Ravenswood Care Home Limited

Ravenswood Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4, 5 and 6 December 2017 and was unannounced. This was a comprehensive ratings inspection. Ravenswood Care Home is a residential home for up to 55 older people. There were 39 people living at the service at the time of the inspection. People who used the service were older people and may have had physical and/or mental health needs.

At the last inspection on 31 July and 1 August 2017, we asked the provider to take action to make improvements to meet regulations 9, 10, 11, 12, 13, 14, 16, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made some improvements so they were no longer in breach of Regulations 9, 10, 11, 13, 14, 16 and 19. They were in continued breach of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was no registered manager in post. There was a manager in post; however they had not undertaken the registration application at the time of our inspection. 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.

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

The number of staff had improved since our last inspection. However people did not always have their needs met in a timely way as staff were not always deployed effectively. This meant people could not always be treated with compassion due to a delay in them getting support.

Medicines were not always stored and administered as prescribed and there were gaps in the recording regarding medicines.

Risks to people's health and wellbeing were not always assessed and planned for, such as agitation, health conditions and following falls, leaving people at risk.

The provider did not have effective systems in place to ensure people received the care and support they needed. The provider did not always take action to make required changes when incidents occurred.

Staff understood their safeguarding responsibilities and appropriate referrals had been made. However, one incident had been documented by staff but had not been reported by management.

Decision-specific mental capacity assessments needed to be put into place and best interest decisions clearly recorded.

Staff training had improved although further improvements were required. We have made a recommendation about staff continuing to receive updated training so all training is up to date and that staff understand what the MCA means for people they support.

The home had improved in appearance but further improvements could be made to ensure it was dementia friendly.

Care plans were not always updated following a change in people's needs so staff did not always have up to date guidance.

Plans for when people were coming towards the end of their life had been considered. We have made a recommendation that the service consistently reviews and records people's wishes in relation to their end of life support preferences.

More activities were now available for people, although it was felt more time for staff to engage with people would be beneficial.

An Equality and Diversity Policy was in place, however people had not always been given the option to discuss their sexuality, if those chose to.

Infection control measures were in place and the home was clean with no malodours.

People had a choice and were provided food and drink appropriate for their needs.

People had access to other health professionals and a multidisciplinary team meeting was established with other organisations in order to work more effectively.

People and relatives told us and we observed interactions whereby people were treated with respect. People told us they were encouraged to be independent.

People were offered choices about their care, such as what food to eat and where they would like to spend their time. Visitors could also visit when they chose.

Complaints were recorded and responded to in line with the provider's policy.

People and relatives had more opportunities to feedback about the service and action plans were shared so relatives were kept up to date with changes.

Professionals we spoke with felt the service worked in partnership with them and the consultant and new management team regularly kept in touch with other stakeholders, such as the CQC and the local authority.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always have support from appropriately deployed staff.

Medicines were not always administered as prescribed.

People did not always have risks to their safety assessed and planned for.

Lessons had not always been learned when things had gone wrong, as action was not always taken following accidents and incidents occurring.

Staff understood their responsibilities about safeguarding and protecting people from abuse.

Infection control was in place and the home was clean and free of malodours.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always have their mental capacity assessed in line with the Mental Capacity Act 2005.

Staff training had improved but further work was required to ensure training was fully up to date.

People were supported to eat food and drink fluids appropriate for their needs.

People had access to other health professionals and the service worked with other organisations.

The home had improved in appearance but further improvements could be made to ensure it was dementia friendly.

Is the service caring?

Requires Improvement

The service was not always caring.

People sometimes had to wait for support and could become agitated or uncomfortable which meant people were not always treated with compassion.

People felt they were treated with respect.

People were offered choices and encouraged to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

If peoples' needs changed, guidance for staff was not always updated or reviewed.

Further work was required to ensure peoples' end of life choices were planned for.

Activities were being offered, although staff felt that more time would for them to engage with people would be useful.

People and their relatives felt complaints were now being resolved.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Arrangements for the quality monitoring of the service were not consistently effective.

People, relatives and staff had more opportunity to feedback.

People, relative and staff were more complimentary of the providers and management of the service.

The service worked in partnership with other organisations

Ravenswood Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 4, 5 and 6 December 2017. The inspection team consisted of two inspectors and a medicines inspector. A medicines inspector provides additional specialist knowledge during an inspection. There was also 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 inspection was to follow up on concerns and breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at the previous inspection on 31 July and 1 August 2017. As part of the inspection, we reviewed the information we held about the service, including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. We reviewed feedback from the commissioners of people's care to find out their views on the quality of the service. We reviewed information shared by the Local Authority Safeguarding Team. We used this information to help us plan our inspection.

During the inspection, we spoke with five people who lived at the service and three visitors. We also spoke with four visiting health professionals and a professional visiting to assist some staff to gain a qualification. We spoke with the consultant supporting the provider to improve the home, the manager, the deputy manager and the activities coordinator. We also spoke with four members of care staff. 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 carried out observations throughout the service to help us understand the experiences of people living at the home and to review the quality of care people received. We looked at the care records for nine people. We also looked at other records relating to the management of the service including staff files, training records, complaint logs, accident reports, audit records, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in August 2017 we rated the service as inadequate as we found that the provider had continued breaches of Regulations 12, 13 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations. This meant people were not always receiving safe care and treatment, were not always protected from potential abuse and there were not always enough staff to support people. There was also an additional breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations. This meant staff were not always recruited safely. At this inspection we found that the provider had failed to make enough improvements and remained in breach of regulations 12 and 18. However the provider was no longer in breach of regulations 13 and 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding protecting people from abuse and improper treatment and safely recruiting staff.

The amount of staff had increased since our last inspection. However we still found there were times when communal areas, which needed to be staffed due to the needs of the people using them, were not appropriately staffed and people had to wait for the support they needed. People we spoke with told us they still had to wait. One person said, "I don't think there are enough staff as it takes such a long time for things to happen." Another person said, "I think it's difficult for the staff, there are more residents and they seem to be short staffed. Sometimes I'm waiting when I'm ready to go upstairs." Other comments included, "Sometimes I have to wait for the toilet a little longer than I would like", "Sometimes I have to wait and they are very apologetic" and "Staff are busy and don't know if they are coming or going." Another person commented, "I've noticed that sometimes there is only one carer in the lounge and people can have to wait for the toilet if they need hoisting as that takes two people." A member of staff said, "I think there could be more staff maybe. Sometimes people have to wait. Lots of people need help at lunchtime." There were three separate lounge areas and three dining areas within the home. In one lounge, we observed an incident where a person was sitting down and no staff were able to see them. The person picked up a lamp and threw it onto the floor. The lamp did not hit anyone else; however there were no staff to intervene which left other people and the person at risk of injury. A member of staff entered the lounge, picked up the lamp to move it away from the person and mentioned that the person must have thrown it. The member of staff then left the lounge briefly, leaving it unattended again when a person had just been sufficiently agitated to throw a lamp, meaning there was a risk of further incidents occurring. We observed that one person had been incontinent whilst sitting in a communal area and staff had not recognised their need for support. We told a manager about this at 10:27. The person was offered the opportunity to have support with personal care at 11:08, a wait of 41 minutes. The person was at risk of their skin becoming damaged and sitting in soiled clothing could put them at risk of getting skin damage, particularly if this repeatedly occurred. This meant staff were not always able to support people in a timely manner which could put people's health and wellbeing at risk.

People were supported to move into the Mow Cop dining room for their lunch. One person was brought into the dining room and staff left, leaving the room unattended. The person became agitated and was repeatedly shouting. Staff came in and out of the dining room briefly, spoke to the person and then left again. The person began shouting again. Another person told the person to, "shut up, oh hush, there is no

one here" and went on to say, "There is no one here, you'll just have to wait." The person's care plan stated that staff should observe the person in communal areas at all times as they were at risk of falls, however staff were not always following this plan as they were left unattended. This meant there was a risk that the person may become more agitated or could fall, putting their health and wellbeing at risk.

We observed in the lounge and dining room called Annex that the communal area was also left unattended and some people had to wait for support. One person needed the toilet and staff asked the person to wait and told them that they were trying to find another member of staff to assist. An Inspector had to request the person be assisted to go to the toilet as they were visibly uncomfortable and needing the toilet. At lunch time in the Annex dining room, one person asked a member of staff at 12:50 to help another person who was asleep as, "Her food will be cold." Staff checked the sleeping person was ok and they woke up. The staff then left and the person went back to sleep. There were no staff available to encourage the person to wake and eat their food again. The person woke on their own and began eating at 13:10, a period of at least 20 minutes since their hot food had been served, which they appeared to enjoy. Their care plan stated they needed to be supervised to eat due to their needs associated with eating. This meant there was a risk that without staff support they may not always eat enough, or eat safely, which could put their health and wellbeing at risk.

There was a dependency tool in place which considered the needs of the service users, however the consultant explained to us that it was difficult to design a tool to also include the layout of the building also, due to there being three lounges and dining areas within the home. They explained that extra hours had been added on to try and take account of this. Whilst staffing numbers had increased since the last inspection, the deployment was not yet effective as people were still having to wait for support and some people were left unattended in communal areas who should not be.

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

We looked at how medicines were managed. One person told us, "Usually I get them on time but sometimes I've waited." People could not be assured that they would receive their prescribed medicines For example, we found staff initials were missing from some administration records so we were unable to establish if the medicines had been administered. We also found that the receipt of medicines was not always being recorded, the provider was not always taking into account the transfer of medicines from one medication cycle to the next and where medicines had been refused the disposal of these medicines was not being recorded.

We found some discrepancies between the quantity of medicines found and the administration records, which indicated that some people had not received their medicines correctly. For example, the records for a medicine used to treat hypokalaemia (which is a condition whereby you have low amounts of potassium in your body which can cause weakness, tiredness, nausea and vomiting) showed that 80 tablets had been received and 22 had been administered. We therefore expected to find 58 tablets remaining however we found 78. Therefore 20 tablets had not been administered according to records. We also found some people who had been prescribed inhaled medicines were not receiving the dose that had been prescribed. For example, the records showed that one inhaler containing 60 doses had been opened and the records showed that 15 doses were administered. We therefore expected to find 45 doses remaining in the inhaler however we found 50. This meant we could not be sure that people were having their medicines as prescribed which could affect their health and wellbeing.

We found the medicines refrigerator temperatures were not being measured correctly to ensure the

medicines stored would be effective. We found the provider was not measuring the maximum and minimum temperatures on a daily basis and therefore the provider was unable to demonstrate those medicines stored in the refrigerator were being stored safely. Readings taken on the day of the inspection showed the maximum refrigerator temperature was above the specified maximum temperature of eight degrees Celsius. We found that the refrigerator was storing temperature sensitive medicines called insulin. Not knowing whether the refrigerator had been maintained between two and eight degrees Celsius the provider was advised to obtain new supplies of the insulin and discard the current stock.

We found where people had to have their medicines administered by disguising them in food or drink (covertly) the provider did not have all of the necessary measures in place to ensure these medicines were administered safely. For example, we looked at the records for four people and found for three people the provider was not able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that there was no written information to tell staff how to carry out this process safely and consistently for all four people. We were concerned that one person had been prescribed a modified release medicine and there was no information about how this should be administered. Modified release medicines are designed to release the medicine into the body over several hours and should be swallowed whole and not chewed. Therefore these medicines are not normally used for people who require covert administration. We spoke with a member of staff and they confirmed they tried to administer it normally with varying success. With no written information in place we could not be sure that other staff members would not alter the formulation of the medicine to administer it covertly. This meant there was a risk of these people receiving inconsistent care which could put their health and safety at risk.

Some medicines that had been prescribed on a 'when required' basis did not have any written information to support staff on when and how these medicines should be administered. Where information was available to the staff in the form of a protocol, we found the information was not detailed enough to ensure that the medicines were given in a timely and consistent way by the staff. This meant there was a risk that people may not receive their 'as and when required' medicine when they needed it as staff did not have guidance to follow. If the 'as and when required' medicine was prescribed for pain relief, this could mean some people could be left in pain.

Risks to people's health, safety and wellbeing were not always effectively assessed and plans were not always put in place to mitigate the risks to peoples' safety. We did see some examples of plans put in place in relation to a person's refusal to be supported and staff we spoke with knew how to support the person. However, another person was noted to be 'unpredictable' with their behaviours and there was no further guidance to ensure that staff knew how to manage the person's risks. We saw the person to throw a lamp in a communal area on the first day of our inspection, which could put the person, other people, staff and visitors at risk. Another person was noted as being diabetic and they were being supported by district nurses in relation to this. However there was no guidance in place to help staff identify if the person was becoming unwell as a result of their diabetes when district nurses were not present. These can be hyperglycaemic or hypoglycaemic episodes and can cause people to become very unwell. One member of staff we spoke with said, "I don't think other staff would know how to recognise symptoms [of becoming unwell from diabetes]." Another member of staff said there was no specific guidance in the care plans. When we asked the consultant about this, they said, "A diabetes plan is being considered for [person's name]." This meant that comprehensive guidance was not always available to assist staff to ensure people's health and wellbeing was protected.

Some people had experienced falls and action had not always been taken to update their care plans and learn from incidents. For example, one person had recently fallen twice. They also fell on the morning of our

inspection. Whilst immediate action was taken to protect the person, such as calling emergency services, an update to their plan prior to their most recent fall had not taken place. Another person had also fallen, and whilst an initial update to their risk assessment had taken place, they had fallen on another two occasions and no review of their care plan had taken place, although a referral to other health professionals had been made. Sometimes the person would put themselves on the floor or slide from chairs. When we spoke to a member of staff they told us, "If [person's name] sits in a low chair they can't get out." However this level of detail was not included in the person's plan so not all staff may have been aware of it. This meant that concerns with people were not always assessed and planned for which could put people's health and wellbeing at risk.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was learning lessons from things going wrong and was starting to make improvements, however further improvements were necessary. During previous inspections we observed poor moving and handling techniques. During this inspection we found that moving and handling had improved and people we saw being moved were supported appropriately. One health professional we spoke with said, "Moving and handling has improved dramatically recently, now they have so many staff trained to deliver training to colleagues." That meant action had been taken to address this concern and people were supported safely. However, further improvements were required in other areas, such as staff deployment, medicines management and assessing and planning for risks to people, as the provider was still in breach of some regulations.

People told us they felt safe. One person told us, "I appreciate this place. I feel safe. I would be on my own otherwise." A relative responded when asked if their loved one was safe, "Yes, they are safe here." During the previous two inspections we found that people were not always protected from abuse. During this inspection we found that some improvements had been made. Referrals to the local safeguarding authority were being made when required and staff were able to tell us the appropriate action to take if they suspected someone was being abused. However, we found an unexplained bruise had been documented for one person and appropriate action had not been taken. We raised this with the management and appropriate action was then taken and the bruise was reported to the local safeguarding authority.

Infection control measures were in place to ensure people were protected. Furniture, such as beds and specialist cushions, were clean and the home had no odours. Bathrooms were also clean and clutter-free. Infection control checks were being carried out in order to check the home was following infection control guidance.

At the last inspection the service was not recruiting staff safely as appropriate references were not always sought and the provider could not be assured staff were of good character. At this inspection we found the service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in August 2017 we judged the service was inadequate as we found that the provider had a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were supported by staff without the appropriate skills and had unlawful restrictions placed on them. At this inspection we found that the provider had made improvements so they were no longer in breach of both of these regulations, however further improvements were still required. At the last inspection in August 2017 there were also additional breaches identified of Regulation 11 and Regulation 14 relating to consenting to care and treatment and meeting nutritional needs.

At this inspection we found that the provider was no longer in breach of these Regulations.

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 so that they can 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). On the previous inspection we found that DoLS applications had been made but a mental capacity assessment had not always been carried out. One person who was being given their medicines covertly had a best interest assessment recorded regarding their covert medicines which was discussed with other professionals. However it did not record the medicines that were being agreed to be given covertly. This meant that if their medicines changed, then their covert administration may not have been agreed with other health professionals as they were not being specified. We found that some people had now received mental capacity assessments when these were required, however these had not all been completed so further improvements were required to ensure people's capacity to consent to their care was assessed and reviewed appropriately. When we spoke with the consultant supporting the service, they said there was a 'next phase plan' to improve mental capacity documentation. Further improvements were required to ensure that people had their capacity assessed for specific decisions and that best interest decisions were clearly recorded.

Staff training had improved overall. One person said, "Staff know what to do." A member of staff told us, "I had an induction which was looking at things on the computer and I had questionnaires after the videos. I had shadowing for a few weeks to get to know people. The training helped me to get to know what was needed." One visiting professional said, "Staff can answer questions about people, or know where to get the information." We also spoke with a visitor supporting some staff to gain a qualification. They commented, "It has significantly improved in the last six months. The staff ask for advice." Staff's knowledge about recognising and understanding their responsibilities in relation to safeguarding had improved from previous inspections. Multiple staff had been trained to be able to train other staff in moving and handling

techniques. We saw that appropriate moving and handling techniques were being used and people were being supported effectively. However, when we asked staff about people's mental capacity and what this meant, some staff were unclear about what this was. Despite this, we observed staff supporting people to make choices. A training matrix was also in place which was tracking the training each member of staff had, which was an improvement from previous inspections. This did note some gaps in some training for some staff; we recommend staff continue to receive updated training so all training is up to date and staff understand what the MCA means for people they support.

The home has two floors, with three separate lounges and three dining rooms adjoining those lounges on the ground floor. Bedrooms were on the first floor. People were able to choose which lounge they spent their time in. There was a lift so people could access both levels of the home. One relative told us, "I noted that after the last CQC inspection all the corridors were painted but not the rooms." The home can be difficult to navigate however there were some signs on doors, such as the toilet symbol, to try and help people orientate themselves. It was observed that the table cloths and napkins in one dining room were yellow. The dessert options were often accompanied with custard, which is also yellow. A symptom of dementia can be that it is more difficult to discern between colours and objects. We observed one person trying to eat a napkin and then eating off the table cloth. Therefore having yellow table cloths may not always be suitable for some people due to their needs. The corridors were well-lit, with plain flooring and were spacious although there were some sloping areas in some corridors that some people may not be able to notice. Some corridors were decorated by outside scenes, such as a seaside theme to bring the outside in. This meant that although improvements had been made to the appearance of the home, more improvements would be beneficial to ensure it was more dementia friendly.

People and relatives told us they had access to health professionals. One person said, "I've seen the doctor very late at night." We spoke with visiting health professionals and they told us there had been a "definite improvement" and that referrals into their service were appropriate. One professional said, "The home is open to trying things out." Another health professional said, "They raise concerns appropriately and act on advice." We were also told of a multidisciplinary team (MDT) meeting held with some health professionals and staff at the home in order to have regular discussions about people's change in needs in order to monitor and take action more effectively than on our last inspection. We saw records which showed people had access to doctors, opticians, physiotherapists, Community Psychiatric Nurses (CPN) and paramedics when necessary. We also saw that the service considered people's changing needs if they had been in hospital as they reassessed people to ensure they could still meet their needs, to try and achieve effective outcomes for people. This meant the service was working across organisations to deliver effective care and support and helped people to access healthcare services.

People told us they liked the food, they told us they had choices and we saw alternatives being offered. One person said, "The food is good and well-cooked and plenty of it. I see that they cater for people on special diets." Another person said, "The choice and quality at breakfast is very good and there are two choices at lunchtime." Another person commented, "The food is fine with a good choice." A relative said, "I've heard residents being offered an alternative if they don't like the meals that are on offer." We overheard a person say, "I've just had a bacon butty, it was lovely" and this matched their care plan. We observed staff asking people what they would like for lunch, people had food that was an alternative to the menu and people were having food appropriate for their needs. If someone needed soft or pureed food, this was provided and matched guidance in the person's care plan. When we asked staff about a person's needs in relation to the consistency of fluid they were able to tell us the correct guidance.

Requires Improvement

Is the service caring?

Our findings

At the last inspection the service was judged to be inadequate. This was because the service was not always caring and people were not treated with dignity and respect. This had resulted in a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding dignity and respect.

At this inspection we found that some improvements had been made so the service was no longer in breach of regulation 10, however more improvements were required.

People had to wait for support and sometimes had to wait to go to the toilet. This left some people uncomfortable. Some people had become distressed whilst no staff were present and this caused a delay in them being reassured and supported to become less upset. One person was calling out, "Help me please" and "I don't know where I am" and staff were not always available to respond. This meant they were not receiving emotional support in a timely way and the person was left distressed with no staff comforting them. We observed one person being supported to eat, however due to other staff not being available in the dining room, the staff member had to leave to go and get a dessert for another person. Therefore the person being supported had their lunch interrupted whilst the staff member assisted someone else. This meant people were not always being treated with kindness and compassion due to a delay in receiving support.

People told us they liked the staff and said they were treated with respect. One person said, "I like them [the staff] all. [Staff member's name] is special they'll do anything for you." Another person said, "'Oh yes staff are caring and generally kind. If I wanted help I'd ask and I would get it. They're all nice. I can't fault anyone." We observed caring interactions between people and staff. Staff would make eye contact and speak directly with people. A hairdresser visited during our inspection and staff would encourage people to visit them; "Are you ready to go? Let's go and you'll have a relaxing time." This meant staff spoke to people with respect and compassion.

We saw that people were supported to make decisions about their care. One person said, "I like my breakfast and lunch in an armchair with a table and usually have my tea in my room." We overheard one carer say to people, "Are you alright do you need a drink?" People were offered choices about their food and where they would like to spend their time.

People were supported to be independent. One person said, "I select my own clothes as I like to be co-ordinated." Another person said, "'I'm able to do quite a lot for myself, it really helps." Another person said, "I'm quite mobile, I have a Zimmer in my room and a three-wheeled walker elsewhere. Sometimes I need help in the night." We observed a member of staff encourage a person to try and eat independently which they then did. This meant people were encouraged to try and maintain their independence where possible.

At the last inspection one person told us their clothing kept going missing. At this inspection we were told that the care of clothing had improved. One person said, "They look after my clothes very well." A relative told us that an issue around laundry had been improved. This meant improvements had been made.

Visitors were able to visit at a time convenient for them. One relative explained, "One of the staff members lives near me and is bringing me in to the home until I'm able to get myself here." We heard staff ask a person if their relative was coming to visit them that day. That meant visitors were supported and able to visit the home at a time of their choice.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2017 we judged the service as inadequate. This was because people's needs were not always reviewed, care was not personalised, people did not have support with activities and their complaints were not acted upon. This had resulted in a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. A breach was also identified of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, complaints. At this inspection we found the provider had made some improvements so they were no longer in breach of Regulation 9 and 16, however further improvements were required.

People did not always have their needs met as they required as staff did not follow peoples care plans. One visiting health professional we spoke with said, "Plans are getting better but they are a work in progress." People had plans of care in place however these had not always been updated following a change to their needs. For example, one person had their falls risk assessment reviewed on a monthly basis up to September 2017. They experienced a fall in October 2017 and their plan had not been reviewed or updated to reflect they had experienced a fall. This meant no additional guidance had been provided to reduce the risk of another fall occurring. Another person's plan stated they were unable to weight-bear and required hoisting, however we observed this person standing with a frame. This meant the person's plans had not been updated following a change in their ability. There was a risk that the person may not receive consistent care. The same person's plan stated they should be supervised in communal areas at all times. There were multiple occasions where staff left this person unsupervised in communal areas. This showed staff had not followed the guidance in place to manage the person's behaviours which meant the person and potentially other people were left at the risk of harm. This meant people were at risk of receiving inconsistent care as plans and guidance for staff had not always been updated following a change in need.

At the time of our inspection, no one living in the home was receiving support due to them being near the end of their life. However, we saw noted in some people's care plan that this would be discussed with people and their families when the time came. It also recorded whether someone had a Do Not Attempt Resuscitation (DNAR) form in place. We saw an example of one person's wishes when they were near the end of their life, such as their religious preferences. However, we also saw examples of a blank end of life care plan. This meant the service had not consistently given people the opportunity to discuss their wishes, if they chose to. We recommend the service consistently reviews and records people's wishes in relation to their end of life support preferences.

People told us they were supported how they liked to be. One person said, "I get just what I want. I get up at the time I want and I sit where it suits me and have my meals how and where I want." Another person said, "'I've been given a choice of male or female carer to help me shower. They work with me so I can get up early and be ready and have a cup of tea in my room and go down for breakfast later." Another comment was, "The staff always help me with my socks, they know I struggle." We saw that people's preferences were recorded in people's care plans, such as when they liked to go to bed and whether they preferred a bath or a shower. We also saw people being supported in ways that matched their care plan, such as the time they chose to go back to their room. People and relatives also told us they were aware of their care plans. One

person said, "Yes I know about my care plan and I've seen it and it is fine." A relative said, "I'm aware of it [care plan] and they keep me up to date." Another relative said, "I leave it to the professionals but they talk to me." People's communication needs were also taken into consideration as people had communication plans and were supported to access services that supported their communication such as opticians and hearing aid services. This meant people were supported involved in the plan of care and were supported to maintain communication.

People were supported to partake in activities, however there was not always enough time available. One member of staff said in relation to activities, "I don't have enough time, I need more time." Despite the lack of time people told us they enjoyed the activities. One person said, "I like to play when there is bingo or cards on. The lady who does activities is good and she really listens to you." Another person said, "The singers we have are good so I support that and we regularly have school choirs in." We observed a member of staff support a person to look at personal photos and the member of staff commented, "There you go, that's better for you." We spoke with the activities coordinator who told us they found it important to 'maintain individuality' for people. They also told us of events that had taken place, such as a food tasting event with a local supermarket and a trip with a minibus was going to be organised. They went on to say, "I love seeing peoples' face light up, it makes the job worthwhile." Another member of staff also said, "I feel I know people well. For example [person's name]. We get on well and have been on trips out for meals and to play snooker." We saw that peoples' hobbies and preferences were recorded in their care plans, such as doing quizzes and attending church services. We observed people carry on with their own hobbies, after staff fetched the necessary items for them and a member of staff supporting a person to do a word search. On one day of our inspection a church service was held and people were invited to attend. We also saw that people's religious preferences were recorded in their care plans. This meant people were supported to partake in activities of their choice and partake in worship, should they choose to.

People and relatives told us there was an improvement to complaints being responded to. One person said, "The owner is here every day so I would be able to talk to her." One relative said, "If I had any issues I would speak to the owners or the staff." Another relative said, "I noticed that some of my relative's clothing had gone missing. I resolved this by going and speaking with the laundry staff." A member of staff we spoke with said, "Relatives are always able to approach me and any complaints are sent to the manager." Another member of staff also confirmed they would pass on a complaint to the manager. We saw that if a written complaint had been received it had been responded to appropriately and in a timely way. We also saw there was an appropriate complaints policy in place. This meant the provider had made improvements and complaints were now listened to and responded to, to improve people's experience of care.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection the provider was in continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they had continued breaches in the regulations and we found the quality and safety of care in the home had deteriorated further. At this inspection we found that some improvement shad been made however they were still in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to governance.

New systems had been put in place to monitor the service and check the quality of care. Whilst some of these had been effective, others had not. For example, nutritional audits were being carried out on a regular basis to ensure the correct food and guidance was available for staff. We found this had been effective as we observed people being given food suitable for their needs and they had started to gain weight.

Medicine audits were being undertaken, however these were not effective. On the day prior to our inspection the deputy manager had identified some stock discrepancies, which our medicines inspector also found. Action had not yet been taken due to the concerns having only just been found. However other medicines audits prior to this had not identified concerns, such as out of date stock, the incorrect storage and monitoring of chilled medicine and the gaps in recording by staff. The audits viewed were not clear as to what had been looked at as part of the review, such as whether it was a single person reviewed, a particular period of time or everything in the home. This meant that the audits were not effective as concerns we found had not all been previously identified and action had not been taken. An audit had taken place at the end of September 2017 which identified more work was required in relation to gaps in the recording of the administration of topical medicine on documents called Topical Medicine Administration Records (TMARs). During previous inspections we found that TMARs were not always in place or there were gaps in recording so we could not be sure people were having their topical medicine as prescribed. TMARs were in place at this inspection, which was an improvement; however we found there were still multiple gaps on TMARs, which meant further improvements were still required. This left people at risk of not receiving their medicines as prescribed which could be detrimental to their health and wellbeing.

There was an accident and incident folder which documented incidents such as falls or if a person became agitated. We found a body map in this folder and staff had recorded an unexplained bruise on a person. There was no further documentation, action had not been taken to investigate the concern and it had not been reported to the local safeguarding authority. This meant appropriate and timely action had not been taken by management to protect the person. The body map detailing the bruising was completed in November 2017. Incidents were analysed on a monthly basis and November's had not yet been analysed. However, incidents regarding potential safeguarding of vulnerable people cannot wait until the end of a month to be identified, acted upon and reported. This meant effective systems were not in place to ensure concerns were identified and acted upon in a timely manner. Once this was raised to the consultant, appropriate action was then taken and the concern was reported.

It was not clear that action had always been taken following accidents or incidents to reduce the likelihood of them reoccurring. Accidents and incidents were audited on a monthly basis, which looked at trends such

as the time of days incidents or accidents were occurring, if it was a particular person or any particular types of incidents. The analysis of incidents was not always effective as some incidents had not been transferred to the incident folder which was the information analysed. For instance, one person had fallen which was noted within their file, however there was no corresponding accident form. This meant the manager or consultant did not have the full information to enable them to effectively monitor the service. Another person had been placing themselves on the floor or sliding from chairs and this behaviour was not being analysed to reduce the likelihood of it reoccurring. Audits that had been carried out had not identified that action had not always been taken to reduce the likelihood of an incident reoccurring and plans had not always been updated. For example, some people experiencing falls and no updates being made to people's care plans or risk assessments. One person had experienced falls, their risk assessment had been updated with the detail of these, however the person had experienced more falls and this had not prompted a review of their risk assessment. When we asked the consultant about this, they said, "I accept that." This meant further improvements were required to ensure comprehensive monitoring was taking place to ensure people's health and wellbeing was being protected and that the systems in place were effective.

One person had behaviour that challenged; their care plan stated staff should record incidents of aggression or agitation on a specific chart, called an ABC chart, in order to try to monitor the incidents. This helps to identify specific triggers which could cause the person to become agitated. We saw that these charts had not been consistently used and episodes of agitation or aggression were recorded in the person's care notes, but they did not always contain the same level of detail which would be prompted on an ABC chart. We could not see that these care notes had been audited, despite multiple incidents being noted within them that were not included in the incident file. Therefore there was a lack of effective monitoring of the person's behaviours. This meant the person's agitation was at risk of continuing as effective monitoring was not in place.

Other documentation was also unavailable so we could not be sure it had been completed. We saw completed repositioning records for one person, however another person's had multiple days missing. This meant we could not be sure that staff were maintaining an accurate record of when they were supporting this person to move, in order to help keep their skin healthy. The person did not have any skin damage at the time of our inspection, but they were at risk of developing skin damage. This meant the provider would not be able to evidence that the correct level of support was being offered without accurate documentation, should the person have developed skin damage.

The provider did not have effective systems in place to ensure staff were deployed appropriately as we were told and we observed that some people had to wait for support and felt there were not always enough staff. This meant people were at risk of receiving inconsistent care or a delay in support.

There was an Equality Policy in place which took account of the protected characteristics, such as gender, religion, race and sexuality. We also saw some examples of people who were supported with their religious needs. However, the service did not consistently collect or utilise information relating to people's sexuality. When we discussed this with the consultant, they explained, "The age group of the people here are not as open about it [sexuality]. If a person offered the information I would happily discuss it." This meant the service could not always be sure they were effectively supporting people with maintaining same-sex relationships or ensuring people could be open regarding their sexuality, if they chose to, as opportunities to discuss this particular area of a person's life were not always offered.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

There was no registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a manager however they had not yet registered with the commission. There was also an external consultant supporting the home in order to make improvements. We found the consultant was notifying us of certain events such as incidents and deaths appropriately. The current rating was on display.

People and relatives were complimentary about the provider. One person said, "The owner's wife is here a lot and she always speaks and is kind in her manner." A relative said, "The owners are very pleasant and they know everyone." We observed one of the providers say hello to a person and the person responded to her, "Oh I missed you this weekend." They then went on to say to us, "She is lovely. Any problems she's always there, and always knows what to do."

Staff also felt more positively about the management of the service. One staff member commented, "Since the consultant has started it's been brilliant. The morale is through the roof." They also went on to comment about the providers, "They are a lot more involved now. It's good to see them involved and they're getting to know people." The deputy manager commented, "We can ask the providers for things and they are receptive and fine with any changes." A visiting professional who was supporting some staff to gain a qualification commented, "Staff are pulling together more now."

People and relatives were encouraged to provide feedback. One person said, "I have noticed lately that there is more discussion with the owners and more effort is being made. There is time for residents to talk and feel more wanted." One relative said, "We've been to a few relatives meetings where they have introduced new staff and got minutes from the meetings." A comments book was in place where relatives could leave notes. We also saw notes from relative's meetings held and a copy of the action plan the home was working on was supplied to relatives. There had also been recent staff meetings providing staff with updates about management and staffing arrangements. Staff were also encouraged to complete their online training. Discussions had also included the previous CQC inspection, how documentation was being completed and how it needed to improve. This meant the provider was becoming more proactive in their communications with people, relatives and staff in order to be transparent and gain feedback.

Visiting health professionals we spoke with felt the service worked in partnership. We were told of regular Multidisciplinary Team meetings that were held to ensure people were supported effectively. The home had also been providing regular updates to the local authority and CQC in relation to actions they were taking to try and improve the service.