Southern Primecare (Brighton) Limited

Hereford House

Inspection report

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Date of inspection visit: 11 & 17 February 2015
Date of publication: 13/04/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Hereford House on the 11 and 17 February 2015. Hereford House is a residential care home that can provide care and support for up to 29 people. On the days of the inspections, 27 people were living at the home. The age range of people living at the home varied between 45 – 90 years old. Hereford House provides support for people living with varying stages of dementia, physical healthcare needs, diabetes, sensory impairment and long term healthcare conditions.

Accommodation was arranged over three floors with a communal lounge and dining area. Although care and support is provided for people living with dementia, the home is not specialised in dementia care.

A manager was in post, but they were not the registered manager and had only been in post two months. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The home has been without a registered manager for eight months.

At the last inspection in September 2014, we asked the provider to make improvements to the recordings of their risk assessments and care plans. An action plan was received from the provider which stated they would meet the legal requirements by 22 January 2015.

Summary of findings

Improvements had been made, but we continued to have concerns with the recording of risk assessments. We also identified further areas of concerns throughout the inspection.

People's needs had been assessed and care plans devised and implemented. However, care plans and risk assessments lacked sufficient guidance and detail to enable staff to provide safe, effective and responsive care. Despite concerns with documentation, we saw that people received the care they required. However, this remained an area of practice that required continued improvement.

People's medicines were stored safely and in line with legal regulations. People told us they received their medicines on time, however, guidance for the use of 'as required' (PRN) medicines were not available. We have identified this as an area of practice that required improvement.

The deployment of staff within the home required improvement. People told us they felt safe and commented the home was sufficiently staffed. However, we observed care practice which could potentially place people at risk. For people living with dementia, they were often seen sitting in communal areas with no staff interaction. This could place people at risk of un-witnessed falls due to not having staff around. We have identified this as an area of practice that required improvement.

Not all staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were not recorded in line with best practice guidelines and staff were not consistently aware of who was subject to a DoLS authorisation and what it meant for the individual. We have identified this as an area of practice that required improvement.

Systems were in place to analyse, monitor or review the quality of the service provided. However, these were not being completed on a regular basis and there were no mechanisms to assess the standards of care. Feedback was not regularly sought from people or their visiting relatives. Incident and accidents were not consistently recorded or monitored for any emerging trends or patterns. We have identified this as an area of practice that required improvement.

Staff spoke highly of the training opportunities provided and commented they felt supported and valued by the provider. However, two members of staff had not received the training required to provide effective care to people. We have identified this as an area of practice that required improvement.

People spoke highly of the opportunities for social engagement and activities. An activities coordinator was in post three days a week and regularly took people out and about, shopping and to places of importance to them. However, on the days the activities coordinator was not present, there was a significant lack of stimulation and engagement for people. We have made a recommendation for improvement in this area.

People felt their privacy and dignity was upheld. However, we observed elements of practice which did not uphold people's dignity. We have made a recommendation for improvement in this area.

Staff had received safeguarding adults training and had a firm understanding of what constituted adult abuse. However, staff were not clear on how to raise a safeguarding alert. We have identified this as an area of practice that requires improvement.

Staff demonstrated a fondness for the people they supported. From observing staff interacting with people, it was clear they had spent time with people, getting to know them, gaining an understanding of their personal history and building friendships with them. People were provided with a choice of healthy food and drink ensuring their nutritional needs were met.

People spoke highly of Hereford House, the staff and the manager. One person told us, "I couldn't be anywhere better." Staff understood the principles of privacy and recognised that people had the right to take positive risks and live autonomous lives. People looked comfortable in the company of management and the manager was committed to the on-going improvement of Hereford House.

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

Summary of findings

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

Hereford House was not consistently safe. Staff had a firm understanding of what constituted adult abuse, but were not clear on how to raise a safeguarding alert. People received their medicines on time, however, guidance was not in place for the use of 'as required' medicine.

People told us they felt safe living at the home. Staff supported people to live autonomous independent lives; however risk assessments failed to record the measures required to keep people safe.

Improvements were needed to the deployment of staff within the home. People living with dementia, were often left unattended in the communal area for over 20 minutes.

Is the service effective?

Requires Improvement

Hereford House was not effective. Not all staff members had received training to provide effective care and support to people.

Mental Capacity Assessments were not completed in line with best practice guidelines. Staff's understanding of Deprivation of Liberty Safeguards (DoLS) varied, and not all staff members could confirm who was subject to a Deprivation of Liberty Safeguard and what that meant for the individual person.

People could see health and social care professionals, when needed. However, care plans did not consistently reflect the measures required to reduce the risk of skin breakdown.

Is the service caring?

Requires Improvement

Hereford House was not consistently caring. People spoke highly of the home, however, we found the design and decoration did not always empower and enable people living with dementia to be as independent as possible.

Care was provided with kindness and compassion. People could make choices about how they wanted to be supported and staff listened to what they had to say.

Staff spoke with fondness about the people they supported and it was clear staff had spent time getting to know people's likes, dislikes and care needs.

Is the service responsive?

Requires Improvement

Hereford House was not consistently responsive. Care plans were not always detailed and lacked sufficient information to provide safe, effective and responsive care.

Summary of findings

People spoke highly of the activities coordinator and the opportunity for social engagement and stimulation. However, on days the activities coordinator was not working, there was a lack of meaningful activities and stimulation for people.

There was a complaints procedure in place and people felt confident approaching the manager with any concerns. Complaints were acted upon; however, where people expressed dissatisfaction with the outcome of a complaint, this was not always clearly documented.

Is the service well-led?

Hereford House was not consistently well-led. There was not a robust system in place for monitoring, evaluating and assessing the quality of care. Feedback from people and relatives was not regularly sought to help drive improvement.

People made positive comments about the management of the home and staff spoke highly of the manager. The manager was open and responsive to the areas of concern identified.

Staff were not consistently clear on the visions and values of the home, but expressed a strong commitment to delivering good care.

Requires Improvement

Hereford House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 11 and 17 February 2015. This was an unannounced inspection. The inspection team consisted of two inspectors. During the inspection, we spoke with six people who lived at the home, two visiting relatives, four care staff, the chef, activities coordinator, laundry assistant, the deputy manager and the manager.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

We usually ask the provider to complete a Provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask for a PIR on this occasion because we carried out the inspection at short notice.

We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounge. Some people were unable to talk to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and procedures. We looked at nine care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Hereford House. This is when we looked at their care documentation in depth and obtained their views on how they found living at Hereford House. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hereford House. One person told us, "Everyone is happy here and we are all safe." Observations found people looked comfortable in the company of care staff and staff respected people's autonomy and freedom. However, we found areas of practice which were not consistently safe.

At the last inspection in September 2014, the provider was in breach of Regulation 20 of the Health and Social Care Act 2008. This was because risk assessments lacked sufficient guidance and detail. During this inspection, improvements had been made, but areas of concern remained.

Staff respected people's individual autonomy and freedom and recognised the importance of positive risk taking. People were seen regularly going outside for cigarettes, people could drink alcohol within the home and people were seen regularly coming and going from the home. However, risk assessments failed to record and reflect the good practice undertaken by staff. For example, one person (living with dementia), expressed a strong desire to go out and about independently. A risk assessment was devised to enable the person to go out to local pubs, shops and other areas of importance to them. However, the measures described by staff to keep this person safe, whilst respecting their autonomy and freedom, were not clearly documented in the risk assessment. Staff commented about ensuring the person was wearing appropriate clothing and footwear and recording the time they left and returned. However, this level of detail was not recorded, therefore for agency staff or new members of staff, this guidance would not be available.

For people living with dementia, they could exhibit behaviour which may challenge, such as aggression, anxiety and walking without a purpose (wandering). We looked at staff's management of behaviour that could challenge and the risk assessments in place to provide guidance and support. Staff demonstrated they understood how to respond to behaviour that could challenge. One staff member told us, "We use distraction techniques and try and take them away from the situation." Another member of staff told us, "We have to be aware of our approach and mannerism when trying to diffuse the situation." A recent incident had occurred whereby two people had an altercation which resulted in verbal abuse and a physical assault. Documentation confirmed staff had to physically intervene. The risk assessment for one person involved had been updated to reflect an incident had occurred, but there was no information or guidance on how to manage the person's behaviour, what the triggers were and what to do in the event of any further physical assaults. The risk assessment identified the risk, but had not incorporated the protective measures required by staff to keep the person and other people safe.

Staff had identified two people who could walk without a purpose and would often walk into other people's bedrooms. Documentation identified this had occurred at night time while other people were sleeping. A visiting relative confirmed they had put a lock on their loved one's doors, as it had caused them great distress. Risk assessments had identified they could walk without a purpose, however, information was not readily available on how to manage this behaviour when it caused distress to other people. For example, one person's risk assessment identified they had gone into another's person's room and got into their bed. Whilst staff supported them to leave they became confused, aggressive and emotional. Guidance was not available on how to manage the aggression and emotion, or how the aggression presented. Staff commented they used talking therapy or distraction techniques to manage these situations and also regularly sought advice from the manager. However, in the absence of the manager or for agency staff members, the lack of detailed risk assessments could impact upon the delivery of safe care.

This issue relating to the recording of risk assessments is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a firm understanding of what constituted adult abuse and could clearly identify various forms of abuse. One member of staff told us, "The safeguarding training was very informative." Staff clearly understood that abuse was not to be tolerated and should always be reported. Any concerns of abuse or neglect were reported to the manager. Documentation confirmed the manager was responsive to any concern of abuse and neglect and raised safeguarding alerts in line with local protocol. However, we posed the question to staff who they would report their concerns to if the manager was away. One staff member told us, "I would contact the nominated individual." Another staff member commented, "I would call the owner." Staff were unaware of their own responsibility to

Is the service safe?

raise a safeguarding alert themselves with the Local Authority. We brought this to the attention of the manager who had already identified our concerns and was working with staff in supervision and staff meetings to raise the awareness. There was still the risk of safeguarding alerts not being raised in a timely manner and protection plans for adults at risk being delayed. This is not a breach of regulation, but we have therefore identified this as an area of practice that requires improvement.

People told us they received their medicines on time. One person told us, "I know what tablets I take every day and if they change, the girls tell me." Some people were enabled and supported to manage their own medicines. This promoted people to remain independent. Although people felt confident in their medicine regime, we found areas of concern.

Medicine Administration Records (MAR) charts confirmed a sample of people were prescribed 'as required' medicines. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. For people living with dementia, medicines can be prescribed to relieve behavioural and psychological symptoms and manage behaviour. Very few people were prescribed PRN medicine such as diazepam (medicine) to manage behaviour and MAR charts confirmed the medicine was rarely administered. Instead talking therapy and distraction techniques were used to help manage the person's behaviour or anxiety. Staff commented if the medicine needed to be administered, this would need to be approved by the manager. However, in the absence of the manager, if the need arose, guidance was not available on when the medicine should be administered, the steps to take before administering it, or the outcome of administering the medicine. This is not a breach of regulation, but we have identified this as an area of concern that requires improvement.

Medicines were stored and administered correctly. Some prescription medicines had legal requirements for their storage, administration, records and disposal. Medicines were stored, recorded and ordered appropriately. The stock levels of medicines were checked on a regular basis and medicines were administered in the presence of two care staff as per good practice guidelines.

People and staff we spoke with felt the home was sufficiently staffed. One person told us, "I can always get help." A team of four care staff and the deputy (or senior) were available throughout the morning. The afternoon consisted of three care staff along with the deputy (or senior). The manager was available throughout the week and provided on-call support at weekends. The night shift consisted of two care staff and on-call support. The manager had no formal mechanism or system in place to calculate the staffing levels, but felt confident the current staffing levels were sufficient. We were informed, "We would notice if the staffing levels were short and I would always increase the numbers when needed." A call bell facility was available in people's bedrooms and call bells were answered promptly.

People were at risk of potential harm and not having their needs met as staff were not adequately deployed throughout the home. Although people spoke positively of the staffing level and we felt the home had sufficient staffing numbers, we raised concerns that people were at risk due to being left unattended for periods of time. For example, on the second day of the inspection, we spent time sitting with people in the communal lounge. We found people living with dementia, were often left unattended in communal areas throughout the day without call bells to summon assistance. Without regular checks and the inability to summon assistance, this could place people living with dementia at potential risk of harm. For example, one lady spilt a cup of cold of tea over herself (if hot, it could have been at risk of scalding her) the inspection team had to find a member of staff to provide assistance. During the inspection, we also identified that some people were able to move around independently, for others, they required assistance from staff members to move and get up. Due to the care needs of people living with dementia, they may try and mobilise independently. This can therefore place them at risk of potential harm or fall or place them at risk of not having their care needs met. Staff were regularly seen around the home, but a staff member was not continually in the communal lounge, therefore, people were left unattended which placed them at risk.

This issue relating to risk of potential harm was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were in place to ensure that only suitable staff were employed. Records showed staff had

Requires Improvement

Is the service safe?

completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

Requires Improvement

Is the service effective?

Our findings

People and visiting relatives spoke highly of the care staff and felt they received effective care. One visiting relative told us, "I've got no concerns about the staff, if I did, my Father would not be here." One person told us, "I'm the best of friends with one girl, she is lovely, always gives me a good shower." Although people spoke highly of care staff, we identified areas of practice which were not consistently effective.

The Mental Capacity Act 2005 (MCA) is a law that protects and supports people who do not have the ability to make specific decisions for themselves. Under the MCA, the assessment of capacity is based initially on the two stage assessment and then the person's ability to retain, weigh up, understand and communicate the decision. Each individual capacity assessment we looked at, recorded that the person could not retain, weigh up or understand the decision due to confusion and memory loss. Confusion and memory loss does not mean that a person is unable to make an informed decision. The assessment of capacity did not reflect whether the person was provided with the nature of the decision, the reason why the decision was needed, and the likely effects of deciding one way or another, or making no decision at all. Staff had an understanding of how to gain consent from people and enable people to make day to day decisions. However, we have identified the recording of MCA as an area of practice that required improvement.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. On the day of the inspection, four people were subject to a Deprivation of Liberty Safeguard.

Staff confirmed they had received DoLS training. One staff member told us, "It's there to help people who really need it." Another staff member commented they had received training but could not recall what a DoLS meant. We asked staff if they could tell us who was under a DoLS and what it meant for the individual. Not all staff could relay this information to us. The manager told us, "I applied for DoLS applications for four people as they can often refuse personal care, but could be sitting in urine soaked clothes. We need to draw the line as this could be seen as neglect if we did not intervene." However, as staff were unaware of who was under a DoLS and what it meant for those individuals, the impact of the DoLS had little meaning for the people subject to it.

We asked the manager to explain how care could be provided to a person subject to a DoLS and when the person continually refused to accept personal care. The manager told us, "Offer care but if refused, offer again, however, after several declines to coax the person, be firm and provide care in their best interest." We asked staff how they provided support to people who could refuse care and become physically challenging. Staff described how they would go back if the person declined, try a different member of staff or a different approach. Staff confirmed that through using these approaches or gaining support from the manager, the person had consented to personal care and they had not yet faced the situation whereby the person continually refused.

We looked at the risk assessments and guidance in place to aid staff, in the event of a person continually refusing personal care and they lacked capacity to make this specific decision. The care plans for the individuals subject to a DoLS, had not been consistently updated to reflect they were under a DoLS. One person's care plan recorded 'DoLS application is now in place as staff sometimes give forced care.' There was no reference to what forced care involved or how to provide this. Information was not recorded on how to ensure care was provided in the person's best interest, but also with regard to the least restrictive option. Risk assessments lacked sufficient guidance and support to enable staff to provide effective care under a Deprivation of Liberty Safeguards, whilst respecting and empowering the person. Additionally, in the absence of the manager, staff would be unable to rely on risk assessments to provide the support needed to ensure people received personal care and were not placed at risk of neglect.

This issue relating to DoLS and risk assessments was a breach of Regulation 11 & 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt regular training was provided and it gave them the necessary skills to undertake their role. Essential training

Is the service effective?

was provided in a number of areas which included manual handling, health and safety, first aid and medication. Specific training was also provided which enabled staff to provide effective care to people. This included dementia awareness and dignity and empowerment. We spent time talking with staff and observing staff interactions to ascertain whether training was embedded into practice. It was clear staff understood the importance of communicating with people living with dementia. They spoke in a simple and slow tone, along with maintaining eye contact and providing the person with time to respond and digest the information. Staff recognised the importance of providing people with choice and control whilst respecting the decisions they made. One staff member told us, "The dementia training taught me a great deal about dementia and how sad the disease is and the various types of dementia." Another staff member told us about the various types of dementia, demonstrating their awareness and understanding of the condition.

Training schedules identified two members of night staff who had not received safeguarding training, dementia awareness, MCA or DoLS training. Within the past seven weeks, these members of staff had worked three night shifts together whereby incidents had occurred. For example, on one night a person was found to be trying to leave the home and shaking the front door. On another night, a person was found walking without a purpose and going into other people's bedrooms. On these nights, staff members working had not received essential training to provide effective care to people living with dementia and could place people at risk. The manager was aware of our concerns and had booked DoLS training but further training was still required. Staff therefore did not have the skills, knowledge or training and this could have placed people at risk of harm.

This issue relating to the effectiveness of staff training and the potential for harm was a breach of Regulation 9 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed they felt supported and valued as employees. One staff member told us, "The new manager is great; I have a lot of respect for her." Systems to support and develop staff were in place through ad hoc supervisions, staff meetings and handovers. Staff commented that if they had any worries they could approach the provider or deputy manager for advice or guidance.

People's health and well-being was monitored on a daily basis. The district nursing team visited the home on a daily basis and documentation confirmed staff regularly liaised with GPs, dieticians and speech and language therapists. People commented they felt their healthcare needs were met. One person told us, "If I'm ever unwell, they get the Doctor for me." Staff recognised how people's healthcare needs could rapidly change and for people living with dementia, how they may not always be able to communicate when they are feeling unwell. One staff member told us, "One resident in particular, if they were not eating, that would be a sign they were unwell." The home had a daily diary which recorded when advice was required, any hospital or GP appointments along with feedback from healthcare professionals.

We looked at the management of skin integrity. Older people can be at heightened risk of pressure ulcers and for people living with dementia this also increases their risk. Staff had a good understanding of the basic principles to prevent the development of pressure ulcers. One staff member told us, "Always check pressure areas and report any concerns. Apply barrier creams and make sure pressure reliving equipment is inflated." The risk of any skin damage was assessed on a monthly basis and each person had a tissue viability care plan. However, when people were assessed at being high risk, this was not consistently reflected in their care plan along with the measures required to manage the risk. For example, one person had been assessed as medium risk of skin breakdown. One person was also observed to be wearing socks which were digging in and leaving a mark on the skin. Staff were regularly seen prompting the person to elevate their legs. Talking to staff and documentation confirmed staff responded to any signs of skin breakdown promptly, however, care plans failed to provide sufficient guidance and support.

This issue relating to care plans was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

People were involved in making their own decisions about the food they ate. People were asked each day what they would like for breakfast, lunch and dinner. One person told us, “I always get to choose and the food is very good.”

We spent time observing lunchtime in the dining area. People could choose where they wished to eat and this decision was respected by staff. The daily menu was on display and tables were laid with table clothes, napkins and condiments. The cutlery and crockery was of a good standard and music was playing in the background.

Refreshments were available and the atmosphere was friendly with people talking and laughing. People’s weights were recorded monthly (if consented to by the individual). Staff told us how they monitored people's food and fluid intake and monitored for any signs of weight loss and malnourishment. One staff member told us, “If someone wasn’t eating or had lost weight, we would refer to the GP and offer fortified drinks and meals and gain advice from a dietician.”

Requires Improvement

Is the service caring?

Our findings

People spoke highly of Hereford House and were positive about the home. One person told us, "It's a very good place for elderly people." Another person told us, "The girls are very caring." Although people spoke positively of the care they received, we observed care practice which was not caring.

The atmosphere in the home was relaxed and friendly. A large communal area was provided which was in continual use. Dining tables were arranged in one area and chairs were placed at the other end, circled around a large television. The communal area was seen as the hub of the home and provided a friendly environment for people. However, for people living with dementia, the design and decoration of the home was not always dementia friendly. People living with dementia could easily become intimidated by their surroundings. A well designed, safe and caring environment can help people be as independent as possible for as long as possible. It can also help to make up for impaired memory, learning and reasoning skills. Certain aspects of the home had been designed to help orient people. Door frames were painted a different colour from the wall to help make them easily identifiable for people; however, other features to help orient people were not available. People's pictures were not on their room doors and throughout the inspection, we heard people asking staff, "Where's my room?" People living with dementia, were therefore dependent on staff to orient them and this impacted upon their ability to walk around the home independently. This is not a breach of regulation but we have therefore identified this as an area of practice that requires improvement.

From talking to staff, it was clear they strove to provide good care; however, we observed elements of care which did not uphold people's dignity. For example, we heard interactions between staff and people, whereby the person was referred to as a 'good boy' or 'naughty boy'. From observing the interaction, staff did not mean any offence, however, consideration had not been given to the use of language and how it impacted upon the person's self-worth. This is not a breach of regulation but we have identified this as an area of practice that requires improvement.

The management of incontinence required a personalised and dignified approach to help people feel in control and promote their dignity. The manager and staff were aware of people who required support to manage their continence regime. Although people wore continence pads, risk assessments reflected that people should be taken to the toilet regularly. The manager informed us a member of staff was allocated to ensure people were supported with their continence regime. We observed staff providing assistance on an ad hoc basis. However, documentation failed to reflect when this support was provided and how often it should be supported. We have identified this as an area of practice that requires improvement.

We recommend that the service considers the Social Care Institute for Excellence, dignity in care advice and guidance.

Despite the above concerns, we saw staff interacting with people in a caring and professional manner. When talking to people, staff knelt down or sat down next to the person. People responded to staff with smiles and it was clear staff had spent time building rapports with people.

Staff demonstrated a compassionate attitude towards people and spoke fondly about the people they supported. One staff member told us, "I love what I do. I've gotten to know each resident, their likes, dislikes and I leave every shift knowing people here are safe and comfortable." Staff had a good understanding of the individual care needs, wishes, likes and dislikes. All were respectful of people's needs and described a sensitive and empathetic approach to their role.

The principles of privacy were understood by staff. One staff member told us, "People need their own space and we always knock and gain permission before entering a person's bedroom." Another member of staff told us how they would feel if people were providing care to them, but not talking to them or explaining what was happening. People told us their privacy was always maintained when receiving personal care. One person told us, "The girl always covers me up in my dressing gown and makes sure I'm covered when giving me a wash." Throughout the inspection, we observed staff knocking on people's doors and waiting before entering. Staff were also observed speaking with people discretely about their personal care needs.

People told us they felt listened to and supported by staff and they felt cared for. One person told us, "They are ever so kind and always look after me." People were able to express their views and were involved in making decisions

Requires Improvement

Is the service caring?

about their care and support. Care plans had been signed by people or their representatives/relative to show they agreed. Relatives were provided with opportunities to read their loved one's care plan and make any further remarks or comments. Visiting relatives said they were always informed about their loved one's progress and kept informed of any changes or updates.

Resident's meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. Minutes from the last meeting confirmed people discussed activities, the menu and possible outings they would like to do. People commented they found the forum of resident meetings helpful to discuss their concerns or raise any queries.

People told us they kept in touch with their friends and family. They were able to visit at any time and were always made welcome. People could see their visitors in the communal lounge or in their own area. One visiting relative told us, "They always make me feel welcome."

Is the service responsive?

Our findings

People and their relatives felt Hereford House was responsive to their care needs. People spoke highly of the opportunities for social engagement and activities. One person told us, "We play bingo, word games and have entertainers in." Although people spoke highly of the home, we identified areas which were not consistently responsive.

A new system of care plans had recently been introduced. Each person had a new care plan which contained a detailed individual resident assessment. This considered all aspects of the person's care and provided a brief overview of the person's individual assessed level of need. Each section of the care plan later covered a different aspect of the person's life, for example personal care, mobility and dexterity and religious needs. Elements of care plans were personalised to the individual and information was readily available on how the individual preferred to be supported. For example, one person liked to be independent with oral hygiene, but required prompting by staff to put the toothpaste on their tooth brush. However, certain aspects of care plans were generic and not individual to the person. For example, each care plan considered how to maintain a safe environment. Recordings in each care plan were generic and lacked detail on how the environment could impact on each person in a different manner. Hereford House had a locked front door. Therefore to exit the home, a key code was needed. Care plans failed to consider the impact of this on the person and whether they would require staff support to exit the home.

The level of support people required was not always clear or contradicted information in the home's daily diary or people's daily notes. One person's moving and handling risk assessment reflected that they required the support of a standing aid to transfer from bed to chair. However, information in the home's daily diary recorded for the use of hoist to be used instead of a standing aid. Information gathered from the person's daily notes reflected staff were using both the hoist and standing aids. Therefore it was unclear which piece of equipment, or both, was required to safely transfer the person. Staff commented they assessed the person on a day to day basis as they were aware the individual did not like using the hoist, but for safety reasons it may be required. However, the information recorded in people's care plans did not contain robust or current guidance to provide safe, effective and responsive care.

Due to the above concerns, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each care plan contained a 'Map of the life of'. This included personalised information on the person's life history, what was important to them and key memories for them. Staff commented that the profile allowed them to build a rapport with people and engage with them. It also worked as a tool to help people reminiscence about their past.

People spoke highly of the activities and the opportunity for social engagement. The provider employed an activities coordinator who worked three days a week. Their primary role was to provide one to one stimulation to people, take people out and organise activities and entertainers. People spoke with enthusiasm about the opportunities to go out and about. One person told us, "I get to go out on the bus into town and go shopping." Another person told us, "They take me to get my favourite sweets." The activities coordinator told us, "It's important people are supported to do day to day activities and live an active life". Along with taking people and out and about, the activities coordinator took people to see family and friends or out to local cafes. This promoted people's freedom and autonomy, plus it enabled them to feel active and respected.

Staff understood the importance of involving and encouraging people to do activities of interest to them. One person enjoyed laying the tables every day for lunch while other people enjoyed folding up laundry. This provided an opportunity for people to feel valued and be involved in the running of the home.

On the first day of the inspection, people gathered in the communal lounge in the afternoon for a game of bingo. People thoroughly enjoyed the stimulation along with participating in a group activity. On the second day of the inspection, it was a non-working day for the activities coordinator. Throughout the inspection, we identified seven people who spent the majority of the day in the communal lounge. For people living with dementia, keeping occupied and stimulated can improve quality of life. The only source of interaction or stimulation was the

Is the service responsive?

television. Staff did not encourage people to pursue their own hobbies or interests, or participate with people in a game or provide meaningful activities. Therefore on the second day of the inspection, there was a significant lack of social engagement and stimulation.

We recommend that the service considers the National Institute for Health and Care Excellence quality standard for mental wellbeing of older people in care homes.

People and their visiting relatives felt confident in raising any concerns or complaints. One person told us, "I would approach the manager if I had any concerns." A visiting relative told us, "I've raised a complaint before and I'd raise another if I felt I needed to." The complaints policy was displayed in the entrance of the home and staff told us they would support people to make a complaint. We looked at the management of complaints and how complaints were dealt with and any learning that had taken place.

Complaints had been acknowledged and investigated, however, in one complaint the respondent had written back expressing dissatisfaction with the outcome of the complaint and said they questioned the role of complaints. We could not see what action had been taken following this and therefore there was a danger this person may not speak up again.

We identified concerns raised by relatives within people's care plans which hadn't been addressed as a complaint. For example, one relative spoke of their loved one sitting in stained clothing and requested staff ensure they had clean clothing on. Documentation failed to reflect what action had been taken and why this was not investigated as a complaint.

The above issues are not a breach of regulation, but we have identified the above issues, as areas of practice that required improvement

Requires Improvement

Is the service well-led?

Our findings

People spoke highly of Hereford House and staff expressed confidence in the manager. One member of staff told us, "The manager is brilliant." A visiting relative told us, "The manager is always on the ball with things." Despite people's high praise of Hereford House, we found areas of practice which were not consistently well-led.

Systems were in place to monitor and analyse the quality of the service provided. These included audits and quality assurance checklists. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. Despite having the mechanisms in place to review the quality of the service provided, the provider was not consistently completing them. For example, the last set of audits completed had been in October 2014. Previous audits included nutrition, training requirements, environment, staffing and care plans. Each audit identified key issues along with reflective learning. Before October 2014, audits had been completed on a monthly basis to help drive continual improvement. The lack of current audits and quality assurance framework meant the provider had no up to date and robust systems to help identify shortfalls or assess the quality of the service being provided or how to drive improvement.

There was a system in place for recording accidents and incidents. We reviewed a sample of these and found recordings included the nature of the incident or accident, details of what happened and any injuries sustained. However, we could not identify how the provider monitored or analysed incidents and accidents to look for any emerging trends or themes. Where action had been identified, recording did not demonstrate whether it was followed up, implemented or no longer required. One person rolled out of bed and the action from the incident and accident log was to discuss the implementation of bed rails. Bed rails were not in situ and their care plan had not been updated to reflect the fall, nor had a bed rails risk assessment been completed. We could therefore not determine what action had been taken, if any and how this on-going risk to this person would be reduced.

This issue relating to incidents and accidents was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Robust systems were not in place to seek the views of people and their relatives. Satisfaction surveys had not been sent out in over a year, therefore, the provider had no formal mechanism in place of obtaining the views of people and their relatives. People and visiting relatives felt able to approach the manager and 'resident meetings' were held on a regular basis which enabled people to contribute towards the running of the home. However, satisfaction surveys provided people the forum to air their concerns or gratitude in a formal manner and ensured those who may not attend resident meetings were given a voice to air their thoughts and feelings. We have identified this as an area of practice that requires improvement.

The visions, values and philosophy of the home were not made readily available to people, relatives and staff. The home had a statement of purpose which detailed the philosophy of the home. This included providing a 'happy, secure environment and congenial surroundings for every resident'. Alongside 'ensuring each resident was recognised as an individual, and care and attention is provided to meet each specific physical and emotional need.' This was not available for people and their relatives to access or view. Staff could not readily tell us the philosophy of Hereford House or the values, but demonstrated a clear commitment to providing individual care. From talking to staff it was also clear they had spent time getting to know each person, their likes, dislikes, personality and individual care needs. One member of staff told us, "We try and offer the best care we can."

Hereford House had experienced issues with retention of management in the past year. The succession of three managers in the past year had impacted on staff morale. One staff member told us, "It's been a tough year but we've tried to pull together." Staff spoke positively of the new manager and their approach. We were informed, "She always comes round every morning and if something isn't right, she sorts it." The manager acknowledged the impact that three managers in one year had upon the culture of the home and commented the culture was very unsettled. This was an area that required addressing and the manager expressed a strong commitment to improving and developing the culture at the home. The manager told us, "My style is to get everyone involved and to shift the focus from 'they' too I'." This was identified as an on-going area of practice that requires improvement.

Requires Improvement

Is the service well-led?

The manager was committed to on-going improvement of the home and was able to describe the key challenges. When discussing concerns found during the inspection, the manager was open and responsive to our concerns. A key area of challenge for Hereford House was the design and decoration. A large number of people living at the home were living with dementia. Hereford House was not registered for dementia care and the environment required improvement to be dementia friendly. The manager told us, "I am meeting with the nominated individual to discuss how to move forward and ensure we provide high quality dementia care."

Management were visible within the home. The manager and deputy manager were regularly providing hands on care and interacting with people and relatives. People looked relaxed in the company of the manager and it was clear they had built rapports with people. On a day to day basis, the manager provided guidance and leadership. In the absence of the manager or at weekends, a team leader would be identified to lead the shift with the manager or deputy manager providing on-call support. The owner and nominated individual were known and recognised by staff and the manager commented they felt supported and valued by the provider.

Communication within the home was valued and respected. Staff meetings were held regularly. This provided staff with the forum to air any concerns and to discuss practice issues. In between each shift, daily handovers were held, which enabled staff to keep up to date and informed of any developments or changes to people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1) HSCA (RA) Regulations 2014** **The provider had not ensured the care and treatment of service users was – (a) be appropriate (b) meet their needs and (c) reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1) HSCA (RA) Regulations 2014** **The provider had not ensured care and treatment of service users was provided with the consent of the relevant person.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(2)(a) HSCA (RA) Regulations 2014** **The provider had not ensured staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a) HSCA (RA) Regulations 2014**

This section is primarily information for the provider

Action we have told the provider to take

The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(c) HSCA (RA) Regulations 2014 The provider did not maintain, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

The enforcement action we took:
A warning notice has been issued. The service is to be complaint within three months of receipt of the warning notice