that's up to them. We might want to ask some questions but it's their decision." Another told us, "To prevent falls we may use bed rails, crash mattresses and sensor mats. Floors must be clear for people and we make sure people are using their walking stick and remind them to use the hand rail. Those people with frames we encourage them to use them."

Clinical risks were identified and plans were developed to reduce the likelihood of them occurring. Risks were assessed in relation to people's nutrition, mobility and skin integrity and risk management care plans to minimise risks. The care plans identified the potential risks to people and gave instructions and guidelines to staff in order to manage those risks. For example, where people had been identified as having a higher risk of pressure sores there was a skin integrity care plan to reduce the risks. People living with diabetes were having their blood glucose levels monitored regularly and there were records of the administration of insulin. It was evident from the health file and progress notes that people with diabetes were being monitored by nurse specialists and the GP.

The premises were purpose built and the layout was such that it did not present difficulties in evacuating people in the event of an emergency. We noted each person's care plan contained a Personal Emergency Evacuation Plan (PEEP) which outlined how the person could be removed or kept safe in the event of an emergency, such as fire or flood and staff were aware of these. There was a file left in reception that could be accessed quickly and easily if needed in the event of an emergency which was updated regularly. There was a service contingency plan so that in the event of an emergency such as a fire or flood people could be evacuated to neighbouring services.

Incidents and accidents were recorded with action taken to reduce the risks of incidents reoccurring. We reviewed the incident and accident reports and found that steps had been taken to reduce the risks. Where one person had fallen a number of times a sensor mat had been placed by their bed so staff knew when they were out of bed. This had reduced the amount of falls the person had.

The staff members we spoke with had undertaken adult safeguarding training within the last year. All were able to correctly identify categories of abuse. In addition, they understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "The manager has to know if someone is not being treated well. I would let the CQC know too." Another staff member said, "I did do safeguarding training quite recently. It helps me know what to look for." A third told

us, "If I see anything I would go straight to the manager. If I'm not happy with their response I would take it further." A fourth said, "I wouldn't worry about escalating any issues. People's safety is too important." Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. We saw that there was an up-to-date record of nurse's professional registration. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. We asked staff about issues of consent and about their understanding of MCA. Staff did not always have an understanding the principles. One member of staff said, "I don't really understand MCA. Is it that the person may be willing to make a decision that does not conform to health and safety? For his wellbeing you may have to make decisions." There were staff that did have an understanding of MCA and its principles.

The registered manager told us that the MCA assessments still needed to be undertaken for people. We found that although a generalised MCA was undertaken for people around staying at the service there was a lack of assessments or evidence of best interest meetings specific to particular decisions. For example, in relation to constant supervision from staff, bed rails and locked doors. There was a risk that care was delivered to people without consideration to whether they were able to consent to this and whether it was in their best interest.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager told us that applications for DoLS authorisations had been made to the local authority where restrictions were involved in people's care to keep them safe. For example when they wanted to leave the service or were refusing care however these were not supported with MCA assessments to establish if people had the capacity to make these decisions.

As care and treatment was not always provided with the appropriate consent this is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did tell us that staff asked for their consent before providing care. One person said, "Yeah they always ask my permission and if I am not ready they will wait." Another person said, "I always give them permission for things that they ask of me like bath and other activities." We saw examples of this during the day.

We asked people what they thought of the food at the service. One person said, "They come and ask me what I would like for lunch." Another told us, "Each day there is a different menu." A third told us, "Very well made, nicely served too." Two people told us that they did not always like the food on offer but acknowledged that the chef always took their feedback on board and acted on this. One person wrote feedback to the chef stating, 'The salmon and butter sauce was to die for.'

We observed lunch in the main dining rooms on each floor. The tables were laid out nicely before lunch with serviettes, cutlery and beverages. People were given the option of having either juice or water and staff sought their choice before they were served. Written and pictorial menus were on the tables for people to

view. Adapted cutlery and plates were provided to people that needed them. People were offered a choice of meal and where appropriate a visual choice was offered to people to help them decide. Where people had a soft or pureed meal this was displayed pleasantly on the plates that made it look appetising. Where people required assistance to eat from staff this was provided. Staff went at people's own pace and chatted with them. One person was reluctant to eat their meal. Staff showed them the alternative which they said they would try instead. The person ate this meal. Staff were attentive, going between tables asking people if they needed anything. Those people who ate in their rooms received their meals without delays.

Each person had a nutritional assessment carried out as part of the initial assessments when they moved into the service. These showed if people had specialist dietary needs. There was a detailed list in the kitchen of people's specific needs. The chef met with people and relatives regularly to ensure that people had meals that they enjoyed. People's weights were recorded and where needed advice was sought from the relevant health care professional. We noted one person had a percutaneous endoscopic gastrostomy (PEG) in place. (PEGs involve placement of a tube through the abdominal wall through which nutritional liquids are placed when taking in food and drink.) We noted staff were knowledgeable about the management of these; all nursing staff had been trained in this area.

Staff were sufficiently trained and experienced to meet people's needs. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. We spoke with staff about their experiences of induction when first coming to work at the service. One staff member told us, "There was a two week shadowing period so that I could become familiar with the service, policy and processes." They told us there was a mixture of online and face to face training. Another staff member told us, "I was new to caring but the induction was good. I didn't work on my own for a couple of weeks, until I was happy. I learned a lot." We noted two care staff members on induction, were on duty on the day of our visit. We were told by the manager that they were not included in the staffing numbers and we confirmed this from the rotas.

Staff had undergone the service mandatory training including moving and handling, infection control and health and safety. Nurses were kept up date with the clinical training including wound care, catheter care, skin integrity, syringe driver and falls prevention. One member of staff told us, "I have done quite a lot of training such as syringe driver management. I don't always expect the manager to come up with training for me. It's up to registered nurses to make sure they're up to date." The nurses we spoke with were aware of their responsibilities regarding revalidation. This is an ongoing process by which registered nurses must demonstrate their fitness to practice to their professional body.

The registered manager had identified a need for care staff to have additional training around the needs of people living with dementia. They told us that the lives of people living with dementia could be improved if staff had a better insight into what living with dementia meant to people. They had organised additional training and had appointed a member of staff to be the dementia champion in the service. Staff had received appropriate support that promoted their professional development. Staff told us they had meetings with their line manager to discuss their work and performance. We saw that staff had meeting with their manager to discuss their performance, learning and development. We saw that appraisals with staff took place annually.

There was evidence in care plans that a wide range of healthcare professionals were involved in people's care, including district nurse, GP, occupational therapist, speech and language therapist, physiotherapist, optician and dentist. People told us that they had access to health care professionals when they needed them. One person told us that the district nurse regularly visited, "I am expecting one today for my dressing." Another person told us, "When needed they (GP) are available, but now I don't need one." We looked at care

plans in order to ascertain whether people's health care needs were being met. One health care professional told us, "Nurses are much more organised and have everything ready. They have the list prepared the previous day and obs and urine dips are done." Another health care professional told us that the hospital admissions had reduced recently. They said, "They have gone down a lot since the new manager has been in post. (The registered manager) has been promoting champions in the service in areas like dignity, hydration, pressure care etc. A good example is that people were having problems with getting access to ear syringing. (The registered manager) arranged for two nurses to do the training and we were able to sign off their competencies."

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought staff were caring. Comments included, "Yes I do, they speak nicely to me", "Very much so no complaints", "They are very caring and always ready to help", "They're terrific young people, working here", "I do think of it as home now. I have the freedom to come and go as I want and the staff are all very caring" and, "It's not home as such, it never could be but the staff are very caring and the manager is always around."

Despite this positive feedback from people there were aspects to the care that people received that was not always dignified. On the unit where people were living with dementia there was a very strong smell of urine in the lounge and in some people's rooms that could be smelled from the hallway. A number of the chairs in the lounge smelled very strongly of urine. The registered manager felt this was due to one person who was refusing support in this area and was frequently incontinent. However the provider had identified in February 2017 that the chairs needed to be replaced and people continued to sit on chairs that smelled strongly of urine. At the end of the inspection the registered manager told us that they had ordered new chairs for this unit. We will check this has been done form the action plan the provider will send us and also when we re-inspect the service.

People on this unit looked unkempt with greasy hair, dirty and jagged nails and stained clothes. One relative told us, "I've had to chase them on the shaving of my husband." One member of staff told us, "Showers and baths tend to be done at weekends. We need to be aware that this is a dementia population and many people can be resistant to personal care. For example a lot of people are resistant to have their hair washed so we have a special cap which massages in dry shampoo. Staff will shower people and wash their hair when they will let them or when it becomes a case of having to do it in their best interests." The registered manager told us that they had also identified that staff had difficulty in responding to people that were refusing personal care and had arranged additional training for staff.

There were staff at the service whose first language was not English. People and relatives told us that they found that at times it was difficult to understand and communicate with them. One person told us, "The only thing is the language barrier. Some of them don't speak English very well." Another person said, "The communication is very poor because the carers do not speak English very well." One relative told us, "Language barrier is a serious concern" and another said, "Staff very friendly but hampered by language barrier that blocks staff from communicating very well." Another told us, "Language barrier is usually a problem." There is a risk that if staff fail to understand people they may provide inappropriate care or fail to recognise people's requests. For people living with dementia there is a risk that a failure to understand or be understood can lead to isolation, confusion, anxiety or anger.

As people were not always treated with dignity and people were not always able to communicate effectively with staff this is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of care where people were treated with respect and dignity. People told us that staff

addressed them in a way that they were happy with. One told us, "They always call me by my first name which is what I asked for." People told us that staff knocked on their door before entering. One told us, "They always knock before coming in." Another told us, "My door is always opened (through choice) so there is no need to knock, they are very friendly here." We observed staff knocked on people's doors and ensured doors were closed when providing personal care.
We observed caring and positive interaction between people and staff. Staff offered people choices and spoke to people nicely, kneeling at the side of them to ask what they would like. People asked for things not on the trolley like fruit juice. One member of staff was heard saying, "I can get that for you, what kind would you like?" People were offered a choice of biscuits and staff took the time to tell people they looked nice. People told us that they were asked what they wanted wear each day. One person said, "They (staff) usually ask me what I want to put on." Another person said, "They ask me what I would like to wear." One member of staff told us that people could choose to have a bath or a shower. They told us that one person liked to have a long bath. They told us that they asked the person if they would mind having the long bath in the afternoon rather than morning and we saw this took place.

We looked at people's care plans in order to ascertain how staff involved people and their families with their care as much as possible. We found evidence that people or their representatives had regular and formal involvement in ongoing care planning and risk assessment. Consequently, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately. Care plans gave detail of past hobbies, interests and occupation that were re-iterated throughout the care plan as positive talking points. The people and relatives we spoke with were happy with their level of involvement in care planning. One visiting relative told us, "We are always kept up to date. The manager is very good at letting us know if there are changes or to pass on messages for us. "The registered manager had introduced 'John's Campaign' a scheme where relatives can stay with people at the service when their family member moves in.

Staff showed sensitivity to people's right to independence. For example, we observed one person walk into the dining room at lunch, select their meal and return with it to their room to eat it in privacy. People throughout the service were able to move around independently where possible.
One person could not express themselves well verbally due to their health care condition. We noted a communication section was contained in their care plan which included information about this and guidance for staff concerning its management and promotion of good communication. We observed staff interacting with this person during our visit. It was evident staff treated the person as an individual and were highly aware that the person needed time and patience in order to communicate effectively.

People that wanted were able to practice their spiritual needs. There were services held at the service. One person told us, "I attend once every two weeks." They told us how much this meant to them. Relatives and friends were encouraged to visit and maintain relationships with people. One relative told us, "I do come every day and they (staff) are very welcoming." We saw relatives and friends visit throughout the inspection.

Good

Is the service responsive?

Our findings

Care planning was detailed and specific to people's needs. Pre-admission assessments provided information about people's needs and support. This was to ensure that the service were able to meet the needs of people before they moved in. Where care plans had been fully transferred to a new electronic system they were more clear, concise and easier to understand. Each person had a summary of their care needs for each section of the care plan, the extended care plan stated the care needed, goals the person was working towards and observations required. One person had a diagnosis of depressive illness, specialist assessment and guidance for support had been sought from a mental health nurse and the person had a care plan for this. Another person had a wound around their PEG site. A tissue viability nurse consultant had provided a specialist assessment and there were clear guidelines for treatment. Photographic evidence of the progress of treatment and healing was in the care plan.

Each person had a 'Getting to know you' assessment in their care plan. The electronic version of these care plans contained useful information about the person's life history, achievements, interests and important people. Each person had a large wipe able poster on their bathroom doors indicating the support they required with personal care, what they ate and details of their family members.

We asked people whether they felt there were sufficient activities to participate in. One told us, "I enjoy bingo and going out to the pub." Another told us, "Jigsaws and reminiscence are my favourite." A third told us, "I enjoy watching TV because I am bed bound."

There were appropriate activities on offer for people specific to their particular needs. Each week there was a schedule of activities displayed around the service including a pictoral version for people that found this easier to read. We observed a newspaper discussion taking place in the morning and staff were very enthusiastic and encouraging with people. Staff clearly knew a lot about people and used this knowledge to encourage people to join in the newspaper group. For example one member of staff said, "We've got quite a few teachers in the room let's see what they think about this…." There was a pleasant atmosphere in the group and staff tried hard to include everyone. People were speaking about the shopping trip the previous day and saying they'd enjoyed it. In the afternoon one person led a music group where they chose classical music to play to people. Other activities during the week included, individual visits to people's rooms, reminiscence sessions, chair exercises, games, beauty treatments and trips out. Regular events were organised, such as a summer fete, to which people's friends and families were invited. Entertainers and schools visited the service regularly.

Complaints and concerns were reviewed and used as an opportunity to improve the service. We asked people whether they would know how to make a complaint. One person told us, "I had an incident but the management has dealt with it properly." Another told us, "As soon as I raise a concern, there is a positive reaction." A third told us, "They (staff) always listen to our problem and deal with it very quickly." We reviewed the complaints at the service and saw that a thorough investigation had taken place and where possible resolved to the person's satisfaction. For example one relative was unhappy that they had not been contacted when their family member had been taken to hospital. The registered manager met with the

complainant to discuss their concerns, followed this up with a written apology and then discussed any learning with staff. Another person complained that the garden maintenance was not good. The person received a written apology and informed that new gardeners had been contracted to make improvements to the garden.

Compliments were received at the service and these were shared with staff. One relative had written, 'Thank you to you and your staff for all your creative problem solving. You have been so supportive.' Another wrote, 'Thank you so much for all the care and support you gave.' A third wrote, 'I shall never forget your kindness.'

Requires Improvement

Is the service well-led?

Our findings

There were aspects to the records management that required improvement and because of this there was a risk that staff would not have the most up to date information for people. There were care plans that had contradictory information in them. One care plan stated throughout that the person received one to one care from a member of staff however this had not been the case for some time. In another care plan it stated that they person's mobility was 'good, walks without aids' however the person had had a number of falls and was now using a wheelchair. In one care plan the entire cultural, spiritual and social needs section was incomplete and the food and drinks preference for one person was found in another person's care plan. The care plans in hard copy contained generic statements with multi-choice boxes for a variety of care needs and this was confusing to read.

The registered manager told us that work was being undertaken to move from paper care plans to electronic care plans. They told us that this would resolve the issue of contradictory care plans. We will check how effective this has been at maintaining accurate and up to date care records at the next inspection.

Where specific care needed to be recorded this was not always being done. For example there were people whose food and fluid needed to be recorded to ensure that they had sufficient food and drink. This was not always being completed by staff. Where it was being recorded there was not always a clear target amount specified so that staff knew they had reached this amount. One member of staff told us staff were not using food and fluid charts at the moment but would be doing so when new electronic monitoring system was fully operational. There was a risk that without this record being maintained there would not be up to date information on the person's intake should they become unwell. Topical creams (medicines in cream format) application was not consistently recorded by staff. On two people's records the frequency box on both sheets stated 'small amount' rather than how often.

There were no formal methods and protocols for assessing and managing pain in people who could not verbally express their needs. We asked staff about this. We were told staff were aware of each person's way of expressing pain and it was judged on an individual basis. Staff were unable to tell us how a new member of staff or agency staff would arrive at this conclusion.

The service quality assurance was not robust and did not always identify what we had identified on the inspection. When improvements had been identified action had not always been taken. The provider undertook regular quality assurance visits to the service. An audit undertaken in May 2017 had identified that staff were not always completing food and fluid charts when needed and for those that were no longer required; this was not updated in the person's care plan. We found that this was still the case. An audit undertaken in June 2017 stated, 'The home appeared to be clean and free from odour.' However the unit where people lived with dementia smelled strongly of urine. The registered manager told us that this had identified in February 2017 that the chairs needed to be replaced but no action had been taken to replace the furniture that was causing the smell.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has sent in comprehensive actions plans since the inspection to address the shortfalls that we had identified. At the next inspection we will check that this has been undertaken.

There were aspects to the quality assurance that were effective and used to improve the quality of care. Each month a 'Resident at Risk' report was reviewed by the registered manager. This report was used to ensure that wound care plans were in place and updated including body maps and people's nutritional assessments were up to date. Internal and external audits were completed with actions plans with time scales on how any areas could be improved. Audits were undertaken that covered health and safety, care plans, training, medication, staffing levels, meals and environmental issues. As a result of these audits improvements had been made around the maintenance of the environment, catering services, activity provision and tools to assist people living with dementia.

People at the service and relatives were complimentary of the registered manager and other senior member of staff. Comments included, "I believe the management is very proactive", "The management is available and all our problems are solved", I trust the management, they are well in control of what they are doing", "They always resolve our problems quickly", "The manager is always available and will answer any questions I have". A visiting relative said, "I think it's much improved lately. I see more staff around that I recognise and the staff seem a lot happier. The new manager seems very good."

Staff were also complimentary about the management of the service. One member of staff said that they had regular contact with the registered manager throughout each day and that they felt supported in their role. They said, "I feel very supported. I can go to the manager with anything. We all work as a team." Another staff member said, "I think the number of agency staff was a problem. I spent as much time looking after them as the residents. I would say it's a lot better now." One health care professional told us, "Things are much better, they've (staff) worked really hard and made great progress. (The registered manager) has put a lot of protocols and processes in place. The management change is what's made the difference. He's brought lots of energy and brought the staff on board with him."

During the inspection we saw the manager and senior members of the management team speaking and interacting with people and staff at the service. The registered manager ensured that people and staff's opinions on the service were valued. There was a large tree in reception where people and staff were invited to write one word that was the most important thing to them about living or working at the service. Words on the tree included 'smile', 'respect', 'passion' 'empathy' and 'welcoming.' We did find elements of all of this during the inspection. One person told us, "The whole atmosphere here makes me happy."

Staff morale was high and staff worked well together as a team. One staff member said that the best thing about working in the service is that there were very clear ways to do things and they got good support anytime they needed it. Another member of staff said, "I think we are getting better. There are new staff starting and we use less agency. That was hard work." Staff felt that they were listened to and action taken when they raised concerns. One member of staff said, "(The registered manager) listens. When I see something I'm not happy with I speak to the nurse and it is always passed on." They gave an example that one person's internet was not working properly. They said that the registered manager ensured that a 'booster' to increase the signals was brought in to the service which rectified the problem.

People had the opportunity to attend residents meetings to feedback on any areas they wanted

improvements on. We saw that matters raised from previous meetings were addressed. For example coffee machines had been requested by people living at the service and the registered manager ensured that this had been followed up. We saw that they were in place at the service. People had asked for the plates at meal times to be hotter and this had now been addressed. One person asked that a different air freshener be used in the hall outside their room and the registered manager ensured that different air fresheners were used. People's feedback about how to improve the service was sought. Surveys were each year and any actions needed would be addressed.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that people were always treated with dignity and that people were able to communicate effectively with staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment was provided with the appropriate consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that appropriate systems were in place to assess, monitor and improve the quality of the service.