

Sherrell Healthcare Limited

# Sherrell House

## Inspection report

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### Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

The inspection took place on the 04 September 2017 and was unannounced. Sherrell House provides accommodation and nursing care to up to 92 people. People living in the service may have care needs associated with dementia. There were 79 people living at the service on the day of our inspection.

We carried out an announced comprehensive inspection of this service on 28 and 29 November 2016. We reported that the registered provider was in breach of the Health and Social Care Act 2008 registration and regulated activities regulations.

Regulation 18 Registration Regulations 2009 Notifications of other incidents  
Regulation 11 HSCA RA Regulations 2014 Need for consent  
Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  
Regulation 17 HSCA RA Regulations 2014 Good governance  
Regulation 18 HSCA RA Regulations 2014 Staffing

We took enforcement action and served a Warning Notice against one of the more serious breaches that we found in respect of Regulation 13, section (1) (2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We gave the provider until 17 March 2017 to ensure they complied with the Warning Notice. We judged the service as "requires improvement" following the inspection of November 2016. You can read the report from our last inspection, by selecting the 'all reports' link for 'Sherrell House' on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

We asked the registered provider to make improvements and they sent us a plan with the actions they intended to take. At this inspection, we found the service had made significant improvements and that all the breaches of regulation found in our visit in November 2016 had now been met.

A registered manager was not in post. 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 registered manager left the service in August 2017. A new manager had been appointed and was due to start in September 2017. A member of the provider's senior management team was managing the service on an interim basis.

People felt safe living at Sherrell House. Staff understood how to keep people safe and risks to people's safety and well-being were identified and managed.

Robust recruitment procedures had been followed to reduce the risks of employing staff unsuitable for their role. There were sufficient numbers of staff deployed to meet people's needs.

Staff received comprehensive training to enable them to meet people's care and support requirements. We

asked staff members about training and supervision. They all confirmed that they now received regular training and supervision throughout the year.

People were given support to take their medicines as prescribed. Daily checks were carried out by unit managers to ensure medicines were managed safely.

Nutritional needs were met and people were supported to access healthcare services if they needed them. People's health needs were closely monitored and any changes to their needs were immediately reflected in their care plans and the care that they received.

Accidents and incidents were recorded, analysed and trends identified. The provider had worked hard to significantly reduce the amount of falls occurring at the service.

We found staff understood the importance of gaining consent from people and when needed people's capacity had been assessed. When people were unable to make decisions these had been considered and made in people's best interests. Deprivation of liberty safeguard (DoLS) applications had been submitted by the service in order to ensure that people were not being detained without authorisation.

Care was delivered to people in a personalised way and information was shared with staff to ensure that they were aware of people's on going needs.

The provider had improved the quality assurance systems in place and regular audits were being completed, and issues identified were addressed in a timely manner. The provider continually sought feedback from people living in the service, relatives and staff in order to improve the 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?

Good ●

The service was safe.

Staff knew how to keep people safe from abuse. There were systems in place designed to keep people safe from harm.

There were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people living in the home.

People had risk assessments based on their individual care and support needs.

People were supported to receive their medicines safely

### Is the service effective?

Good ●

The service was effective.

Staff were trained and supported to meet the needs of people who used the service.

The service worked in line with the requirements of the Mental Capacity Act 2015.

People's nutritional needs were assessed and met. People were supported to maintain good health.

### Is the service caring?

Good ●

The service was caring.

People were supported by staff that were kind and caring.

Positive relationships had been developed between people and staff.

Staff communicated effectively with people and treated them with compassion and respect. People's privacy and dignity was respected by staff.

### Is the service responsive?

Good ●

The service was responsive

There was a complaints procedure in place and complaints were addressed and acted on.

There was an activities programme in place which was reflective of the needs and preferences of the people living in the home.

### **Is the service well-led?**

The service was well- led.

The provider had systems in place to regularly assess and monitor the quality of the service the home provided. The provider had met breaches in regulation from the previous inspection.

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

People told us the staff were friendly and supportive and management were always visible and approachable.

Staff were encouraged to contribute to the improvement of the service and staff would report any concerns to their manager.□

**Good** ●

# Sherrell House

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was undertaken 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 4 September 2017 and was unannounced.

The inspection team consisted of two 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 care.

Before our inspection the provider completed 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 reviewed the previous inspection reports to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including notifications they had made to us about important events. We also reviewed all information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with twelve people who used the service and four people's relatives. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to thirteen people's care. We spoke with the acting manager, the care manager, the head of care and nine members of staff, including nursing and care staff. We looked at records relating to the management of the service, eight staff recruitment files including training and supervision and the systems for monitoring the quality of the service.

# Is the service safe?

## Our findings

At our last inspection the registered provider had not operated robust procedures that made sure people were protected against the risks of abuse and ensured safe processes had been implemented and followed. This meant they were in Breach of Regulation 13, section (1) (2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the service had followed their action plan and had met the conditions of the warning notice we issued. We found that there had been significant improvements since our last inspection and the provider was no longer in breach of this regulation.

Staff had received training in safeguarding that was face to face and were able to give examples of what would constitute as abuse. Staff were also able to discuss whistleblowing and knew they could contact external organisations if necessary. Safeguarding concerns were now identified, reported and investigated appropriately. An agency nurse told us, "I choose to work here because it is safe, I always get a good handover and I can work anywhere as I have a lot of experience, but I choose here as it is a good home."

The Head of Care kept a detailed analysis month by month, this report recorded the safeguarding concern, the impact on the person and all preventative actions that had been taken. Where incidents had occurred lessons learned sessions were held with staff to understand how similar incidents might be prevented. The provider was clear about the service's responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission [CQC].

We asked the people living in the home and those visiting whether they felt safe. People we spoke with told us they felt they were safe. Comments included, "I can press the button and they come quite quickly, I feel safe", "Carers and nurses are really good here, I feel safe."

At our last inspection in November 2016, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people living at the home. We found that there had been improvements since our last inspection and the provider was no longer in breach of this regulation. Records we looked at confirmed this.

The service had enough staff to meet people's needs. During the inspection we observed staff were able to respond to people in a prompt manner. Staff told us they had enough time to carry out their duties and there were enough staff to support people in a safe way. Since the last inspection the provider had recruited three unit leads and a care manager all of which were supernumerary and provided support including direct care to staff and people that used the service.

People and their relatives told us they received the help they needed from staff. One person told us, "The girls are good at night, sometimes they are a bit harassed when there's one off sick but they still do the job. I have to have an injection every four hours and I know they will be spot-on with their timing." We observed two nurses arrive to administer the injection at the exact time and the person added, "There you see, right on time." A relative said, "My [family member] is unable to use the call bell, but the staff make regular checks

on them. They send me letters with updates on [family member]." A senior staff member told us, "For the amount of people we have, we have enough staff, we are on the floor with our team and make sure they are doing the right thing." A staff member recently returning from maternity leave told us, "I have seen some positive changes, everybody now helps especially [named care manager], and we work as a team and have enough staff. We now have time to have a chat with people." Another staff member told us, "We get busy sometimes, but we have enough staff."

At our inspection in November 2016 we found that the registered provider was in breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. The registered provider had not protected people against the risks of inappropriate care and treatment. At this inspection we found that action had been taken and that the required improvements had been made.

Risk assessments and resulting care plans had improved since the last inspection and the care plans were comprehensive. For example, diabetes risk assessments covered signs and symptoms to look out for which meant staff had the necessary information required to respond to any concerns promptly. One person had recently had a fall and their care plan had been reviewed in full. Another risk assessment identified that a person may walk and forget to use their stick, the risk assessment guided staff to watch out for this and remind the person. When we spoke to staff they were aware of the risks associated with this person forgetting their stick and increasing their risk of falling. Another care plan contained information related to a supra pubic catheter, which showed staff assessing independence risk safely and making effective plans. A staff member told us that handovers were also used to discuss any risks to people that staff needed to be aware of.

One care plan identified a risk of bruising and detailed actions staff needed to take to move the person safely. Other people had care plans for risk of pressure sores, and we could see evidence in the notes of external agencies being involved. We noted good evidence of diligent skincare and saw that people received suitable care and treatment. Regular and appropriate wound assessments were made to check on their healing. Charts for wound care showed reliable evidence, which confirmed healthcare professionals could screen wound healing and evaluate the care required. Nursing staff referred people with pressure sores to a tissue viability nurse (TVN) for assessment when required.

Pressure relieving mattresses, equipment and bedrails were checked and cleaned every day. Staff reported there was adequate equipment to meet the needs of residents. Staff demonstrated skilled moving and handling techniques when transferring residents. Hoists were used and staff communicated with people clearly. A staff member told us, "I always transfer with two staff and I am trained."

The provider had introduced various falls prevention initiatives that had significantly reduced the amount of falls in the service. These initiatives included improved lighting, sensor mats, luminescent floor footprints, LED toilet seat lights, improved processes for falls team referrals and an increase in social occupation.

Following concerns identified in the previous inspection the provider had undertaken a comprehensive review of all medication processes. At this inspection we saw an improvement in the management of medication. People's medicines were managed and administered safely and people received their medicines as prescribed.

Medicines were administered by staff trained to do so in a calm and unrushed manner, ensuring people received the support they required. The provider had introduced a more robust induction process for new staff to ensure that completed training in medication administration achieved a higher standard than previously accepted. All staff administering medication had their competency checked and now received

additional support understanding what constituted a medicine error and the process to follow if an error did occur. A detailed medicine error analysis was carried out monthly by the acting manager and resulting actions discussed with the staff team. This approach and improvements to audit processes has meant that errors have significantly reduced month by month.

The new unit leads now reviewed medication management daily and the Head of Care analysed data weekly so the monthly audit could focus on trends and concerns. A daily 11 am meeting for all senior staff supported nurses and unit leads to discuss any concerns and take action promptly.

Medicines were stored safely, securely, and at appropriate temperatures, including medicines which required refrigeration. There were suitable arrangements for the storage and recording of medicines which required additional safe storage.

Medicine administration records (MAR) were accurately and fully completed, showing when people received their medicines. There was appropriate guidance for the administration of covert medication and medication administered as required (PRN).

## Is the service effective?

### Our findings

At our inspection in November 2016, we found that the registered provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment were not provided with consent of the relevant person. At this inspection, we found that action had been taken and that the required improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

When we looked at records we did find one authorisation where we could not find evidence that the condition of the authorisation had been met. The acting manager immediately reviewed all authorisations and following the inspection sent us all information and evidence related to any conditions that were included within authorisations.

Mental capacity assessments were in place in care plans for bed rails, finance, medication, continence, personal hygiene, nutrition and sensor mats. Evidence of best interest meetings held and family being involved in decision making was detailed on some best interest sections of the electronic care plans, but some lacked specific detail about who was involved, and often referred to family being involved. Family members we spoke to during the inspection confirmed they take part in a monthly reviews and that they were involved with the care plan. They also confirmed they had been part of best interest decision around mental capacity assessments. The acting manager confirmed they would review this documentation to ensure more detail was included about who was involved in the best interest meetings.

We observed staff seeking consent from people before they helped them move around, before they helped them with personal care and with eating. People's wishes and refusals were respected. For example, people were asked if they wanted a clothes protector on at lunchtime. Staff knew their responsibilities in line with MCA/DoLS, one senior told us, "We support people to make decisions but if they need support we involve their family or representatives." The senior went on to explain that the service had a resident of the day and as part of that the seniors would ring the relevant family members to discuss all aspects of the persons care and support.

At our inspection in November 2016 we found that the registered provider was in is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not provided staff with necessary support, training, supervision and appraisal to

enable them to carry out their duties. At this inspection we found that action had been taken and that the required improvements had been made.

Training was a mixture of e-learning and face to face training. Most of the staff had taken part in the virtual dementia training and comments included. "The virtual dementia training was excellent it really made you think about things." And, "I loved the training I feel it has helped me in my job role." Competency assessments were undertaken on some subjects whilst the staff member was carrying out their job role. For example, communication, dignity and respect, manual handling, safeguarding, MCA/DoLS.

A training matrix seen used a traffic light system to highlight any outstanding training and organise refreshers for staff. Staff were encouraged to undertake additional professional qualifications. New staff were expected and supported to achieve the care certificate, which sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Senior staff assumed their roles with ease and confidence. They confirmed their training was comprehensive and up to date. One staff member just returning from maternity leave told us that all their statutory training was refreshed prior to their return.

There was evidence in personnel files of regular supervisions and annual appraisals taking place. Staff told us this was now happening consistently. One staff member told us, "Everybody now helps so we feel supported and work as a team."

We observed the lunchtime meal and people were offered a choice of where they would like to sit by the staff. Tables were laid with tablecloths and lined napkins and condiments. There were colourful menus on each table showing pictures of food and drinks available. During the meal we noticed people chatting happily to each other.

Some people remained in the lounge to eat their meal and there was a staff member present to assist where necessary. Staff interacted gently with people about the meal and offered words of encouragement. Music was playing quietly in the background and people were offered a choice of fish or beef casserole and shown the food on the plates, they were also offered a visual choice of three different drinks. One person was taken to the food trolley to select their meal. Two people requested alternatives to the choices offered and staff responded to these additional requests straight away. Staff enabled people they were supporting to take their time and eat at their own pace. Some people were on a pureed diet and staff were knowledgeable about the risk identified that had led to this diet being appropriate for some people.

There was a nutritional support folder kept in the kitchen that contained information related to calorie boosters, monthly weights of each person, dietary needs, allergies and food consistency needs, calorie fortification of meals and details of people who required specialist equipment to eat for example, plated guards and non-slip mats. There was a dietary profile of each person including their likes and dislikes even down to what bread they preferred. The nutrition profile recorded goals for each person that included, 'what I would like help with' and 'how I need my food prepared' along with mental capacity assessments. People were encouraged to be independent and scoop plates and adapted cutlery were used.

People were appropriately referred to health care professionals when they needed it, for example to a GP, or to a speech and language therapy team. Staff were aware of the healthcare professional's recommendations, such as implementing special diets and followed these in practice.

During our inspection and whilst assisting their [family member] to take their cardigan off, one relative noticed an area of broken skin on their upper arm, they told the care manager who immediately went to

request a nurse to attend to it. One person told us, "The nurses check my ulcer on my leg every day and I would tell the nurse if it was not comfortable, if I get any pain, I ask the nurse for tablets." On the day of our visit the opticians were on site and several people were assisted to visit the optician.

A project was being carried as part of the provider's dementia care strategy to promote engagement and wellbeing using design, decoration, signage and other adaptations. Corridors were themed using murals and redecoration and lighting levels had been increased. People had taken part in choosing these murals by being shown pictures and asked which ones they preferred. We heard one person say, "My room is by the fish and chip sign." These murals helped people to recognise the part of the floor where their room was and provided areas of interest and talking points for staff to interact with people. Pictures included a beach theme and a countryside theme on another floor was in the process of being completed. The bedrooms were personalised and each door was brightly coloured and included a memory box that helped to support people with dementia to find and recognise their bedrooms. The memory boxes contained individual items to help people recognise their room, some had photographs, ornaments, or items of memorabilia that were important to that person. Storage cupboards were made to look like beach huts with a poem inscribed on the doors.

## Is the service caring?

### Our findings

People and relatives gave us positive views about the care provided in the service and felt staff were kind, considerate and caring. One person told us, "They look after me and make sure I'm all right, I've made lots of friends here. I get plenty of food here. If I don't feel like going to the dining room, they will bring my food to my room on a tray, I have my hair done, and I've not seen anybody treated badly."

Another person told us, "Some carers come in on their days off to see people. They come in to see someone who is passing away on their day off. The activity worker does shopping for residents in their own time." A relative told us, "Staff are on hand, they are never left long. Everyone seems happy".

Care plans had been compiled with input of family members and were reviewed every month. Each day there was a 'resident of the day' which meant the persons care plan was reviewed and family were invited to comment about their family members care and support. We spoke to a relative who was positive about the care their [family member] received and told us, "Yes the staff are lovely you won't hear me complain they have been brilliant."

People's records included their life history, which gave staff information about the person and their interests. The records also included people's likes and dislikes and how they wanted to be cared for. For example, in one care plan it stated the person enjoyed watching football and liked their family member's approval before they made a decision.

Information related to end of life care had improved and the service had re-joined the Gold Standard Framework Award (GSF) to work towards gaining accreditation. The care plans included relevant information to support wellbeing at the end of a person's life and additional training provided through the GSF network will further support the improvements seen. GSF is a systematic, evidence based approach to optimising care for people approaching the end of life. They run training programmes in end of life care for frontline staff.

One relative told us their family member was receiving palliative care and they wanted the person to stay in the service rather than be transferred to hospital and they told us, "The home has been great nothing is too much trouble. [Name of relative] has lived here for two years now, this is their home and they would be so stressed about going into hospital, the staff have got a hospital bed for them it is coming this afternoon."

We spent time in the communal areas and observed how people and staff interacted. Staff had time to spend one to one with people and support them. There was a homely feel to the service and we heard conversations and laughter as staff stopped to chat with people. Staff were constantly 'popping' their heads into people's rooms checking everything was okay.

People were cared for by staff who knew their needs well. People were treated with dignity and respect. Staff said they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, explaining what was happening and gaining consent before helping them.

The staff members we spoke with showed that they had a good understanding of the people they were supporting and they were able to meet their various needs. They told us that they enjoyed working at Sherrell House. One staff member told us, "I am passionate about helping people and whilst it is challenging, I enjoy my job." Another staff member told us, "I am 100% sure people get good care here."

Independence was promoted and respected. People were provided with equipment to support their independence including utensils to eat their meals. People's care records included information about the areas of care that people could attend to independently and what they needed assistance with. One person told us the food was not to their taste, so they ordered takeaways two or three times a week using their mobile phone.

It was evident that family members were encouraged to visit the home when they wished. One relative told us they visited their family member five days a week, they assisted them to eat and was given a meal too, to enjoy with their family member. They said, "[Family member] is happy here, it's a good home. [Family member] loves the food, they call him Granddad." One relative had brought their dog in, they told us, "Residents like seeing him."

## Is the service responsive?

### Our findings

The provider's system to manage complaints had improved since the last inspection. An easy read complaints policy was in place and a free telephone complaints line was available directly through to the providers head office. The service was now managing complaints effectively in line with their policy. Complaints were kept in date order within a folder and logged onto an electronic system. There was a record of complaints holding letters, investigation reports and response letters. For example, we viewed a complaint that said there were not enough wheelchairs available, on the day of our visit we saw staff unpacking newly purchased wheelchairs available for people to use if they did not have their own and wanted to go out with relatives. People we spoke to said that if they were worried or had concerns, they would speak to their family or a staff member. One relative said, "At one time, there were always different staff, but now it seems a lot better. There is a book in reception to write concerns. I have no concerns about my [family members] care and have been to meetings at the home."

Communications processes in the service had improved to support a more responsive approach. A dashboard meeting was held each morning at 11am. This meeting included one person from each department including the kitchen and housekeeping team. The meeting shared general comments about any situations occurring in the service, everyone was updated with information including appointments, falls, delivery of items, hospital admissions or discharges, medication changes and health professional visits.

At the beginning of each shift the handover form was completed for all staff and contained information about each person including manual handling and nutritional needs, this was then filed at the end of the day and signed off by each staff member to say they had read the form. This demonstrated that all staff had updated information and were aware of any changes to people's care needs. This handover form was also used for staff new to the service so they could have important information about people that used the service to hand.

Before people moved to the home an assessment of their needs was completed to ensure the service could meet their needs. The senior staff met with people and their families and discussed their care needs and what was important to them. This information was then used to generate care plans to guide staff to know how to provide the care they required when they moved into the service. This ensured people's care plans were reflective of their health care needs and how they would like to receive their care, treatment and support. Each staff member had a log in for the electronic care planning system and any agency staff were supported by a senior staff member to enter their records.

People and relatives said they were aware of their care plan and they had been involved in discussions about how they wanted their care and support. They also said they felt involved in the care of their family member on a day to day basis and that the home kept them informed when anything happened.

The service had two activity staff that worked in the service, one was on leave on the day of inspection. We were able to observe the activities coordinator and saw that they split their time between doing some group activities and interacting with people one to one. We observed an activity session on the second floor.

People were singing and playing musical instruments, the activity coordinator offered people a choice of instruments. One person told us "I used to be in the band at school, I played the tambourine". The activity staff member gave them a tambourine to play. Two people were singing into microphones and others were smiling and tapping their hands to the music. Some people were having their nails painted by another staff member. We observed the activity staff member move around the room also spending time with other people not part of the group. The care manager working alongside staff was asked by one person if they could go to the garden, the care manager supported them to do this and spent time chatting with them in the garden.

Other staff were spending time one to one with people, either chatting or offering people things to do. A variety of items were available placed around the communal areas including twiddle muffs, which are knitted muffs with interesting items attached. People living with dementia can find them comforting and therapeutic as they help encourage movement and occupation. Some people looked at newspapers, one person was pushing a pram with a doll in it. Another person was busy laying tables. Some people were in their rooms, the staff said the activity coordinator employed by the service suggested activities for the staff to offer to people that might not want to join in the group activities. One person told us the staff enabled them to visit friends in the community each week and another said, "I have a church service in my room because I can't get to the service in the lounge." A relative told us, "My [family member] was bored downstairs as people stayed in their rooms so they agreed to move them to this floor and she they are happy here."

## Is the service well-led?

### Our findings

At our last inspection in November 2016, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because the registered provider had not operated effective systems to protect people against the risks of inappropriate or unsafe care as robust arrangements were not in place to assess, monitor and improve the quality of the service provided. During this inspection we found that improvements had been made. The registered manager had recently left the service and the provider told us a new manager had been appointed and was due to start the following month. The service was currently being overseen by the Head of Care who was a senior manager working for the provider. The management oversight of the service had been further improved by the appointment of three unit leads and a care team manager, all of which were visible in the service.

Effective systems were in place to ensure the quality of care at the service. Internal and external audits were completed with actions plans and time scales on how any areas could be improved. We saw that a gap specific action plan was in place that addressed any issues raised in audits and the management team worked collaboratively to ensure actions were completed within timescales set. A considerable amount of work had gone into analysing data weekly for incidents, accidents, medication errors, complaints and concerns; this information was then used to work with staff in lessons learned sessions and identify preventative initiatives from best practice guidance.

We were able to see that this collaborative work had supported the service to significantly reduce medication errors, safeguarding incidents and falls in the service. In particular, the falls prevention initiative had helped to reduce falls from 41 in January 2017 to just nine falls May 2017. These initiatives included, a robust falls team referral, increased screening for infections, exercise classes, improved LED lighting, increase in sensor alert equipment, improved hydration, increased levels of occupation, hand bells in lounges and additional corridor seating. The service was also trialling for one person a toilet seat with LED lighting, with luminescent footprints leading to the person's toilet. The service was hoping that this would support the person to more easily find their toilet during the night and promote their continence.

The provider had a dementia strategy with plans for 2017/2018; this included improved dementia care training for staff, improvements to the environment, meaningful occupation and improvements to meal times. Another senior manager was leading this project and told us that they were spending a lot of time at the service coaching and supporting staff to implement this strategy.

We could see the improvements to the environment and the way in which people that used the service were included in this project. The care team manager was also instrumental in working with staff to support them to understand people's individual needs. They told us that they had looked at incidents of challenging behaviour and tried to identify what the person was trying to communicate. One person had been given a soft toy dog to interact with, the care team manager told us this had not only reduced their anxieties, the person was also having less falls as they appeared more relaxed and occupied. We observed this person interacting with the soft toy, saying, "That's my boy" and stroking the dog affectionately. A staff member at lunchtime made sure the dog was sat next to the person, knowing that it would be important to the person

to be able to see this while they ate.

Staff were also complimentary about the acting manager and the service. Staff we spoke with told us that they felt well supported and were clear about their roles and duties. The acting manager was around the home on the day of inspection and had a good rapport with people that used the service and staff. They appeared to have a hands-on approach and knew people individually. One staff member told us, "There have been a lot of changes in management but I can speak to any of the seniors." Another staff member said, "I love working here. We are a good team." A senior staff member had recently carried out a night visit at the home to make sure standards were being maintained at all times.

Regular staff meetings took place including general staff meetings, managers meetings and daily heads of department meeting at 11.00am. We saw that meetings included discussions about training, new initiatives and recruitment. Staff confirmed that they attended these meetings and found them useful.

People were given the opportunity to share their views of the service in meetings. The minutes of meetings were made available for people, and included information about new personnel in the service and the laundry service. A staff and relative newsletter was sent from the service and feedback forms were visible in the reception area that people could complete and post in the box provided. The reception area also provided a forum to display information about the services new initiatives, which included plans to involve people in the interview process for new staff, plans to increase work with local schools so people in the service could enjoy the company of children and information offering people and relatives the chance to attend dementia training.

The service had received compliments about the service that included, "Looking after my mum must have been difficult at times but all the staff have been kind and considerate at all times thank you." And, "If ever I have had any requests no matter what, they have been carried out as communication is excellent."

An employee of the month scheme was in place for staff where they received vouchers to congratulate them for the work they do.

An independent dementia mapper had carried out a dementia map at the service and staff were positive about the report. Dementia mapping is an observational tool that is only used in 'public' areas of care environments. It usually involves one or two trained mappers sitting in areas such as a lounge or dining area and observing what happens to people with dementia over the course of a typical day. It is an established approach to achieving and embedding person-centred care for people with dementia, which is recognised by the National Institute for Health and Clinical Excellence. This demonstrated the provider was committed to trying to achieve a person centred service.