Swanton Care & Community Limited

Swanton House Care Centre

Inspection report

Dereham Road
Swanton Novers
Norfolk
NR24 2QT

Tel: 01263860226
Website: www.swantoncare.com

Date of inspection visit:
14 March 2018
19 March 2018
20 March 2018

Date of publication:
21 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The last inspection to this service was on the 7 and 9 August 2017 where we found wide spread failings and seven regulatory breaches. We rated the service inadequate in two key questions we inspect against, Safe and well led. The breaches included a breach for Regulation 12: Safe care and treatment, Regulation 13: Safeguarding, Regulation 18: Staffing, Regulation 11: Consent, Regulation 12: Safe Care and treatment and Regulation 17: Good Governance. Regulation 18 (registration)

At the last inspection, the provider agreed not to take any new admissions until they had made the improvements we had identified as part of our inspection. We also put a condition on their registration in respect to staff training as we found a high percentage of staff had inadequate or no training in some key areas of practice. We found their knowledge poor and we were not confident that they would be able to carry out their job safely.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the overall service with particular emphasis on key questions relating to safe and well led and how they were going to meet the regulatory breaches and conditions on their registration. The action plan was submitted to us in a timely way, and updated at regular intervals. We noted over the last three years this service has not achieved an overall good rating.

Because the service was rated inadequate, it was placed in special measures. Services in special measure will be kept under review and if we have not taken immediate action to propose to cancel the provider's registration of the service, we undertake to inspect within six months of the last inspection. The expectation is that the provider should have made significant improvement within this period.

We re-inspected this service over a number of different dates due to its complexity and size. The first date was 14 March 2018 and was unannounced. A pharmacy inspector visited on the 19 March 2018 and the lead inspector returned on the 20 March to follow up on some concerns and provide feedback. The service had nine vacancies so had 40 people living on site at the time of the inspection.

Swanton House care centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided. The care home accommodates up to 49 people in three separate houses. Some of the

accommodation is self-contained. The three houses are referred to as Holly Court and Bluebell, which are single storey and purpose built. The third house is Birch, which is a converted period building. The service accommodates people who require residential in Bluebell and in Birch and Holly Court for those requiring nursing care. People may have a mental health need, a learning disability, a physical disability or a dual diagnosis. Some people are over 65 others under 65 and some living with dementia.

At the time of the last inspection, there was no registered manager, an acting manager left shortly after the last announced inspection. According to our information, the service has not had a registered manager since 30th November 2016. Just prior to the departure of the last manager, the service employed a management consultancy team to help improve the service and achieve compliance. One member of the team agreed to stay on as manager and has submitted an application to the CQC to become the registered manager. However two fit persons interviews had to be cancelled which has resulted in the manager resubmitting their application to register. In this report, we refer to them as the general manager as they are not yet registered.

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

The service has a manager for each house and for those houses providing nursing there are qualified nurses. The service also had regular support from the regional manager who is on site at least weekly and clinical nurse support. There is also a quality assurance advisor said on average they spent three days on site. They told us their contract was initially for three months and they came into post in September 2017

In summary, we found at this inspection the provider had worked hard to make improvements in the service and the general manager had gained the confidence of the staff. Morale had improved and there had been a real drive to improve staff training and increase staff's knowledge, confidence and competence. This had a positive impact on people using the service. We requested the staff training matrix which demonstrated that since June of last year training in all key areas of practice for adult social care had gone from 47% of care staff to 87% of staff having completed it. The percentage of staff receiving regular supervision had also increased, with records demonstrating this was not happening frequently before.

Although clear improvement was identified, we found the whole service still required improvement in each key area with several repeated breaches. We found a number of people had not received the care and treatment we would have expected in a timely way. Some of this was due to the pressures on the emergency and primary care services. The service has provided evidence of this and had meant people received delayed treatment and were put at increased risk of dehydration and poor pressure care. We could not see how the service was working closely with other services to improve care outcomes for people. Information about people's on-going needs and care was not adequate to enable hospital staff to care for people adequately and it was not always possible for staff at Swanton House to escort people.

Staffing at the service had considerably improved with better recruitment and retention of its own staff. Staff were better supported, inducted and trained to help ensure they had the core skills and competencies they needed to provide good care. They had also introduced house managers for the individual services, which helped to develop teams and ensure people received consistent and cohesive care. However, the service still relied heavily on outside agency staff to help ensure they had enough staff to deliver care. The general manager reported last year prior to the last inspection weekly agency usage fluctuated but could be as high as 800 hours. In the last week, they reported 260 hours of agency care. They said this was likely to continue

to reduce as they had designated human resources and recruitment was robust. For people at the service this meant they were supported by lots of different staff, some of whom were not as familiar with their needs. This was particularly true at night where a higher percentage of staff were agency and we found there was poor monitoring of the standards of care people were provided at night, which could lead to unsafe, differential care. We also identified that night staff were less likely to have regular supervision or observations of practice and thus less scrutiny of their practice, which was a concern.

The service is complex due to the wide range of needs of people using the service. It is therefore difficult to provide an individualised approach particularly in relation to activities. We saw for example some people benefitting from music therapy, which was provided as a group activity and a one to one activity. Whilst some people clearly enjoyed this, others did not. Some people enjoyed the recent weekly trips but staff were limited to how many people they could take and a lot of people's needs were not compatible. There was not the opportunity for people to have one to one support to access the community unless it was for a medical appointment. No one had one to one funding to enable staff to meet their individual needs. However the service was reviewing people's needs with the local authority and health authority to see if funding was adequate to meet their needs.

Care plans were in situ and were reviewed monthly. A few minor issues were identified with record keeping and records did not always include enough detail about people's needs and what was important for staff to know. We saw little information about what a good day would look like for a person taking into account what was important to them and any goals or things they would like to achieve.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found people's rights were being upheld and staff supported people in lawfully and in line with legislation around mental capacity and deprivation of liberties.

Staff understood what constituted abuse and what actions they should take to safeguard people. They were confident in raising concerns and the manager made themselves available and was responsive to feedback.

People were supported to eat and drink enough for their needs and their weights were monitored to help staff recognise any unplanned weight loss or weight gain. Staff sought advice from other health care professionals who were mostly responsive.

Staff training and support had improved but staff recruitment records could be more thorough to demonstrate that robust recruitment practices were being followed.

Medicines were administered safely and there had been a reduction in medication errors. Where these had been made, the reasons for this were investigated to help reduce the likelihood of this happening again.

Staff were mostly caring but we did identify a few isolated incidents of poor practice. However, the service had worked extremely hard to improve staffs practice and give them the necessary support to change. The general manager and house manager were positive role models.

Staff understood how to raise concerns and recognise abuse. They felt confident in raising concerns and felt feedback was acted upon.

Overall, the service had improved but changes were not clearly embedded across the service and there were some differences in terms of how each house was managed. This was in part due to the fact that changes were been trialled in one part of the service before being rolled out across the whole service.

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 is not always safe

Risks were not fully managed in all areas.

Staffing levels had improved but people did not always have continuity of care and there was some poor staff practice.

It was not clear how lessons were learnt following incidents to help ensure it was not repeated.

People received their medicines as intended but there were some minor gaps in recording.

Recruitment was not as robust as we would expect.

The service was cleaned to a high standard.

Is the service effective?

Requires Improvement

The service is not always effective.

Staff training and professional development had improved to help ensure staff had the necessary skills.

Staff supported people lawfully where they lacked capacity to make decisions about their care and welfare.

People's health care needs were mostly met but people did not always receive joint up care.

People were supported to eat and drink sufficient to the needs and risks were largely mitigated.

Is the service caring?

Requires Improvement

The service is not always caring.

Staff were largely caring but did not always uphold people's privacy and dignity.

People were encouraged to be independent but at times staff undertook tasks people could do for themselves.

People were consulted but communication about people's care needs and care plans could be improved.

Is the service responsive?

Requires Improvement

The service is not always responsible.

Staff knew people well and some people experienced good care outcomes.

Some people had limited opportunities to activity, which enhanced their well-being and met their individual needs.

People's care plans were not necessarily descriptive enough or show how the person would want to be cared for or how their individual needs should be met.

The service took into account feedback from people but outcomes were not always clearly recorded.

Is the service well-led?

Requires Improvement

The service is not always well led.

The service had significantly improved; however, there was no registered manager.

Changes across the service were not significantly embedded and there was not robust consultation with people that used the service.

Incidents/safeguarding concerns and other events were recorded but we could not always see what lessons had been learnt or evidence of changing practice. Joint sector working could be improved upon.

Staff development had improved but there were still areas, which needed to be addressed such as annual appraisal of their performance.

Swanton House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 14, 19, and 20 March 2018 and was unannounced on the first day of the inspection. On the first day of inspection, there was a lead inspector, and two other inspectors, a specialist advisor who was a nurse 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. A medicines inspector went to the service on the 19 March 2018 to complete a medicines audit along with the lead inspector. A further visit was undertaken by the lead inspector on 20 March 2018 in order to complete the inspection and give written feedback to the provider.

Before we carried out the inspection, we reviewed the information we held about the service. This included statutory notifications. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. Before the inspection, we requested a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider.

During our inspection, we spoke with eleven people who used the service and one relative.

As part of this inspection, we went to every house to look at records and complete an inspection. On Birch, we spoke very briefly with the house manager, the registered agency nurse who had been coming for more than two years and interviewed two care staff. We spoke to the domestic (briefly) and the staff responsible for the laundry. We observed care in the main lounge and in the dining room. We looked at two care plans.

On Holly Court, we spoke with the house manager, an agency nurse and three care staff. We also observed the care and support people received through the day and over lunch- time. We case tracked four people and looked at a sample of medication records and practices.

On Bluebell, we case tracked two people and observed the care and support provided to people. We spoke with three staff.

We spoke with the general manager, the regional manager, the activities person, the catering staff, maintenance staff and the quality assurance person.

We looked at staff files, training records, incident records, maintenance records and other records relating to the management of the service.

Requires Improvement

Our findings

At our last inspection carried out on 7 and 9 August 2017, we rated this key question as inadequate with three breaches to the regulations including concerns about staffing levels, safeguarding people and reporting incidents. We found staffing levels were not adequate to meet people's needs. At this inspection, carried out in March 2018, we found that some improvements had been made and we rated this key question as requires improvement.

At our most recent inspection carried out on 14, 19 and 20 March 2018 we found that although staffing levels had improved, we identified enough concerns to warrant a continued breach in regards to staffing. Staffing levels on shift were assessed in line with people's needs. There had been some issues with rolling out the new staffing assessment tool and additional training was being provided to the house manager to ensure they used the tool correctly. This tool worked out how many staffing hours were needed in line with people's needs and staffing was provided accordingly. However, the tool had been ineffective and we found that there were not enough staff deployed to meet people's needs on an individual basis.

Staff spoken with raised concerns about staffing. One person said they really enjoyed working at the service but said they did not like what they perceived as the current challenges around low resident to staff ratios, which they stated affected the quality of care. Other care staff said that there was not enough of them to meet people's needs. One staff member said, "There is three staff for 14 people, it's not enough". They stated that the numbers had improved recently but there was a heavy reliance on agency staff. They stated that they had raised this with management but there had been little action. The challenges emerged specifically at mealtimes on Holly court when all staff were engaged in helping people who required assistance, which left no one in the day room. The service had a policy that there should always be a staff member in the day room at all times and we saw, during our inspection, that there were people left unsupervised.

On Birch, one person's appointment to hospital had been cancelled because there was not the staff available to take them. Staff training was taking place and was usually planned around the needs of the service but we saw that the house was at least one member of staff down. We noted that a number of people had been assessed as requiring two members of staff to support them in order to mitigate risk. However, staff told us that this was not always possible due to lack of staff available. This was raised with the general manager who was not aware of this and said they would investigate. They told us that funding for people was not in line with their needs and they had raised this with the commissioners and requested a review of people's needs to help secure the right level of funding.

During our observations, we saw people did not always receive timely care, which we attributed to staffing levels. For example, a staff member agreed to assist a person to the toilet, but then went to help someone else and did not come back. Another staff member then came to assist the person but also then got distracted by the needs of another person. This resulted in the person waiting an inappropriate amount of time to use the toilet.

We saw another example of where a person did not receive the care and support they needed due to lack of staff. When a person was recently admitted to hospital, staff were unable to go with them despite the person having no family, as there was no one available to accompany them. The hospital admission was poorly managed due to hospital staff having insufficient information about the person's needs and the person's reluctance to receive support. This could have been avoided if staff had accompanied them. The general manager told us on that specific day a second person also went to hospital and they had agency staff working so it was not possible to release permanent staff.

Staff said some people were difficult to assist and unless they had continuity and time, they did not eat. This was a concern were there were at times a lack of continuity.

These concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consistency of staffing had improved significantly with a clear reduction of the use of agency staff in favour of their own staff. The service readily admitted recruitment was their biggest challenge possibly due to the remoteness of the location. The service used multiple agencies to recruit staff on a temporary basis. The manager reported using 260 hours of agency staff in the week of our inspection. They told us it had been as high as 800 hours last year. The general manager confirmed that whenever possible they used the same agency staff and booked them in advance to try to ensure continuity of care for people using the service.

The general manager/regional manager told us there were still three nurse vacancies and five full time care support vacancies to fill but they had appointed human resources to help with active recruitment

We were not assured that risks were always fully mitigated to help ensure people did not suffer from avoidable harm. During our inspection, we identified a number of concerns. A number of people had acquired pressure ulcers and while there was documentation regarding the wound, treatment and any factors to be taken into account to mitigate the risk such as pressure relieving equipment. We noted for one person who had a pressure ulcer that this had become worse during a recent hospital stay. The staff had failed to ensure that relevant information regarding the risk management of their pressure areas had been known to hospital staff. Had the information been known to the hospital, the person might have received better continuity of care that prevented the pressure ulcer from deteriorating from a grade two to grade three.

The documentation around pressure ulcer care was adequate but we did not see a root cause analysis, which might help determine if the pressure ulcers were avoidable and what, if anything, could have been done differently to reduce anyone else developing a pressure ulcer.

The service had a further incident, which was subject to a complaint because the person's admission to hospital was delayed which resulted in the person not getting timely treatment. A further incident also resulted in a person not getting the treatment they required from medical services, which resulted in them going into hospital and again facing delays in their treatment with poor care outcomes and weight loss. The person was developing sepsis, which could have possibly been avoided if all services had worked together.

The records in the service did not show a clear investigation, outcome and lessons learnt to reduce the likelihood of something similar occurring again, although some of the circumstances were outside the services control.

We noted that some people had poor mental health and one person had gone to another service for a mental health assessment due to a decline in their mental health/ behaviours putting themselves and others at risk. The service assessed risks associated with people's poor mental health in relation to their needs and the environment in which the care and support was taking place. However ligature risks had not been considered across the service. The general manager told us they would immediately address this.

These concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone apart from one person told us they felt safe and trusted the staff. All had agreed to be interviewed and felt able to answer the questions asked. One person said, 'I feel safe in my room. Another said, "I find staff approachable, concerned and listening."

People told us staff had not been unkind or shouted at them and said they could chat to staff if they were worried about anything. Most informed us that they would report concerns to the general manager, a relative or their social worker. Only one person did not know who they would speak with.

There was good guidance about the management of individual risk, for example manual handling plans, guidance around meals, the support needed and any risks of choking. Guidance from other professionals had been sought and acted upon by staff. Falls assessments were in place and equipment in situ. Some of the detail such as type of continent pad used was not included, which would be useful.

We spoke with one member of the maintenance staff. There were four across the site. They were able to show us the detailed records for each house in terms of maintenance: fire safety, water safety, health and safety. We viewed other records such as the maintenance of hoists and slings and we saw that these were effective.

Equipment was safe to use because it was regularly checked. Staff were trained to act in an emergency and respond to fire drills and follow a clear evacuation plan. People using the service had been assessed as to what support they needed in the event of a fire or other emergency and there was a clear plan in place. Equipment around the service such as ski pads were used to evacuate people and staff told us they had been trained to use equipment. Staff also confirmed there were fire marshals and first aiders on site and were able to tell us who they were. The maintenance person was not able to provide all the records we requested. For example we asked for a risk assessment for the whole site, as we were aware people travelled from house to house to attend different activities and staff rotated across the site. They carried two-way radios but we were not clear how other potential hazards might be managed or if people were off site how this was recorded. We were not asked to sign the visitor's book when first arriving on site and taken to a house. We were asked to sign in when visiting the office.

The service had sufficient numbers of weighing chairs and special hoists used to weigh people. We were unable to see a cleaning log for weighing chairs in one house but the general manager assured us this was done .This point applies to other shared equipment in the home such as blood pressure monitoring cuffs. The general manager confirmed equipment and weighing scales were calibrated regularly.

We toured the houses and found the environments were appropriate in terms of space they provided to

people. Doors were locked and key-coded where appropriate such as cleaning cupboards, which helped keep people safe. Fire evacuation plans were clear. People had individual fire risk assessments, which stated what support people might need in the event of a fire or other emergency. We found on Birch there were many internal stairs, which might be difficult for people to navigate. There was however a lift which some people could use independently. We also found the service to be very hot and people looked uncomfortable. Staff told us individual radiators were thermostatically controlled.

Despite there being a domestic staff member off sick, the houses were clean and the service did not have odours. The staff worked hard to complete both general and more detailed cleaning schedules. They reported they were well supported and received the same training as the care staff as well as role specific training. The laundry room was attached to one of the houses and used to do the washing for all three houses. There were two full time staff who worked seven days a week between them. They reported the two washing machines and two tumble dryers were on constantly throughout the day and were getting old and in need of replacement. The general manager confirmed they had recently had a full overhaul and they were looking to increase the number of machines.

In Holly Court, we noted the corridor area was clean and clutter-free. Some wood chips and paint splashes noted but in fair general repair. Some staining was noted on the majority of chair seats (at end of corridor and in the day room). The clinical room was meticulously clean. The office door was locked with code-entry access. Files and notice boards appeared to be well organised and easily accessible by staff. The office space was generally tidy.

Due to the size and complexity of this service, we asked a pharmacy inspector working for the CQC to complete a full audit of medication at the service in the individual houses. They completed an audit on the 19 March 2018.

Some improvements in medication had been identified such as trialling medication cabinets in people's bedrooms. Feedback has been positive. They were also exploring different medication systems including the use of an electronic record system. Many adhoc audits were being completed and medication errors were said to be reduced significantly.

The member of the CQC medicines team reported that staff handling and giving people their medicines had received training and had their competence assessed regularly to ensure they managed people's medicines safely.

Medicines were stored securely for the protection of people who used the service and at correct temperatures. The service had made improvements to its arrangements for the storage of people's medicines.

Records showed people living at the service received their oral medicines as prescribed. Audits were in place to enable staff to monitor medicine stocks and their records to help identify areas for improvement. A system was available for reporting and investigating medicine incidents or errors, to help prevent them from happening again. However, we noted there were gaps in records of medicines prescribed for external application such as creams and ointments. So the records of these medicines did not confirm they were applied as directed by prescribers.

Supporting information was 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 additional notes about how to give people their medicines. 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 and when to give them to people. The information we saw was sufficiently detailed to ensure the medicines were given consistently and appropriately. 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. However, for some medicines prescribed for external application such as creams and ointments, more information was needed about where on the person's body these medicines were to be applied.

Records showed when prescribers had changed people's medicines but records were not available to confirm people received a regular review of all their medicines. In addition, when people were given their medicines hidden in food or drink when they would otherwise refuse them (covertly), records about assessments of their mental capacity, best interest decisions, or advice from other healthcare professionals about this were in need of review.

We found at our last inspection, carried out in August 2017, that staff had insufficient knowledge of safeguarding. They had not had adequate training to enable them to recognise, identify and report any safeguarding concerns. At our most recent inspection on 14, 19 and 20 March we found staff had sufficient knowledge of how to identify and raise concerns if they suspected a person to be at risk of harm or actual abuse. Staff said they received training to help them do this and had access to policies, procedures and flow charts. Whilst at the service one person raised concerns about their care and we asked the general manager to follow this up. This was followed up by the service but not until 19 March 2018, which was an unacceptable delay given that staff were still working at the service. We have asked the general manager for their report.

We were concerned that a safeguarding concern raised because of an allegation in October 2017 was still being investigated and although this had been flagged up, it was still unclear as to the stage of this investigation and whether it was founded/unfounded. We have subsequently been provided with evidence that these concerns were unfounded and the safeguarding referral closed. We found for other safeguarding investigations there was not a clear audit trail although the general manager said they met regularly with the safeguarding team and went through any outstanding issues and this was much improved. We saw some evidence that staff did challenge practice and flagged up concerns about practice and this was acted upon.

Staff recruitment files were inspected and each file showed a discrepancy. For example, one staff file did not include details of a disclosure and barring check. We were then shown an electronic record, which also did not provide any details. Another staff file had two personal references and not a professional reference from the last employee. Another file had one reference where the service terms of employment state two references should be provided. Another record had references received after employment. Records included interview notes and some had a front sheet, which made it easy to see when information was received, but not all records had this. All records had some identification such as passport, proof of address but only one included a staff photograph. We have not made a breach because electronic records provided adequate information but paper records did not.

Requires Improvement

Our findings

At our last inspection carried out on 7 and 9 August 2017, we rated this key question as requires improvement with two breaches including concerns about how the service was complying with the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards and around supporting staff with their training and professional development.

At our recent inspection carried out on 14, 19 and 20 March 2018 staff training had significantly improved and we did not identify a breach. However there was evidence of poor staff practice, which was a concern and meant we were not assured people always had their needs met.

Agency staff were predominantly used at night and there had been some recent concerns about night care practices identified by the general manager. They were carrying out investigations and providing staff with supervisions as an initial means of discussing and recording the concerns. The general manager lived on site and often saw staff across the different shifts as they arrived/left but there had not been regular audits of the care people received at night. An audit completed on nights just before our inspection on 14 March 2018 found two out of three night staff in one house asleep. There was no evidence people had come to any harm but records of night checks had not been completed. On another house, the alarm, which alerted staff, should a person try and leave had been switched off. This could have had serious consequences. By the second day of our inspection on the 20 March, the general manager had not completed their investigation but supervisions had been carried out for their permanent staff. The two staff who had been found asleep had been agency staff and had not been permitted back on site. We found staff had not been subject to stringent and regular supervision of practice and night staff had been more difficult to engage with in terms of training and supervision. This was slowly being addressed.

The service was trying to develop their managers and staff. Nurses spoken with told us they were supported to keep their professional development up to date and had numerous opportunities for study and attending relevant courses. Examples given were that all nurses had been assessed as being competent in effective wound care.

Staff described training as very good. Examples given included Deprivation of Liberty safeguards, Mental Capacity Act, safeguarding, manual handling, first aid, dementia training and infection control. More recently there was training around positive behaviours and breakaway techniques should staff need to diffuse a situation. The general manager provided us evidence of staff training which showed this was almost completely up to date or planned. There was a rolling programme of planned training.

Staff saw supervisions as effective and enabling them to raise any issues and for house managers to identify areas for improvement. Supervisions were planned and now far more frequent than at the previous inspection.

The general manager was also professional and facilitative. They told us they had a thorough and useful period of induction into their new role as manager. They showed us the competency assessment booklet and induction pack, which they were required to complete on an on-going basis to support them in their new role. Further, a support worker described their period of induction, which involved online training, and later, the completion of a care certificate.

The quality team were supporting staff as part of their induction and on-going training was being provided. Every new member of staff received a welcome pack and management were working hard to improve staff retention. Training was now being held on site, which had increased attendance and was being planned in bite size components making it more accessible.

We saw that agency staff were supported and received an induction before starting their shift. Staff reported that they knew each house and staff were rotated according to the needs of people using the service. However, there was no skills mix audit so the general manager was not able to give us a clear breakdown of how many staff held additional qualifications i.e. NVQ or who had completed the care certificate, which is a recognised national induction, which covers all the core competencies required. The general manager told us they were sourcing an alternative provider to get more staff undertaking their NVQ. Within the service, there were no identified champions, which are staff who take the lead in key areas of practice such as manual handling. Staff would be identified as champions because of a special interest in the subject area or because they had key competencies in this area. The general manager told us they would be developing this.

We saw an example of where an agency staff member's practice had been pulled into question regarding the management of an incident. The investigation did not include evidence of how the staff member was supported and inducted thoroughly to manage the shift and know that actions they should take in regards to incidents. We were confident that nurses and house managers had the necessary competencies and skills but less sure that all staff had received adequate inductions. For example, we met a care staff new to care that had not completed the care certificate and was not able to give us details of their training or how they had implemented this. However, they did tell us they spent a long time shadowing other staff, as they had not been confident. We spoke to the general manager who said all staff had received regular training and should be able to describe training they had received. We said it might be helpful for mock inspections to be held at the service so staff became familiar with what CQC inspectors were looking at during their inspections and what questions they might be asked. We spoke with one of the house managers who said some staff have had training on dementia and mental health awareness. They said they carried around a checklist on MCA and started quizzing staff to test their knowledge and how it was applicable in the service in terms of supporting people to make their own decisions. This was good practice and helped staff to embed their training into their work practice.

People's dietary needs were known by staff and we could see on the individual houses which people were at risk of choking or required a specialist diet or were diabetic. Lunch was served promptly and on Holly house, meals were staggered to help ensure people got the right level of support for their needs.

Comments about food was mixed, most people were positive, One person said, "It's a good place, I like it here the foods great." We did not observe much waste, which indicated that people had enjoyed their food.

People had a choice of different options, which staff had ascertained earlier. However, people were given choices verbally, which for some people was difficult. We thought menus on tables and being offered a picture menu or offered different plated options might enhance people's choice. During feedback, the manager told us a pictorial menu was being developed and they were going to use an electronic device to show people food options visually to help promote their choices.

Staff were not initially observed sitting with people in one house but the general manager said they were trying to encourage staff to sit with people and have a meal as they recognised this enhanced people's experiences. We observed in one house, drinks were not put on the table and people were offered a choice of two different squashes. Some people would have been capable of pouring their own drinks should jugs be on the table. One person asked for tomato sauce, this was provided but staff put it on for the person rather than letting them do it for themselves. There was no reason why sauces could not be on the table and available for people who perhaps could not ask for them.

On Holly house, we noted meals came from the main kitchen. Staff told us the temperatures of these were checked but we saw for three meals wrapped in cling film and carried outdoors from the main kitchen the temperatures of these were not checked. We spoke with catering staff and they told us that the kitchen had recently been awarded five stars and numerous checks had been carried to ensure food was stored, cooked and served at the right temperature. They told us its policy for food temperature to be checked on leaving the kitchen and arriving at the house.

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.

We saw a number of Deprivation of Liberty Safeguards had been approved whilst others were waiting for approvals. The service had a spread- sheet to help them keep track of this and chase any still awaiting approval. We saw one DOLs authorisation, which was due to expire on the day of inspection but these were being re-authorized.

Some people had recently moved around the service to reside in a different house, which was more suited to their needs. Multi- disciplinary meetings had been held to ensure this was discussed and considered in the person's best interest where they lacked capacity to make the decision themselves.

There was a lot of information and guidance around the service to help staff recognise when people might lack capacity and what actions they should take to ensure they supported people lawfully.

Whilst on site we raised concerns about access in and out of the houses. We found there were unnecessary restrictions on people's movement. Since our first inspection, date on the 14 March 2018 the service has taken action to ensure the buildings were more accessible and people who were not deprived of their liberty could get out unassisted. We did ask the general manager to consider improved signage around the whole site to aid visitor's access.

People had a do not attempt pulmonary resuscitation (DNARR) in place where appropriate and this had been discussed with the GP and with family where people lacked capacity.

People's health care needs were met with registered nurses on site who kept their professional practice up

to date. We reviewed the needs of a person who was approaching the end of their life, a person with a physical disability, a person with a pressure ulcer and someone who was diabetic. This person with diabetes was on insulin and there was a diabetic care plan in place, which was reviewed each month. Blood glucose levels were monitored 4-5 times each day. There were challenges to maintain the person's blood glucose levels due to the person's dietary preferences, habits and food choices. Care home staff had requested diabetes nurse specialist input through the GP.

The service liaised with relevant health care professionals in terms of planning and meetings people's needs. Examples included close liaison with the dietician and speech and language team. Staff said the chiropodist visited regularly. We did see some areas of poor practice where people had not received seamless care when transferring from one service to another, examples included poor information between care staff and hospital settings and poor information about people's current needs when being transferred from one house to another within this service. For example one person moving from one house to another had a pressure ulcer which staff in the new house were not initially aware of as there was nothing recorded. Greater collaborative working would improve outcomes for people.

The service was making cosmetic changes to the environment to make it less clinical and more homely. One person told us, 'I have my own bathroom and toilet. I love my room'.

The provider was revamping the dining areas in Bluebell and Birch and had purchased new curtains, tables, chairs and tablecloths. Holly was the next home scheduled for redecoration. In Holly, individual bedrooms and communal areas were being redecorated. It was noted in Holly House there were eight dining room chairs and two tables which was not enough for people living at the service if they were to choose to dine together. The only issue we felt needed addressing was signage and improved safety around the site.

We identified some areas of the service were very hot. Staff told us people had individually controlled thermostatic valves but not everyone would be able to use these. We saw some people were visibly uncomfortable and hot looking. The general manager agreed the service could get hot and had purchased some fans, which were not evident on the day of our inspection.

Requires Improvement

Our findings

At our last inspection carried out on 7 and 9 August 2017, we rated this key question as requires improvement with a breach around respecting people's dignity.

At our recent inspection carried out on 14, 19 and 20 March 2018 we saw some improvements and saw there had been a high investment in staff training which should help improve staff understanding of people's individual needs. The observations carried out by inspectors in each house were mostly positive with some clear leadership and staff who were not afraid to challenge. Most people had no concerns about their care. One person did raise concern about their care and treatment and this was flagged up with the general manager to investigate.

We saw some areas of staff practice, which could be improved upon. We noted that staff were supported through regular training and through regular supervision but this had only been recently established. We asked the house managers if they did observational supervision of practice and they told us no. This would help to identify areas of practice, which could easily be improved upon. They did do observations of concern and one house manager had developed a form to make notes/ observations of staff practice to be used as part of their supervision but this had not been rolled out across the service. This was something we highlighted at our last inspection. At this inspection, we identified poor areas of care included: manual handling practices, communication and people's dignity not always being upheld.

For example, we saw staff mostly supported people with their manual handling needs safely. Staff used a screen to help ensure the person's dignity was respected. However, we also noted some of the staff interaction was poor. Staff did not always clearly explain what they were doing or what was going to happen next when using a hoist. The hoist can be a frightening experience and staff should be mindful of this. Staff interactions at times were poor with minimal engagement with people. One of the contributing factors was the poor English language skills of some of the staff. We observed one person walking with their trousers that had fallen down; staff came and pulled them up without warning or without explaining to the person what they were doing.

Staff did not always respect people's dignity. In one house, a person we spoke with told us they were unhappy about two male carers who did not respect their dignity e.g. entering their room when they were only in their nightdress. They said a male carer had come into their room this morning when they had been on the toilet which they said was embarrassing and they did not know who to tell.

Staff referred to one person who would sometimes scream. When asked how they managed this was told, "We put them back in their room because it's not fair on others". We were concerned that staff did not demonstrate how they were meeting this persons needs or upholding their rights or if they tried other strategies to reassure the person and try and establish why they screamed.

We observed staff in another house engaging well with people and using gentle and caring interactions to people who they showed genuine warmth for the person. However, the carer did not knock when entering the person's bedroom.

These concerns constituted a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with were mostly complimentary about the service, the care they received and the staff that supported them. Most people said that the staff were kind and listened to them.

We noted throughout the service there was a lot of information reminding staff about positive behaviours and treating people with respect and dignity. Staff training was being focused on as a way of improving staff practices and incorporating clear values and behaviours the provider expected staff to demonstrate.

The service had purchased special cigarette lighters for people who smoked and for whom a flame lighter would pose undue risk of fire and/or harm because of their condition. These special lighters have no naked flame and no fuel as they are electronically charged. There were risk assessments in place for these. These lighters meant that those who chose to smoke could light their own cigarettes without having to wait for a member of staff to come and light their cigarette for them. It is an example of how the service was thinking about mitigating risk in order to maintain both independence and self-esteem for people using the service.

Consultation with people using the service and relatives was improving but still limited. We could not see how people were regularly engaged with on a one to one basis about their care needs and whether their care plan remained appropriate to those needs. Resident meetings were held but these were not appropriate to everyone. Newsletters and surveys helped visitors and relatives know what was going on at the service and give feedback.

Most people could not recall their care plan or if they had a copy of it. One person said when we asked the question, "I do not know about my care plan. What does it say?" We could not see from the care plans viewed how people had inputted into these.

Requires Improvement

Our findings

At our last inspection carried out on 7 and 9 August 2017, we rated this key question as requires improvement with a breach around person centred care and the lack of structured/meaningful activity.

At our recent inspection carried out on 14, 19 and 20 March 2018, we saw the service was making improvements but these were not fully embedded and there was still enough evidence to support a breach. We found gaps in records and could not see how the service was always meeting people's individual needs.

People had a wide range of needs and in the last couple of weeks, some people had moved within the service to a house, which was more appropriate to their needs. For example as a result of a continuing health care assessment where people had been assessed as needing nursing support rather than residential care. Prior to moving, people were supported and best interest meetings were held to agree the move.

There was evidence to suggest that people did not get their needs met throughout the night due to some poor staff practice or staff taking breaks without ensuring there were staff available to support and check on people as required. We found some records incomplete such as behaviour charts and records, which did not contain dates, so could not see if information was still relevant. Monthly reviews were sometimes being missed. We found resident of the day was established in one home and the two care plans looked at were in good detail.

Hospital passports were in place, which was designed to go with the person, should they need to go into hospital. This would then help ensure the staff in hospital had enough information to support the person. We found information varied but was not thorough and did not include people's main needs.

One of the people using the service mentioned a party last week for the Chinese New Year, with noodles and rice. Some people were not aware of what activities were planned or if these happened often. One person said, "I like to go to Church every Sunday." However, they said this did not happen. Another said, "We sometimes go on a pub trip every Friday." And a third said, "I get bored because there is nothing to do." Staff told us with regards to activities that there was something every day. Although one staff member said, "It is not exactly planned."

Activities varied according to the house we visited. On Birch there were fifteen people using the service. We saw throughout the morning some limited engagement with people. One staff member was sitting chatting to people another was doing a jigsaw puzzle with a person. No one went out. In the afternoon, there was a

music therapist and they held a session in one house, Holly court and asked staff to bring people over. We saw staff on Birch ask some people if they wanted to go over. Some people did not do any activity and we did not see an activity planner. However the provider told us planned activities/events are included on the notice board in the individual houses. We asked several people if anything was planned for the day and people were not able to tell us. One person said, "I don't know it's up to staff." Activity staff did go around speaking to people about their needs and asking whether they wished to be involved in activities. There were notes for each person, which showed what they had been involved in. Through our case tracking, we identified one person who had not been out for several months. Staff told us they were in pain when they sat in their chair for a long time. We could not see how the service was meeting this person's needs or if any goals or areas important to the person had been discussed and recorded. We saw their daily experiences were very limited and nothing about their emotional well-being or mental health had been considered in the care plan. We asked the general manager who told us they had funds to support them and access the community and a trip was planned in the near future but this had not been a regular occurrence for which the general manager could not provide an explanation. Funding for appropriate equipment to enable people to go out on trips was something the service was trying to address.

The inspectors on Holly Court commented that there was a high level of activity evident in preparation for a St Patricks day party that afternoon. All staff and some people were involved in preparation and most were observed to be enjoying it. Further events were planned.

Some people appeared to be able to enjoy key activities such as the trip on the Norfolk Broads the previous day. However, the extent to which everyone was able to select and to participate in all activities, was questionable. The activities appeared to be staff -driven as opposed to people focused. This challenge appeared to emerge given the vast range of people's conditions and requirements within the individual houses where diagnoses ranged from end of life care to people with specific learning difficulties, physical illnesses, acquired brain injuries and mental health issues.

The general manager told us that since the last inspection they had two full time activity staff and with the music person equated to sixty hours a week which was significant. They told us there had been some reluctance on the part of the staff to take people out but staff were gaining confidence doing this and they had been doing this successfully. They said up to two trips a week were planned and people were consulted about where they wanted to go and who wanted to go. They gave an example of people with quite complex needs who went to the pub and were gone for some time. The general manager said it had been highly successful and helped staff and people build better relationships. Some of the feedback was great and was indicative of how far the service had come. For example, staff confirmed the new activities co-ordinator was 'really good' and had started to identify one to one activities for people, for example, one person liked horseracing and was invited to attend the local racecourse. Others enjoyed church and this was being facilitated. Staff said they have opportunities to get people into community e.g. encouraged to buy own food on shopping trips. One person has a slow cooker and likes to use it to cook some meals for themselves. Another person went to coffee mornings in local village day centre.

In a number of the houses, there was limited consideration of noise levels. Loud radio music was playing and radios were tuned to stations playing modern pop music. We did not see how the music enhanced people's well- being, i.e. no one was tapping or singing along to music. At lunch time in Birch the activities co-ordinator arrived half way through lunch and asked if people wanted to listen to the current channel and turned it over to something more sedate

We reviewed a number of care plans. They were held securely in the office. We found they contained basic information about people's needs but could be more detailed to focus on what was important to the

person, what they wanted to achieve and what a good day might look like. There was a one- page profile, which contained some information, but this was limited and did not really show how it informed staff of what the person's needs and wishes were. For example, it included the person's likes, how best to support them and what was appreciated about the person (their best attributes). There was also some life history. These were very brief. Care plans contained some ambiguous statements such as, 'What staff should do if I am anxious. Answer- 'Try and find out what makes me anxious if not try later.' Another said- 'How I communicate-' answer, 'talk to me'. Some of the records relied on a tick sheet such as activity schedule with things the person might enjoy doing but we could not see how these were then built into the persons plan of care to help ensure they had opportunities to do things they enjoyed. We found notes brief and some illegible or crossed through. They referred to regularly checking people without specifying frequency and times.

We case tracked a person whose health was declining and noted a number of anomalies in their care record. They had developed a pressure ulcer. This had been recorded and reported to the GP. There was a waterlow assessment, which documented the person's risk of developing pressure ulcers, this had recently been updated and the level of risk increased without a clear rationale as to why. The person was meant to be turned two hourly but omissions in their record was established as staff forgot at times to complete the record. Their fluid intake was poor and they were not reaching the target agreed but it was felt this was due to the person approaching the end of their life and reluctance to drink. There was evidence of end of life care planning and any anticipatory medicines the person might require to manage their pain.

These concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not have any concerns about end of life care. Staff we spoke with were knowledgeable about how they would support someone who was approaching the end of their life. Staff had undertaken necessary training in end of life care and worked with other health care professionals to ensure people received appropriate care. Although no one was receiving end of life care at the time of our inspection some people were quite frail or had progressive physical illnesses. We saw as part of people's care records there was relevant documentation in place stating people's preferred priorities of care and if people wanted to die at the service or go into hospital. We saw for some people they were not prepared to discuss this and staff had recorded this and had asked people at a different time. Families could be supported to stay with their relatives when approaching end of life and there was accommodation on site.

We asked people about raising concerns or complaints and no one felt they had ever needed to but felt able to approach the staff. We did not see any one to one recorded meetings and residents meetings were not clearly established across the service so it was difficult to see how people could always feedback concerns. There was guidance around the service about how people or their visitors could make a complaint/raise a concern and suggestion boxes were around the service.

We viewed complaints. There were not many and actions had been taken to address the concerns. However, we could not see conclusions reached or lessons learnt. For example, one involved a specific complaint and the general manager had met with family on a number of occasions but we could not see this recorded or if the family were happy with the outcome.

Requires Improvement

Our findings

At our last inspection carried out on 7 and 9 August 2017, we found wide spread failings and seven regulatory breaches. We rated the service inadequate in two key questions we inspect against, Safe and Well led. The breaches included a breach for Regulation 12: Safe care and treatment, Regulation 13: Safeguarding, Regulation 18: Staffing, Regulation 11: Consent, Regulation 12: Safe Care and treatment and Regulation 17: Good Governance. Regulation 18 (registration)

At the last inspection, the provider agreed not to take any new admissions until they had made the improvements we had identified as part of our inspection. We also put a condition on their registration in respect to staff training as we found a high percentage of staff had inadequate or no training in some key areas of practice. We found their knowledge poor and we were not confident that they would be able to carry out their job safely or that they had adequate supervision.

At our recent inspection 14, 19, 20 March we found some improvements had been made and the service had demonstrated through their action plan that improvements were on going and beginning to become embedded in staff practice and there was a changing culture within the service. Despite good feedback, we felt there was enough evidence to support a continued breach of regulation 18, staffing, Regulation 10, Dignity and respect, Regulation 9, Person centred care. Regulation 12, Safe care and treatment and Regulation 17, good governance. We therefore need to consider whether we take any additional action against the service.

Consultation with people using the service was an area, which needed to improve. Resident of the day was still to be introduced to two houses. This was the situation at the last inspection so the provider had not made significant progress in this area. Residents meetings were being held but these were more established in one house- Blue Bell. The regional manager said in the other houses people were more difficult to engage with. There were no surveys being sent out or completed by people using the service. There was no evidence of one to one meetings to take into account people's feedback although the general manager said feedback was sought and this was seen as an activity.

Some staff felt communication across the whole site still required improvement given the level of change in all key areas of practice and the high use of agency staff who might not have access to the same training/information. Head of department meetings were being held but these were weekly which we questioned if this was sufficient given how quickly risk could develop. We saw minutes for these meetings..

We asked what had changed because of people's feedback and was told, the hairdresser was changed because of feedback and the pets for therapy dog reinstated.

We had concerns about how information was acted upon to help ensure it was reviewed and conclusions were reached about the service provided and how it could be improved. For example how people received care across different parts of the care sector in a timely, effective way. Records in some instances were poor. We could not see adequate consultation with people about their needs and wishes. There was some evidence that people had not had good care but the service response to this was sometimes slow and we did not see particularly robust, root cause analysis to help review information and agree lessons learnt.

These concerns constituted a continued breach of Regulation 17 of the Care Quality Commission (Registration) Regulations 2009.

Previous Incidents had not always been well recorded so we could not see clearly what actions the service had taken to reduce the likelihood of things happening again or if they had managed the incident well. There was a record of accidents and incidents in the service. The manager told us staff had received additional training so the information was captured early and reported effectively. Records were viewed by the house manager within 24 hours and then passed to the general manager. A quarterly analysis was carried out to identify patterns and themes and to review actions taken.

We asked for an example of actions taken in regards to a recent incident and was told about a person who had a number of falls. Additional assistive technology has been brought in for them, which would alert staff when they are mobilising. They have been reviewed by the GP and their medication changed. Staff have been given additional one to one time to support this person. Their care plan in relation to their mobility and manual handling had been changed. Incidents sheets for each service were seen and clearly stated actions taken to address the issue/risk.

The organisation had collated feedback from staff as part of its overall quality assurance system. The service was trying to improve communication across the service and had sent out family and friends surveys. This was sent out to 44 families and friends, 10 returned. The feedback showed respondents were generally satisfied with the friendliness and approachability of staff. One person noted improvement in quality of communication. Another spoke of how challenging it was to visit the service due to the rural location. Suggestion boxes in each house had been added. Newsletters had been introduced every two months. These gave a detailed view of the service, including activities which had taken place or were planned. It also took into account feedback received about the service and how this was being addressed or used to show people receiving good outcomes.

The general manager told us that relationships with other agencies were improving. They told us the safeguarding team visited every couple of months and viewed the safeguarding arrangements, which they viewed as satisfactory. A recent scheduled audit was abandoned due to heavy snow. A number of incidents of concerns were not concluded when we inspected the service, which included a concern we raised on the first day of our inspection, another safeguard was still not concluded months later.

There has not been a registered manager for some time, the service now has a manager in place who has submitted an application and an interview is imminent. Since the last inspection, the separate houses each had a manager in situ who had a clear oversight of the house and the needs of people within the service. We found the house managers professional and courteous throughout. They were supportive of the inspection and transparent in their approach. A venture capital group bought the service out last year. New CEO and Director of Operations were in place. They provided regular support. The changes made to the staffing

structure also included a manager being rostered on every weekend.

The house managers were competent and being supported to develop their professionalism and improve outcomes for people. On the day of our inspection, two of the house managers were attending a management conference. This gave them the opportunity to meet other managers and share ideas.

Staff referred to the 'Beast from the East' (recent blizzards) and said some staff stayed overnight in separate accommodation. One staff said 'it was lovely to see us all come together and work together'. Staff confirmed that agency staff are 'regulars' one staff said, "It is nice for the residents to see familiar faces. They just fit in and get on with providing the care."

Some staff referred to previous management and said they had not felt supported but were now. One said there were changes every day. When asked what these changes were, they said more recording, more staff more activities, (one staff, now two.) more training. They said, "Some people don't want to go out but when they do they enjoy it". They said staff were rotated around the houses and it is better. Another staff member said, "Everything used to be a mess, no one knew what they were doing. Things are more organised now with house managers and general manager walks round every day."

The general manager had been in post since June with the consultancy group but transferred to being employed by the service in December 2017. They had a proven track record of supporting failing services and bringing about the necessary improvements. They stated that the service had been through a recent difficult time of considerable change with high staff turnover. The general manager told us they were seeking to embed many changes and engage staff in new processes and a new philosophy of care. There were reminders throughout the service about values and behaviours they expected to see staff demonstrating. The 'Swanton ethos.' All the staff we spoke with talked positively about changes in the service and said they were well supported by the managers in each of the houses. The general manager was visible on site and staff felt well supported by them and not afraid to approach them with ideas of feedback. It was clear there was a positive relationship between the general manager and house managers but some concern about the general manager's health and hours they were working. Because of the current arrangements in place to support the general manager, it was not clear how much autonomy they had to manage the service as they saw fit.

All staff spoken with suggested morale had improved and things got done. One staff rated it 7 out of 10.

The house manager told us they had looked at the skills mix and had sought to introduce staff to each house and rotate staff whilst ensuring there were always staff sufficiently familiar with people's needs. They said this was being done in a supportive way and helped to break up cliques that had developed within the service.

The general manager reported on improving staff morale with regular house meetings and small rewards and incentives for good staff practice.

Changes to staff induction and skilling the work force had been one of the main priorities for the service with on-going learning and development for staff. Staff supervisions were established but staff had not yet had annual appraisals of their performance.

As the service was in special measures, we spent a good deal of time going through their action plan and progress made towards meeting it. An updated action plan has been sent to CQC initially weekly, then monthly. The service was systematically reviewing and improving the service it was providing and doing so

in consultation with staff and people using the service to a lesser extent. Examples of some of the changes included the development of a dependency tool and reviewing every person to establish the number of staffing hours needed. It was recognised that some of the nurses were struggling to use the tool effectively so more training was being provided. The service had also looked at where people's needs best fitted within the service and there had been some movement.

Improvement around weight recording had occurred. Weekly weights were being completed electronically and entered on a graph. This enabled the managers to see as a glance how weights had fluctuated and any specific action they needed to take. Special diets were provided to those who needed them. The general manager was auditing food and fluid records more readily. We looked at records and saw staff were not always recording when people had been offered snacks in between meals or instead of meals when meals were declined.

Recruitment was a definite challenge but progress was being made. There was dedicated human resources support for the site, who were undertaking advertising and providing support on induction. There had been a pay review for nurses and incentive to complete competency assessments. They were looking at having more team leaders to give a career structure. They were exploring introduction of a care practitioner, which would mean care staff took on some additional responsibilities usually undertaken by nurses for additional pay. The tasks would be carried out under the direct supervision of nurses.

Improvements in medication practices had been rolled out and a significant reduction in medication errors, which had partly been attributed to using more of their own staff rather than agency staff.

The service had introduced 'resident of the day' where they checked every document over a two day period for every person monthly. This was being rolled out across the service. The general manager said this was likely to happen by April.

Improvements had been made in how choices around mealtime were communicated to people and staff sat with people to enhance their experiences. Changes had also been made to the environment to make it more harmonious.

The service told us activities had improved and they had recruited a full time activity worker. They reported staff were initially resistant in going out but had and really enjoyed seeing people in a different light and doing something new. We still had concerns about how the service could meet people's individual needs given the range and complexity of needs and the compatibility of individual people.

Overall, the service was very much improved but given the service history we needed to be assured that the service would be able to sustain the improvements over a period and have a stable management team and registered manager who can drive improvements forward.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care records were not always up to date and did not accurately show how people's needs were being met. People did not always get support around their individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff were observed not always upholding people's privacy and dignity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way, the provider must assess, and as far as reasonably practicable, to do so mitigate risks. Premises must be fit for purpose for its intended use. Regulation 1 2 (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Diagnostic and screening procedures Treatment of disease, disorder or injury	The service must assess, monitor and improve the quality of the service it provides and enhance the experiences of people who use the services. It must assess, monitor and mitigate risk in relation to the health, welfare and safety of people who use the services and the premises where the regulated activity occurs. It must maintain an accurate, contemporaneous record for each person using the service. Regulation 17 2 (a) (b) (c.)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were always sufficient staff to provide timely care which was appropriate to people's assessed needs.