

# Larchwood Care Homes (South) Limited

## Silver Birches

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The inspection took place on 8 and 9 May 2017 and was unannounced. Silver Birches is a residential care home that can accommodate up to 27 people living with dementia or other mental health conditions. At the time of the inspection there were 12 people accommodated, including one person who was in hospital.

The service had a registered manager. 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.

People and their relatives told us there was a lack of social stimulation and that they were bored. People said they were not supported to follow their interests. Staff did not all appreciate the need to regularly engage with people besides when providing their practical care. The registered manager had taken action to fill the vacant activities co-ordinators post. However, the interim arrangements were not sufficiently robust to ensure people's needs for social stimulation were sufficiently met.

Staff had undergone safeguarding training and had access to policies and guidance to enable them to safeguard people from the risk of abuse.

The risks to people from falls and other risks had been regularly assessed. Although some people had experienced a number of falls the correct actions had been taken to decrease the likelihood of repetition for people or to accommodate them in an alternative environment if the risks to them of falling again had become too high.

People and their relatives told us they did not think there were sufficient staff rostered. The staffing level provided did not demonstrate how variations in people's care needs, which resulted in some people requiring support from two care staff on occasions; would be met, especially at weekends. Adequate consideration had not been given as to how staff could best be deployed during shifts to ensure they were available to meet people's needs. Appropriate recruitment checks had been undertaken in relation to staff to ensure people's safety.

There were processes for the safe ordering and disposal of medicines. Staff told us they had undertaken medicines training and had their competency assessed, which records confirmed. Staff were provided with the relevant information to administer people's medicines safely. We observed one incident of potentially unsafe medicines administration which the registered manager took immediate action to address for people's safety.

People were supported by staff who received an appropriate induction to their role. The registered manager had initiated regular supervisions with staff, who reported they felt well supported in their role. People were supported by staff who had received sufficient training relevant to their role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had dietary care plans in place which identified their nutrition and fluid requirements. Staff were observant as to whether people had eaten or drunk sufficiently for their needs. People appeared to enjoy their lunch and some people interacted with each other as they ate around the large communal dining table.

Staff identified if people had health care needs and ensured these were addressed for them.

Attention had been given to the environment for people to ensure there were items of interest for people to look at and touch on the walls of the corridors as they walked around the service.

Relatives told us people were happy and well treated. Staff were caring towards people when interacting with them. Staff were familiar with people's personal life histories, their passions and interests. People's individual communication needs had been identified and responded to in the provision of their care.

Staff received guidance about people's ability to make decisions for themselves and this was followed to ensure people were offered opportunities to make decisions about their care. People's rights to exercise choices about their care were respected. Staff ensured people were treated with dignity and respect.

People's care plans were clear and identified their personal care needs. A process was in place to ensure people's care was regularly reviewed with them and their relatives where possible. Staff had a good knowledge of people's preferences about how they liked their care to be provided and were regularly updated regards changes to people's care needs.

People were provided with details of how to make a complaint and when complaints were received; appropriate action was taken. Processes were in place to enable people to provide feedback on the service provided.

The provider had a philosophy of care for the service; the aim was to provide people with a home that was safe and where their wishes were respected. There was a positive culture amongst the staff team.

People and relatives provided mixed feedback on the leadership of the service. Staff provided very positive feedback about the new registered manager. The registered manager had not been in post for sufficient time to enable them to address the issues within the service or for them to be able to consistently demonstrate good leadership over time.

Aspects of record keeping required improvement to ensure that they were completed contemporaneously and accurately reflected the care offered to people. The registered manager has informed us staff will be receiving training in this area.

The service was regularly audited and the results used to improve the service for people.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the providers 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 consistently safe.

People were safeguarded from the risk of abuse.

Risks to people had been assessed, managed and reviewed to ensure they remained up to date and relevant for people's safety.

The staffing level provided did not demonstrate how variations in people's level of care needs, resulting in them requiring occasional support from two care staff, would be met, especially at weekends.

Appropriate recruitment checks had been undertaken in relation to staff to ensure people's safety.

Medicines were managed safely overall. However, the registered manager had to address a medicines administration issue during the inspection to ensure staff followed safe medicines administration guidance.

### Is the service effective?

**Good** ●

The service was effective.

People were supported by staff who had received relevant training to undertake their role and who were supported in their work.

Where people lacked the capacity to consent to aspects of their care legal requirements had been met.

People were supported by staff to eat and drink sufficient for their needs.

Staff supported people to access health care services as required.

Consideration had been given as to how the environment met the needs of people living with dementia.

### Is the service caring?

**Good** ●

The service was caring.

People experienced positive and caring relationships with the staff who provided their care.

People were encouraged to participate in day to day decisions about their care and their choices were respected.

Staff ensured people were treated with dignity and respect.

### **Is the service responsive?**

The service was not consistently responsive.

People's needs for social stimulation were not being sufficiently met; they told us they were bored and we observed limited opportunities for stimulation were provided.

People's care plans were clear and identified their personal needs.

People's care was regularly reviewed with them and their relatives where possible.

There were processes in place to seek people's views of the service provided.

**Requires Improvement** ●

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

The service was not consistently well-led.

A positive culture was promoted and staff liked working with people at the service.

The new registered manager had not been in post for long enough to enable them to have had the time required to address the issues within the service or for them to be able to consistently demonstrate good leadership over time.

Improvements were required to ensure records were completed contemporaneously and that they accurately reflected the care people were offered.

The service was regularly audited and the results were used to improve the service for people.

**Requires Improvement** ●

# Silver Birches

## 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 checked 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.

The inspection took place on 8 and 9 May 2017 and was unannounced. The inspection team included an inspector 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. The expert by experience had experience of caring for older people including those living with dementia.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with eight people, six relatives and a community psychiatric nurse. We also spoke with two care staff, the deputy manager, the chef, the registered manager and the general manager. Not everyone was able to share with us their experiences of life at the service. We 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.

We reviewed records which included three people's care plans, three staff recruitment and supervision records and records relating to the management of the service.

The service was last inspected in July 2016 and no concerns were identified.

# Is the service safe?

## Our findings

Staff told us they had undergone safeguarding training, and this was confirmed by records. Staff were able to describe the purpose of safeguarding, their role and the signs which might indicate a person had been abused. Staff had access to relevant safeguarding guidance and contact numbers if required. Where required referrals had correctly been made to the local authority, who are the lead agency for safeguarding, the registered manager told us they provided staff with feedback about the outcome from safeguarding alerts that were raised. This ensured openness within the service and provided staff with the opportunity to reflect on safeguarding incidents and learn from these. People were kept safe as staff had received relevant training and understood their role in relation to safeguarding people from abuse.

The risks to people from falls had been assessed. Staff underwent falls training as part of their moving and handling training to ensure they were aware of the factors that could increase the likelihood of falls. Staff told us how the risks to people from falls were managed, for example, by walking beside them and by ensuring they had their mobility equipment. If people were assessed as unable to use their call bell to request assistance, then there was guidance for staff to check upon their welfare regularly. We noted that there had been a number of falls within the service during 2017. Incident records relating to people still accommodated showed there had been a total of 20 falls during the period 1 January 2017, up to the date of the inspection. When people experienced a fall staff completed an incident form which was then reviewed by the registered manager to identify if any further actions were required; such as arranging to have the person's medicines reviewed, de-cluttering their environment or requesting the GP to make a referral to the falls clinic, where people can access specialist advice in relation to the management of the risks of experiencing falls. The registered manager told us that two people had recently been transferred to another service due to the risk of them falling to ensure their future safety. Although a number of falls had been reported, the correct actions had been taken to decrease the likelihood of repetition or to accommodate people in an alternative safer environment for their needs.

Other potential risks to people had been assessed such as those associated with moving and handling, pressure ulcers and choking for example. Where risks were identified plans had been put in place to manage the identified risk for the person, for example, through the provision of equipment. The risk assessment identified the nature of the risk, how the risk was to be managed and how effective the measures were at reducing the identified risk. Staff reviewed people's risks on a monthly basis to ensure they remained up to date and relevant.

People and their relatives told us they did not think there were sufficient staff. Their feedback included: "There's not enough staff and they don't have enough time to spend with people." "There's less staff around and that shows in a decline in care. There's only ever two staff on duty." "There's just not enough of them and they don't have time to do everything."

Staffing of the service in the day had been reduced from three to two care staff with effect from 27 February 2017, in response to a decrease in the number of people using the service. The registered manager had last completed a staffing dependency tool on 14 April 2017 which demonstrated the service was providing 119

extra care staff hours per week above what people required. No-one using the service was assessed as having high care needs, although three people had higher care needs in relation to some aspects of their care, such as washing and dressing and continence care and on occasions required two staff to support them with these care needs. They were relatively independent in other aspects of their care and therefore did not meet the threshold for high care. However, when one of these people required two care staff to assist them into the shower or to provide their continence care there were then no care staff left to meet the needs of the other people accommodated or to supervise them. Staff told us staffing levels were not sufficient and that it was hard to monitor people across the service. During the weekdays, the registered manager was able to provide assistance and we saw them support staff to take a person to the shower. Although people received their care within the staffing provided; at weekends when the registered manager was not working, if a person needed two staff for their care, then other people could potentially be placed at risk whilst the two care staff rostered attended to the one person. Although staff could access assistance in such a situation from one of the provider's other two locations based on the same site this could cause a delay in meeting the person's needs. Following the inspection the registered manager informed us they had recruited an additional member of staff to work on a Monday, Wednesday and Friday. However, the staffing level provided still did not demonstrate how variations in people's level of care needs resulting in them requiring support from two care staff would be met at weekends.

Consideration had not been given regarding how best to deploy staff across shifts to meet people's care needs. For example, at breakfast we noted one care staff was administering medicines whilst the other provided people with their breakfast. If a person required personal care at this time, then staff would have either had to stop what they were doing if it was a weekend to support the person or during the weekdays ask the registered manager to assist. A relative commented to us, "I don't think the care is tailored to the individual's needs, I think it's tailored to fit in with what's easiest for the home and the staff." Consideration had not been given as to how staff could best be deployed across the staff shift to enable them to meet people's needs as required.

Staff told us full employment checks had been completed during their recruitment. Staff files showed criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). The provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of staff's references, interview notes, proof of identification and a health declaration. Appropriate recruitment checks had been undertaken in relation to staff to ensure people's safety.

Staff told us they had undertaken medicines training and had their competency assessed, which records confirmed. Staff understood the risks associated with giving people their medicines, for example, who was likely to refuse them and the actions they should take in response and who was likely to try and avoid swallowing them. However, staff did not always apply this knowledge. On the second day of the inspection it was observed that a person's liquid medicine had been left on the table for them to take and they had since walked away. There was a potential risk that another person might have swallowed the medicine. The registered manager took immediate action to secure the medicine and to address this incident with the staff member to prevent the risk of reoccurrence.

There were processes for the safe ordering and disposal of medicines. Medicines were kept securely. Controlled medicines are medicines which require a greater level of security. They were kept in accordance with legislative requirements for safe storage. We found stock balances we checked were correct. We observed that stocks of controlled medicines were checked when they were administered, which for the one controlled medicine staff were currently administering was weekly. This created a potential risk that any discrepancies would not be identified quickly. We brought this to the attention of the registered manager for



them to consider whether the current frequency of checks were sufficiently robust and they advised us they would be ensuring they were checked twice a week which is in accordance with the provider's policy.

People's medicine administration records (MARs) contained guidance for staff about where to apply people's topical creams. Staff dated people's topical creams when they were opened, to ensure they were not used beyond a safe date. Staff also had access to information about when to administer 'as required' medicines for people. Staff were provided with the relevant information to administer peoples' medicines safely.

The registered manager was keen to minimise the use of medicines within the service which was confirmed by a community psychiatric nurse and people's medicines had been reviewed with the GP and reduced where possible. Covert medicines which are those which are administered without the person's knowledge were used as a last resort and in accordance with legal requirements.

## Is the service effective?

### Our findings

Staff told us they had received an induction to their role when they commenced work. Staff without a professional qualification in social care were required to complete the Care Certificate. This is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. People were supported by staff who received an appropriate induction to their role.

Staff informed us they received supervision and felt well supported within their role. Records showed not all staff had received regular supervision. However, the registered manager had already identified this issue and had commenced supervisions and annual appraisals with staff to ensure they were adequately supervised within their role.

Relatives commented "I think the staff they have are fairly well trained." Staff told us they were up to date with the provider's training requirements. The registered manager confirmed that they had identified the need for staff to complete the provider's required on-line staff training and that this was an area they had focused on with staff since commencing their role. The need to complete their training had been addressed with staff at the staff meeting held on 22 March 2017. The registered manager informed us that the level of staff's on-line training completion was now in line with the provider's requirements. In addition face to face training for staff was scheduled in relation to: dignity and respect, continence and equality and diversity to enable staff to further develop their knowledge in these areas. Staff received both on-line and face to face dementia care training, which covered a comprehensive range of topics to provide staff with the knowledge required to support people. Five of the seven permanent care staff who were rostered were either undertaking, or had obtained a professional qualification in social care. People were supported by staff who had received sufficient training relevant to their role.

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

Staff spoken with told us they had undertaken MCA training which records confirmed and understood how the act related to their role when working with individuals. People had been asked to consent to each of their care plans. Where people lacked the capacity to consent to their care a MCA assessment had been completed and a best interest decision documented, following consultation with relevant others such as relatives and professionals. The registered manager had a good understanding of the MCA and was able to provide an example of a recent MCA assessment and best interest meeting for a person who lacked the capacity to make a specific decision. This ensured legal requirements had been met and the person's

human rights protected.

DoLS applications for people were underpinned by a MCA assessment which demonstrated how the decision had been reached that an application was required and was in the person's best interests. Legal requirements had been met in relation to the submission of DoLS applications for people.

People had dietary care plans in place which identified their nutrition and fluid requirements. People were weighed monthly and their Malnutrition Universal Screening Tool (MUST) score calculated. This is a screening tool to identify adults, who are at risk from either malnourishment or from being overweight. There was guidance for staff regards the actions they should take if they had concerns about a person's weight which they had followed.

Staff were observed to provide people with hot and cold drinks across the day. If people requested a drink between meals or tea rounds, this was provided. People were also encouraged to have snacks between their meals to ensure they received sufficient nutrition for their needs. This was particularly important as a number of people were observed to spend a lot of time walking around the service and so expended more calories which they needed to replace. Staff understood that people living with dementia may require additional snacks and these were provided. No-one was currently on food or fluid charts, which are used to monitor the adequacy of peoples' intake. However, staff were observant as to whether people had eaten or drunk sufficient for their needs.

Most people chose to eat their lunch at the dining room table. The chef informed us that the single tables in the dining room had recently been re-arranged into a large dining table to enable everyone to sit together and to encourage interaction between people. We observed at lunchtime that some people did interact with each other over their lunch.

People were offered a choice of drinks and starter at the beginning of their lunch. The meal provided was well presented and people seemed to enjoy it. People told us the food was "Okay" or "Good". If people did not want one of the two main courses on offer for their hot meal then they were offered and provided with an alternative that they did want. The chef told us how they responded to people's views regarding their food by trying to accommodate their wishes. For example, a person wanted to try a specific ingredient so the chef had bought it for the person and was planning to use it in a meal for them as requested.

People's records showed people had seen GP's, dentists, social workers, opticians, psychiatrists, chiropodists, community psychiatric nurses and district nurses. In addition requests had been made via the GP for people to access the continence service and the falls clinic where required. Staff had ensured that peoples' healthcare needs were identified and met.

The corridors provided visual interest for people with a seaside mural and photographs of people. A display contained items people could touch such as a light switch and doorbell. There was a 'bus stop' for people to sit at and a fruit and vegetable stall. Attention had been given to the environment for people to ensure there were things for people to look at and touch.

## Is the service caring?

### Our findings

Relative's told us people were happy and well treated. Their comments included, "She seems to be happy there so I suppose that's the main thing", and, "I think they treat them with kindness."

The registered manager told us they demonstrated to staff how they expected them to interact with people, in a friendly and non-judgemental manner. People were observed to be relaxed and comfortable in the presence of staff who spoke with them in a kindly and friendly manner. A member of staff told us, "We treat people like family." Staff checked if people were comfortable and asked a person if they would like to sit more upright in their chair. Staff were caring towards people when interacting with them.

Staff told us they spent time sitting and talking to people to get to know them and that when people were admitted, the person and their family were asked to provide details of the person's life history for staff, this was documented as a 'Social profile'. This detailed the person's family, past, education, homes, jobs, experiences, hobbies, interests, aims and aspirations. Staff were familiar with this information and were able to tell us about people's personal life histories and their passions and interests. Having this information available enabled staff to give reassurance to people using familiar references from their life if they became anxious or confused

Staff recognised that some people used different methods to communicate their wishes. One person had been provided with symbols which they used to inform staff of whether they were in the mood to be approached or if they wished to be alone. This enabled the person to communicate their wishes. People's communication care plans documented what topics the person liked to talk about, such as their family. People's individual communication needs had been identified and responded to in the provision of their care.

People's care records noted the decisions they could make for themselves in relation to their daily care, for example, in relation to choosing their clothing. Staff offered people choices about their day to day care such as what drink they would like and what they would like for their breakfast. Staff were observed to ask people if they would like a protective cover for their clothes at mealtimes, rather than making an assumption that the person should wear one. Staff received guidance about people's ability to make decisions for themselves and this was followed to ensure people were offered opportunities to make decisions about their care.

People's wishes about their care were respected for example, a person wished to stay in bed on the first morning of the inspection and they did. If people did not want to eat in the dining room or they wanted to eat whilst walking about then they were able to. Staff accepted that it was people's right to make these choices which were respected.

The registered manager told us they touched on people's end of life care wishes at the start of their residency. This was done to ensure these difficult discussions were initiated with people and their relatives at a time when people may be able to participate in the discussion. It also communicated to people and

their relatives that staff were there to listen and support them with these conversations.

Staff told us they would knock on a person's bedroom door before entering and were observed to do so. Staff were able to tell us about how they upheld people's privacy and dignity in the provision of their personal care. For example, by knocking on their door, ensuring the bedroom door curtains were kept closed during the provision of care. Staff understood how to uphold peoples' privacy and dignity and ensured this was followed.

## Is the service responsive?

### Our findings

A hairdresser attended the service weekly and an entertainer was booked monthly. There was an activities schedule which showed a range of twice daily activities were planned for people. However, there was a lack of evidence to demonstrate these took place as planned. People and their relatives unanimously told us there was a lack of social stimulation. One person commented, "I have nothing to do all day long, there's nothing going on." Their relative confirmed, "My father is bored - he says he doesn't do anything or go out." Another relative commented, "Really there should be more to life than just being washed and dressed, fed and sat in a chair." Another person's relative said, "There's no activities at all. My mother used to be an avid church goer but she doesn't get to do that now." The person confirmed to us that they used to go to church and would still like to. We asked a member of staff if this could be arranged and they said, "No, it would only be possible if a family member took her because there is only two of us on duty at the weekend and we don't have enough staff to cover if one was to take her to church." A person's care plan documented that they enjoyed walking. The registered manager told us staff did take people out for walks in the gardens. However, whilst this could be done during the weekdays with their support it would be difficult for staff to do this at weekends with only two care staff rostered. We observed that people spent a lot of time sat in the main lounge with the TV on. During the first day of the inspection the only activity was the choice between a DVD or a CD of country music in the afternoon. People often appeared to be asleep, but when we sat down next to them they turned to engage with us, indicating people were dozing as there were limited opportunities for social stimulation.

We observed that when staff provided people's care they interacted well with them. However, outside of these times there was more limited interaction. We did see staff on occasions strike up conversations with people; however, this was not consistent. On several occasions people approached us seeking to chat. People wanted to engage with staff, however, these opportunities were not always as available to people as they wanted and needed. The registered manager said they told staff, "Anything that involves people is an activity." However, not all staff followed this guidance. The registered manager told us there was still further work to be completed with staff around their understanding of good care for people living with dementia.

The registered manager told us that the activities co-ordinator had left the service some months ago and that their post had been advertised but not filled as yet. They informed us that because they had three staff absent on long-term sickness there was no capacity to cover these vacant 25 hours; in the interim the two care staff rostered were also providing activities. The registered manager tried to minimise the use of agency staff to ensure people received consistency in the staff caring for them and therefore had not covered these vacant hours with agency staff. There were two volunteers who visited the service twice weekly; however, any social stimulation they provided should be in addition to the regular staff input. The registered manager had taken action to fill this post; however, the interim arrangements were not sufficiently robust to ensure people's needs for social stimulation were being met currently. Following the inspection the registered manager informed us they had recruited an additional member of staff to work on a Monday, Wednesday and Friday, this would enable people to receive additional social stimulation on three days of the week.

The failure to meet people's needs through the provision of sufficient levels of social stimulation was a

breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care needs had been assessed in relation to various aspects of their care needs including: nutrition and hydration, personal hygiene, oral health, elimination and continence, breathing, communications, mental health, mobilising, skin integrity, social interaction, night routines, medicines and end of life care. People's care plans were clear and identified their personal needs in relation to each of the above areas.

Staff had a good knowledge of people's preferences about how they liked their care to be provided. They understood people's personal routines for the day and night, for example, what they liked to drink and if they wanted the light left on or not at night. Staff had access to clear information in people's care plans about their personal preferences.

Staff received a handover at the start of each shift to ensure they were updated on changes in people's care and health. The registered manager told us they encouraged staff to handover information over several staff shifts to ensure they all received any additional information about people. In addition there was a handover sheet providing information for staff regards people's medical history and mobility needs. Staff were provided with sufficient information about people to provide their care.

Each person was 'Resident of the Day' once a month. Aspects of the person's care reviewed included their: care plans, medicines, housekeeping, nutrition and activities. The chef confirmed to us that they met with people monthly as part of this process to seek individual's feedback on their meals. Staff spoke with the person about their care where possible and tried to contact their family as part of this monthly review, to provide an update on their care. This ensured people's care plans were reviewed monthly to ensure they remained up to date and relevant.

Where people were resistant to receiving the care they required their care plans provided staff with written guidance about how to work with the person to provide the care they needed, for example; a person could become distressed when receiving personal care so there was guidance for staff to be clear with the person about what was happening. Staff told us they explained to people what they were doing when providing their care.

The registered manager told us people were provided with a copy of the complaints policy when they were accommodated. Staff understood their role in supporting people who wished to make a complaint. Two complaints had been received, since the last inspection. Both had been actioned and the appropriate actions taken in response. Feedback was received from one complainant following their complaint and this demonstrated that they were satisfied with the actions taken.

The registered manager informed us they were in the process of arranging a resident and relative's meeting as part of a planned dinner dance for people. This would enable people and their relatives to be provided with a social event at which to provide their views on the service. The chef sought people's views about their meals through regular 'food committee' meetings. As a result of the feedback received a meal had been put back on the menu which people enjoyed.

The general manager and the registered manager told us a quality assurance survey had been circulated and records showed three people and one visitor had returned their surveys. The registered manager was waiting for the results to be collated by the provider. The general manager told us the results would be displayed for people so that they could see what the feedback was and the actions taken in response. Action had been taken to seek people's views on the quality of the service provided. Processes were in place to enable people to provide feedback on the service.

## Is the service well-led?

### Our findings

The provider had a philosophy of care for the service; the aim was to provide people with a home that was safe and where their wishes were respected. We observed the service provided a homely atmosphere for people and people were able to make their own choices.

The registered manager told us staff pulled together in response to the staffing levels by having their lunch break with people in the lounge. This ensured people were monitored by staff whilst they ate their lunch. Staff had also come in on their day off to take people on a day trip to Portsmouth, as within the current staffing levels trips out could not be facilitated. Staff told us, "We all work together as a team." The registered manager was building on this and held their first meeting with staff on 22 March 2017, giving staff the opportunity to hear the registered manager's expectations of them and the chance to express their views. There was a positive culture amongst the staff team.

People and relative's provided mixed feedback on the leadership of the service. Their comments included, "I don't think it's well led", "The new manager is trying his best but I don't think he's able to do as much as he would like because of funding", "I think there's room for loads of improvement there's been such a decline in the care."

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. There had been a change of registered manager since the last inspection and the new registered manager told us they had been in post for five weeks and they had only been registered with CQC as the manager since 11 April 2017.

Staff provided positive feedback about the new registered manager. They told us they were, "Good to work for", and that they set, "Clear boundaries", for staff to operate within. They also commented, "X (the registered manager) is brilliant, he is so helpful. He explains things."

The registered manager told us they, "Led by example." We observed that when the two care staff found a person's behaviours more challenging to meet, the registered manager supported them to ensure the person's care needs were met. They said they spent a lot of time on the floor with people across the day. This commenced with them greeting each person and doing pre-breakfast aerobics with people in the dining room and concluded with them saying goodnight to each person. They told us "I would spend all day with residents." The registered manager exhibited a passion for caring for people living with dementia.

The new manager is a qualified dementia nurse and the trainer for all three of the services located on the site. They have brought a wealth of knowledge and experience in caring for people living with dementia to their first role as a registered manager. They demonstrated a good understanding of the challenges and the issues facing the service. However, they had not yet been a manager at this service for long enough to enable them to have sufficient time to address the issues identified in the other areas of this report and the breach of regulations, or for them to be able to consistently demonstrate good leadership over time.



In addition to the registered manager there was a deputy manager and each shift was led by either a senior care staff or a shift lead to ensure staff were provided with guidance and direction during the shift. The general manager was based on-site and was very supportive of the registered manager in their new role. The regional manager visited the service regularly. There was a clearly defined management structure and at each level staff reported feeling well supported.

On the first day of the inspection we found that the temperature record for the office where people's medicines were stored had not been documented since 3 April 2017. The registered manager told us that this was the date when the storage of medicines had been moved from the upstairs medicines room which was no longer in use. The registered manager completed this record retrospectively which is not good practice. Although the completed records did not indicate that medicines had been stored at an unsafe temperature. Records should be completed contemporaneously, to ensure prompt action could be taken if there was an increase in the room temperature. The registered manager then addressed the issue with staff to ensure that the temperature record book was completed by them daily so an up to date record of the room temperature was maintained. The required record had not been kept; however, the registered manager took action to ensure this was addressed for people and that a contemporaneous record was maintained.

Some people had identified needs in relation to their personal care, but could be resistant to receiving staff support to meet them. A person's relative commented to us, "There are times when I visit and I can smell my mother's pad has not been changed and I have to ask for it to be done." People's records clearly documented each day whether they had accepted assistance with washing or bathing or refused this care. However, people's records did not so clearly and consistently demonstrate what continence care they had been offered or accepted across each day. Staff told us they supported people to go to the bathroom regularly across the day and changed people's incontinence products two hourly. However, this was difficult to corroborate as although we saw staff supporting individuals, people's daily records just stated 'refused personal care' rather than documenting at what times they had been offered assistance with their continence care that day. We brought this to the attention of the registered manager for them to address with staff, to ensure there was a clear record of the continence care people had been offered and provided with. They have informed us staff will be receiving training in this area to ensure records of care are complete.

The registered manager completed a weekly report for the provider to update them across aspects of the service: including for example, staffing, complaints, whistleblowing's, safeguarding and training. They also completed a monthly clinical audit. They audited any infections people had experienced, wounds, pressure ulcers, falls and nutrition. A health and safety audit was completed on 15 March 2017. This identified the need to arrange staff training which had been actioned and to repair damaged glazing which was in process. An infection control audit was completed on 28 March 2017; this identified the need to replace the carpet in some bedrooms which was underway. People's medicines were audited monthly. People's care plans had been audited and where actions were required these had been completed and signed off. A first impression of the service audit was completed on 27 March 2017. The regional manager completed regular audits of the service looking at different aspects of the service provided. No issues had been identified from their visits. The service was regularly audited and the results were used to improve the service for people.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider's failure to meet people's needs through the provision of sufficient levels of social stimulation was a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>