Sanctuary Care Limited

Hawthorn Green Residential and Nursing 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We conducted an inspection of Hawthorne Green on 17 and 18 December 2018. The first day of the inspection was unannounced. We told the provider we would be returning on the second day.

At the last inspection on 30 and 31 October and 1 November 2017, we found breaches of regulations relating to the provision of safe care and treatment, maintaining good staffing levels and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve. The provider sent us their action plan detailing their planned actions to improve the service. At this inspection we found improvements had not been made in relation to the provision of safe care and treatment or good governance. We found improvements had been made in ensuring safe staffing levels. This is the sixth time the service has been rated Requires Improvement.

Hawthorne Green is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hawthorne Green provides care and support for up to 90 people who require nursing and personal care. There were 71 people using the service when we visited. There are three floors within the building and each floor consisted of two units. Four of the home's units are for people who have nursing needs and two of the units are for people with residential care needs, some of whom have early onset dementia.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been registered with the CQC for one day at the time of our inspection and had been managing the service for approximately one month.

Medicines were not always managed safely. We found one team leader was administering medicines without having the training to do so safely. We found medicines care plans were not always up to date.

The provider did not consistently assess and mitigate risks to people's safety. We identified some examples of people without clear, written risk management guidelines in place for care staff.

There were enough suitably trained staff scheduled to work during our inspection. The provider conducted safer recruitment practices through appropriate pre-employment checks. However, we found that they did not renew their criminal record checks every three years after appointment as per best practice.

Both permanent and agency staff received an effective induction to the service. Care staff received supervisions and appraisals of their performance, however, we found these were not conducted regularly as some people had not received a supervision in the nine months prior to our inspection.

Care records contained insufficient information about people's mental health needs and care staff had limited understanding about how to support people with these. People received appropriate support with their physical healthcare needs and care staff assisted them to access external healthcare professionals when needed.

People told us care staff were caring but we observed varying levels of kindness and attentiveness towards people using the service. Care staff had a good understanding of people's preferences in relation to how they wanted their care delivered. People told us care staff respected their privacy
People told us they felt safe within the home and the provider had an appropriate safeguarding policy and procedure in place which care staff were aware of. However, we found safeguarding investigations were not conducted in a timely way to manage potential risks to people's safety.

The building was clean and tidy at the time of our inspection and care staff practised good infection control practices. There was a dedicated sluice on each unit for the hygienic removal of disposables such as incontinence pads.

People were supported with their nutritional needs. Care records contained sufficient information about people's needs and included their likes and dislikes in relation to food. Kitchen staff were aware of people's needs and people gave good feedback about the food provided.

People using the service and their relatives were involved in decisions about their care and how their needs were met.

Care staff had a good understanding of their responsibilities under the Mental Capacity Act 2005. Mental capacity assessments were completed when needed and we saw these in people's care files. The provider made applications to the local authority for authorisation where it needed to restrict someone's liberty for their safety.

People told us they knew how to make complaints and there was a complaints policy and procedure in place.

The provider operated a varied activities programme which included a range of activities both inside and outside the home and people told us they enjoyed these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. The provider did not always manage people's medicines safely.

Appropriate risk management plans were not always in place to mitigate known risks.

The provider recorded, but did not always conduct timely investigations into safeguarding incidents and accidents that occurred. The provider had an appropriate safeguarding policy and procedure in place which care staff were aware of.

There were enough suitably trained staff working at the service.

The provider operated safer recruitment procedures by carrying out appropriate pre-employment checks of candidates. However, DBS checks were not always repeated every three years to ensure that staff were still safe to work with people.

Good infection control practises were maintained throughout the home and the environment was clean and tidy.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's care records included a good level of detail about physical healthcare needs, but we found there was limited information about people's mental health needs. People were given adequate nutrition in accordance with their needs.

Care staff received appropriate training to conduct their roles and told us they felt well supported. However, records indicated that care staff had experienced a delay in receiving supervisions.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff understood their responsibilities to ensure that people were only provided with care in accordance with their valid consent and people were deprived of their liberty for their safety in accordance with legal requirements.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed some examples of inattentive behaviour towards people using the service.

Care staff had a good understanding of the people they were supporting and were mindful of their privacy and dignity.

Care staff supported people to be as independent as they wanted to be.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider did not effectively audit different aspects of the service.

The provider had a new management team in post who were committed to securing improvements within the service. We found they were open about the challenges they faced and had a realistic plan to secure improvements.

Care staff told us they were well supported by the management team and were positive about the improvements being sought.

The provider sought feedback from people using the service, but participation rates in surveys were low.

submitted notifications of significant events to the Care Quality Commission as required.

Hawthorn Green Residential and Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 17 and 18 December 2018. The inspection team consisted of two inspectors, a specialist advisor and a pharmacy inspector. The first day of our inspection was unannounced, but we told the provider we would be returning for the second day.

Prior to the inspection we reviewed the information we held about the service. We spoke with the service GP and communicated with a representative from the local authority to obtain their feedback.

During the inspection we spoke with 13 people using the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with 10 care workers, one team leader, three nurses, the clinical lead, two activities coordinators, the deputy chef, the registered manager of the service and regional manager for the provider. We looked at a sample of 11 people's care records, ten staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Our conversations with people did not identify any safety concerns. People told us they felt safe with the care workers. Their comments included "The staff keep me safe" and "They [care workers] take care of us all."

However, despite these positive comments, we found aspects of the service were not safe. At our previous inspection we identified concerns in relation to risk assessments relating to people with diabetes and pressure area needs. At this inspection we found the provider did not always conduct appropriate risk assessments and have effective, written risk management guidelines in place. We found people's care records usually contained risk assessments in relation to different areas of their care needs including their risk of falling, malnutrition or developing a pressure sore. The assessments identified whether the person was at risk and usually included written risk management guidelines either in the body of the assessment or within an associated care plan. However, in relation to people's diabetes care plans we found that whilst some care plans included sufficient information for care workers to mitigate the risk of the person suffering hypo or hyperglycaemia, some did not. We identified two examples of care plans that did not contain this information. In addition, we identified one example of a person with diabetes without having sufficient guidance within their record about how to control this through dietary means and there was no record about the signs and symptoms of hypo or hyperglycaemia.

We identified some further examples where there was insufficient recorded information for care workers to mitigate risk. For example, we saw one risk assessment in relation to one person's risk of going outside alone. The assessment identified that the person was not safe to go outside alone and they had a history of leaving their previous place of residence by themselves despite being legally restricted from doing so for their safety. However, there was no subsequent guidance for staff in how to ensure that the person was safe and did not go outside unaccompanied. We saw another person's care record included inconsistent information about their risk of falling. We saw their risk assessments which had been reviewed monthly since stated that they were not at risk of falling. However, their plan of care stated that they were at risk of falling. When we spoke with the nurse on this unit they agreed that the person was at risk of falling and that one safety measure which was a crash mat had been removed at the person's request. They agreed that the person's risk assessments and care plan needed to be updated to reflect this information as the absence of the crash mat could potentially increase their risk of sustaining an injury from falling.

At our previous inspection we found that people who required assistance to turn in bed in order to relieve the symptoms of a pressure sore, did not have this assistance recorded consistently to evidence when and how frequently they were being turned. At this inspection we still found that records were inconsistent in detailing when people were assisted to turn in bed. For example, we saw the record for one person stated that they were required to be repositioned in bed with a sliding sheet, however, there were no recording charts in place for care staff to note when and how often they were doing this.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although turning charts were not consistently completed, we found care plans and risk assessments for people at risk of pressure ulcers were robust. We found that people had appropriate risk assessments conducted in relation to this risk. Where people already had a pressure ulcer, we saw this was recorded on a body map and there was evidence of advice from either a district nurse or a Tissue Viability Nurse (TVN). Where people had not developed a pressure sore, we saw that their records included a risk assessment which identified the level of risk as well as written risk management guidelines detailing how care staff were required to mitigate this. For example, we saw one person's care record stated that they required their pressure area to be moisturised with a specific cream on a daily basis, that they used a pressure relieving mattress and care staff were required to monitor the person's skin when providing the person with personal care.

Care workers had a good understanding of the risks involved in people's care and knew how to respond in the event of an emergency. Care workers told us they had received training in first aid and explained the main risks involved in caring for people in each unit. One care worker told us the main risk to people in the unit they worked in was the risk of falling. They gave us examples of how they mitigated the risk of people falling and said "If people are in bed we will put the bed at its lowest setting and a crash mat underneath it… Some people have bed rails in place and an assessment is carried out for this." Another care worker told us they thought the main risk to people in the unit they were situated in was the risk of developing a pressure sore. They told us "Sometimes people's skin can look bruised, but it could be a reaction to their meds, we report this anyway." We found all care workers we spoke with demonstrated a good knowledge of how to provide people with pressure area care and gave us examples of the types of actions they were required to take to manage the risk of skin breakdown. They also demonstrated a good understanding of fire emergency procedures and knew how to respond in the event of a fire. We saw people's records contained personal emergency evacuation plans (PEEPs). A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. These documents were detailed and showed the number of staff and type of equipment required for the safe evacuation of each person.

Prior to inspection we received a concern that people were at risk of leaving the building when they were not safe to do so due to insecure building security on some of the units. We checked the entrances and exits to the units and found that these were protected by a PIN code entry. We spoke with care workers about the entry numbers and they confirmed that the codes had recently been changed and people whose movement was legally restricted for their own safety were not aware of these.

Records of safeguarding incidents demonstrated that appropriate investigations were not always conducted in a timely manner when concerns were raised. We saw written records of safeguarding concerns that had been raised in June 2018 and in the months since then, with no completed investigation or written outcome recorded. For example, we saw one concern that related to a person sustaining a bruise to their face and leg. We did not see a record of how this was likely to have happened or what action or further learning had been taken to prevent a repetition of this. We therefore, could not be assured that appropriate learning had been disseminated to staff in relation to this incident. We saw another example of a safeguarding concern regarding a pressure ulcer that had been sustained by another person. Again, there were no recorded details about how this incident occurred and how this could be prevented in the future. We spoke with the registered manager and she agreed that it was unlikely that care staff had learned from all safeguarding incidents as they were not aware of the results of safeguarding investigations.

The above issues constitute a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding policy and procedure which stipulated the process that was supposed to be followed in the event of a safeguarding concern and care workers were aware of this. The provider had an appropriate safeguarding policy and procedure in place. Care staff had a good understanding about the process they were supposed to follow if they suspected someone was being abused. Care staff referred to the organisation's whistleblowing procedure. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. One care worker told us "I would report any concerns that I have. If there is nothing done about it I would tell the manager. I have never had any concerns here." We looked at records of safeguarding incidents and found they were reported to the local authority as required.

Prior to our inspection we received notification of two incidents that involved people not receiving their medicines as prescribed. We discussed the incidents with the registered manager and other staff members and found the provider had plans in place to ensure these incidents did not reoccur. We were told that the reason the incidents took place was due to poor scheduling of staff who were not available to administer people's medicines. However, after our inspection we were notified that a similar incident had reoccurred where 10 people were not administered one dose of their medicines. We discussed the incident with the provider and were told that this occurred due to the error of one member of staff who did not escalate the need for an alternative staff member to be scheduled to work at the service on a night shift. The provider has produced plans to ensure that such incidents do not reoccur and the member of staff involved has been given further training as a result.

At this inspection we found that people's medicines were not always managed safely. Registered nurses and trained team leaders usually administered medicines to people. However, we identified one team leader who was administering medicines to people and had not completed their medicines training and competency assessment.

Staff signed medicines administration record (MAR) charts to provide assurance that medicines were given to people as prescribed. However, there were some discrepancies on the MAR charts we saw. For example, we saw one MAR chart which stated that Lactulose solution was to be used for one person when their Senna tablets were not available. However, this person was receiving both Lactulose and Senna. Staff told us they had not updated the MAR charts accordingly. In another example, a person was having a dissolvable tablet which should have been given in 200mls of water. However, some staff were dissolving the tablet in a smaller volume of water to aid the person's compliance in taking this. They had not confirmed with a GP or pharmacist that it was safe for them to do this.

We saw people's care plans were not always up to date. For example, one person's care plan stated, 'check blood sugars monthly', but staff were not doing this. Staff told us the person's care plan was outdated and needed to be reviewed. They assured us they would do so as soon as possible.

The provider stored medicines (including controlled drugs) securely at this service. We found that only relevant and authorised members of staff could access them. Ambient temperatures of clinical treatment rooms where medicines were stored were monitored daily and found to be satisfactory. However, whilst staff monitored fridge temperatures every day, we were not assured that the readings were accurate. This was because there was a discrepancy between the records we viewed and the fridge temperatures we saw when we checked the fridges, during this inspection. We advised staff to seek training in this area to ensure medicines were stored at the correct temperatures.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The provider managed controlled drugs (CDs) appropriately. When required, staff disposed of CDs correctly and made records of this activity. Other unwanted medicines were returned to the pharmacy each month. We saw accurate records were kept of medicines that had been disposed of.
MAR charts were used to keep records of medicines given to people. MAR charts included a photograph of each person to aid staff with identification. This was useful as some people were living with dementia and unable to communicate. Staff also had access to known allergy information on the MAR charts as well as people's preferences regarding the administration of their medicines. Staff conducted daily stock checks to ensure that all medicines were given as prescribed, and to ensure medicines were available. We found that medicines were available to give to people.
Staff communicated well with other health professionals to keep people safe. Staff were proactive in raising issues with medicines via the appropriate channels.

We saw that covert administration of medicine was managed appropriately and in line with best practice. Legal authorisation and advice had been obtained from a GP and Pharmacist as required and we saw records of these.

Staff completed medicines incident forms if any errors were highlighted. These forms were dealt with by the Registered Manager who investigated all medicines incidents. Any learning from medicines incidents was discussed with all team members. The provider had systems to ensure that staff received medicines related alerts and we saw that staff completed medicines audits to highlight areas for improvement in medicines management.

We observed that people cared for in bed had call bells within reach. People told us that when they used their bell, care staff responded to these. One person told us "I pressed the bell once and someone came."

Prior to our inspection we received a concern that there were not enough staff available to meet people's needs. At this inspection, care workers gave mixed feedback about whether they felt there were enough care staff on duty. Care workers comments included "In an emergency, when someone calls in sick, things are harder" and another care worker told us "I think there are enough staff scheduled to work." From our observations, review of staff rotas and conversations with care staff, we found the provider was now meeting their obligation to ensure sufficient numbers of staff were on duty to assist people.

We spoke with the registered manager about staffing levels. She explained that people's dependency needs were assessed upon admission. This assessment determined the level of support the person required with their care needs, including whether people needed the assistance of two people with personal care or moving around. The registered manager had used this information as well as her own observations to determine the appropriate number of staff required to provide care for people. The registered manager agreed that prior to our inspection there were not enough staff and explained that those numbers had been increased immediately since she joined and have been maintained since. From our observations we found there were enough staff to assist people. Care staff did not seem rushed and they responded promptly to people's specific requests.

We reviewed the staffing rota for the week of our inspection. We found an appropriate number of care staff had been scheduled to work and this reflected our observations during the inspection.

The provider conducted safer recruitment practices as senior staff carried out appropriate pre- employment checks of candidates. We reviewed the staff files of 10 care staff. We saw these included evidence of criminal

record checks, at least two references (one from the person's previous employer) application forms which detailed people's previous employment history as well photographic identification and people's right to work in the UK. Records for nurses also included their Nursing and Midwifery Council registration details. However, we found some criminal record checks were not repeated in line with best practice, after a period of three years to ensure that staff remained safe to work with people. We spoke with the registered manager and other senior staff members about this and they explained that they were seeking further advice about this and were in the process of reviewing their current process.

The provider followed good infection control practices. Each unit had a dedicated sluice, which contained wash facilities for bedpans as well as space for cleaning equipment. Domestic staff were seen at work during the inspection, and all areas were found to be clean and tidy. Care staff told us they were provided with sufficient personal protective equipment (PPE) such as gloves and aprons for use when providing personal care and had received training in infection control procedures. We saw staff used these when caring for people and saw staff washing their hands and using hand sanitisers which were in place at the entrances to the units. Records also indicated that staff had received appropriate training within the last year.

Care staff gave us good examples of how they incorporated good infection control practices into their daily routines when at work. One care worker told us "You've got to wash your hands thoroughly and regularly". Another care worker said "We wear PPE and change our gloves."

Requires Improvement

Is the service effective?

Our findings

People's care records included sufficient detail about people's physical healthcare needs, but there was insufficient information relating to their mental health needs. We saw examples of people with significant psychiatric histories whose records contained insufficient information about what treatment they had received and what conditions they still had. For example, we saw one person's care record stated that they had a history of aggressive behaviour and had previously been sectioned under the Mental Health Act, but there was no further information about this. We saw from looking at the accident and incident records that they had been involved in two incidents where they had displayed sexually disinhibited behaviour towards two different people using the service, but their care record did not include this information. There were no written details about the triggers for this behaviour or how care staff could act in order to minimise the risk of this reoccurring. We spoke with one care worker and the team leader of the unit this person was staying in. Both staff members were aware of this person's mental health history as well as the incidents that had occurred. The team leader stated there was no written record of this person's history as the person was now settled into the unit and there had been no repeat of the incidents. However, we found there was not enough recorded information for care staff who were less familiar with this person, including agency staff who were employed at the service.

We saw the care record of another person who had been involved in a number of safeguarding incidents that had occurred. Actions had been taken to stabilise this person's stay at the service and this included providing the person with a one- to- one care worker and to ensure that they spoke in the language as the person. This appeared to have a calming and stabilising effect on the person as they had not been involved in any further incidents since these measures had been implemented. However, we saw in their medical notes that they had a previous psychiatric history of hospital admissions, but there was no information about this in their care record and the nurse in charge of the unit could find no further information relating to this. We spoke with the person's one- to- one care worker and they told us they suspected the person had depression as their temper and mood was variable, but they could not be sure about this. We therefore could not be assured that this person was being assisted by care workers with all the information necessary to appropriately manage their mental health needs.

Another person's care record stated that they had schizophrenia. However, there very limited information for how this condition manifested within their record. The record stated that the person could become agitated and when this occurred it was advised that the person was left alone to calm down. We heard and observed this person to be distressed at various points throughout our inspection, with limited staff intervention. When we spoke with the person they became visibly distressed at different points in the conversation, but became much calmer at other points. We spoke with the team leader in the unit who was an agency staff member and told us they were not yet completely familiar with the people using the service. They confirmed that they had heard this person talking to themselves and they therefore suspected that the person had visual hallucinations, but could not be sure of this. We therefore could not be assured that this person was receiving care by staff who had all the information necessary to appropriately manage their mental health needs.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a general practitioner who visited the home on a weekly basis. They spoke positively about the relationship between their local GP surgery and the care staff and praised the skills of staff at the home. The GP also stated that the provider was involved in multi-disciplinary team discussions to ensure care was provided appropriately. Care staff had a good level of knowledge about people's physical healthcare needs. Care workers we spoke with gave good descriptions of the healthcare needs of different people using the service.

At our previous inspection we identified concerns in relation to staff supervisions as we found not all staff had received timely supervisions. At this inspection, whilst we found care staff were receiving supervisions, this was not conducted in a timely manner as some staff had not received their supervisions for some time. We checked the supervision records for 10 care staff and found that nine of these had not received a supervision session since May 2018. We spoke with the registered manager about this and they confirmed that it was their policy to conduct supervisions every two months, but agreed that at the time of the inspection, they were not being conducted in a timely manner. Care staff told us that they had received regular supervision sessions and felt they were being supported to do their jobs. One care worker told us "We get supervisions… we are supported" and another care worker stated "We get supervisions every three months.. they are useful."

Few care staff had received an annual appraisal. Records indicated that few care workers had received this. We reviewed the provider's supervision and appraisal matrix and this indicated that approximately one third of care staff had received an appraisal within the last year. We saw a sample of care workers' supervision booklets and these contained details of appraisals conducted. Out of the 10 records we viewed, we found one care worker had received an appraisal.

The above issues constitutes a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we identified some concerns in relation to staff training as records showed that compliance rates for some staff training was low. At this inspection we found that compliance rates for staff training had improved and the overall compliance rate of care staff with training was 72%. We spoke with the registered manager and they told us they were continuing to ensure that care staff completed all training as required and they were working to improve this percentage. Care staff told us they received a wide range of training which was refreshed every year. One staff member said "We do get a lot of training. A lot of it is e-learning, but some of it like moving and handling is face to face". Records indicated that some training modules were conducted face to face such as moving and handling training which involved the usage of equipment.

People were supported to eat and drink a balanced diet in accordance with their needs. We saw people's care records included details of their nutritional needs including whether they had any allergies, as well as their likes and dislikes in relation to food. The provider also conducted a risk assessment on a monthly basis through using a Malnutrition Universal Screening Tool (MUST). The MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. Where people had been identified as at risk of malnutrition, we saw they were referred to the dietitian for advice and this was incorporated into their care record. For example, we saw one person's record whose risk assessment had identified they were at risk of malnutrition. As a result, they had been referred to the dietitian and they had advised the person take dietary supplements as well as have their food cut up for them. This advice was incorporated into their care

plan and staff were aware of this.

Kitchen staff were also aware of people's nutritional needs. We visited the kitchen and spoke with the deputy chef on the second day of our inspection. They were able to tell us personalised details about people's likes and dislikes as well as whether people had any particular nutritional needs. We saw these were displayed on a white board within the kitchen area, so there was a record available for newer staff. We were shown that the provider had a four- weekly menu which was rotated and the deputy chef confirmed that people could choose options that were not on the menu if they chose.
People told us they liked the food at the service. Their comments included "The food is nice", "I like the food, but sometimes I ask for something different and they'll get this for me." We sampled the food on the first day of our inspection and found the food to be appetising, of a good portion and served at the right temperature.

Care staff provided people with care in accordance with their valid consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care staff understood the requirements of the DoLS and documents demonstrated that the appropriate procedures had been followed. Where people were deprived of their liberty for safety reasons, we found authorisations had been provided by the local authority or applications were pending. People's records also showed that mental capacity assessments were conducted appropriately and included the involvement of the person's next of kin or advocate, as well as their doctor or healthcare professional.

We saw there was restricted entry and exit to and from all the units, via use of keypad codes. The codes were displayed by the entrance to each unit, albeit hidden in a picture which was displayed on the wall. Care staff explained that people were reminded of these codes provided their movement was not restricted by a DoLS authorisation.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care staff and told us they were kind and caring. People's comments included "They are polite and helpful" and "Staff are very nice."

However, despite these positive comments we observed varying levels of attentiveness being shown to people using the service during our inspection. Whist most of our observations were positive, we saw examples of care staff not acknowledging some people who were visibly distressed, we saw some examples of care staff speaking loudly to one another over people using the service and we overheard two examples of one care worker speaking to two different people in a stern manner when asking them to do something. However, we also saw some examples of very caring interactions between care staff and people using the service and their relatives. For example, we saw one relative was visibly distressed by how their family member spoke with them. We observed the care worker kindly approach them and explain the symptoms of their dementia and how this was affecting their behaviour. We saw this interaction appeared to comfort the person's relative. We saw numerous other examples of care staff laughing and joking with people, approaching them to offer hot drinks or to check how they were feeling.

When we spoke with care staff, they demonstrated a good understanding of the people they were caring for. We saw people's care plans included a good level of detail about people's personal histories before they came to use the service. These records included information about people's early childhoods, how many siblings they had, where they were born and what their parents occupations were. They included details of the person's life as a young adult and throughout their middle age including whether they had any children or had married as well as their different occupations and other interests throughout their life. There was also information about places people had visited and other events that had been important to them. For example, we saw one person's record stated the holidays they had taken with their children had been important to them and there was detail about the different places they had visited with their children.

At our previous inspection we identified some concerns in relation to people's dignity not being maintained as we saw that some people had not received appropriate personal care in accordance with their needs. At this inspection we found people maintained a dignified appearance and care staff were seen to approach people to offer assistance in this area. For example, we saw one person was wearing their dressing gown outside their room. One care worker approached them and quietly asked if they would like some help in getting dressed. We heard the person declining this assistance and the care worker asked the person to let them know if they changed their mind. We saw another person's trousers were creased near their waist. We saw another care worker offering to assist the person with their trousers and the person agreed to this assistance and thanked them for this.

People were supported to be as independent as they wanted to be. Care records included details of what support people required from their care workers as well as details about their individual dependency needs. For example, we saw people's nutritional care plans stated whether people required their food to be cut for them and their personal care records stated whether they required the assistance of one or two people. Care workers gave us examples of how they encouraged people to be as independent as they could be. One care

worker told us "We try to involve people in things as much as possible… for example if they can do some of their personal care we encourage them to do this." We observed care workers encouraging people to walk independently and providing them with guidance whilst doing so.

People told us they were treated with respect. People's comments included "they're polite. They respect me" and another person said "They knock on the door and they [care staff] respect us." We observed care staff knocking on people's doors before they entered their rooms. Care staff also gave us examples of how they maintained people's dignity particularly when providing people with their personal care. One care worker told us "We make sure the door is closed and the curtains are shut." We saw people's care records contained details of whether they wanted a male or female care worker to assist them in their personal care and daily records of the care provided indicated that people's wishes were being adhered to.

Care records included some details about people's cultural and religious requirements. This included whether they attended a religious service or whether they had any particular requirements which emanated from their religion. For example, we saw one person's care record stipulated that they were a Muslim and as a result required Halal meat to be provided. Another person conducted their prayers whilst in bed and their care worker had a good understanding of their routine and the importance of their religion within their life.

Good

Is the service responsive?

Our findings

People told us they were involved in the assessment of their care needs. Whilst most people we spoke with did not have a clear understanding of their care plan documentation, they agreed that they were provided with care in accordance with their wishes. One person told us "They asked me questions and I think they've written things down somewhere" and another person said "They do what I ask them to- I get what I want."

Care records included details about different aspects of people's care needs. Whilst we saw limited information about people's mental health needs, we saw information about people physical healthcare needs, any known risks and their social and recreational interests. We saw people's care records were personalised and contained specific information in relation to how the person wanted their care delivered. For example, we saw details about how people wanted their personal care to be delivered including whether they liked to have a bath or a shower and how frequently they wanted this to happen. We also saw a good level of written detail about people's bedtime routines including whether they liked to have a snack or a hot drink before they went to bed, what clothes they liked to wear when sleeping and what time they liked to go to sleep.

The provider encouraged people to take part in a wide variety of activities. The service had two activities coordinators in post who delivered an activities programme through the assistance of external volunteers and occasionally some care staff, seven days a week. We saw the activities programme and saw this included a mix of group and individual one to one activities including group quizzes, pampering sessions and singing and dancing. We observed people participating in a quiz which was taking place during our inspection. We saw people actively participating in the session and we saw the activities coordinator encouraging people to respond to questions and to take part. People had specific activities care plans within their files. We saw these included details of their personal interests as well as details of the sessions they had participated in. We spoke with both activities coordinators and they explained that they sought people's feedback in relation to activities to ensure they enjoyed them and the programme was of interest to people. They also explained that they reviewed the records they kept of people's participation in relation to activities in order to ensure that people were involved in sessions or otherwise, mitigating the risk of social isolation. They told us they provided one to one activities such as pampering sessions or listening to music for people who could not leave their rooms.

Care records contained information to assist care workers in their communication with people. We saw people's care records included communication care plans which included specific advice for care workers in accordance with people's specific health conditions. For example, we saw one person's care plan stated that the person was sometimes confused as a symptom of their dementia. Care workers were therefore advised to speak clearly and gently to them and to maintain eye contact.

The provider had an appropriate complaints policy and procedure in place. People told us they felt comfortable about reporting any issues that arose and would speak with a member of staff if they had any problems. One person told us "If I had a problem I would tell staff."

The provider had a complaints policy which included the procedure that needed to be followed when dealing with complaints. This involved the necessity to record complaints and promptly respond to the complainant. We looked at complaints records that were kept by the management team within the service. These indicated that complaints were logged and investigated to people's satisfaction. Where necessary, we saw examples of changes made to rectify issues. For example, we saw one complaint record detailed that one person had complained that some of their relative's laundry was missing since they entered the home. The provider therefore spoke with staff to ensure laundry provision was more organised to alleviate the risk of a reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

The provider had good quality assurance systems in place to monitor and improve care, but these were not appropriately completed. The provider's systems required the completion of various audits relating to medicines errors, analysis of DoLS, people's weights, pressure ulcers, infections, falls, infection control and auditing of the kitchen. A care plan audit was supposed to be conducted every month. However, these checks did not identify the issues we found in relation to care records.

There was a lack of monitoring of safeguarding investigations. There had a been a significant delay to the investigations of numerous incidents and it was therefore not possible to determine whether care staff had learned lessons from incidents and whether risks had been mitigated. We spoke with the provider about the issues identified with the completion of effective quality monitoring. The provider was open and honest about the challenges being faced and we found they had a realistic plan to make improvements. The registered manager, the regional manager and their manager were newly appointed and were focussed on making positive changes to the service. At the time of our inspection, the registered manager had been in post for approximately two months, but had only been registered for one day. We found the registered manager and regional manager had already conducted a comprehensive audit of the service and their findings mirrored those found during our inspection. They explained it was their intention to invest funds in order to secure improvements, for example, through the implementation of an improved electronic call bell system. However, they needed more time to secure improvements.

Our conversations with care workers demonstrated that they were aware of the efforts being made by the registered manager to secure improvements and they were supportive of these. Care workers gave very good feedback about the registered manager and stated that she had made a significant impact to their working environment within a short period of time. Their comments included "We have a new manager and she is trying her best to make sure we're not short of anything which is brilliant" and another care worker told us the registered manager was "absolutely perfect. You don't need to book an appointment. You can just call her and she will see you."

The provider had a clear governance framework that identified the roles and responsibilities of different staff members and they were aware of these. We met with both the registered manager and the regional manager during our inspection. The registered manager was clear about her responsibilities within the organisation, but also received support from her regional manager. This ensured that higher levels of the management team were aware of what was happening within the service and that the registered manager had direct, senior management support to manage known issues. Care staff, team leaders and nurses stated that there had been some confusion in the past about who was responsible for some of the quality monitoring within the home. We spoke with the clinical lead about this issue and they explained that since the management structure within the home had stabilised all roles and responsibilities were clear.

Care staff also had a good understanding of their roles and responsibilities. They told us they had been given a job description prior to starting work at the service and that their roles had met their expectations. One care worker told us "We know what we have to do and I think we're on track now."

The provider sought people's feedback in relation to the care they received. Annual surveys were conducted in relation to care and questions relating to safety, the staff and food were asked among other matters. We saw the results of the survey conducted in 2018 were very positive, but less than 20 percent of people using the service had participated.

The law requires that providers of care services send notifications of changes, events or incidents that occur within their services to the Care Quality Commission (CQC). We found the provider was reporting incidents to the CQC as required.

The provider safely handled people's confidential data. We saw people's care records and daily notes were safely stored within a locked cupboard. on each unit of the building. The provider also kept records on its computer system which could only be accessed by authorised staff with a secure password.

The provider worked in partnership with other agencies. We saw numerous examples within care records which demonstrated contact that staff had with health and social care professionals. This included pharmacists, social workers and hospital teams. We also spoke with the GP who commented positively about their working relationship with staff at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that care was appropriate and met the needs of service users. 9(1)(a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure the proper and safe management of medicines. 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not always fully investigate, immediately upon becoming aware of, any allegation of abuse. 13(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure persons employed received appropriate and timely supervisions and appraisals as necessary to enable them to carry out the duties they are employed to perform. 18(2)(a).