

HC-One Limited

# Stoneyford 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?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

We inspected this service on 24 and 25 April 2018. The inspection was unannounced.

Stoneyford Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Stoneyford Care Home is a nursing home that accommodates up to 60 older people with varying support needs, including nursing and people living with dementia. Accommodation is provided at the service over two floors. There were 23 people using the service at the time of our inspection.

At our last inspection on 18 and 19 October 2017, we identified significant failings and multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, need for consent, meeting nutritional and hydration needs, person-centred care and good governance. In addition a breach of the Care Quality Commission (Registration) Regulations 18 notifications of other incidents. CQC had not been notified of incidents the provider was required to inform us about.

Following the last inspection the provider sent us an action plan to tell us what action they would take to meet these breaches in regulation.

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.

Since our last inspection, the registered manager had left the service and two registered managers within the organisation, separately managed the service for a period. A new manager was in place and they were in the process of submitting their registered manager application. We will monitor this. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Since our last inspection, the registered provider has announced that they wish to relinquish the regulatory activity that enables them to provide nursing care. The registered provider had taken all reasonable action to recruit and retain nurses to provide clinical care but was unable to achieve sustainability. At the time of writing this report, the management and staff team were working with commissioners (who fund care for

people), people who use the service and their relatives and representatives to transfer people with nursing needs to alternative placements. The service will continue to be a care home providing accommodation and personal care.

Risks associated with people's needs had been assessed and planned for. Improvements had been made to how some risks were managed such as wound care. However, further time was required for improvements in documentation and monitoring to be embedded and sustained. Audits and checks in relation to risks associated with the environment had been monitored and equipment was safe and met people's needs.

Safeguarding procedures had improved. Staff were aware of their responsibility to protect people from avoidable harm and safeguarding incidents had been acted upon. Some people experienced heightened anxiety that affected their mood and behaviour, but information available to guide staff in relation to how to support people, lacked detail.

There were sufficient staff available to meet people's needs and safe staff recruitment checks were in place and followed. Overall improvements had been made with the management of medicines; some shortfalls were identified that required further attention. Improvement had been made with infection control measures and cleanliness. Staff were knowledgeable about how to manage infections and understood the risk of cross contamination and followed best practice guidance. Accidents and incident were recorded, but these were not consistently completed or analysed to consider lessons learnt.

We saw that staff obtained people's consent before providing care to them. Where people could not consent, assessments to ensure decisions were made in people's best interest had not been consistently completed. People's food and hydration needs were met and choices offered and respected. People's health care needs were assessed, planned for and monitored, but information available to staff to support these needs were not always clearly recorded. Staff were working more effectively with healthcare professionals.

Staff received an induction; ongoing training and improvements were being made to the frequency of staff supervisions and appraisals. People lived in an environment that met their needs including any diverse needs, to ensure they were not discriminated against.

Staff were kind, compassionate and treated people with dignity and respected their privacy. Staff had developed positive relationships with the people they supported, they understood people's needs, preferences, and what was important to them. Advocacy information was available should people have required this support.

Some improvements had been made to information available to staff to assist them to provide a responsive and person centred service. However, information was not consistently recorded or easily found in people's care records always. People and or their relatives received opportunities to be involved in review meetings to discuss the care and treatment provided. People received opportunities to participate in a variety activities and staff had time to spend with people. The provider's compliant procedure had been made available. Some consideration and plans were in place in relation to people's end of life wishes, but further action was required to complete end of life care plans.

A new management team was in place who had worked hard with the staff team to make improvements. They acknowledged further time was required for improvements to fully embed and be sustained.

Staff were positive about the new management team and reflected on the changes made to the service, this

included improved communication and documentation. Staff were found to be more organised and had a clearer understanding of their role and responsibilities.

Systems and processes used to monitor the quality and safety of the service were completed more effectively and any shortfalls were added to the overall improvement plan to ensure action was taken to address these.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe.

The management of risks associated with people's needs had improved. Some improvements were required with documentation. The environment was safe and met people's needs.

Safeguarding procedures had improved; any incidents were reported and acted upon appropriately. Where people's mood and behaviour was affected by their anxiety, staff had limited information of how to support people at these times.

There were sufficient staff available to meet people's needs and safe staff recruitment checks were in place and followed.

Improvements had been made to the management of medicines. Further improvements were required to address some shortfalls.

Improvements had been made with infection control measures and cleanliness.

Accidents and incident records were not consistently completed or analysed.

**Requires Improvement** ●

### Is the service effective?

The service was not consistently effective.

Mental capacity assessments were completed but improvements were required to ensure assessments and decisions were consistently completed.

Improvements had been made to meeting people's food and hydration needs, including the documentation to record this information.

People's health care needs were managed sufficiently and monitored, and staff were working with external health care professionals.

Staff received an induction; ongoing training and improvements

**Requires Improvement** ●

were being made to the frequency of staff supervisions and appraisals.

The environment met people's needs.

### Is the service caring?

Good 

The service was caring.

People were cared for by staff who showed kindness and compassion in the way they supported them. Staff were knowledgeable about people's individual needs.

People had information about independent advocacy services to represent their views if needed.

Improvements had been made to how staff respected people's privacy and dignity and independence was promoted.

### Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

People and their relatives were involved in reviewing their care plans. Improvements had been made in how people received their care and treatment.

People's diverse needs had been assessed and planned for. Care plans varied in detail. People received opportunities to participate in activities.

People had information made available about how to make a complaint. End of life care plans had not always been completed.

### Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

Improvements had been made in the governance of the service. There was new leadership and improved oversight and accountability. The service required additional time for improvements to be sustained.

Staff were positive about the new management team and their approach in making improvements to the service.

People received opportunities to give feedback about the service.

# Stoneyford Care Home

## Detailed findings

### Background to this inspection

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

This was a comprehensive inspection that took place on 24 and 25 April 2018 and was unannounced. The inspection team consisted of one inspector, two specialist advisors who were a registered nurse and a pharmacist, 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law. We also sought feedback from the local authority and local clinical commissioning group who commission services from the provider and from Healthwatch Nottinghamshire who is an independent consumer champion for health and social care services.

On the day of the inspection, we spoke with five people who used the service and three visiting relative's for their views. We observed care and support in communal areas of the service and used the 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.

During the inspection, we spoke with the manager, care home manager, area director, two area quality directors, the managing director, two senior care staff, three care staff, a nurse, a nursing assistant, two domestic staff, the head chef, cook and activity coordinator. We also received written feedback from an agency nurse that worked at the service, a visiting pharmacist and spoke with three external visiting

professionals. This included a community nurse, outreach nurse and advanced nurse practitioner.

We looked at all or parts of the care records of 11 people, along with other records relevant to the running of the service. This included how people were supported with their medicines, quality assurance audits, training information for staff and recruitment and deployment of staff, meeting minutes, policies, procedures, and arrangements for managing complaints.



# Is the service safe?

## Our findings

During our previous inspection on 18 and 19 October 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to how risks associated with people's needs were assessed and managed.

At this inspection, we found improvements had been made and the breach in regulation had been met. We also identified that further time was required for improvements to fully embed and be sustained.

Since our last inspection, new documentation had been introduced about how wound and skin care was assessed, recorded, monitored and managed and this followed best practice guidance. Where people required repositioning to manage risks associated with their skin, people's records confirmed they were supported at the frequency their care plan and risk assessment stated. Improvement's had been made to the monitoring of people's weights. Where concerns had been identified people were weighed weekly and external healthcare professionals such as the GP and dietician were involved.

In addition, improved procedures were in place to share information with staff about people's risks and the action required to manage these effectively. For example, the handover record used to share information with staff at daily handover meetings was more detailed. This information included known risks people had and any new concerns and the action required to respond to these, such as additional observation or a referral to a health care professional. Staff were better organised with senior staff delegated tasks and responsibilities.

Staff confirmed that new improved procedures had been implemented. One staff member said, "Care plans and risk assessment have been reviewed and are more detailed. The supplementary records (repositioning, eating and drinking and weight monitoring charts) are much better, we're completing them all the time, we understand more now how important they are."

Feedback from external health care professionals overall gave a positive picture of how people's needs and risks were better managed. One professional said, "It's taken a long time but I've come in today to review a person's care plan and found it to be very well detailed and specific. The person was found to be supported as per their care plan. I'm pleased, things have improved." One external professional had some ongoing concerns in relation to how nursing needs were met. Whilst they acknowledged some improvements, the use of agency nurses still impacted on continuity of care for people and follow up action. They did however; speak positively about the current manager and new care home manager and their approach.

Where people were at risk of choking improvements had been made to ensure people were supported safely. For example, new documentation had been implemented to advise staff of who was at risk of choking and the support they required. This information was kept on the drinks trolley, in a folder in a discreet area in the dining room and in the kitchen. In addition, information in people's care records identified any recommendations made by the speech and language therapist to support safe eating and drinking. Eating and drinking care plans and risk assessments were found to be up to date. On reviewing this information we

identified some records required a more detailed explanation of the support a person required, to avoid any misunderstanding or incorrect interpretation by staff. We also identified one person's risk assessment had been incorrectly completed with a lower risk assessment scoring. Whilst this had no impact on the person, as the incorrect scoring did not affect the action taken, it could have made a difference if the scoring was lower resulting in the risk of no action being taken. We discussed what we found with the management team and some action was taken immediately to make improvements with an agreement to further review processes in place.

People told us that they felt safe in the home or that the home was a safe environment for their family member. A relative said, "I know [family member] is safe, they (staff) look after them. When they lift them, they obviously know what they are doing. There's always two of them, often three."

Our observations found people received on the whole safe care and treatment. For example, staff were seen to support people with their mobility needs such as transferring them using a hoist. Staff followed best practice guidance ensuring people were safe; they were unhurried and gave people reassurance and explanation. People received support with their eating and drinking as needed. There was one exception to this when a person on the first day of our inspection, was given their food in the dining room before a staff member was present at the dining table to oversee them eat safely. Whilst staff were present and the length of time the person was unsupervised was minimal, we raised this with the management team who agreed to speak with staff. The second day of our inspection we saw the person was supported appropriately and staff had been reminded about their support needs. Where people had specific equipment to manage any known risks such as pressure relieving mattress and cushions these were available and being used appropriately.

Improvements had been made to the procedures to check and audit equipment and the safety of the premises and environment. A new maintenance person had been appointed that all staff spoke highly about in terms of being efficient. Checks on health and safety such as bedrails, water temperatures and equipment had been completed and were up to date. External contractors had also serviced and checked equipment and the environment.

Improvements had been made to how people were protected from abuse and avoidable harm. Where safeguarding incidents, concerns or allegations had been made appropriate action had been taken. The management team had followed the local multi-agency safeguarding procedures correctly. This included working with the local authority safeguarding team to investigate safeguarding concerns and incidents. Where action was required to reduce further risks this had been completed. An example of this was the implementation of staff disciplinary procedures when concerns had been identified of unsafe staff practice.

Staff were aware of the signs of abuse. One staff member, "I would report to the nurse or the new care manager." This person told us the telephone number for the local authority safeguarding team was available for staff in the staff room and we saw this was available. They told us they were able to escalate any concerns to senior managers if required.

Three members of staff told us about one person that sometimes showed distressed behaviours which others may find challenging. We found this person's care records did not provide sufficiently detailed guidance, of the strategies to use to support them at times of heightened anxiety. We discussed this with the management team who agreed to review this person's needs and provide staff with the guidance required to effectively support the person.

People who used the service and visiting relatives told us there were sufficient staff available. One person said, "There's always somebody here. You've only have to press the button and they are here in a couple of

minutes." Another person said, "If I ring they come and help me, I don't wait." We saw this person had a call button on the bed by their side to use should they have required assistance.

Staff told us they felt there were enough staff rostered on duty to provide the care people required. One staff member said, "Staffing levels are good, we've also had new staff and this is positive."

During our inspection, we found there to be sufficient staff available to meet people's needs. We noted one person had one to one staff support and saw this support was provided. However, we saw the one to one worker needed to go to another room and they advised a staff member of this. Whilst the second staff member agreed to observe the person, they then left the room leaving the activity coordinator in the room, but they were supporting another person. We shared our observations with the management team who addressed this with the staff team.

Since our inspection, the registered provider had recruited nursing staff but these staff were no longer working at the service. There was one nurse employed at the service and the new manager was also a registered nurse, this meant the service remained largely reliant on agency nurses. The management team told us due to the significant and continued difficulties with recruiting and retaining nursing staff, they had taken the decision to relinquish the nursing element of the service. At the time of our inspection people with nursing needs had started to transfer to alternative placements.

Improvements had been made to medicines management in terms of ordering, storage and administration of medicines and overall we found people were protected against the risks associated with medicines. However, some shortfalls were identified that meant improvements needed further time to fully embed and be sustained. For example, one person's liquid medicine had not been dated when opened and was found to have expired. This was taken out of use by the nurse on duty and a replacement was already available. One of the clinic rooms were found to have dust in some areas. A nurse was seen to administer a person's medicines via a Percutaneous Endoscopic Gastronomy (PEG) feeding tube. Whilst we saw the nurse sought permission from the person to administer the medicines in the lounge, we noted they did not wear gloves or an apron. Additionally, they did not protect the person's dignity until this was pointed out, and a dignity screen was used. We also noted a person's medicine administration record showed their morning medicines at 6am, which were time critical, had not been administered and there was no reason given for this. This same person was asleep at the next time they were due their medicines but the nurse did not wake them. We discussed this with the management team and advanced nurse practitioner who advised staff should ensure time critical medicines were administered. The manager said they would immediately complete a care plan advising staff of this.

Where people had their medicines administered covertly, usually disguised in food or drink, appropriate action had been taken to ensure best practice guidance had been followed. This included authorisation from the GP, the pharmacist had also been asked to advise on the correct method of administering the medicines covertly. We saw a record of a multi-disciplinary 'Best Interest' meeting to discuss this was in place which showed that the person's relative was involved in the process. The registered provider's written policy on covert administration of medicines required that the decision to administer medicines covertly was reviewed at three monthly intervals. We noted that an audit by senior care home staff on 15 April 2018, stated that this had not been taking place. It is important that the decision to administer medicines covertly is reviewed regularly by a multi-disciplinary team with involvement of the person or their representative.

At our previous inspection, we identified some shortfalls in how the service met infection control best practice guidance. At this inspection, improvements were found. All staff confirmed that cleanliness and hygiene standards had improved. A domestic member of staff told us, and showed us the new

documentation that had been implemented to improve cleaning standards. This member of staff said, "There's been lots of improvements, we have new cleaning cloths and buckets, there're colour coded so we know what they are for. Deep cleaning is happening now." Cleaning schedules were found to be up to date. Overall, the service was found to be clean. However, we found a pressure-relieving cushion that was heavily soiled and one person's bedroom had a strong odour coming from underneath the flooring. We discussed what we found with the management team. The pressure-relieving cushion was removed from use and it was agreed the flooring to the bedroom would be replaced.

The registered provider had a system to record accidents and incidents, which were recorded on an electronic system that was accessed by senior managers. This meant senior managers were alerted to entries added to the system, which they reviewed on a regular basis. Accidents and incidents were monitored and reviewed for consideration of any patterns and trends that required action to be taken and lessons learnt to reduce reoccurrence. We reviewed incident forms and found there were inconsistencies with the level of detail recorded and the action taken to mitigate against further risks. Such as reviewing care plans and risk assessments. We noted due to a high number of incidents involving one person, they were in receipt of one to one staff support to reduce further risks. Some accidents and incidents had a 'root cause analysis' completed that gave details of the investigation and action taken to reduce the risk, but this was not consistently completed for all accidents and incidents.

## Is the service effective?

### Our findings

During our previous inspection on 18 and 19 October 2017 we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to people who were restricted of their freedom and liberty. Where a person had a Deprivation of Liberty Safeguard authorisation in place with conditions these had not been acted upon as required.

At this inspection, we found improvements had been made and the breach in regulation had been met.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). Where people had an authorisation in place this was in the person's care records to inform staff. Some people had conditions as part of their authorisation and we saw these were being met as required. For example, one recommendation was made for a person to have some health issues investigated at an outpatient's clinic; we saw documentation from the hospital to confirm this had been completed. Staff were aware of who had an authorisation in place.

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. Staff were aware of the principles of MCA. One staff member said, "We have to believe a person has capacity, if not we have to do a two stage capacity assessment. Each decision is specific, best interest decisions have to show who and how decisions have been made."

We found MCA assessments and best interest decisions had been made in areas such as medicines, personal care, eating and drinking and mobility but documentation varied in detail. For example, it was not always clear how decisions had been reached and that least restive options had been considered. The management team told us they were aware of this and improvements were being made by the organisation and new documentation was in the process of being implemented. Due to the registered provider relinquishing the nursing element, people with nursing needs were having their needs reassessed. This included their mental capacity to consent to transferring to an alternative placement, where they lacked mental capacity best interest decisions were being made involving their relative or representative.

When bed rails were used records indicated the person's consent was obtained for their use. Consent for the use of photographs in care records was obtained from the person using the service. We saw some care records for people who had a do not to attempt resuscitation order (DNACPR) in place and found these to have been completed appropriately. Some people had lasting power of attorney (LPA) that gave another person legal authority to make decisions on their behalf and this was recorded.

During our previous inspection on 18 and 19 October 2017, we identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to how people's

nutrition and hydration needs were met.

At this inspection, we found improvements had been made and the breach in regulation had been met.

People told us their hydration needs were met well. One person said, "They (staff) make me drink so much water I think they are trying to drown me, but I know it's for my own good." The people we spoke to in their rooms had drinks to hand. We also saw there were jugs of drinks or drink dispensers and glasses at several points around the service on both floors. We also saw staff frequently offered people a choice of drinks and snacks. People were satisfied with the choice of meals. One person said, "The food is lovely." A relative said, "The food is seriously delicious and they will get [family member] whatever they like, it's exceptional."

Staff told us improvements had been made to the records kept of people's food and fluid intake requirements. One staff member said, "A lot of work has gone into making sure people receive the food and fluids they need. The charts are checked twice a day by senior staff before they leave their shift and any gaps staff are asked for an explanation." Another staff member said, "Records are constantly discussed in handover meetings, staff meetings and supervisions."

We found food and fluid charts were well completed. However, we found that the records of nutritional and fluid intake for people receiving PEG nutrition, indicated they were not always achieving their fluid targets. We raised this with the manager who identified some issues with the accurate completion of the charts. They told us they would ensure the recording was improved and they would monitor to ensure the correct amount of fluids were administered. Nutritional risk assessments were completed and care plans were in place. The care records we reviewed showed people were maintaining or increasing their weight. When people were at risk of losing weight, staff weighed them weekly. Where people had been prescribed supplements to increase their calorific intake, we saw they were receiving these.

Kitchen staff had information about people's nutritional needs, preferences, including dietary needs associated with their religious or cultural needs. The head chefs said documentation and checks about people's nutritional needs had improved. Records kept by kitchen staff were readily available and reflected information in people's care records.

Where people required support with eating and drinking, staff assisted people in a relaxed manner, chatting to them as they assisted them at the person's pace and continually reassuring the person. People's food looked appetising and was well presented. People were offered seconds and independence was promoted with the use of dignity plates. These had a slight ridge to help prevent food from spilling off the plate. People's dining experience was calm, organised and pleasant..

During our previous inspection on 18 and 19 October 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to how people's health care needs were met.

At this inspection, we found improvements had been made and the breach in regulation had been met. We also identified that further time was required for improvements to fully embed and be sustained.

We saw people had access to community and specialist nurses, the community falls team, speech and language therapist, optician, and their GP when required. However, the outcomes of health reviews were not always clearly documented. For example, a person was seen by a specialist nurse regarding a specific health condition in March 2018. Staff told us there were concerns that the person refused a particular medicine for this condition or were asleep when required. However, it was not clear from the care records

due to fragmented and missing information and a letter received from the nurse, if this concern had been discussed. This suggested the specialist nurse was not given the full detail when they reviewed the person.

A person who used the service said, "I've been to hospital several times, my blood pressure drops suddenly, they get an ambulance. The chiropodist comes in too." Relatives were positive their family member's health needs were met.

Feedback from an external community nurse confirmed improvements had been made to how people's health needs were responded to. They spoke highly of some senior staff being knowledgeable and competent but said this could be variable. They also said they were more confident that recommendations made were implemented and followed.

The provider used best practice guidance and care was delivered in line with current legislation. For example, the provider used recognised assessment tools used in the assessment and monitoring of nutritional needs. Assessment of people's needs, included the protected characteristics under the Equality Act and these were considered in people's care plans. For example, people's needs in relation to any disability were identified. This helped to ensure people did not experience any discrimination.

Staff received an induction, training and ongoing support to develop their skills and awareness. Staff told us that whilst there had been a change of managers they found the management team to be supportive and approachable. The staff training plan showed a good compliance rate of staff being up to date with training that the registered provider had identified as required. This included, manual handling, health and safety, emergency procedures, infection control and dementia care. Nursing assistants had also completed additional training in nursing tasks required of them. Staff received an appraisal of their work and performance and opportunities to meet with their line manager to discuss their work and development needs. We noted staff had not received the frequency of these meetings as identified by registered provider as required. However, the management team had started to meet with staff and had a plan to ensure staff did receive support as required.

The adaptation and design of the service met people's needs. The service was purpose built over two floors. There were large social areas on the ground floor and smaller lounges on both floors. There were also several small, discreet areas with comfortable seating and tables where people could sit if they wanted quiet or privacy. People's doors had number and display boards with names and photos and toilets/bathrooms had signs with text and images to support with orientation.



## Is the service caring?

### Our findings

At our last inspection, we identified staff did not consistently provide dignity and respect when supporting people. At this inspection, we found improvements had been made; staff were attentive, kind and caring in their approach.

People who used the service and visiting relatives told us that staff were caring. One person said about staff, "Lovely, I get on very well with them, they are very kind." Another person said, "They are wonderful, all of them. They'll get you anything you want."

A visiting relative told us they felt the home was, "Very good, clean with sociable, caring staff who seem to be happy here and that seems to make people happy too." Another relative said, "Staff treat [family member] like family which is rather lovely, they tend to spoil them, they are extremely well looked after."

The management team had an inclusive approach in providing care whereby all staff worked together; there were no boundaries between care and the provision of services. For example, we saw domestic staff spending time chatting with people and kitchen staff assisting people with their meals. We saw all staff including the management team, care, kitchen and domestic staff all treated people in a caring respectful, kindly and non-patronising manner. Interactions between staff and people were person centred with positive social interactions, where staff took time to engage meaningfully with people. We saw there was lots of appropriate physical comforting such as hugs and hand holding.

Staff were seen to meet people's comfort needs and they had time to spend with people showing that they mattered. For example, we saw a person was sitting in a wheelchair at a dining table with a drink. We saw a staff member go to the person and ask if they had finished. The staff member did this in a kindly manner, talking gently to the person and stroking their arm. On finishing the drink, the staff member gently removed the person's apron and then crouched down to eye level with the person and ask where they would like to go and sit. We saw a member of the management team acknowledge a person as they walked past their room. We saw this staff member stopped and waited for a response from the person and then ask the person if they wanted a drink. When they said they did, we saw that the member of staff poured them one; they sat talking to the person for a while and then asked if the person wanted the television on before leaving them.

During our inspection, we saw one person constantly carried therapy dolls about and obviously gained enjoyment and comfort from this. Research shows (Dementia UK) the use of dolls can bring great benefit to some people living with dementia. We saw that staff acknowledged the presence of the dolls in a kindly caring manner. For example, at lunch we saw that the person was holding the dolls and when served their meals staff encouraged them to put the dolls on a chair by their side. One staff member said to the person, "So you can look after them." This was said in a respectful and kind manner.

We saw two staff supported a person to transfer from a wheelchair to an easy chair. Staff were attentive and explained to the person what they were doing. One staff member said to the person, "You look tired [name



of person], let us know if you want to go to bed." One person told a staff member they were not feeling well, we saw that the staff member got the person a drink and took time to sit with them and calm and reassure the person.

People's received opportunities to be involved in meetings and discussions about the care and treatment they received. The care home manager told us they had a plan to review people's care and treatment with them and or their relative. This review programme had commenced and some meetings had occurred with the person and their relative.

Staff told us improvements had been made to how people were supported to participate in their care. A staff member said, "We try to assist them to do whatever they want to do." They added that people were offered more choices and care was more person centred.

We saw a staff member ask a person's permission to put their feet on the wheelchair footrests, before moving them and then ask the person where they would like to sit. Staff encouraged people to maintain their independence and do as much as they could for themselves. A staff member said, "It's important to encourage people to stay as independent as possible and we do this, the little things matter."

People had access to independent advocacy information should they have required this support. . An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. Some people, who had restrictions on their freedom and liberty, had paid representatives that visited them and acted on their behalf in an advocacy capacity.

People received care and treatment that promoted their privacy, dignity and respect. People told us that all staff treated them with respect and helped them maintain their dignity. One person said, "I can have a bath or a shower if I want, when I want. They are gentle with me, keep my privacy and dignity. The woman that does the clothes is very good and very friendly. She hangs my clothes up, keeps them tidy." Another person said, "They treat me with respect oh yes, I'd tell them, they'd get it back, they are quite polite though."

Staff were given training in privacy and dignity values and staff we spoke with showed they understood the values in relation to respecting privacy and dignity. Staff told us how they provided care using a sensitive and discreet approach. One staff member said, "We knock on people's doors before entering, keep people covered as much as possible during personal care to protect their modesty. Another staff member said, "I treat people as I would want to be treated if in the same position."

People's care records contained information as to whether the person preferred to have a same gender staff member for personal care. People's diverse needs had been assessed and staff had important information about people's individual needs, such as their sexuality, religion and cultural and spiritual needs.

There were no restrictions about people receiving visitors and relatives confirmed they could visit their family member at any time.

## Is the service responsive?

### Our findings

During our previous inspection on 18 and 19 October 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to how people received care and treatment that was responsive to their individual needs.

At this inspection, we found improvements had been made and the breach in regulation had been met. We also identified that further time was required for improvements to fully embed and be sustained.

People's care records contained a personal profile, which included important details about the person's life such as life history, and care and treatment needs. This information was used as an easy read reference by staff to know people's needs and was particularly useful to inform new or agency staff about people. In addition, staff were required to read people's full care plans. Staff told us and records confirmed, any changes to people's needs were discussed at staff handover meetings and care plans were reviewed and updated monthly or earlier if required.

Improvements were found in the management and documentation of wound care. People's care plans showed healing was assessed regularly and a tissue viability nurse was consulted when required. A person with a urinary catheter had a detailed care plan for care of the catheter and the required records of catheter changes were maintained. Care plans were in place for the care of a person with Parkinson's disease and another person's mental health needs.

Some care plans were found to be variable as to information about people's needs and preferences in relation to their care. Some contained only basic information about the assistance they required whilst others contained more personalised information about their preferences. We found the care plans were not always well organised and there was information missing from some care plans, but documented elsewhere in the person's file. For example, a person was receiving nutritional supplements and this was not documented in their nutrition care plan but was documented in their tissue viability care plan. Another person had oxygen prescribed, but there was no care plan for the management of oxygen, when it should be used, the rate of flow or other safety considerations. Reference to some of this information was elsewhere in the person's file. A short term care plan was developed when a person had a chest infection but there was no date on it and the evaluations did not indicate when the infection had resolved. One person receiving PEG nutrition had a care plan for care and management of the tube and surrounding skin, and also a plan for tube replacement. However, another person did not have a specific PEG care plan but records of tube care and administration of the feeds were kept in the daily records.

Whilst we found improvements in how staff were responsive to people's needs, we identified a concern about how staff responded and supported a person with a particular need. A person was assessed as being at very high risk of choking, and their care records indicated they should only be given a few spoons of liquid by a nurse when they requested something to drink. We observed the person asked a member of staff for a drink at 2.47pm. The member of staff said they would tell the nurse. They asked another member of staff five minutes later and they said they would find the nurse and returned shortly after saying the nurse was busy

but they would be free in approximately 15 minutes. At 3.20pm, the person was still waiting and asking anyone who passed. The inspector therefore informed the manager and the care home manager immediately went to assist the person. The manager took immediate action to ensure this did not occur again by identifying other staff, such as a senior staff member or nurse assistant who would be competent to support the person.

Staff spoke about people in a person centred way demonstrating that they knew people's individual routines, likes and dislikes. One staff member said, "Staff are more conscientious and have more time to spend with people. I think staff are more aware of people's needs and what's important to them." People's communication and sensory needs had been assessed and planned for. A staff member told us about a person who was registered blind and how staff had developed activities, they could enjoy and could access. The management team told us information could be provided in different formats if required to ensure no person was disadvantaged due to their sensory or communication needs. This meant the provider had considered the requirements of the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss.

Consideration of people's religious and spiritual needs had been planned for. The activity coordinator told us about developments with the local community. They said, "We have bible readings and talks from people from the local churches, these are generally the Anglican, Catholic or Methodist churches, we have no others come in at the moment as they are not needed but we would contact others if anyone wanted that." During our inspection, a visiting group provided people with opportunities to participate in bible reading, prayer and singing. We saw how staff supported those that wanted to join in.

An activity coordinator was responsible for developing and providing activities for people based on their interests, hobbies and pastimes. They told us they learned about people's life stories and likes and dislikes by talking to them and their families and from looking at the care plans. They also said, "I have a 'Resident of the Day' and spend time with them and finding out all about them, make sure we are doing things they want to do, check out what they'd like to do." One person told us, "I go downstairs once a day for my midday meals if I'm up to it and see the activity coordinator down there. I don't like games so don't do anything but she's marvellous, she pops in, she does my nails." Another person said, "I don't want to go downstairs, they (staff) do come and ask me but I'm quite happy here. The activity person comes and sits and talks." A visiting relative whose family member was cared for in bed said, "They (staff) keep them involved. For example when they made Easter bonnets they (staff) took the ones who were able to walk to their room wearing the bonnets to show them, they don't ignore them."

The activity plan showed people received opportunities to participate in a variety of activities such as chair exercises, a mini zoo visited and an entertainer such as a singer or keyboard player. External visitors supported people with crafts, for example making bird feeders. A mini bus was also available to support people to access the community. The activity coordinator said, "We have pampering days for the ladies and we have a hairdresser come and I do their nails but we do some things for the men, particularly they enjoy the garden and watching sport." I do short interventions, perhaps 10 minutes with people, we might do word searches. Some can't communicate too well but I give them time. I have picture cards. I have a sensory part of the garden and spend time with them there." Records were kept of people's involvement in activities and we found activities matched what we were told, we also saw photographs of people joining in activities showing relaxation and enjoyment by the smiles seen. Since our last inspection, a new coffee area had been developed with a radio and information of interest available for people.

People who used the service, relatives and visitors received opportunities to share their experience or

concerns. A relative said, "If I see something not quite right I don't go immediately to the top I take it up with the carers, that usually sorts it."

A complaints procedure was available and an electronic feedback system meant people could raise any concerns or complaints as an additional method. This information was reviewed and responded to by senior managers within the organisation. The complaints log showed any complaints had been responded to as per the provider's compliant policy and procedure. Staff told us they would report any concerns to the manager if they were reported to them.

People's end of life wishes had been considered. For example, a person's care records indicated they had been reviewed by the community palliative care specialist nurse and a meeting had been held with the person's family. Records indicated some decisions were made in relation to the person's preference in relation to a particular support need. However, the person did not have an end of life care plan in place.

# Is the service well-led?

## Our findings

During our previous inspection on 18 and 19 October 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the governance of the service.

At this inspection, we found improvements had been made and the breach in regulation had been met. We also identified that further time was required for improvements to fully embed and be sustained.

People who used the service and visiting relatives told us of their concerns in relation to changes within the management of the service. One relative said, "Staff wise there's some lovely people work here, they work hard but there's been a raft of managers, a lack of continuity of management and a lack of skills in management."

Since our last inspection, the registered manager had left the service and three separate covering managers within the organisation, had been managing the service on an interim basis. A new permanent manager had been appointed, but subsequently did not commence their employment. A fourth experienced manager from within the organisation was managing the service and at the time of the inspection, was in the process of submitting their registered manager application to CQC. Also since the last inspection a new care home manager has been appointed and a new area director and area quality director. Staff were complimentary and positive that the current management team were supportive, approachable and were making improvements. We were told the manager and care manager were fair and everyone was treated equally. Another member of staff talked about the enthusiasm and motivation of the management team. They said, "It feels as though we are moving forward. There is 'oomph' about them." They went on to say the managers gave a clear direction and they were being led.

Feedback from external professionals told us they felt positive improvements were being made, they acknowledged care and treatment of people was better and improvements needed to be sustained. An agency nurse that had worked at the service told us the staff team were dedicated, and improvements to systems and documentation was continually being improved upon. They said, "The team have tried hard to make changes, however without a stable nursing team this has been difficult." A visiting pharmacist said, "They (staff) have been very welcoming and cooperative regarding the new work I am doing with them around the medication reviews and have been really helpful and engaged with that."

The manager told us about the systems and processes the provider had in place to monitor all aspects of the service in terms of quality and safety. Whilst these were not new, the manager and senior management team responsible for the service, were completing these in a timely manner and more effectively. There was improved accountability and oversight of the service, the senior management team visited the service weekly and worked with the staff team to make improvements. They also completed audits and checks and their findings were fed into the overall improvement plan that was forwarded to us on a regular basis. Audits and checks covered areas such as health and safety of people's needs, including the environment, medicines management, reviews of people's care records, staff training and supervision and appraisals.

Since the last inspection there had been improved communication systems introduced with staff and a better understanding of people's clinical risks. This included an improved and more detailed staff handover documentation that highlighted people's specific needs and any changes. The clinical risk register was up to date and used more effectively to monitor people's needs.

The senior management team told us that they were confident improvements had been made in the governance of the service, but these had been hard to sustain in some areas, due to the difficulties with recruiting and retaining nursing staff. Whilst every effort had been made to recruit and retain permanent nursing staff this had been unsuccessful. This led to the decision by the registered provider to relinquish the regulatory activities that enabled nursing care to be provided. At the time of the inspection people with nursing needs were having, their needs reassessed and were being supported to move to alternative placements. The care home manager was facilitating people's transfers and this was being completed very effectively in an organised manner. When this has concluded, the registered provider will formally request the removal of their nursing registration and become a residential care home only. We will continue to monitor this.

Overall, we found staff to be positive and had a commitment in working together to further improve and sustain improvements. However, we found a very small proportion of staff less engaged in moving the service forward. Some staff did not feel the concerns raised by the CQC at the last inspection involved them. There was also a reluctance to accept personal responsibility for aspects of care amongst some staff. For example, one staff member said, "The nurse is in charge at the end of the day."

Other staff spoke about changes being made in a positive way and said the changes were having a positive impact. Staff told us there was always a senior manager on call out of hours and at weekends. One staff member said, "We are more focussed now and have more direction." Another staff member said, "Staff have more responsibility and everyone pays more attention to the paperwork. We do checks to ensure the daily records are completed."

The staff team was found to be working better with external health and social care professionals, communication was better, referrals were made in a more timely manner and recommendations made were acted on and implemented.

Relatives told us that they had been invited to attend resident and relatives meetings. One relative said, "They have a residents and family meeting every three or four weeks. We all sit together, perhaps a dozen of us. The activity coordinator chairs and sometimes gets the manager if anything they feels needs that. They do listen to us, for example the bell on the front; you couldn't hear it in here (dining room) and people couldn't get in. They (manager) sorted it that day."

During our previous inspection on 18 and 19 October 2017, we identified a breach of Regulation 18 of the Care Quality Commission (Registration) 2009. This was in relation to the registered provider not informing us of incidents they were required to do.

At this inspection, we found improvements had been made and the breach in regulation had been met. Since our last inspection, CQC had been notified correctly of any incident the provider is required to notify us about. The management team have been open and transparent in all their communication. The latest inspection report was found to be displayed within the service and on the registered provider's website as required.