HC-One Limited

Silverwood (Nottingham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 and 30 March 2016 and was unannounced.

Accommodation for up to 80 people is provided in the home in two buildings and over two floors in each building. The service is designed to meet the needs of older people. There were 54 people using the service at the time of our inspection.

At the previous inspection on 14 and 15 April 2015, we asked the provider to take action to make improvements to the areas of person-centred care, meeting nutritional and hydration needs, premises and equipment, good governance, staffing and fit and proper persons employed. We received an action plan in which the provider told us the actions they had taken to meet the relevant legal requirements. At this inspection we found that improvements had been made in all areas, however, more work was required in the areas of person-centred care, good governance and staffing.

A registered manager was in post and she was available during 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.

Sufficient numbers of staff were not on duty to meet people's needs. Staff did not always safely manage identified risks to people. People felt safe in the home and staff knew how to identify potential signs of abuse. The premises were managed to keep people safe. Staff were recruited through safe recruitment practices. Safe infection control and medicines practices were followed.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People did not always receive personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective. People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered

manager and that appropriate action would be taken.

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

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.

Sufficient numbers of staff were not on duty to meet people's needs. Staff did not always safely manage identified risks to people.

People felt safe in the home and staff knew how to identify potential signs of abuse. The premises were managed to keep people safe.

Staff were recruited through safe recruitment practices. Safe infection control and medicines practices were followed.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate.

People's needs were met by the adaptation, design and decoration of the service.

Is the service caring?

Good

The service was caring.

Staff were caring and treated people with dignity and respect.

People and their relatives were involved in decisions about their care.

Advocacy information was made available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs.

Care records contained information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the registered manager and that they would take action.

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Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 March 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nursing advisor with experience of dementia care and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted visiting health and social care professionals, the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with 12 people who used the service, three visitors, a housekeeper, a domestic staff member, a laundry staff member, the cook, an activities coordinator, three senior carers, four care staff, one nurse and the registered manager. We looked at the relevant parts of the care records of 13 people, four staff files and other records relating to the management of the home.

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.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Entrances to the buildings were not fully secure and hazardous materials were left unattended. Call bells were not always in reach of people or working. The environment and equipment were not clean. At this inspection we found that improvements had been made in this area and the regulation had been complied with.

We saw that the premises were well maintained, safe and secure. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified. Call bells were working and within the reach of almost all people. We told the registered manager of one call bell that was not within reach of the person.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People told us the home was clean and their clothes were well cleaned. A person said, "I'm very happy with how clean it's kept. They keep my clothes fantastic." Another person said, "As you can see, it's spotless!" Staff were able to clearly explain their responsibilities to keep the home clean and minimise the risk of infection. Laundry staff felt that they had sufficient time to complete their work effectively though cleaning staff told us that they would like an additional staff member on duty.

During our inspection we looked at all bedrooms, all toilets and shower rooms and communal areas. All areas were clean and we observed that staff followed safe infection control practices.

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were put at risk due to insufficient numbers of staff on duty. People's needs were not met due to insufficient numbers of staff on duty. At this inspection we found that improvements had been made in this area, however more work was required and the regulation had not been complied with.

People told us there was not always enough staff to meet their needs. A person said, "There's not enough of them to take me to my room. I have a really long wait. If I ring in my room it's about 15-20 minutes wait often." Another person said, "I have to buzz if I need the bedpan – sometimes it's a good half hour to wait. But they're short of staff so can't help it."

A person said, "Some days they are very short; they do admit it. Nights are when they are most short staffed." Another person said, "There are not enough staff. I need two staff to assist me and that makes it worse. One night they left me on the commode for an hour. I get sciatica and I was sore." They added, "Everything that

goes wrong here is always down to lack of staff." We saw that a person had raised staffing levels as an issue at a meeting for people who used the service in September 2015. We saw that a relative had raised the same issue at a meeting in February 2016.

Most staff we spoke with told us they thought they had enough staff but just needed to be, "well organised." A staff member said, "Staffing levels work at the moment but when we get more people in, we will need more staff." One staff member felt there were sufficient staff on duty in the morning, but in the afternoon there was one less staff member on duty and they felt people often had to wait for attention. Another staff member told us that staffing levels could be improved.

We observed that people did not always receive care promptly when requesting assistance in the lounge areas and in bedrooms. We saw that staff were not always visible in communal areas. We checked buzzer response times for the last three days for one of the buildings and saw that buzzers were not always responded to promptly. We saw separate buzzer response times of between 10 and 61 minutes.

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. Staffing levels were calculated according to the amount of people who used the service and whether they were defined as requiring residential or nursing care. However, no documentation was in place to show whether people's differing dependency levels had been considered when calculating staffing levels.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe recruitment processes were not followed at all times. At this inspection we found that improvements had been made in this area and the regulation had been complied with.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service, including a volunteer. The files contained all relevant information and appropriate checks had been carried out before staff members started work. Clear staff disciplinary procedures were being followed where appropriate.

People told us they felt safe. A person said, "Oh yes, I feel safe as houses here." Another person said, "I feel very, very safe – I've enjoyed my stay here." A visitor said, "[My family member]'s as safe as can be."

Staff told us they felt people were safe at the service. Staff were aware of the signs and symptoms of abuse and told us they would report any concerns to the registered manager. A staff member said, "If I suspected any type of abuse, I would report it to the person in charge straightaway." Most staff were also aware of the procedure for reporting to the local authority safeguarding team, however, an agency staff member was not aware of this but told us they would report any concerns to the registered manager or the on-call manager if the registered manager was unavailable.

A safeguarding policy was in place and staff had attended safeguarding adults training. Appropriate safeguarding records were kept. However, information on safeguarding was not displayed in the home to give guidance to people and their relatives if they had concerns about their safety.

Risks were not always managed so that people were protected and their freedom supported. People told us

that staff regularly checked to make sure they were safe. A person said, "[Staff] check on me as they go past day and night." Another person said, "[Staff] peep in at night."

Care records contained detailed risk assessments advising staff what the risks to a person were and how these risks could be reduced. Risk assessments had been completed for the person's level of risk in relation to nutrition, choking, pressure ulcers, falls and moving and handling. Risk assessments identified actions put into place to reduce the risks to the person and were reviewed regularly. However we saw that when bed rails were being used a risk assessment had been completed but this assessment did not always consider whether the person was likely to try to climb over the rails, or the risks of entrapment.

We saw that staff were not always following actions identified to reduce risks to people. We saw examples of risk assessments in relation to pressure care management which advised a person at risk of pressures sores needed help to change their position every two hours. The care plan also advised use of a specialist mattress and chair cushion. However when we checked the person's charts, we saw there were times when the person had not had their position changed for six hours. We saw that the person was sat in a chair without a pressure cushion as recommended in the care plan. The person was without a cushion for more than four hours. This could put the person at increased risk of damage to their skin. We raised this with the registered manager.

We saw another person's care plan stressed the importance of a person sitting on a pressure relieving cushion at all times when they were out of bed. On the day of the inspection the person sat in a recliner chair in the lounge without a cushion being in place. This was a person who had had previous problems with their skin. We raised this with the registered manager.

We checked a person's charts in relation to the checks needed on the mattress settings on a special bed to reduce the risk of pressure sores. We saw that the bed setting was supposed to be checked twice daily but the setting had not been checked for over twenty four hours. The setting on the bed was not correct according to the instructions on the chart. This was important as the pressure relieving beds have to be set at the correct setting for the person using the bed in order to work properly. We raised this with the registered manager.

We saw in another person's care records that they had been assessed at a medium level of choking and the tool used to calculate this risk advised there should be clear guidelines on what supervision and support the person needed at mealtimes. We spoke to two staff members but neither of them were aware that the person could be at risk of choking and there were no specific guidelines on how meal times should be managed for this person. We observed this person sitting eating by themselves with no supervision. We raised this with the registered manager.

We saw that a person with bedrails was supposed to have checks hourly during the night but the chart showed periods when the person had not been checked in over three hours. However, care records showed that staff were carrying out hourly checks of other people.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans in order to minimise the risk of re-occurrence. Falls were analysed to identify patterns and any actions that could be taken to prevent them happening. Staff told us they felt incidents and accidents were investigated and acted on to prevent re-occurrence.

People told us that they staff used equipment appropriately to keep them safe. A person said, "I use a [standing aid] so rely on them to keep me safe. I'm happy with it." A visitor said, "It's all done well. [My family

member] had a few falls with their walker so now [they are] assisted to use [their] frame and they follow with [their] wheelchair." Staff said they had sufficient equipment to meet people's needs and we observed staff using moving and handling equipment safely.

People told us their belongings were safe. A visitor said, "[My family member] left some money in [their] trouser pocket one day and the laundry lady came and told [them] and gave it back."

People told us that they received their medicines safely. One person told us, "[Staff are] very, very good at doing it. They find my right level of painkiller. They always wait while I take them." Another person said, "I have them three times a day – it's well done."

We observed the administration of some people's medicines and saw they were administered safely in line with requirements. Medicines Administration records (MAR) contained a picture of the person and there was information about allergies and the way the person liked to take their medicines. MARs confirmed people received their medicines as prescribed. PRN protocols were in place to provide information on the reasons for administration of medicines which had been prescribed to be given only as required.

Processes were in place for the timely ordering and supply of medicines and we were told medicines were received in a timely manner to ensure any discrepancies were corrected prior to them being required.

Medicines were stored in locked trolleys within locked rooms. However, the refrigerator used to store medicines in one of the rooms was not locked on the day of the inspection. The temperature of the rooms and refrigerator had been completed daily except for three consecutive days for one of the rooms. We found liquid medicines were not always labelled with the date of opening.

Staff administering medicines told us and we saw documentation indicating they had had competency checks for medicines administration. They told us they had completed training in medicines administration.

Good

Is the service effective?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received appropriate training, supervision and appraisal. At this inspection we found that improvements had been made in this area and this part of the regulation had been complied with.

People told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "They're all pretty steady." Another person said, "Most certainly they're capable." However, a visitor said, "Some are good at the job, some not so." We observed that staff competently supported people and interacted appropriately with them.

Staff felt supported. They told us they had received an induction. Staff felt they had had the training they needed to meet the needs of the people who used the service. They told us they received regular training updates and a staff member showed us a mobile phone application which the provider uses to keep all staff updated of what training they are required to do in any particular time period. Staff told us they had training both face to face and by e-learning. Training included a course developed by the provider called 'Hearts and Minds.' This is a course to help staff respond to the needs of people living with dementia. Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training.

Staff were mixed in their responses to frequency of staff supervision meetings. One staff member said when asked if they had supervision, "Not really. We do self-appraisal forms to try and focus on what we are doing well and on other areas that we need more training on." However other staff told us they received regular supervision. Supervision and appraisal records contained appropriate detail.

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always appropriately supported at mealtimes. People's nutrition and hydration risks were not always effectively managed. At this inspection we found that improvements had been made in this area and this regulation had been complied with.

People spoke positively about the food choices available and told us that they received meals that met their needs. One person said, "It's beautiful! It looks lovely on the plate and is hot. I asked them to reduce my portion size as so generous. They made me an omelette when I asked or I can have beans on toast if I fancy it. The girls made me a sandwich one night." Another person said, "Meals are my highlight of the day! I enjoy mealtimes." Another person said, "There is a good choice of food; if I don't like it I'm offered something different."

People told us that they had sufficient to eat and drink. A person said, "I've got my jug of water here. Then I have juice at lunch and plenty of coffees in the day." We saw that people were offered drinks throughout the inspection.

We observed the lunchtime meal in both buildings. People received their meals promptly and when people needed assistance staff sat with them and helped them without hurrying the person.

People's care records contained care plans for eating and drinking and there were records of their preferences and the support they required. Nutritional risk assessments had been completed and nutritional care plans were in place with actions to reduce the risks to people for example, choking. The food and fluid charts we examined indicated people had a good fluid intake and satisfactory food intake.

People were weighed weekly and monthly as required and appropriate action was generally taken if people lost weight. We saw that when one person had been losing weight, a dietician had been involved and their recommendations had been implemented. However, another person who was initially of a low body weight had lost a significant amount of weight over a period of approximately eight months and their care plan did not indicate the need to fortify their food and there was no evidence of the involvement of a dietician. We talked to the chef about this person and they said they had not been asked to fortify the person's food. However, we saw there were records of the person's food intake which indicated some of their food had been fortified with milk and cream, suggesting action was being taken by care staff despite a lack of a dietetic referral and documentation.

A person was receiving nutrition from a percutaneous endoscopic gastrostomy (PEG) tube. A PEG is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Staff were supporting the person appropriately with this need.

We saw staff asked permission before assisting people and giving them choices. Where people expressed a preference staff respected them. A person said, "They always ask me before they do things."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were being followed as when a person lacked the capacity to make some decisions for themselves; a mental capacity assessment and best interests documentation had been completed. When people were unable to make some decisions for themselves an assessment had been carried out identifying the reasons why they were unable to make decisions in relations to a number of aspects of their care and support.

We saw a person was being given their medicines covertly following a mental capacity assessment and best interest decision. The GP had been consulted and agreed with the decision. Medicine is provided covertly when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them.

Not all staff we spoke with were very knowledgeable about MCA and DoLS. One staff member did not know what a DoLS was. None of the care staff we spoke with could tell us if any of the people were subject to a

DoLS. This is important as sometimes when people are subject to a DoLS, there might be certain instructions that legally have to be followed.

Staff were able to explain how they supported people with behaviours that may challenge others and care records generally contained guidance for staff in this area. However, we heard a person calling out repeatedly for attention during the day of the inspection. When staff attended the person, they often did not need assistance and appeared to just want company. Staff did not spend any extended time with the person but provided reassurance before going on with their tasks. The person was living with dementia and their care plan identified this but did not mention this behaviour, any action to reassure or occupy the person, or ways to minimise the behaviour.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had been completed appropriately.

People told us they were supported with their health care needs. A person said, "The doctor reviews my tablets." Another person said, "A lady came to see my eyes. A man comes to do my feet as I've a sore toe."

There was clear evidence of the involvement of a wide range of external professionals in the care and treatment of people using the service. Within the care records there was evidence people had access to a GP and other health professionals.

Adaptations had been made to the design of the home to support people living with dementia. A staff member told us they felt the premises were suitable for the needs of the people using the service. The home had been recently refurbished and people's bedrooms were clearly identified. Bathrooms had been refurbished and toilet seats and handrails were brightly coloured so that people could identify them easier. However, not all bathrooms were clearly identified and there was no directional signage to support people to move independently around the home.

Good

Is the service caring?

Our findings

Some people told us that all staff were kind, caring and considerate. A person said, "Very, very kind." Another person said, "I love this place. All the staff are kind people."

Some people's views were mixed on this issue. A person said, "[Staff] have looked after me; the majority are very kind." Another person said, "I've made such friends of them – nothing but kindness." However they told us they were not happy with the attitude of one of the staff and with their permission we raised this issue with the registered manager who assured us they would address the issue.

Another person said, "Some are a bit rough. They move me too quick." However, they did not provide us with sufficient information to identify individual staff members. A visitor said, "75% [of staff] are nice, 25% not so – it's just a job so they do the minimum."

Staff were generally kind and caring in their interactions with people who used the service. We saw some examples of caring relationships and excellent communication between staff and people using the service, however, some staff did not communicate as effectively and were more task focused.

People felt staff knew them and their needs. A person said "Staff know me. It astounded me that the lady who works in the kitchen can tell you exactly what I've had and eaten." Another person said, "They know me so well." Most staff knew people and their needs.

We saw staff responded appropriately to people when they showed distress. We saw a person coughing after lunch and becoming anxious. A staff member rubbed the person's back and calmly said, "Take some deep breaths. You can cough it up if you want – here's your napkin. You're quite safe, just relax." The person had a drink and was much calmer.

People views were mixed on whether they had been involved in making decisions about their care. Some people told us they had; others told us they had not. Most people told us their family were involved in decisions about their care. A person said, "They don't directly involve me. My husband does it." However, we saw that people had often signed their care plans which showed that the care plans were being discussed with them. Documents had also been completed to demonstrate the involvement of close family members in the regular review of people's care plans when it was not possible to involve the person themselves. We also saw that each month staff asked people about their current care plans and whether they were happy with them.

Care records contained information which showed that people and their relatives had been involved in their care planning. Care plans were person-centered and contained information regarding people's life history and their preferences. Advocacy information was also available for people if they required support or advice from an independent person. Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us.

People felt that their privacy and dignity were respected. A person said, "Oh yes, they give a rap and wait. I'm fine with them keeping it private." Another person said, "They always knock. And close my curtains and door when they see to me."

We saw staff take people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. The home had a number of areas where people could have privacy if they wanted it. However, we saw a person's blood glucose levels were checked and their insulin administered whilst they were sitting at the dining table for their breakfast. Two other people were sitting at the table and one of them made a comment about the person's stomach; however the person receiving the medicine appeared unconcerned. The person's privacy and dignity did not appear to have been considered by the staff in relation to this procedure, but it did not appear to have had an impact on the person.

Staff were able to describe the actions they took when providing care to protect people's privacy and dignity. We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

People were supported to eat their meals independently; adapted cutlery was used by some people. A person said, "They let me do as much as I can." Another person said, "They let me wash myself and shave if I can." Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction and people we spoke with confirmed this was the case. Visitors told us that they were discouraged from visiting during mealtimes if possible, but were welcomed by staff when they visited and were offered drinks or could make their own.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive responsive care that met their needs. Activities were limited. Care records did not consistently contain information on people's individual needs and how to meet them. At this inspection we found that improvements had been made in this area, however more work was required and the regulation had not been complied with.

People we spoke with told us that they often had to wait for staff to assist them and at times for unacceptably long periods. Some people told us that call bells would be re-set and they would be told by the staff member that they would return but this didn't always happen. We observed this taking place on the second day of our inspection. A person's buzzer sounded for over 10 minutes and then stopped. We checked the person's room and there were no staff present. The person told us that they wanted to go to the toilet and the staff member had turned the buzzer off and told them they would come back. We waited 15 minutes and no staff member returned so we asked a senior carer to ensure that a staff member responded to the person.

A person told us that before living at the home they liked to have a daily shower but now only had a bath once a week. They said, "I'd like a shower every day but it's just not possible. Staff haven't got time." Another person said "If it's in the middle of the night when I press my buzzer, they turn the buzzer off and go. If you still need them you have to buzz again." Another person said, "If no-one comes, I bang on my table with the TV thingy and that works. It can take them a while to come if I ring when I need the loo."

We observed that people did not always get the support they needed at the time they required it. A person said, "I have to rely on them to wash me when they can as they're so busy." Another person said, "I'm tied into their routine. I usually got up at 7am at home – today it was 10.30am when they came and I had breakfast at 11.15am. No drink or anything before - I would have loved a coffee to keep me going." We saw that another person's care record stated that they got up at 7am and they did not get up until 10am on the second day of our inspection. On the second day of inspection we saw that staff were still supporting people out of bed at 11.10am.

We saw a person sat in a wheelchair in the lounge had been trying to attract a staff member's attention for support, but the staff member present did not notice and the person stood up. We had to intervene and asked the staff member to assist this person, as they were unsteady and may have fallen.

At one point an emergency call bell was activated and there was only one carer in the lounge area, who advised they could not leave the lounge as they were the only person there, this staff member advised that two staff were on their break. At the same time another call bell had been ringing for fifteen minutes. We went to the room with the emergency call bell and a staff member had already responded to the emergency bell but needed a second staff member. We then went to the other unanswered bell. The person told us they had been waiting 15 minutes for the toilet. Staff arrived to assist five minutes after our arrival.

We heard people calling for staff on a number of occasions with no response. On hearing a person calling for a nurse for several minutes and no staff being in the vicinity of their room, we talked with the person and suggested they pressed their call bell. We assisted them to do this, and monitored the time taken for a response from staff and noted it was 10 minutes before the call bell was answered.

A person sitting in the first floor lounge started to knock on their side table to attract the attention of staff. There was no call bell to hand. The person did this intermittently for several minutes before a member of staff came into the lounge. They spoke with the person who told them they needed to go to the toilet. The staff said there wasn't another member of staff to help them at the moment but the drinks round would be there shortly and left the lounge. The person settled for a few minutes and then approximately 10 minutes later started to knock on their table again. They continued to knock on the table off and on for several minutes but when a member of staff entered the lounge the person was not knocking. We alerted the staff to the person and they asked another staff to assist them in moving the person and taking them to the toilet.

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

People's views were mixed about the activities that were provided. A person said, "I get offered different things to do but I prefer to spend time in my room listening to my favourite music and watching television I liked the singers and music movement things. They get me to join in. It's a pub lunch this week I think." Another person said, "Yes, they organise activities, games and all sorts. One of the staff is particularly good." However a person said, "The Easter crafts were good. It's a similar theme all the time though. I'd like gardening." People who preferred to remain in their bedroom out of choice or were bedbound told us that they did not receive any regular offer of entertainment or activity one-to-one by the activity staff. We checked activity records for some people who stayed in their rooms and the entries were limited.

The two activities coordinators work part-time on different days to cover Monday to Friday 9.30am - 2.30pm. They told us that they had several volunteers who helped on outings, including a regular volunteer who drove the minibus on outings such as a pub lunch, a boat trip, the church coffee morning, shopping and visits to the garden centre.

A daily activities list was displayed on noticeboards in both units – with a morning activity in one unit and an afternoon in the other unit. Activities include cookery, fruit tasting, chair exercise, film session, arts and crafts and music. Outside entertainers also visit for singing, music motivation, animals and a church service.

We observed a group of people taking part in a quiz led by two staff members. However five people, all of whom were living with dementia, sat alone during this period with little interaction with staff.

A pre-admission and admission assessment had been completed and a range of care plans developed covering people's care and support needs. These provided a good level of detail and the plans had been completed from the perspective of the person with information about their personal preferences. There was a variety of information in people's care records about their life, important relationships, things they enjoyed and their interests. Care plans had been reviewed monthly.

Care plans were in place for the management of people's health needs such as diabetes, skin integrity and PEG nutrition. However, we found two instances where the information in the care plans was not complete and we had to ask, in order to discover the action which had been taken, the current position in relation to a person's skin integrity and the investigations which had taken place in relation to a person's infection status and the outcome of these.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences. We also saw that a person was supported with their cultural needs.

People were aware of who to complain to and understood the home had a complaints policy. A person said, "There is always someone you can go to higher up if you want to complain and they do listen if you complain." Other people told of us of complaints that had been satisfactorily resolved. Staff were able to explain how they would respond to complaints.

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service. There was a clear procedure for staff to follow should a concern be raised.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audits had not identified or addressed shortcomings that we found during the inspection. At this inspection we found that improvements had been made in this area and the regulation had been complied with, however more work was required.

The provider had a system to regularly assess and monitor the quality of service that people received, however it was not fully effective as it had not identified and addressed the issues we identified at this inspection.

We saw that regular audits had been completed by the registered manager and also by representatives of the provider. Audits were carried out in a range of areas including infection control, care records, medication, health and safety, mealtimes and catering. Action plans were in place where required to address any identified issues. Night time visits were also carried out to check the standard of care provided at night.

Some people were aware of meetings for people who used the service and their families. A person said, "They hold meetings for people and their relatives. You can go and say what you think and what's not right. I don't want to go but my relative goes. They are about every couple of months." Another person said, "My husband goes to the meetings." Meetings for people who used the service and their relatives took place. There were notices displayed in the home to inform people and their relatives of the upcoming dates for the monthly meetings.

Visitors told us that their views were asked for and responded to. A visitor said, "We get asked maybe twice a week about if we're happy with the care." Another visitor said, "Definitely they listen to us." We also saw notices displayed in the home to inform people that the registered manager had a regular weekly surgery where visitors could book appointments to discuss issues with her.

We saw that surveys had been completed by people regarding the quality of food and the registered manager told us they were awaiting the results of a more detailed survey that had been completed by people who used the service and their families.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service and displayed in the main reception.

Staff we talked with were committed to their job and demonstrated their care for people. One staff member said, "The home is a lot better now, friendlier. Everything seems to be working much better." Staff were positive about their work and told us they worked well as a team. The registered manager felt that the culture of the home had changed and it was, "Open and upbeat."

People and visitors were very positive about the registered manager. A person said, "She's very good and helpful." Another person said, "She comes and has a chat. She says I've only got to ask if I have any problems." Another person said, "The [registered] manager is very kind."

Staff told us they felt the leadership of the home was good. People and staff were positive about the registered manager. A staff member told us, "The registered manager is great. They are proactive, supportive and sort any problems out." A staff member said, "The registered manager tried to give us more responsibility, they look at an area we can personally be responsible for and it makes me feel valued." A member of staff said the manager was strict but good. They said they felt able to ask if they were uncertain about anything and on the day of the inspection we saw the person asking the advice of the manager when they were unsure of something. Another staff member said, "I've seen so many changes over 4 years. [The registered manager] is such a great person – so very approachable and it's so much better now for the [people who use the service] and for the staff too." We saw that regular staff meetings took place and the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post and was available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. She felt well supported by the provider. She told us that sufficient resources were available to her to provide a good quality of care at the home. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The current CQC rating was clearly displayed in the both buildings of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 1.The care and treatment of service users must— a.be appropriate, b.meet their needs, and c.reflect their preferences. Regulation 9 (1).

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 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Regulation 18(1).