St. Cloud Care Limited

Stowford House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Stowford House Care Home over two days. The first visit was on 11 May 2017 and was unannounced. We returned to complete the inspection on 16 May 2017.

Stowford House Nursing Home is registered to provide residential and nursing care for up to 51 older people some of whom are living with a dementia. At the time of this inspection, 38 people were living at the service.

At the last inspection on 5 and 8 December 2016 the overall rating was Inadequate and the service was placed into special measures by the Care Quality Commission (CQC). Seven breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. Following the inspection, we received regular action plans which set out what actions were been taken to bring the service up to standard.

We undertook this inspection on 11 May 2017 in line with our special measures guidance to see if improvements had been made. At this inspection we found considerable improvements in the service. We could see that action had been taken to improve people's safety but further improvements were needed in some areas. We have made a recommendation about the management of some medicines. Improvements on recording were required so that accidents and incidents could be better monitored and managed.

There was a registered manager in place. 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.

Staffing numbers had been increased to ensure there were sufficient numbers of suitable staff to meet people's needs. Staff had been recruited safely to ensure they were suitable to work with vulnerable people. Staff knew what action to take if they were concerned that someone was being abused or mistreated.

Risks to people's safety were appropriately assessed and managed. We found the premises were clean and tidy, with no unpleasant odours. There was a record of essential inspections and maintenance carried out. The service had an infection control policy and measures were in place for infection control.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Records showed staff received the training they needed to keep people safe. The manager had taken action to ensure that training was kept up-to-date and future training was planned.

Staff told us they felt supported by the management and supervision and appraisals had been scheduled in to ensure these meetings were undertaken regularly. Training and development plans were in place for staff.

People were supported to ensure they had adequate nutrition and drinks and were supported to access a range of services to meet their health care needs.

People and their relatives told us staff were caring. Staff treated people with compassion and dignity and respect during delivery of care.

Each person had a personalised care plan containing information about their life histories and support needs. The care plans had been updated in line with people's changing needs. People said they were involved in making decisions regarding their care.

People were provided with the opportunity to participate in the activities they found interesting. People and their relatives were aware of how to make a complaint. Complaints had reduced considerably.

The management had acted on people's and relatives' opinions on the service, including complaints. This had been used to implement changes to improve the service. The service had engaged an external consultant to support with improvements in the quality of care. People and staff had confidence in the management of the home and were complimentary about the improved positive culture within the service.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Incidents and accidents had not always been correctly identified and recorded.

Sufficient experienced and trained staff had been deployed to work in the service and recruitment was ongoing to ensure suitable staff were employed.

Risks were identified and appropriate steps taken by staff to keep people safe and mitigate the hazards they might face.

People's medicines were safely managed although some records needed to improve.

The environment was safe and well maintained.

Is the service effective?

Good

The service was effective.

Staff had the right skills and had received training and support enabling them to do their jobs effectively and safely.

People were assisted to eat to ensure they received sufficient food and drink.

Appropriate arrangements were in place to assess whether people were able to consent to their care and treatment.

People were supported by a range of health care professionals as required.

Is the service caring?

Good

The service was caring.

People and relatives we spoke with told us they were happy with

the care provided.

People were treated with dignity and respect.

Staff demonstrated they understood and cared for people in the service.

Is the service responsive?

Good

The service was responsive.

Care records contained sufficient information to guide staff on the care to be provided. The records were reviewed regularly to ensure information was reflective of people's care needs.

Complaints had reduced and where made, complaints had been dealt with effectively.

A range of social activities were provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements had been made but needed to be embedded into the service to ensure ongoing plans were sustained.

The provider had listened to and responded to concerns raised by CQC and other interested stakeholders. This meant that people were receiving an improved quality of service.

Staff spoken with told us they felt the management team were approachable and supportive.

People, relatives and staff had increased confidence in the management and leadership of the home.

Stowford House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 16 May 2017 and the first day was unannounced. The inspection team consisted of two inspectors, two pharmacist inspectors, a specialist professional 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.

Before the visit we reviewed the monthly audit plans the service had sent us after the last inspection in December 2016 to update the Care Quality Commission (CQC) on ensuring the regulations were being met. We reviewed notifications. Services tell us about important events relating to the care they provide using a notification which is a requirement of law. The registered provider was not requested to submit their provider information return (PIR). The PIR 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 also reviewed information from the local authority safeguarding and commissioners.

Over the course of two days we observed the care provided to people who used the service. In order to gain people's experiences, we spoke with six people who used the service and eight relatives. We also spoke to the management team comprising of the registered manager and deputy manager. We spoke with three nursing staff and four care staff, two activity co-ordinators, the chef and assistant chef and the maintenance person. Finally we spoke with a dementia consultant who has been supporting the service whilst it was in special measures.

During the inspection we observed staff practices and completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also reviewed six staff records, recruitment records, and the training and supervision matrix for staff. We

looked at seven care records including food and fluid records. We reviewed eleven people's medicines charts. We also reviewed other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in December 2016, we identified that people were not safe and the safe domain was rated as inadequate. There were not enough staff to support people safely to meet their needs. People's medicines were not safely managed and not always administered as prescribed. Plans to minimise and manage risks were not in place. Not all information was up to date and clear in risk assessments. We found not all equipment used was of an adequate standard to keep people safe and people were not always protected by the prevention and control of infection. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent the CQC regular action plans which set out what actions were been taken to bring the service up to standard. At this inspection in April 2017 we found improvements had been made.

Care staff recorded the application of creams or other external preparations on separate charts. However, these were not available for the creams administered by the nursing staff and were sometimes not fully completed. Whilst the administration was recorded, this meant that the specific guidance on administering creams was not easily accessible in the MAR chart if the nurses applied creams.

We saw that protocols were in place for most prescribed 'when required' medicines. For example, for pain relief. Staff knew the residents very well and people were asked or assessed to see if they needed these medicines However, we did observe that two medicines were not in the records to provide guidance for staff to decide if it was appropriate to give a dose of the medicine. The nurse was fully aware of this and was in the process of checking all the charts to ensure they contained the correct information.
We recommend the providers should take action to ensure all administration records are always completed correctly and contain all relevant advice for administration, including when required and homely remedy protocols and topical administration charts.

During this inspection we looked at the systems in place for managing and administering medicines. We observed some medicines being given to people in the morning, and saw that these were given in a safe and caring way, and as prescribed. We could see that medicine administration records (MARs) were completed when medicines were given, and reasons were recorded if doses were not given; we could clearly see when people had taken their medicines. Staff double signed handwritten additions or amendments on the MARs. Medicines were given by nurses who had received training, and had been assessed to make sure they gave medicines safely. The medicines policy for the home had been updated and information about medicines was available for staff and residents.

Arrangements for ordering and receiving people's medicines from both the GP and pharmacy were appropriate. In addition, records identified any allergies or particular areas of risk for each resident.

Records were maintained of medicines received into the home and those sent for disposal, which helped to check how medicines were looked after in the home. Nurses also maintained a running balance of stock which meant it was easier to identify if the medicines had actually been given and that there was enough stock for residents.

Medicines were stored safely and securely and room temperatures were monitored daily. Medicines refrigerators were kept at a safe temperature for storing medicines. Suitable storage was available for medicines that required additional security. Staff made regular checks of the clinic room including medicines management checks.

Each resident could also be administered "homely remedies" (non-prescription medicines that allow staff to respond to people's minor symptoms appropriately) and these were supported by a policy and protocols, developed with the GPs, to provide guidance to staff on what medicines could be given and when to give the medicines.

We saw that there was a system for reporting any medicines errors and incidents. We saw that these were investigated and discussed so that measures could be put in place to prevent them from happening again. We saw that regular audits were now being completed by staff, to pick up errors and there was evidence that issues had been dealt with appropriately.

At the last inspection in December 2016, people's risks were not always safely managed. At this inspection, we found risk assessments were not always updated in accordance with changes in a person's condition. For example, we saw two people had wounds covered by dressings that had no care plans providing guidance for care of the wounds. We found that incidents and accidents did not always contain information on skin tears and wounds. For example, we saw a body map showing a skin tear was identified on 4 May 2017 but had not been recorded on the incident and accident record to demonstrate it was investigated. This meant wounds and skin tears were not been monitored to record the causes and ongoing care needed. We spoke with the registered manager who took appropriate action to ensure these issues were followed up and plans put in place to ensure this was monitored more effectively. We saw evidence that staff had been contacted and asked to ensure that recording was completed consistently.

Other risk assessments had been completed and were kept under review. Risks were identified such as choking, pressure damage, moving and handling, bathing and nutrition and had management plans in place. For example, one person's records said 'High risk of choking if left unattended. [Name] must not be left with any kind of foods. Puree diet following SALT assessment'. We saw the person being supported at mealtimes.

At the last inspection, not all equipment, such as bed rails, slings and pressure relieving mattresses were adequate to keep people safe. At this inspection, we found improvements in all of these areas. For example, all bed rails were at the correct height. This meant people were protected from falling out of bed. Pressure relieving mattress settings were in line with people's weights and care plans.

At the last inspection, people were not always protected by the prevention and control of infection. At this inspection, we found improvements had been made. We saw staff were following good hygiene practice, washing hands between care tasks and before preparing drinks or serving food. At lunch people were offered the choice of having their hands wiped. Laundry trolleys were used to collect soiled linen and staff were wearing protective equipment such as aprons and gloves. One person said, 'Everywhere very clean. They really care about the place." A member of staff said, "We now have trolleys so we don't walk the corridors with laundry" and "We wear aprons and gloves when doing personal care."

The premises were safe, free from trip hazards and remedial actions had been taken to ensure that health and safety legislation was fully complied with.

At the last inspection in December 2016, we found there were not enough staff to properly care for people. These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent the CQC regular action plans which set out what actions were being taken to bring the service up to standard. At this inspection in April 2017 we found improvements had been made. We found there were sufficient staff on duty to meet people's needs. People were assisted promptly when they called for assistance. After the last inspection, the dependency level of people was reviewed and the staff levels increased accordingly to be able to meet people's needs.

Recruitment for permanent staff was ongoing and it was anticipated that the use of agency staff would be reduced when prospective employees had undergone the necessary checks and training. Staff rota's confirmed planned staffing levels were consistently maintained. One member of staff told us, "More staff has made a massive difference". Another said, "Staffing is so much better. Have to use agency, but use the same so they know the residents."

People told us they felt safe. Comments included; "Good place absolutely safe, couldn't wish for better", "Quite happy- safe. I have experience of a lot of different places [care homes] and this one is safe because doors are locked and my things are safe" and "Pretty good, safe they [carers] make sure all is well." Relatives felt improvements had been made to people's safety. Comments included, "She's definitely safe now. There's always someone around. Staffing levels are vastly improved."

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; ""I would report anything to [registered manager] and she would sort it out" and "I'd go to CQC if they didn't do anything."

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

Good

Is the service effective?

Our findings

When we inspected in November 2015 we found that people were not always supported to have their nutritional needs met. At the last inspection in December 2016, we found people were still not having their nutritional needs made and the effective domain was rated as inadequate. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent the CQC regular action plans which set out what actions were been taken to bring the service up to standard.

At this inspection in April 2017 we found improvements had been made but further action was needed to ensure that people's dietary preferences were accurate and reviewed regularly. For example, records for catering staff were not up to date to reflect specialist diets such as pureed diets and food allergies. We spoke with the registered manager and by the second day of the inspection the information had been updated. An experienced chef had started work at the home four days before the inspection took place. We heard that the menus were being reviewed and a person's relatives was assisting with this. The chef was positive about ensuring robust systems were in place to evidence and record that peoples' nutritional needs were being met.

People had positive comments about the food such as, "Food is better now. Hot and more tasty", "Food, lots of ways of improving it but it's getting better. Was always cold, now hot and seems better" and "They will do you alternatives, omelettes, salad, things like that."

We saw that people had access to drinks in the communal areas and in their rooms and observed staff encouraging people to drink during the day. Morning coffee, afternoon tea, and snacks were served from trolleys and a choice of snacks were available. Staff were able to supply snacks during the night.

Meals were served from heated trolleys which maintained food at the correct temperature. We observed that the temperature of the food was checked, by the assistant chef, before it was delivered to people.

We observed the lunchtime period and there was a calm, relaxed atmosphere throughout. People enjoyed their food and were encouraged to eat, being offered choices. We saw good interaction between care staff and people whilst being supported with eating. The care staff explained the meal and offered small sized portions. Support was offered in an unhurried way and drinks were offered throughout. We saw a staff member encourage a person after a few mouthfuls. When the person declined the staff immediately offered a choice of pudding. We saw a member of staff encouraging interaction between people, talking about what was for lunch. We saw a member of staff kneeling down, talking quietly to a person who was feeling unwell. The staff member encouraged some fluid, showed empathy and understanding with a very gentle approach. Staff moved around the dining room talking to everyone and spoke with each other to ensure everyone had eaten.

Staff had an understanding of people's dietary needs. For example, a member of care staff told us of one person who needed a pureed diet when they were sleepy and their fluids required thickening to minimise the risk of choking. This was reflected in the person's care plan. The nurses held a monthly weight and

nutrition meeting was discuss any weight losses or other concerns to ensure this was closely monitored.

When we inspected in December 2016, the principles of the Mental Capacity Act 2005 (MCA) had not always been followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a report saying what action they were going to take. At this inspection we saw improvements had been made.

The 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 found at this inspection, improvements had been made. For example, staff acted in people's best interests when supporting them with personal care. A staff member told us, "Use a soft approach, encourage but must work in their best interests."
We looked at the care plans for people receiving their medicines covertly (without their knowledge). There was documentation to show that these people's capacity had been assessed and it had been discussed with the GP and their families to determine that this was in the residents' best interest. The pharmacy had been asked for advice on the best way to administer these medicines.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Where restrictions were in place the registered manager had made DoLS application to the supervisory body. People's care plan detailed the restrictions in place and how people were supported to ensure any restrictions were the least restrictive. For example, where bed rails and sensor mats were in use, a capacity assessment and best interest decision had taken place in accordance with the MCA. These were reviewed regularly whilst waiting for authorisation.

Staff had completed training in MCA and DoLS. Staff understood their responsibilities to support people in line with the principles of the Act. One member of staff told us, "I try and persuade them to have care, but have to consider their best interest."

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they had received an induction and completed training when they started working at the service. Induction training included dementia awareness, nutrition, moving and handling, first aid, fire safety, health and safety infection control. Staff were positive about the training they received and were supported to attend regular updates to ensure their skills and knowledge were kept up to date. Staff were provided with specialist training where necessary. A staff member said "I have had training to help me deal with challenging behaviour. They are good at giving us specific training. I've had Huntingdon's disease training." We saw the nurses had been provided with relevant training such as syringe driver and pain management training.

Staff told us they had effective support. A member of staff said, "I've just had supervision. I talked about how I'm feeling about things. I want to do [a national care qualification] and they are finding out if there's funding." Not all staff had records of supervision. Supervision is a one to one meeting with their line manager. We discussed this with the registered manager who said they had scheduled in dates for the future to ensure these took place.

Care records showed people were referred to health professionals when needed. People told us they had seen their GP, district nurses, a dentist, chiropodist and optician. Comments included, "I have seen the GP

recently and have seen the dentist", "Seen the nurse from time to time" and "Someone trims my nails and looks after my feet."

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home and benefitted from caring relationships with the staff. People were positive in their praise for staff. Comments included; "Staff very friendly, caring", "Pretty good people, always willing to help and do all the things I can't do. Couldn't wish for anything better" and "Get on with the carers-all good."

People were supported by a staff team who genuinely cared for people. We observed caring interactions, for example, a member of care staff discreetly wiping a person's mouth and making sure people had tissues available. We saw a person who was upset and needed emotional support. We saw a member of care staff put a supportive arm around the person's shoulder and offered reassurance.

People were cared for by staff who were knowledgeable about the care required and what was important to them in their lives. Staff showed a good knowledge of people's needs, likes and dislikes and we saw them talking to people about their families and asking questions to encourage engagement. Staff comments included: "Now we have more staff we have time to sit and talk and get to know people. We have time to build relationships."

The service had recorded a DVD to use in staff training. This had captured the experiences of two family members in relation to their parent going into care and the effect this had on them. It was an interview style and discussed issues such as how they felt when they left the home the first time and how they felt the home responded to concerns raised. It was reported that staff had found this a powerful learning experience which helped them to empathise and understand the importance of providing a high level of care.

During the inspection we saw numerous positive interactions between people and staff. For example, a member of staff was walking with someone as they had just been for a walk. They provided encouragement about improvement in mobility due to the person's "hard work and determination". The staff member clearly knew the person well and they were chatting about what they had seen during their walk.

We observed staff communicating with people in a very patient and caring way. We saw a person had a swollen hand. A member of staff found a pillow and rested the person's hand on it to make them more comfortable. We saw another member of staff admiring someone's shoes before offering to wipe their hands. Staff showed genuine concern for a person who was sleepy. Staff recognised they had been unwell and were on antibiotics. They offered to remove lunch and give something later.

People were given choice and this was respected. For example, when people were offered food and drinks they were shown the food available. People's independence was promoted. For example, a person was given plate guards to assist independent eating. Staff suggested moving closer to the table for comfort which was welcomed by the person. Crockery had also been purchased by the home which was dementia friendly. The plates had a raised rim to help avoid food being pushed off the plate. They had a dark blue band around the edge to assist visually and were tastefully decorated.

People who required support with their meals were supported at their own pace in a respectful manner. Staff explained what was being served and checked people were happy with meal. When member of staff had to leave a person to support someone who was coughing they explained they were leaving. They were very supportive and caring of person who was coughing.

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful. Language used in care plans was respectful. We saw people were treated with dignity and respect throughout our inspection. A person commented that staff were "Very respectful and treat me with dignity." Another said, "Got a notice on my door to remind staff that I am blind, usually knock and introduce themselves." We saw a member of staff knocking on this person's door, and they introduced themselves and waited to be asked in. At lunchtime we saw people were asked if they would like a protective cover for their clothes. One person declined and their wishes were respected.

People's personal and medical information was protected. The provider's policy and procedures on confidentiality were available to people, relatives and staff and gave details of when and how information would be shared with other professional bodies once the person's consent had been obtained. Care plans and other personal records were stored electronically and required passwords to access the information.

People's care was recorded in daily notes maintained by staff. Daily notes recorded what support was provided and events noted during the day. These provided a descriptive picture of the person's day. For example, one staff member had noted in one person's care plan 'appears fine today and continues to eat and drink well'. Another record stated '[Person] had a lovely rest this afternoon and woke up happy'. This evidenced staff cared for the people they supported.

Where people had expressed a preference their wishes relating to 'end of life' care were recorded and respected. Advanced care plans recorded people's preferences and wishes. For example, whether people wished to be buried or cremated, funeral and family arrangements and what clothes they would like to be dressed in. Staff had received end of life care training. One staff member commented, "I like end of life care, it's a privilege. However, I sometimes think we need more support around bereavement."

Relative's needs had also been considered so they could be with their relative if they wished. A fold up bed and toiletries were provided for relatives if they wanted to stay the night.

Good

Is the service responsive?

Our findings

When we inspected in December 2016, up to date and accurate records of people's care were not always maintained. This meant staff had not been kept up to date with changes to a person's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a report saying what action they were going to take. At this inspection we saw improvements had been made.

People's records had lifestyle care plans to assist them to have personalised care. This contained details of people's personal histories, careers, likes, dislikes and preferences and included people's preferred names, interests, pets, hobbies and religious needs. Families had assisted, where needed, in developing the care plans providing relevant history to produce these. For example, one person had information about a former career. We saw a box outside the person's bedroom door had items in it relating to this career. Another person's lifestyle care plan had guidance that if a person seemed sleepy and in bed to 'Spend time with them and sit for short periods, listen to music, support with gentle hand massage or read short story poetry.'

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person was exhibiting some signs of anxious behaviour and began pushing at a door. A member of care staff took him out for a walk in the garden, aware of how to prevent the situation from escalating.

Stowford House had three activities staff covering six days a week. Activities were arranged on an individual basis, or small or large groups. We heard of one person who can become very anxious when not with their relative. The service had done a video of their relative reading the paper and put this on to calm the person if needed. Music groups and doll therapy had also been successful in helping the person's anxieties. A rummage box had been prepared based on the person's former interests such as knitting, crafts, fabrics and sorting and counting.

We also heard that a person after hearing a song at a concert had said "I wish I could say that to [name]". On their return an activities member of staff wrote out the words and assisted the person to decorate and sign it to give to their relative. This had been very positively and emotionally received.
People were offered a range of activities including games, sing a longs, arts and crafts. We saw on one person's records that they liked one to one support but disliked group activities. It was recorded that the person enjoyed sensory items such as a lamp, puzzle, colouring, looking at books, music and watching dancing and music shows.

We observed people had access to a range of activities during the day of the inspection. One person, who had previously been a good table tennis player, had been enabled to continue playing at a local sports centre. People had opportunities to access the wider community through trips in the minibus. For example, people went to a local garden centre on the day of the inspection. People had also been on outings to classical music concerts, trips to familiar places, drinking coffee and people watching.

People's comments on the activities included, "I join in with various activities. Pass the time keeping up with my languages and reading", I join in with things or be bored out of my skull" and "Go in to the garden. I love sitting outside." People also enjoyed more one to one activities. One commented, "Carer takes me out shopping and "I like one to one things, like quizzes and puzzles because I don't like groups of people." People were encouraged to join in. A member of the activity team said, "[Name] wouldn't come out of her room and did no exercise. When it came to Christmas dinner we managed to tempt them out. They now join in with some activities and freely walks from their room to the lounge." Relatives said, "[Name] enjoys all activities. Likes the singing and chit chat club". "Her [condition] has never been a barrier to her doing activities" and "Activities people are great."

People were able to play an active part in supporting staff. One person liked to lay the tables for lunch. A cookery club had been set up one morning a fortnight. Cherry scones, chocolate chip biscuits and tea loaf had been made and were provided to people in the home for afternoon tea.

Guidance on how to communicate with people were recorded. We saw on a person's care records staff should ensure eye contact was made when communicating with them. The record said "[Name] can express all her needs and can initiate conversation with staff and likes to have social input to fulfil her day as she tends to feel lonely when family are not visiting." We observed staff approach this person where they called the person's name and gently touched their arm to get their attention and maintained eye contact to assist good communication.

The service had purchased two dolls to reflect babies. These had been provided so that those experiencing dementia may choose to spend time providing care and to provide a meaningful activity for them. We saw one person caring for the baby doll and receiving support from the staff.

At the last inspection in December 2016, we found complaints had not always been dealt with thoroughly. The registered manager had received a high level of complaints in relation to staffing levels and quality and quantity of food throughout the year prior to the last inspection. However, there was little evidence of improvements being addressed in relation to these trends so that they may be improved in an acceptable timeframe. These issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made.

The service's complaints procedure was clearly displayed in the home. It had details of internal and external contacts to approach if a complaint needed to be escalated. We saw the number of complaints received had reduced from 10 in January to six over a three month period. We saw all complaints had been dealt with in line with policy. People told us they would complain if necessary and went on to say that they were confident that any issues would be sorted out. One person said, "No real problems but know people would help me sort things out" and "Go to the carers if I have a problem."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in December 2016, the service was rated inadequate and placed into special measures. There were six breaches of the regulations including Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent the CQC regular action plans which set out what actions were being taken to bring the service up to standard.

At the last inspection, we had concerns from relatives that despite them raising concerns at relative meetings, the required changes did not happen. At this inspection, we had feedback about the improvements that relatives had noticed. Comments from relatives included, "It's a different place, they really are trying. So much better now. Place is cleaner, more carers on duty, more focused, more professional, more team effort generally. The deputy manager is always about monitoring staff which is just what you want and it is lovely to see the manager out and about." Another relative said how the approach of staff had changed over the last six months in terms of translating professional's advice on care needs into practice. "They take everything on board now and implement what (the health professional) suggests. This didn't happen before" and "The manager is good. It's much better now", "The manager has had a free rein and things are improving" and "We're being listened to. This manager has always listened". "Quality of care is much better. It's always been a systemic issue." The service had also recruited a receptionist for weekends to meet and greet people when they arrived and to answer the telephone.

Relative meetings were held monthly. "A real sea change with this [registered] manager and she is not at all defensive. The culture is less defensive; it's rubbed off on the staff". "My fear is that when you (CQC) pass them they'll go back to the old staffing levels."

Staff told us the registered manager was supportive and approachable. Comments included; "Very supportive around personal life" and "I could go to [registered manager] at any time." Staff felt the culture of the organisation had improved. We had comments from staff such as "Everyone's working together as a team. We all want things to get better", "New working in teams means you can focus on people, spend more time with people", "Problems are addressed. Morale is so much better. We're all more positive". "It's like a little family" and "Atmosphere is better. Morale has improved. Staff are less stressed."

Regular staff meetings were held and recorded. We saw staff were able to raise and discuss issues. A member of staff said "At last team meeting we discussed mealtimes. We watched a video and were asked our opinions. [Registered manager] listened to our ideas and they've been actioned." Another member of staff said, "Communication is better, we have staff meetings so we know what's going on." The nurses also held weekly meetings to discuss people's weights, pressure care, and other medical areas."

Staff felt communication had improved. We had comments such as "A lot better. It's improved quite a lot". "We have better recording. It's made such a difference falls have reduced" and "[Deputy manager] is moving people around. The teams are better. More structured and responsible for less people", "It's changed a lot. It's improved loads, care is much better. Good teamwork, we have good communication. Gives you all the information at handover."

At the last inspection, areas to be addressed had been identified during audits. However, there had been a failure to take effective action to ensure that medicines were managed safely and people received the nutrition they required. At this inspection, we saw the quality of the service provided had been monitored. Improvements were required, however, as we found the overview of incident and accidents could be improved by ensuring recording was consistently undertaken in respect of skin tears, bruises and wounds. This would ensure the registered manager was able to have an overview and ensure timely investigation, management and action was taken as a result of audits.
A range of audits were completed on care plans, medicines, infection control, staff files, catering, activities, equipment checks and maintenance. For example, equipment servicing dates were recorded and equipment was marked with the next servicing date. This ensured equipment was operational and safe to use.

We found not all polices contained sufficient detail to inform and support staff to provide care based on evidence based best practice. For example, the falls policy did not advise staff what to do in the event of a possible head injury following a fall or the correct observations to undertake and record following a fall resulting in a possible head injury in an elderly individual. The wound care or pressure ulcer policy did not refer to the duty of candour or the correct reporting of wounds. Neither the wound policy or pressure ulcer policy included pictorial examples to illustrate the correct grading of wounds which staff may have found useful to refer to in order to accurately grade wounds. We discussed this with the registered manager who took steps to update the policies and we saw these had been sent to all staff to read.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

Following the last inspection, the provider took action to improve the management of Stowford House. Staffing was increased immediately and the management consulted with relatives and staff on how improvements would be urgently made. The service worked co-operatively with the local authority safeguarding and contracts team to provide regular updates. An external consultant was brought in to oversee improvements in care planning and to improve the way the home supported people with dementia. They had worked in the home for three days a week since the last inspection and made a large contribution to improving the service. We need to ensure that the improvements made are embedded into the service and that they are sustainable.