The Orders Of St. John Care Trust

Ashwood Care Centre

Inspection report

Gipsy Lane
Warminster
Wiltshire
BA12 9LR

Tel: 01985213477
Website: www.osjct.co.uk

Date of inspection visit:
23 March 2016
29 March 2016

Date of publication:
20 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashwood Care Centre is a purpose built home that provides accommodation which includes nursing and personal care for up to 82 people. At the time of our visit, 77 people were using the service. The inspection took place on 23 and 29 March 2016. This was an unannounced inspection. The home was a newly registered service and this was the first inspection to take place.

There was a registered manager in post when we inspected the service. 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 was accessible and approachable throughout our inspection. Staff, relatives and people who used the service told us the registered manager was available if they needed to speak with her and had confidence in her abilities to manage the service.

Medicines were not always managed appropriately in the home. This included the recording of medicines and the management of people who needed their medicines covertly.

People and their relatives spoke positively about the care and support they received. They said that if they had any concerns they could speak to either staff or the management team. They said they felt their concerns would be listened to and where required appropriate action taken.

Staff had not been receiving regular supervisions and for new employees there were no recordings of their induction support and progress. This will be addressed with the introduction of the new care certificate induction the home is implementing.

People were given choices at mealtimes and alternatives were provided if required. For people who had been assessed as losing weight or with reduced fluid intake action had not been taken or appropriate referrals made.

Where necessary the registered manager had made the appropriate referrals to the supervisory body when people were being deprived of their liberty. However consent was not always sought in line with current legislation and guidance.

The manager was approachable and available for people to see. People, their relatives and staff felt confident that the home was well managed.

Communication and participation in the development of the home was encouraged and feedback was considered and where appropriate acted upon.

Systems were in place which assessed and monitored the quality of the service but some findings indicated

that action was not always taken in response to these audits.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not always managed safely.

People were kept safe by staff that were confident in recognising safeguarding concerns and were aware of their responsibilities in protecting people.

Risk assessments sometimes lacked consistency and detail for staff to follow.

The home was kept clean and preventative infection control measures were in place.

Is the service effective?

Requires Improvement

The service was not effective.

There were gaps identified in staff files relating to induction support and staff supervisions.

Consent to care was not always sought in line with current legislation and guidance.

People's nutritional and fluid intake was not managed appropriately and referrals were not made when needed.

The home was designed to afford people space and was decorated in a modern style with thought given to the interactive items displayed.

Is the service caring?

Good

This service was caring.

We saw that people were comfortable in the presence of staff and had developed caring relationships. People and relatives were very positive about the staff and said they were treated with kindness.

We saw two episodes of undignified care towards a person but

all other interactions observed were respectful.

People were encouraged to retain their independence.

People and their relatives had access to information on dementia and the home had two dementia leads.

Is the service responsive?

Good

The service was responsive.

Care plans contained information on a person's likes and dislikes and social history, however not all care plans were updated after a review.

There was a good programme of activities in the home but these did not always extend to one to one activity for people due to reduced activity staff. This post was currently being recruited for.

Relatives told us the home was good at communicating with them about their loved ones.

People were confident that any complaints they made would receive an
appropriate response.

The service encouraged people to provide feedback and listened to people's views and responded.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had implemented systems of quality checking to monitor the service; however things we identified during our inspection had not always been identified or actioned.

The registered manager provided good leadership and promoted a positive culture operating an open door policy for anyone wishing to speak with her.

Participation and contribution to the development of the service was encouraged from people, their relatives and staff.

Ashwood 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 23 and 29 March 2016 and was unannounced. The inspection team consisted of three inspectors. The home was a newly registered service and this was the first inspection to take place.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 10 people living at the home and 6 relatives, 12 staff members, the deputy manager, operational manager, quality compliance manager and the registered manager. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for 12 people, medicine administration records (MAR), five staff files, the provider's policies and a selection of the services other records relating to the management of the home.

We observed care and support in the communal lounges and dining areas during the day and spoke with people in their bedroom. We spent time observing people's experiences at lunch time and observed the administering of medicines.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely, because guidance in relation to the administration of covert medicines was not being followed. We looked at the documentation in place in relation to three people who were receiving their medicines covertly. This is when essential medicines are disguised in food or drink when a person may previously have refused to take them. However, the provider's own policy around this procedure was not being followed and neither was National Institute for Health and Care Excellence (NICE) guidelines "Managing Medicines in care homes" (2014). The provider's policy stated that "a broad and open discussion amongst the multi-disciplinary team, including the pharmacist" should take place. In addition it stated "Decision and action taken including names of all parties concerned must be documented in the care plan". Although mental capacity assessments had been completed, it was not clear what the outcome of these were. There was no evidence of best interests meetings; covert plans stated that covert administration had been agreed between the GP and the person's family but there was nothing documented to show what had been discussed.

Some people's medicines were being crushed, but only one person's plan contained a pharmacist's signature to confirm that the medicines mode of action would not be compromised by doing this. The service had a Boots Pharmacist advice visit on 9 March 2016 where this issue was also raised. In addition, it was not clear how often covert administration was reviewed. In one person's plan it was documented 'Covert medication to still be in place unless mental health changes which is unlikely'. The provider's policy advised that 'Full reviews at less frequent intervals' should take place. The policy did not specify what the intervals should be, but the person in question had been receiving medicines covertly since July 2015.

We observed part of two medicines rounds. Staff administered the medicines safely to people. They asked if people required pain relief, didn't rush them and checked they had swallowed their tablets before signing the medicine administration record (MAR) chart. When one person couldn't remember if they had pain, the staff member gently reminded them where they had said they had pain earlier in the day. They said "Just let me know if it comes back and I can give you something". The charts were all signed and up to date which indicated that people had received their medicines as prescribed. MAR charts had photographs of people at the front to make identification easier for staff; however not all of these were dated so it was difficult to assess if the pictures were still a true likeliness of people.

People's preferences had been noted, such as 'Tip pot of tablets into my hand'. PRN (as required) protocols were in place but these did not always provide staff with enough detail on when the medicines should be administered. Protocols for the use of anti-anxiety medicines did not specify what, if any, other methods should be used before resorting to medicine. For example one person's protocol informed staff 'If becomes distressed/shouting, becoming aggressive towards other residents or staff, give half a tablet'.

When people had been prescribed anticoagulation medicines, regular blood test monitoring had been undertaken by the local surgery. Communication of blood results and instructions relating to the required dose was held within the MAR charts to inform staff of the updated dosing. However, these instructions had been transcribed onto the MAR chart but had not been countersigned by another member of staff to

indicate the transcription was accurate.

Topical medicines were applied by care staff. The MAR charts for these were held separately and were available for staff to sign. However, although body maps were in place indicating where creams should be applied, there was no frequency of application noted and some gaps in the charts were seen which indicated that people did not always have creams and lotions applied as prescribed.

Medicines were stored safely but expiry dates were not always noted correctly or acted upon. In one of the medicine cupboards there was a bottle of prescribed medicine that had been dated as opened on 25 June 2015. The label stated the bottle should be discarded three months after opening, but it was still in use nine months later. Another medicine bottle was dated as opened on 13 February 2016 and the expiry date had been written as '10/18'. This information was incorrect and was rectified when we pointed it out to the member of staff. Stocks of controlled medicines were checked twice a day. Medicines were disposed of safely, although there was not always a record of a witness signature when medicines were logged for disposal.

We looked at the records of one person who was self-administering their medicines. A risk assessment had been completed and had been reviewed monthly. The person had signed a self-medication disclaimer and the GP had written to confirm they agreed the person was able to self-administer their medicines. The provider's policy stated that people who were self-administering their medicines should have a care plan in place to reflect this. The registered manager showed us a care plan relating to this person self administering their medicines on the second day of our inspection. However there were no formal stock checks taking place. Although staff said they did check the person's stock balance regularly, it was difficult to find this information because it had not been completed formally and in line with the provider's procedure which stated 'Each month the resident's quantities of remaining medication should be assessed as accurate. Stocks should be checked to verify that they are not stockpiling or conversely taking too much'.

Medicines competencies for staff were completed every two years. An assessment of competency to safely store, administer and dispose of medicines was completed and the staff member would then be observed and their knowledge would be tested.

This was a breach of Regulation 12 (2) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home saying "I feel safe here, I would speak to a carer if I was worried" and "I very much feel safe, I lived alone before, I feel completely safe here". Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff comments included "It's a safe home, people feel safe, families feel that too", "We make sure people are taken care of, they are safe in environment", "Residents have a bell on a red ribbon and if in trouble they can press it and it tells us where the resident is" and "I would be happy to challenge any bad practice".

We saw sensors were in place on the outside of people's bedroom doors. Staff explained these could be switched on for people at risk of falls to alert staff when a person was up and moving about and may be unable to communicate they needed help by pressing a call bell. Staff could then go and check on the person and offer assistance if required. One member of staff told us "If a resident had a fall we carry phones so can ring for assistance at any time. The senior will check the person and assists further to see if person is able to stand or requires further medical assistance".

Care plans contained risk assessments for areas of support such as moving and handling, falls, fire, nutrition and tissue viability. However, where risks had been identified, the care plans did not always provide enough detailed guidance for staff on how to minimise the risks. Some plans showed that staff had acted to minimise the risks but this was not consistent. For example, in one person's care plan staff had documented that the person preferred to have their door closed at night. It was documented that the person's relatives had asked that staff did not check on them during the night so that they didn't become nervous. It was also written in the person's plan that they sometimes put items of furniture behind the door. This was clearly a risk to the person's safety. However, the plan informed staff to 'Be aware that (person) puts objects in front of the door' and 'Reassure if (person) puts furniture behind the door and explain it is a fire risk'. A risk assessment had not been completed in relation to this. In addition despite it being documented that the family had requested the person was not checked throughout the night, it was also documented 'Carers to check regularly'. This conflicting information and lack of risk assessment meant there was a risk to the person's safety.

We saw for one person who had been assessed as at 'high risk of falls', action had been taken to minimise the risk. Staff were advised to ensure the person's sensor mat was in place, and that their pendant call bell was being worn. The person had fallen four times during January 2016 and the falls had been analysed by the registered manager. Subsequently a referral had been made to the occupational therapy team. The referral had resulted in the person's chair being changed. The person had not fallen during February and had only fallen once during March 2016.

Moving and handling plans provided staff with clear information on hoist and sling requirements. When people had variable mobility, staff had been informed to assess the situation prior to moving them. We overheard staff discussing one person and that they were unsteady on their feet that day. A senior staff advised them to follow the care plan and use the hoist to ensure safety. We saw that hoists, wheelchairs and other assistive equipment was kept in designated areas that did not impact on people's safety.

The registered manager told us that people were not discouraged from taking risks saying "We look at measured risk, people have a right to make what I may think is an unwise decision, as long as it's safe. If someone said they want to do something we would reduce the risk and observe them".

There were sufficient staff levels to meet people's basic care needs. At the time of our inspection there were no agency staff being used and staff were visible throughout the home. The registered manager told us the home over recruit on staff hours so there are reserves if required. Alongside using a dependency tool to calculate the appropriate numbers of staff the registered manager explained how important it is "to listen to the team". Previously the top floor staff had raised a concern that staffing was a struggle and the team and registered manager looked at different ways of working to address this. The handover has now been shortened to passing over the essential things about people so staff are not absent from the floor.

Staff comments in relation to staffing included "On the whole it manages well, we have enough staff", "There's enough staff, I get time to chat with people" and "People want us to sit with them but we are busy, we don't have enough staff to engage with them for activities". Relatives also commented saying "Occasionally need more staff but there is enough", "there are enough staff", "I think they could do with more staff, staff have said they would like to spend more time with people" and "There are enough staff, but I wish they could do more activities, and get outside".

Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to

work with vulnerable adults.

We found the service to be very clean and homely. Staff were able to explain how standards of cleanliness were maintained and cleaning schedules were in place to record that all areas of the home were being cleaned. On the cleaning trolley was a folder containing the personal protective equipment policy, and the health and safety policy. One Housekeeping staff told us "We have only had compliments about the cleanliness, never a complaint". Relatives also made comments including "The place is clean and tidy" and "It's always clean".

At the time of our visit there was a few people affected by a stomach bug in the home. This was being well managed with the people affected staying in their rooms to reduce the spread of infection. Staff told us they were regularly checking on these people and encouraging them to drink fluids. Visitors were pre-warned so they could postpone their visit to the home if they chose. The housekeepers were following correct infection control measures when managing people's laundry to reduce the risk of contamination.

Requires Improvement

Is the service effective?

Our findings

We viewed the training records for staff which confirmed staff received training on a range of subjects. However we saw gaps in some training where staff had not received the appropriate training yet. For example 28 staff did not have any dementia training. There were also gaps in end of life training. The registered manager explained that a new dementia training course was replacing the previous training and 7 staff had attended this in March 2016. The staff who attended, worked on the dementia floor of the home and it was considered important they receive the training first. The registered manager further explained staff members had been identified who needed training in end of life and one course had taken place in February 2016 which eighteen staff had attended.

We saw that staff had been booked onto training for April 2016 in subjects including pressure care, emergency life support and infection control. Staff spoke about their training saying "Training, I have done it all, fire safety, moving and handling, safeguarding", "I have done safeguarding, dementia and mental capacity" and "I'm doing mentor training at the moment for new staff".

People who had been employed within the company for a long period of time and had moved from the previous location had an induction checklist in place to support what training had been completed and what policies had been read. For more recent new starters their files did not demonstrate that they had received an effective induction or any documented evidence of their progress and support. One staff commented "My induction was not great; I haven't had all my training yet". Another member of staff said "Not much support through my induction, just e-learning training". We raised this with the registered manager who informed us that the care certificate induction was being piloted as the new induction for anyone starting from 1 April 2016. The registered manager said "the care certificate will improve the induction experience". The registered manager agreed that the workbooks new employees would have during their induction needed to be cross referenced with the staff files to evidence new employees have received an appropriate induction process and support.

Supervision records which detailed staff's (one to one meeting) with their line manager were not fully completed and long gaps in-between the last supervision showed they were not always regular. For new starters who were completing a period of probation before becoming a permanent member of staff their probation reviews were not consistently taking place within the time limit. For example one staff member was due a review in March 2016 but it had not been signed to say a review had taken place or any information documented about the person's progress. We raised this with the registered manager who confirmed it had not taken place yet but a new date had been set. One staff had received no supervisions between March 2015 and January 2016 and another had no supervisions recorded since May 2015.

Staff we spoke to told us they were now receiving supervision commenting "Supervisions are useful, I can talk about things to be improved, they always listen to me", "Supervisions are regular, you can air your views but if we have any grumbles senior staff are always there" and "We often ask and have conversations about practice which isn't recorded, but could be used as evidence for supervision". The registered manager explained there had been a change with seniors leaving and people being moved onto different floors so

supervisions had not been happening as they should have. This has now been addressed, and new seniors are being recruited. We saw in the administration office a supervision matrix was displayed detailing when people had received supervision and were due another one. The registered manager said this has helped identify the gaps and will ensure people are now receiving regular supervisions.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the appropriate supervisory body and we saw this had been documented in people's care plans.

Consent to care was not always being sought in line with legislation and guidance because mental capacity assessments had not always been fully completed and the outcome of these assessments was not always clear. In one person's plan staff had documented 'Capacity assessment has been undertaken re: taking anti-depressant – best interest meeting to be organised'. However, there was no evidence of this meeting having taken place. We looked at capacity assessments for the administration of covert medicines (when medicines are disguised). There was a section at the end of the assessment form used in relation to whether the person completing the assessment had considered the views of people engaged in the person's care or treatment, and these had been left blank.

One person had a DNAR (do not attempt resuscitation) in their care plan which stated they lacked capacity. However the person's care plan contradicted this stating the person did have capacity. The DNAR had recorded no family involvement or discussion about this decision which is a requirement. We addressed this with the registered manager who is going to speak to the GP and ask for this to be reviewed.

Another person had a care plan relating to end of life treatment and wishes which had been completed by the person's relative. The care plan stated that this relative had lasting power of attorney but there was no copy available of this in the care plan or information recorded that stated it had been seen by the home. We asked the registered manager if this document was held in a more secure place but the registered manager was unable to locate a copy of this on site This meant the home could not be sure if decisions were being made for this person by someone who had the correct legal authority to do so. The registered manager informed us on our second day of inspection that the family had been notified and were going to bring this in.

This was a breach of Regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living in the home would at times display challenging behaviour. We looked at the care plans for these people to see how it was being managed. Behaviour plans did not contain guidance for staff to manage these behaviours or recognize triggers. For example, one person had experienced periods of anxiety and agitation. The plan informed staff to 'Supervise (person's name) if in an area where it may become noisy' and 'Reassure if confused or agitated'. The plan went on to inform staff 'give Lorazepam when becomes agitated'. There was nothing documented to inform staff of any specific triggers for their anxiety, other than noise, and there was no detail of how they should provide reassurance or how to deescalate any agitation.

For another person staff had documented the person displayed "anxiety and occasional aggressive behaviour". Staff were informed to "Reassure when becomes nervous" and "Give time to express why

(person) feels that way". This person had been admitted to the service during 2012, but there was nothing documented to indicate whether staff had explored the reasons for the nervousness and anxiety. Again, there were no instructions for staff on how they could reduce any aggressive behaviour. We spoke with staff about managing challenging behaviour and they were able to give examples of the action they take. Comments included "We have people with challenging behaviour, we listen to them and what they have to say, we get advice from the seniors" and "I support a person with challenging behaviour, it's managed well, we have to diffuse it or change the staff member or leave it for a while, to make them feel comfortable".

We observed the mealtime experience for people during our inspection. People were seated at the dining tables and waited up to half an hour for their lunch to be served. One person asked "Why are we still waiting" and a staff replied "It's coming". Staff were unsure what the food was because there was no menu available for that day; however a staff member did phone the kitchen straight away to check prior to serving people. Laminated cards showing pictures of the meal were usually provided but these had not been brought up from the kitchen. Staff said this was because the kitchen staff were currently not coming onto the floors to reduce the risk of infection from the stomach bug.

The lunch option was fishcakes with tomatoes or sandwiches. People had their main meal in the evening instead of at lunch and this had proven to be popular with people. Choices for meal options were made at mealtimes, rather than people having to choose prior to eating. We saw food available in the unit kitchens for people to access at any time, and snack bowls of fruit and chocolate were placed around the home.

We observed a member of staff assisting one person with lunch. They asked them if they liked it and when the person indicated that they didn't, they asked if they would like some soup instead. However, they then assisted the person with their soup standing to the side of them rather than seated next to them. During the tea time meal, we observed four people sat at one table and four at another. The staff member served three people at one table and then served two people at the next table. This meant one person was waiting for their meal while others ate around them. The person asked if they could be served next, and they were.

For people who had their meal in their bedroom we observed that their meal had been placed in easy reach. One staff member was sat next to a person who was in bed explaining it was lunchtime and encouraging the person to sit up and have something to eat. People gave mixed reviews about the food available saying "The food is very good, there's a choice every day and there is enough to eat", "The food could be better, more special, mostly its ok, I have made suggestions but they will give me anything I ask for, it's very easy going", "The food is ok" "There's never any decent food" and "The food is nice, I get a cooked breakfast every day if I want". One relative commented "The food seems really nice", whilst another relative said "My relative doesn't like the food, more fruit would be good". The home operated a 5 week seasonal menu and the chef kept records of people's allergies, intolerances and likes/dislikes.

Risk assessments were completed in relation to people's nutritional needs, but although risks had been identified, appropriate action had not always been taken, and care plans were not always being followed. For example, one person had been assessed as high risk of malnutrition. On 6 February 2016 staff had documented 'GP to refer for SALT (Speech and Language therapy team) assessment', but there was nothing documented to confirm if this had happened or what the outcome was. The care plan informed staff to weigh the person weekly, but weights documented showed this had only happened on 8 February, 20 February and 27 February. There was no record of any weight for March 2016. Another person had been consistently losing weight and scored high on the MUST tool (malnutrition universal screening tool to identify adults at risk of malnutrition). It was recorded that this high score should result in a referral to the dietician. There was no record of this person having been referred. We addressed this with the registered manager who agreed that the care plan needed to be reviewed.

One person had been observed sitting in a wheelchair in the middle of the room for a period of twenty minutes during lunchtime. Staff walked past without engaging in any interaction. We asked why this person had not been assisted to eat at a table with others and were told they did not really eat anything. We looked at this person's care plan and saw they had consistently refused to be weighed. The records showed that their food intake was very low; however no referral had been made to a dietician. We raised this with the registered manager who was aware of the situation and told us staff had been trying to encourage this person to eat and agreed a referral should be made.

We reviewed fluid monitoring charts for people where staff would document a person's fluid intake throughout the day. These did not state why the person was having their fluid monitored or who had made the decision. One person's target intake was documented as 1275 mls per day. However, on 11 March 2016, the total intake was recorded as 870mls. On 12 March it was 570 mls, 17 March it was 710 mls and 18 March it was 400mls. The daily record notes did not demonstrate that the reduced fluid intake had been identified or acted upon. We were shown the handover form used by staff between shifts and this did contain notes such as "encourage fluids", but it was not clear if there was any formal escalation procedure in place for staff to follow when a poor intake was noted or indeed how a poor intake would get noted. Although staff said the charts were checked daily, these had not been consistently signed to indicate they had been checked.

This was a breach of Regulation 14 (4) (a) Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access a GP when needed. One person commented "Carers have taken me to doctors' appointments, everyone is most helpful". A health professional told us "If staff notice a change in a resident whilst on shift they will raise this with the senior who will contact the GP if it is felt relevant". One member of staff confirmed people are not sent alone to hospital saying "If someone needs to go to hospital a carer will go with them or we ask family". GP's visited the home holding a weekly surgery for people needing to see a doctor.

Where people had plans in place to prevent skin breakdown, the guidance was clear. Some people had SSKIN bundle documentation in place. This was a five step model used by healthcare staff to prevent pressure ulcer formation. The frequency of required position changes was clear and the documentation had been completed in full. Body maps had been completed to show staff where people had minor wounds or scratches. Where necessary specialist support and advice had been sought; one person had a small skin tear and district nurse advice had been sought and followed to promote wound healing.

The home was light and spacious and allowed people to spend time on their own if they wished.
Each unit had a main lounge, an open plan dining and kitchen area and two separate lounges for people to retreat to. These smaller lounges all had different themes, these included a garden room, dressing room, a beach, and a sewing room complete with sewing machine and fabric swatches. Along the corridors were items of interest, such as bird cages and accessories, this was seen especially in the dementia units to engage people as they navigated around their environment. We saw clear signs displayed around the home informing people and visitors of what each room was and all the units had their own name.

Good

Is the service caring?

Our findings

There were two examples of undignified care that we saw involving the same person and staff member. We raised our concerns with the manager who took the appropriate action in addressing these immediately. The person concerned did not have the capacity to understand the situation they had been placed in and has not experienced any further negative impacts from this. These observations were not representative of our other observations of care during the inspection.

We spoke with staff about the importance of respecting people's privacy and dignity and they told us "I knock on doors, and close them behind me, I always ask residents first and explain what I'm doing" , "I always treat people's clothes like it's my grandmothers clothes" and "I make sure someone says come in before we go in". Relatives told us that privacy around people going into one another's rooms could be improved upon with one relative commenting "People go into each other's rooms, few things sometimes go missing but it's mostly ok". Another relative said "Some belongings are misplaced, people go into other's rooms, it's nothing intentional".

People were treated with kindness and compassion by the staff. We observed staff crouching down to speak to people so they were at eye level with them, they held people's hands and offered gentle support. The atmosphere was calm and unhurried and people were seen relaxing in communal lounges or in their rooms. Comments from people included "Staff are becoming more like friends as we progress, I felt as if I was coming home", "I have confidence in the staff, 99 per cent are caring, kind and helpful, I can't find fault with them", "The home and the staff are all very nice" and "Staff are very good here. I saw several homes before I chose to come here, and I haven't regretted it".

We spoke with people's relatives who praised the care their loved ones received saying "It's nice, relaxed, homely and friendly, they look after people well", "Staff are caring, nothing but praise for them", "Staff are fantastic, they come across as caring and interested" and "The staff are caring, my relative is very settled". One health professional who visited the home regularly told us "From my observations when I visit, residents are all treated with care and respect and their care needs are met with courtesy and kindness". Another health professional commented "It is a home which feels very calm and homely".

We observed genuine caring interactions from staff who knew the needs of people well. One member of staff had recently been on holiday and we saw them giving people sticks of rock that they had brought back with them. All staff roles within the home were involved with the people living there and one staff member responsible for maintenance around the home told us they help out with breakfast in the mornings saying "I have a good chat with people; I get to take one person to the shops and spend time with another person walking in the garden". Other members of staff said "I get to chat with residents, I love that part of it", "We are key carers to certain people and spend extra time with them, and its lovely having a chat whilst supporting them", "You work so closely with people they become like your family, they trust you" and "It feels like a home, you have to enjoy your job and that passes through to people, everyone works as a team".

People were encouraged to remain as independent as possible and make choices relating to their daily

care. One person told us "You can always say if there's something you don't want". Another person told us "I thought long and hard about coming here, I needed to go where I would be looked after and had my worries taken away". One staff member spoke about the importance of people feeling involved and gave an example of a person who always carries another person's pressure cushion to the dining room before each meal. Other staff commented "I pick two outfits and encourage people to choose, I have had training in person centred care", "I encourage people to do what they can, give a choice, and if they are not managing I prompt" and "We find out what people like when they first come, as we get to know them their tastes change as they get older, we also ask family". A health professional said "People are supported with independence by staff getting to know and understand them as individuals".

We saw a dementia notice board on the ground floor which explained what dementia is for people who may not fully understand. Information was available on the different types of dementia supplied from the Alzheimer's Society and it stated who the lead person for dementia was in the home. A sign was displayed on the board which read 'We do not remember the days we remember the moments'. During our visit staff told us they worked on set floors to build up consistency for the people they supported. One staff commented "I get to know the person, look at their abilities not any disabilities".

Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. The registered manager told us there was an employee's assistant helpline should any staff need to talk to someone after supporting a person through end of life care. The registered manager commented "A reminiscence meeting with residents, relatives and staff is held to remember the person. We have a picture of the resident and a poem is read".

Good

Is the service responsive?

Our findings

Care plans contained "All about me" booklets; which recorded information on people's life history, which meant staff had an opportunity to learn more about the people they were caring for. We saw that some care plans had been reviewed monthly, but not all of the one's we looked at. However when they had been reviewed there was little evidence of the content of plans changing. One person was recorded as being independent in managing their personal toileting needs but another assessment said they were not continent and needed reminding. A further dependency assessment recorded the person as needing full support around toileting. This meant the person's most current needs could not be ascertained from their care plan. The registered manager explained that the care leaders are allocated a certain number of care plans to review once a month, known as 'resident of the day'. The staff member should sit with the person and they agree if it's right and relevant to them. We looked at a resident review folder, which took place every six months. A person would be asked how they are getting on and if they had any concerns. The registered manager would then go through this and action anything required.

For people who needed assistance with regular repositioning due to being at high risk of developing pressure ulcers, a turning chart was in place. However these were not always completed appropriately. One recorded entry recorded the person as 'sat up', another as 'rolled' and 'a further entry said 'tilt'. It had not documented the position the person had last been in and what position they had been assisted to move into.

The home afforded opportunities for people to spend time doing things they previously enjoyed. This included an on-site coffee shop, cinema and hair salon. The home had Wi-Fi throughout so people could access the internet and keep in touch with people and interests online should they wish. The home had community volunteers who would visit and spend time with people and chat. Staff would also volunteer during planned trips out to events such as the ballet, or garden centres.

The home had an activities co-ordinator who was passionate about the role. A range of activities were provided for people to participate in should they wish. We saw an activity events notice for the week we were inspecting which included Easter crafts, an entertainer, a mobile farm visiting and Easter holy communion. We observed people joining in the Easter crafts activity which took place in one of the unit's dining rooms and then again later on in the coffee shop. The activities co-ordinator told us that "Everyone receives a weekly diary of planned activities and I also prompt them and put it on the noticeboard". Activities that people had participated in were recorded in a folder and their experiences of that activity were also documented.

At the time of our visit there was only one activities co-ordinator in post. The service was currently recruiting for a second person, however the budgeted hours for both activity staff did not go much beyond one full time role. People who spent large amounts of time in their bedrooms and were unable to join the communal activities were not always having the opportunity to have activities brought to them on an individual level. Staff we spoke with felt people needed more time invested in activities commenting "We need an activity person on each floor, the activities person has good ideas", "Need's to be more activities,

there is a lot of people just sitting around", "They never have enough to do but that's staffing" and "It's very hard to cover all floors for activities". We spoke with the registered manager and the operations manager about this who agreed that for a large care home this was not enough to provide a suitable scope of activity time. This is going to be looked into by the operations manager.

People we spoke with about activities told us "I spend a lot of time in my room. I don't do much. I don't see the activities. The staff pop in for a chat", "Sometimes it's difficult to get things done. I keep asking, but nothing happens. The only thing I can think is that there aren't enough staff to deal with these things", "I don't go out much, that's how I want it to be" and "I prefer to do what I want to do, I'm not antisocial". The activities co-ordinator explained that a craft tower was available on each unit so people had access to crafts, paints and games, and told us "When people come into the home I go and speak to them and read the care plans, and feed this into the planning. We have resident meetings and I ask if there is any new activities they would like". During our inspection we observed three people enjoying watching a 'Mrs Browns Boys' DVD especially the risqué parts which produced much laughter.

Relatives praised the home for keeping them informed and involved in their loved one's care commenting "Staff know us well, they are good at ringing us", "Staff are brilliant, they ring me, I get phone calls regularly", "Relative staff are happy, say hello even if they don't know you" and "We are offered a meeting to discuss care if we want to". One staff member told us "I have a lot of contact with families when they come in".

People's concerns and complaints were encouraged, investigated and responded to in good time. A complaints folder logged all formal and informal complaints made, detailing the action taken. We saw that acknowledgement letter's had been sent to people sent offering an immediate apology. A further meeting was offered if the person making the complaint was not satisfied with the investigation response from the home. One staff member told us "Residents have made a complaint to me, I listen to them I apologise and emphasise with how they are feeling, I tell the care leader and record it in care plan". People were confident to raise any concerns with one person saying "I would go to the manager, if it was about food I would speak to the kitchen direct". One relative told us that "Concerns are dealt with properly".

People's feedback was sought about the service and their suggestions were welcome. In the reception 'review us' feedback forms and a comment suggestion box were available for people, relatives, staff or visitors to leave comments at any time they wished. We looked at minutes from resident meetings that had been held and saw events relating to the home had been discussed and people were given the opportunity to have their say. Where suggestions had been made we saw these had been considered and actioned if possible. One comment had related to the type of activity people wanted to do and the activities co-ordinator confirmed to us this had been made possible.

During our inspection we viewed some of the compliment cards that had been received by the home praising the care and support families and their relatives had received. The registered manager spoke about a survey the home has recently started which asks people about a particular area for feedback. We reviewed some of these forms and saw one person had been asked about their bedroom décor. The person had identified they needed a towel rail and this was then actioned. The registered manager explained that not everyone likes to speak up in a formal meeting in front of others so this is a way of ensuring their views are heard.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place who was supported by a deputy manager, a regional manager and a quality compliance manager.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Where people had experienced falls, incidents or accidents a form had been completed and was signed by the registered manager who then logged it on the computer system. The forms were kept in peoples individual care plans. The manager would audit falls, accidents and incidents each month and print off a falls monitoring matrix. This helped identify any trends such as if there were certain times a person has experienced falls, and if the same person was falling regularly. This also documented the action taken, for instance if a sensor mat or a falls observation chart had been put in place or a referral made to a GP. The registered manager told us they are thinking of holding falls meetings with staff, to identify triggers and discuss prevention ideas saying "We learn from incidents and look at patterns to minimise what we can".

Medicine audits were completed and we saw one that had been done in February 2016. An external one had recently been undertaken by head office. The registered manager explained that medicine audits are going to be done by a person from another floor so they all swap and check one another's medicines. Antipsychotic medicines were also monitored by the home and the information sent to head office every six months.

However some of the issues we had identified during our inspection had not been picked up by the quality monitoring or audit tools and action had not been taken. For example in relation to two people not having been referred for nutritional assessments and issues in regard to the management of people's medicines. We raised this with the registered manager in feedback who is going to ensure these concerns are addressed.

People were able to approach the registered manager when they needed to because the registered manager operated an open door policy to their office. Staff said the manager was very supportive and approachable. Comments included "The manager is very supportive, I have seen her so many times, she always listens and is confidential", "The manager is very approachable, can't fault her, we see her up on the floors regularly, if a resident asks to see her, she's straight up there", "I see the manager a lot, she asks how I'm getting on" and "She is a very approachable manager, I can go and ask her anything".

People who use the service and their relatives told us they had confidence in the registered manager. One person said "I see the manager, she's always about, very approachable, it's well managed". Another person said "I see the manager about, she's very pleasant, it's well managed, and all seems to be running ok". Relative's also commented saying "The manager is very approachable, from what we have seen it is managed well" and "There's not a sense of doom and gloom when you walk in, its first class, the system works". The registered manager praised the staff team saying "We have a dedicated team of people here for the residents".

The service's statement of purpose was clearly displayed in the reception and staff were able to talk about the visions and values within the home with one commenting "We are here to provide a home and encourage independent living and freedom of choice". We looked at the minutes from the last few team meetings and saw that staff responsibilities had been discussed. It was recorded that staff had been given time to raise any concerns they had, and actively input into the meeting. Staff comments included "We have team meetings, the manager is present, and we get to ask questions", "The home has a homely feel, the teamwork is good, we help each other", "There is a good team, we help each other out" and "The home has a good team, it's very caring and staff go above and beyond". One staff explained how learning from events is promoted saying "With medication errors for example, we have reflective meetings together to try and learn from the mistake".

Opportunities were available for staff to progress within their role through gaining their diplomas in health and social care, promotions to shift leaders or senior position, and taking on a lead role within the home. The registered manager informed us that some staff have taken on leads in dementia, infection control and liaising with the continence nurses.

Communication and participation was encouraged within the home. One person was involved in the home newsletter and another person spoke to us about the resident committee meetings that they chaired. Another person described a situation they had raised where the home had listened to their views saying "I did make one suggestion once, and it was improved, so it does work". The registered manager told us they advertise a coffee morning in a local area brochure, but are "hoping going to make it more targeted, invite admiral nurse in to talk about dementia, and invite family".

At the time of our inspection the home was not currently carrying out the regulated activity of treatment of disease, disorder or injury. This was because the service had been unable to recruit nurses for employment within the home. Trained senior staff were currently responsible for the management and administration of medicines and the district nurses were visiting anyone who had nursing care needs. The home had submitted the appropriate notifications to remove this regulated activity from their registration until further notice.

The registered manager told us about the support she receives and the opportunities open to further her knowledge saying "There are monthly managers meetings, we have formal trust ones and then another one where we have learning sets and share practice". The registered manager has completed a certificate in dementia and spoke about attending conferences commenting "I have opportunities to do things". The registered manager told us that herself and a manager from the Wiltshire care group had looked around each other's care homes, and then presented feedback from their observations to offer insight.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care was not always being sought in line with legislation and guidance because mental capacity assessments had not always been fully completed. A DNAR had no recorded family discussion and the care plan stated the person had capacity but had not been involved. A relative had consented to care and treatment without the home checking they had the appropriate legal authority to make these decisions. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed appropriately. This included the management of covert medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Risk assessments were completed in relation to people's nutritional needs, but although risks had been identified, appropriate action had not always been taken. Where people needed referrals to dieticians this had not been done. Fluid intake was being monitored but no action taken when people were drinking below their necessary amount. Regulation 14 (4) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been receiving regular supervision. New employees probation period was not always reviewed within the time limit or progress and support recorded to ensure they had received an effective induction. Training for some subjects such as dementia and end of life had not been given to staff despite this being a part of their role. Regulation 18 (2) (a).