Larchwood Care Homes (South) Limited

Sherford Manor Care Home

Inspection report

Wyvern Road
Taunton
Somerset
TA1 4RA

Tel: 01823337674

Date of inspection visit:
14 March 2016
15 March 2016
16 March 2016

Date of publication:
23 May 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 was unannounced and took place on 14, 15 and 16 March 2016.

Sherford Manor Care Home is registered to provide care and accommodation for up to 105 people. However, the registered manager confirmed they only accommodated 77 people when full. The home specialised in the care of older people living with dementia. At the time of the inspection there were three units, with a fourth planned for people who were more mobile and independent. Rose unit provides residential and not nursing care. Redwood and Sutherland units both provide nursing care; registered nurses on these two units provide support and advice for the care staff on Rose.

At the last inspection carried out in April 2015 we identified concerns with some aspects of the service and care provided to people. The service was found to be in breach of two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the provider sent an action plan to the Care Quality Commission (CQC) stating how and when improvements would be made. At this inspection we found that action had been taken to improve the service and meet all the compliance actions set at the previous inspection. However; we found further improvements were needed.

At the last inspection we found people were not always protected against risks to their health and safety because some risks had not been considered or recorded. People's care plans did not always reflect the care they received. At this inspection we found people's care plans contained risk assessments and clearly reflected the care and support they needed.

There is a registered manager in post. 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.

Before this inspection concerns had been received about some areas of care provided in the home. These concerns included safeguarding concerns around the undignified treatment of people living in the home. They also involved people's wishes and preferences not being recognised. People were got out of bed very early in the morning, whether they wished to or not. On receiving these concerns the registered manager had acted immediately and with the support of senior staff had carried out spot checks in the home throughout the day and night. The concerns and how they could improve had been discussed with staff at team meetings and supervision. The registered manager had taken further action and worked in partnership with relevant authorities to make sure people were protected.

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when a person living in the home experiences an accident that results in a visit to the accident and emergency department or requires medical intervention. Another is when a safeguarding incident occurs. We found the registered

manager and person delegated by the registered manager to send notifications to CQC had not carried out the role correctly. They had failed to inform CQC of two falls and one safeguarding incident. The content of a safeguarding incident that was sent was not recorded correctly.

We found although there were quality audit systems in place they had failed to identify some shortfalls. For example the registered manager had failed to pick up issues such as an out of date list of staff and people living in the home provided in the emergency grab file. The lack of a dementia friendly environment in the new unit. They had also failed to identify the failure to send notifications to CQC and the incorrect monitoring of accidents/incidents by a delegated member of staff. However we found the audits for care related issues were being followed up appropriately and action was being taken to improve, review and update records and equipment in the home.

The minutes of team meetings showed the concerns raised by the local authority had been discussed. However the minutes for one unit meeting showed how a culture of task orientated working had developed on that unit. This culture did not always take into consideration the wishes and preferences of the people. However, throughout the inspection we did observe people being supported to make choices about their day to day life. People were supported to follow activities meaningful to them, for example, one person enjoyed sweeping leaves in the garden.

People were supported by sufficient numbers of staff who had a clear understanding of their personal needs. We observed staff took time to talk with people during the day. One person said, "There seems to be plenty staff about, I never have to wait long for someone to help me." A relative said, "I am impressed there always seems to be enough staff around, never have to look for someone."

People received effective care and support from staff with the skills and knowledge to meet their needs. One person said, "They are excellent they do everything exactly how I need it done." One relative said, "I'm really impressed by them, it's the whole team, the care is spot on, I cannot fault them and I cannot praise them enough." All staff had access to training specific to their roles and the needs of people, for example some staff had received training in diabetes care. A visiting healthcare professional said the training had been successful and people's diabetes was more stable.

The provider had a robust recruitment procedure which minimised the risks of abuse to people. Staff said they knew how to report any concerns, and people who lived at the home said they would be comfortable to discuss any worries or concerns with staff.

People saw healthcare professionals such as the GP, district nurse, chiropodist and dentist. Staff supported people to attend appointments with specialist healthcare professionals in hospitals and clinics. Staff made sure when there were changes to people's physical wellbeing, such as changes in weight or mobility, effective measures were put in place to address any issues.

The service had a complaints policy and procedure which was available for people and visitors to view in the home. People said they were aware of the procedure and knew who they could talk with. People and staff said they felt confident they could raise concerns with the registered manager and they would be dealt with appropriately.

The registered manager had a clear vision for the home, on their website they said, "Our philosophy is simple; we want everyone to enjoy life to the full. We never forget that all our residents are individuals and we treat them with dignity, privacy and respect while offering freedom of choice and as much independence as possible." We could see through staff meeting minutes this philosophy had been shared with staff, and

staff we spoke with said they aimed to provide care and support in a dignified manner. Observations throughout the inspection supported the aim to provide an environment where people could maintain some independence when able and enjoy themselves with meaningful activities.

We found the service was in breach of two of the Regulations of the Care Quality Commission (Registration) Regulations 2009 (part4). 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?

Good

The service was safe.

There were systems to make sure people were protected from abuse and avoidable harm. When concerns were raised the registered manager acted promptly to ensure people were safe.

Staff had a good understanding of how to recognise abuse and report any concerns. However, some staff were not confident about reporting concerns to certain senior staff.

There were enough staff to help maintain people's safety.

People received their medicines when they needed them from staff who were competent to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all areas of the home were adapted to meet the needs of people living with dementia.

Adaptations to support people to remain independent were not readily available.

Staff had the skills and knowledge to effectively support people.

People received a diet in line with their needs and wishes.

People had access to appropriate healthcare professionals to make sure they received the care and treatment they required.

Is the service caring?

Good

The service was caring.

People were cared for by kind and caring staff who went out of their way to help people and promote their well-being.

People were treated with respect and dignity.

People, or their representatives, were involved in decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care that was responsive to their needs because staff had a good knowledge of the people who lived in the home. However on one unit people's preferences were not always respected.

People had access to a range of activities meaningful to them.

Arrangements were in place to deal with people's concerns and complaints. People knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not always well led.

The registered manager and the delegated staff member had not notified the Care Quality Commission of significant events in the home.

Quality audits had not been effective in identifying certain shortfalls in the service and ensuring on-going improvements for people.

People and staff were supported by a registered manager who was approachable and listened to suggestions for continued development of the service.

Sherford Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 14, 15 and 16 March 2016 and was unannounced. On 14 March 2016 we arrived at the home at 0600hrs. The inspection was carried out by three adult social care inspectors, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit. At our last inspection of the service in April 2015 we found people were not always protected against risks to their health and safety because some risks had not been considered or recorded. People's care plans did not always reflect the care they received.

Before the inspection visit we looked at information we held about the home. This included information regarding significant events that the home had informed us about and concerns which had been raised with us through the local authority safeguarding team.

During the three days of this inspection we spoke with 42 people who lived at the home, and 22 staff members. We also spoke with nine visitors, two visiting community nurses and a visiting general practitioner [GP]. The registered manager was available throughout the inspection and the regional manager was available the second day of the inspection and for the final feedback meeting. Throughout the three days we observed care practices in communal areas and saw lunch being served in the dining rooms.

We looked at a sample of records relating to the running of the home and to the care of individuals. These included the care records of 14 people who lived at the home and staff personnel files. These included four recruitment records for recently employed staff, training and supervision records. We also looked at records

relating to the management and administration of people's medicines, health and safety and quality assurance.

Good

Is the service safe?

Our findings

At the last inspection we found that although care plans contained some risk assessments, risks had not always been considered for the use of bedrails or for a person who went out independently. At this inspection we found all care plans looked at included risk assessments to minimise the risks to people. These included risk assessments for the use of bedrails when needed, and for people who went out independently either into the community of using communal outside areas.

Before the inspection we were informed of concerns by the local authority safeguarding team. They had been informed people were being bullied, shouted at and treated roughly on a specific shift. On receiving this information the registered manager had taken immediate action. The registered manager and senior staff had carried out unannounced spot checks at all times of the day and night to talk with staff and to ensure the safety of people living in the home. Team meetings with staff had been arranged to discuss people's rights and ensuring they were respected. The registered manager had taken further action and worked in partnership with relevant authorities to make sure people were protected.

Each person who lived at the home had an emergency evacuation plan. These gave details about how to evacuate each person with minimal risks to people and staff. Two sealed envelopes containing the contact numbers of staff and people's next of kin, dated 22/04/2015, were in the emergency file. These details needed to be updated as in the 11 months since these details were recorded there had been changes to staff and people living in the home. This could have resulted in a deceased person's relatives being contacted. The registered manager ensured the records were all updated before the end of the inspection.

Staff told us, and records seen confirmed all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident any concerns reported to the registered manager would be fully investigated and action would be taken to make sure people were safe. However, one staff member said they did not feel they could be confident all senior staff would manage concerns in line with the homes policy. We discussed this with the registered manager and regional manager. They had been informed prior to the inspection of this concern and a meeting with the person had been arranged to address the issues raised.

People who were able to express an opinion told us they felt safe living in the home. One person said, "Oh yes love it, it is really good living here, I have no worries and everybody is nice." One staff member who had not worked at the home long said, "When I go in to provide personal care nobody looks worried or frightened. That is a good indicator that people feel safe here." One relative said, "I am more than happy with the care and feel [the person's name] is safe and well cared for." During the inspection we observed staff to be caring and kind when providing care and support. People appeared relaxed around staff and on Rose Unit people talked and joined in activities cheerfully.

Risks of abuse to people were minimised because the provider had a robust recruitment procedure. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and carrying out disclosure and

barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Registered nurses employed at the home had current personal identification numbers (PIN). This meant registered nurses employed in the home had their professional qualifications and status checked.
The registered manager showed us a diary that detailed PIN numbers and the expiry dates so they could be monitored.

The registered manager confirmed they also used agency workers to support their permanent team of staff. They showed us an online facility they used when requesting agency staff. This enabled the registered manager to see their DBS number, working eligibility, qualifications and the opportunity to give feedback on their performance. The registered manager said, "I'm confident it is a good system."

People were supported to live their lives with reduced risks to themselves or to the staff supporting them. Care plans contained risk assessments which identified the risks to the person and how these should be managed by staff in the least restrictive way. For example one person liked to sweep the yard daily and they were enabled to continue with this activity. The registered manager explained how the new unit, due to be opened, was set up so people could take part in preparing meals and making their own tea and coffee. One person was enabled to move around the home through the provision of an electric wheelchair. They said they were happy they could move around at ease and was later seen joining in an activity in another part of the home. Care plans also contained risk assessments which included assisting people to mobilise and reducing risks to people who were at high risk of malnutrition and pressure damage to their skin. Staff informed the unit manager if people's abilities or needs changed so risks could be re-assessed. We saw care plans had been up-dated following changes in the risk assessments.

There were enough staff to help keep people safe. People did not have to wait long for staff assistance. For example call bells were answered promptly and staff responded quickly when people requested assistance with their personal care needs. Staff members said they felt there were enough staff to carry out the essential care, but sometimes they were unable to provide extra social interaction when unexpected absences occurred. On the second day of our inspection, one staff member said, "We are one care staff member down for the shift. With an extra member of staff we have more time to talk with residents and do one to one."

The registered manager explained how they adjusted staffing levels to meet the needs of people. They used a dependency tool to establish the number of care hours required and the numbers of staff to meet them comfortably. At the time of the inspection the tool identified they required 212 care hours however the home was staffed to provide 312 care hours.

The registered manager confirmed they had a contract with an agency to provide extra staff to ensure people were safe. The agency provided a regular team of staff to ensure consistency of care. They also provided the one to one support for some people in the home. We observed people receiving one to one care and staff taking the time to sit a chat with people and socialising in communal areas.

Before the inspection we had been informed people had received covert medicines without the correct agreements in place. Covert medicines are given to a person secretly either hidden in food or drink. This is done when a person refuses to take medicine that is needed to control certain medical conditions and the individual lacks the capacity to make the decision. During the inspection we looked at the records for people receiving covert medicines. We found in each case the general practitioner (GP) had agreed to the covert administration of medicines and where possible family members had also been informed and involved. The decision to administer medicines covertly was only taken once the person had been fully assessed as to

their capacity to understand the importance of taking the medicine. Each person had a mental capacity assessment and a record of a best interest meeting with the relevant people involved in their care.

Systems were in place to ensure people received their medicines safely. All staff received medicine administration training and had to be assessed as competent before they were allowed to administer people's medicines. Staff confirmed they had received training both on line and on a face to face 'shadow' type basis. Regular competency assessments were conducted and a pharmacist had recently visited the home and checked medicines. A visiting GP told us the home used minimal medication and liaised with the practice pharmacist to ensure reviews of people's medicines were carried out regularly.

We observed the medicines procedure on two units in the home, Redwood nursing care unit and Rose residential unit. We found the ordering, storage, administration and disposal were all in accordance with the homes medicines policy dated 2015. On Redwood nursing unit medicines were always dispensed by a registered nurse. On Rose residential unit medicines were administered by the unit manager and senior carers. We observed good hand hygiene techniques and staff dispensing medicines wore a red apron that asked not to be disturbed as they were conducting a medicine round. This helped prevent distraction and aided concentration and focus; this reduced the risk of medicine administration errors.

We checked a random sample of Medicine Administration Records Sheets (MARs) on both Redwood and Rose units and found medicines had been administered as prescribed. The medicines were contained in what is known as 'blister' packs. We checked a random sample of these blister packs and found all medicines had been administered in accordance with the MAR sheets. We checked a random sample of medicine bottles and eye drops on both units and found they had all been labelled with the date of opening and were all within date.

Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. We saw these were stored and records kept in line with relevant legislation. The stock levels of these medicines were checked by two staff members.

Before the inspection we were informed staff had been observed to follow unsafe infection control procedures, such as not changing gloves and aprons between procedures. During the inspection we observed good infection control procedures followed by staff. Gloves and aprons were used appropriately and changed following each procedure. Staff said they had access to plenty of personal protective clothing. All areas of the home were clean and tidy there were no unpleasant odours throughout the home. One relative said, "Standards are good, always clean and tidy." One staff member said, "We have training in how to protect residents from infection and the senior staff do spot checks. We all know what aprons to wear when and to make sure it is all changed and hands washed between doing care."

Risks to people, visitors and staff were reduced because there were regular maintenance checks on equipment used in the home. These included checks of the fire alarm system, fire fighting equipment, fire doors, and hot and cold water temperatures. Specialist hoists, the lift and the call bell system had also been serviced and were maintained in good working order.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found people were not able to make choices about their meals and were not given the opportunity to enjoy a sociable mealtime experience. At this inspection we found some improvements had been made. Whiteboards were used to record the menu of the day, and people experienced a sociable atmosphere during the mealtime. However the meal time experience for people still differed over the three units.

All three units in the home were clearly adapted to enable people living with dementia to maintain independence. For example, large signage was used and toilets and bathrooms were clearly signposted. However, the new unit which was intended for the use of people who could maintain a level of independence; did not provide dementia friendly toilet facilities. For example, the toilet and tiling behind where all brilliant white. By highlighting an article such as the toilet or the surround of a door in a different colour some people can maintain a higher level of independence. This could mean an improved quality of life for those people who might benefit. At the time of the inspection three people had moved onto the unit however they continued to use the communal facilities on Rose unit. The lack of adaptations has the potential to impact on people's independence once they begin to use the facilities there instead of the existing units. At the time of the inspection there were no plans to change the décor in the toilet facilities. We also observed the plates people used at lunchtime were white and placed on white tablecloths, this could make it difficult for people with a dementia to determine the position of the plate or even if a plate of food was on the table.

People received effective care and support from staff with the skills and knowledge to meet their needs. One person said, "They are excellent they do everything exactly how I need it done." One relative said, "I'm really impressed by them, it's the whole team, the care is spot on, I cannot fault them and I cannot praise them enough."

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. In addition to completing induction training new staff had opportunities to shadow more experienced staff. This enabled them to get to know people and how they liked to be cared for. One recently employed staff member said, "I am doing fine I am working through my induction with the unit manager. It is all really good."

After staff had completed their induction training they were able to undertake further training in health and safety issues and subjects relevant to the people who lived at the home. Staff spoken with demonstrated a sound understanding regarding dementia and the therapeutic management of challenging behaviours. For example we observed several potential altercations between people living in the home were promptly and sensitively diverted by skilled staff intervention. Many staff had nationally recognised qualifications in care which helped to ensure they were competent in their roles. This meant people could be assured staff would understand their specific needs such as frustration around communication. We observed one person was anxious as they wanted to use the toilet but were unable to communicate the need. Staff recognised their pattern of behaviour and assisted them before the person became increasingly distressed. One person said,

"They certainly know what they are doing. I never have any concerns they will not know what to do."

Staff confirmed they received training and attended regular updates. All staff had received a letter from the registered manager detailing what mandatory training needed to be completed and by what date. One staff member said, "I think the training is good, we try to be proactive and we have an external company trainer." Another staff member commented, "We have two people going on to do their training and a number of people doing diplomas." I have had good training and a good induction."

The home's training and development plan detailed what training was required by which staff and what the expected benefits would be to the service. Subjects on the plan included: care planning and person centred care, The Mental capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), infection control, communication skills, dementia awareness, safeguarding, challenging behaviour, moving and handling and pressure area care. All of these training sessions were planned to be delivered by the provider's in house trainer during the month of May 2016. Diabetes training had recently been delivered by a practice nurse from the surgery and this had been valued by the staff. The home had also taken advantage of training offered from the local district hospital on catheter care and verification of death.

We saw evidence the home supported and encouraged staff to enhance their skills and had competency assessment tools for moving and handling and safeguarding of vulnerable adults (SOVA). These competency assessment records detailed how staff members implemented learning and if they required any further training or if improvements were needed to fully understand the subject.

People only received care with their consent. Care plans contained copies of up to date consent forms which had been signed by the person receiving care or a relative, if they had the relevant authority. If the person declined to sign, or were unable to, staff indicated why there was not a signature. Staff were observed seeking consent throughout the inspection. For example during a moving and handling procedure staff were observed to explain clearly to the person what they wanted to do and obtained consent before they continued.

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. The unit managers demonstrated a clear understanding of the MCA and there was evidence in people's care plans that MCA assessments had been carried out. Where it had been identified that a person lacked capacity to make a decision a best interest meeting had been held with the relevant people present and a best interest decision recorded. The registered manager confirmed they obtained proof relatives had obtained lasting power of attorney, before they gave consent on a person's behalf.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Assessments about people's capacity to consent to living at the home had been completed and DoLS applications had been completed for people who were unable to consent to this and for those who required constant monitoring by staff. Records showed staff had ensured an independent advocate or Independent Mental Capacity Advocate (IMCA) was involved when required. An IMCA is an independent advocate who will find out the persons views and wishes about the decision. They can challenge a decision made on behalf of the person.

The home had a menu plan over four weeks. The menus provided people with a variety of homemade meals

which were well balanced and used fresh produce. The meal choices of the day were displayed on a whiteboard in each unit. We informed the registered manager that the whiteboards were not clearly written and were difficult to read. The home was in the process of obtaining pictures of the food they provided to enable people to make a more informed choice. People made the choice for their meal the day before and would be reminded by staff if they changed their mind an alternative could be provided. On Rose unit we observed one person said they did not want either of the choices and they choose an omelette which was made at the time.

We observed an unrushed social lunchtime on each unit. However the experience for people on each unit was different. For example on Rose and Redwood the tables were well laid with flowers and cruet sets. Interactions with staff were relaxed and a positive experience was observed. However on Sutherland the tables did not have cruet sets and when the meals were plated the person's preference for portion size was not taken into consideration. We noted people were not given drinks with their meal. When we asked a staff member said, "If they want a drink they will be given one." Following this conversation we noted people had been offered a choice of blackcurrant juice or coffee. The lunchtime was not rushed and staff did appear to have an understanding of people's likes and dislikes. Whilst staff were observed engaging well with people in a cheerful, manner there was also evidence of a task orientated routine to the day.

People told us the food was always good, although one person said, "It could be hotter, but it is always good." Another person said, "Excellent the food is always worth waiting for." One relative said, "They [staff] have been great, they have encouraged [the person's name] to eat more and they have put on a stone. I am so pleased."

We did notice people did not have water jugs and drinking vessels in their rooms. We were told hourly rounds were conducted and we could see on fluid charts drinks had been given regularly. Following a conversation with the registered manager we noted water jugs had been positioned in some people's rooms and the manager felt a misunderstanding had occurred regarding a recent alert about thickened fluids being left near people without supervision.

People's health was monitored by registered nurses/staff to make sure they received effective care and treatment to meet their physical and mental health needs. On the first morning of our inspection we spoke with the registered nurse on duty. They demonstrated a good knowledge of their role as the registered nurse for the nursing units and as support for care staff on the residential unit. They had a very good understanding of the needs of people throughout the home.

We spoke with a visiting GP who said the home had worked well with the district nurse team to improve the outcomes for people with diabetes on the residential unit. He stated that up to three months prior to the inspection the residential unit reported a high level of hypo-glycaemic incidents. This is when a person with diabetes experiences low blood sugar levels. The visiting GP said there had been an outstanding response by the staff working in the home to the support his surgery and the district nurses had put in. The numbers of hypo-glycaemic incidents was now lower and staff demonstrated a good knowledge of how to ensure people with diabetes received effective care and support. A visiting district nurse also confirmed there had been issues with the care and support people had previously received but following training and support from their team the home was managing the impact on people well.

Care plans indicated people had access to healthcare professionals other than the GP and district nurses. They contained records of chiropodist, optician and dental appointments as well as outpatient appointments at the local hospital and clinics.

We recommend the provider seeks information on current best practice on providing a dementia friendly environment which promotes independence.

Good

Is the service caring?

Our findings

Before the inspection we had received concerns from the local authority safeguarding team that people were not being treated and cared for in a dignified and respectful manner. Concerns raised mentioned people being left in soiled clothing, being shouted at and told to sit down when they wanted to walk around. However, throughout the inspection we saw very caring interactions with staff and were told how caring staff were. We observed people were well dressed and nobody was left in soiled clothing.

As soon as the registered manager had been informed of these concerns they and senior staff took action to discuss the issues with staff. A resident's relative meeting was also held. Staff were reminded through the team meetings, supervision and through internal memos the importance of treating people with dignity and respect and supported to be involved in decisions about their care and the way they spent their day.

People were supported by kind and caring staff who showed patience and understanding when supporting them with their care needs. Everyone was very complimentary about the staff who worked at the home. One person said, "They look after me, I'm treated with respect and dignity. It's all going extremely well, I have no problems with it. They have all been very nice to me". Another person said, "The care is very good here, I think it's a wonderful place. I choose my radio station; they treat us with respect and dignity." One relative said, "It's very good here. The staff are very caring, lovely, make you feel welcome. I can't say a wrong word about it." Another relative said, "They [staff] keep me informed and they are so observant and caring. I couldn't wish for [the person's name] to be anywhere else".

Throughout the inspection the whole inspection team observed very caring considerate and compassionate interactions between staff and people. There was an unhurried atmosphere with people given time to complete things in their own way. For example one person was distressed in the lounge. Repeatedly telling staff they were worried about a family member. On each occasion staff responded in a gentle caring way, providing them with the reassurance they required. They then took the opportunity to divert their anxieties by talking about their love of fishing. On Rose unit staff were observed to spend time with people laughing and chatting supporting them to enjoy their breakfast. One person said, "It's always like this, lovely lot really." One staff member said, "People are well looked after from what I have seen. Staff are caring. Different residents like different things; they make choices if they can." Another staff member said, "I like to think I care for the resident as I would for my nan and granddad. We spend quality time with people. I think the care here is fantastic. Staff go out of their way, they go above and beyond."

People were treated with respect and dignity. When people required support with personal care this was provided discreetly in their own rooms. One person said, "I am always treated with dignity and respect." One relative said, "They always listen to [the person's name] and treat her with kindness and respect." For example, we observed one person required assistance with personal care, staff assisted them from the lounge to the toilet area with the minimum of fuss protecting their dignity the whole time.

Each person had their own bedroom which they could access whenever they wanted. Some people chose to spend time alone in their rooms whilst others liked to socialise in communal areas. Staff respected people's

choices about how and where they spent their time. One person said, "I sit in my chair all day and stay in my room. I feel safe and I like to keep my door open." Staff were observed visiting the person throughout the day, one staff member said, "I like to make sure they are alright and not lonely, they do like to come out and join in sometimes so I make sure they have been reminded if something is going on."

Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Staff always knocked on doors and waited for a response before entering. We observed people responded immediately in a relaxed cheerful manner. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality. When they discussed people's care needs with us they did so in a respectful and compassionate way.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis. This enabled people who were able to express a view and relatives, where relevant, to make comments on the care they received and voice their opinions.

Staff were able to provide care to people who were nearing the end of their life. Care plans outlined how and where people would like to be cared for when they became very unwell. The home was accredited to the 'National Gold Standards Framework.' This is a comprehensive quality assurance system which enables care homes to provide quality care to people nearing the end of their lives. The registered manager confirmed staffing levels would be adjusted so the person had a member of staff sat with them at all times if they wanted.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found some care plans had not been updated to reflect how people's needs had changed. We also found the care plan for a person with challenging behaviours did not contain any information on how staff should manage their behaviour when they became distressed.

At this inspection we found improvements had been made in the way staff updated care plans when people's needs changed. We found care plans showed when changes had been made following a review of care needs or when the person's needs changed. We also found care plans for people with challenging behaviours contained information and guidance for staff including possible triggers which may indicate the person was becoming distressed.

Before the inspection we received concerns from the local authority safeguarding team that people were not being supported to make choices about some aspects of their day to day lives. For example people were being made to get up very early in the morning whether they wanted to or not.

As soon as the registered manager had been informed of these concerns they and senior staff carried out spot checks on night shifts and the early hours of the morning. They spoke with staff at these visits and at team meetings. The registered manager felt this was a culture adopted by a small team of staff. Staff confirmed the registered manager and senior staff had held meetings and one to one supervision. During these meetings they discussed the concerns raised and ensured all staff were aware people should be supported to maintain choice and control over when they went to bed and got up in the morning. Notices were on the office walls of each unit informing staff that nobody should be got out of bed early in the morning if they did not want to.

The minutes of team meetings showed the concerns had been discussed. However the minutes for one unit meeting showed how a culture of task orientated working had developed on that unit. This culture did not take into consideration the wishes and preferences of the people. For example it was recorded that one staff member said, "Night staff seem only to get the same people up every day which are the singles. Certain people like [person's initials] prefer to be up after 8am, and other residents such as [person's initials] prefer to be up earlier…. Can we take it into consideration to mix it up please? Some days there's barely anyone up, and I know nights can be short staffed sometimes but we always work really hard to make sure everyone has had personal care and most people are in bed by 8pm." This indicated that routines on the unit were organised for the benefit of staff rather than people's preferences and personal wishes. We brought this record of the meeting to the attention of the registered manager.

Following an initial assessment care plans were written with the person, as far as possible, or a responsible person where needed. One relative explained they had been able to have some input into decisions about the care and support agreed. They also confirmed they had been involved in reviews as and when changes had been identified. Care plans were personalised to each individual and contained information about personal preferences and wishes. Some care plans contained very clear life histories to enable staff to relate to the person better. However this was not consistent throughout the home. This meant care plans were not

being consistently used in a person centred way and people's preferences likes and dislikes could be overlooked. We discussed this with the registered manager, as a handout in the staff induction pack for care workers recommends, "reading the personal history in care plans, to aid communication with a resident who has memory problems."

The first day of our inspection was carried out at 0600hrs. We visited all three units and assessed the number of people up, washed and dressed. We spoke with six people about their wishes; they were all able to say they wanted to be up and had enjoyed a cup of tea. One person said, "I am always up early, I like it that way always have." Another person said, "I don't like getting up early but I can't sleep so no good lying around in bed." One staff member said, "We only get people up who want to or who are unsettled and at risk of falling." Another staff member explained, "[The person's name] was sat on the edge of the bed shouting so we have got them washed and dressed and they have had a cup of tea and biscuits." By 0800hrs there were a few people up on each unit however most people were still in bed with lights turned down low and sleeping. Care plans clearly identified people's preferences for going to bed and getting up in the morning.

During the inspection we did observe people making choices and exercising some control over their day to day life. For example, one person liked to spend their day sweeping the leaves up in the garden. Staff enabled this person to complete this task. The person would sweep the leaves and put them in a sack through the day. Then the night staff would put the leaves back so they would not be distressed at nothing to do the next day. Another person was observed sweeping the dining area after breakfast, they took pleasure in ensuring the area was clean and tidy. We also saw people choose to go out into the garden and staff supported them to wear the correct clothing for the weather.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. The registered manager confirmed they would only take a person into the home if they felt they could meet their needs. They confirmed the assessment would include the person, as far as was possible, healthcare professionals and relatives involved in their care.

The care plans we looked at were large and contained a lot of information. One unit manager said they did not like the lay out of the care plans and was working on ways to improve them. They confirmed a new format was about to be introduced. We discussed this with the registered manager and regional manager. They also confirmed the home would be moving towards using a new format which had successfully been used in other care homes within the organisation. The home also used 'mini care plans'; these were more concise about daily needs and enabled care workers to record people's daily activities, food, night checks and turns to prevent pressure areas developing. These mini care plans and the daily diaries showed staff provided care and support in line with people's needs. Care staff would also discuss the entries with senior staff to ensure the information was added to the main care plans and communicated at shift handovers.

Staff responded to changes in people's needs. Care plans showed they had been reviewed when people's needs changed. Each unit operated a 'resident of the day' system. This ensured each person's care needs were reviewed and the care plans were up dated to reflect changes in people's needs and wellbeing. One person said, "They mentioned some paperwork to me but I'm not interested. I get to do what I want and I can get around the place so I am happy." One relative said, "The communication is really good I am kept informed and involved in decisions."

At handover meetings staff discussed each person and made sure staff coming on duty knew about any changes in people's needs. We observed staff handover between shifts; this showed staff noticed changes in people's well-being. Staff told us if they had observed a person was unwell, or not their usual self, they

would inform the unit manager and a GP visit would be arranged. The local GP surgery visited the home regularly to review people's needs and carry out a surgery for people who were not so well.

People were supported to maintain contact with friends and family. One person said, "Plenty of chance for visitors they come and go all day." Another person said, "I like to sit here I can see everyone's family coming in and they always say hello to me." A visiting relative said, "I come here three or four times a week. I am always made to feel welcome and we can spend time in private away from the hustle and bustle if we want to." We observed one visitor brought their dog who had become a regular visitor and friend to many of the people in the home.

People were able to take part in a range of activities according to their interests. The home employed two activities organisers. At the time of the inspection one organiser was working in the home. They also directed care staff on what activities they could organise when they were not providing personal care. We observed people were occupied throughout the inspection. A visiting singer/musician visited on Rose unit with people from the other units joining in and there was much laughter and dancing. On the second day of the inspection people were observed enjoying the horse racing on the TV. Staff had arranged chairs so a number of people were laughing and talking about their preferred horse. A regular activity was provided by local school children who visited the home to do 'wake and shake.' This is a musical exercise programme for people to join in. One person showed us their knitting and we observed staff helping them with the wool. Another person said they liked to draw and colour pictures in. We observed staff provided them with suitable colouring books and pens. One person said, "I can get down here and join in the fun." Another person said, "There's plenty to do if you want to join in, depends what mood I'm in."

The organisation sought people's feedback and took action to address issues raised. Any issues raised from the feedback questionnaires were dealt with and people and relatives informed of the issue raised and action taken. For example, a visiting GP explained how the home had been very responsive and listened to suggestions made. This meant the outcomes for people on the residential unit were more relaxed and promoted wellbeing. Resident/relatives meetings were held so people could comment on the running of the home and make suggestions for change. One relative confirmed they attended regular resident/relative meetings.

There was clear documentation to show a complaint or concern had been received and how it had been managed. Complaints had been dealt with promptly and included outcomes for the person as well as a record of what could be learnt. This showed the service listened to, acted on and learnt from any concerns raised. For example staff had followed up an occupational therapy referral as a relative felt there had been some delays in obtaining a chair. The complaint was responded to with a clear explanation and the home offered to lend a similar chair until the referral could be completed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found improvements had been made arising from the previous inspection. At the previous inspection we found the services quality assurance procedures were not fully effective. We found where internal audits had identified shortfalls and areas for improvement, action had not been taken within agreed timescales.

At the last inspection although improvements were found we did not revise the rating from requires improvement to good. To improve the rating would have required a, "longer term track record of consistent practice."

At this inspection we found the improved practices had not been consistent with internal audits failing to identify when shortfalls had occurred.

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when a person living in the home experiences an accident that results in a visit to the accident and emergency department at a hospital or requires medical intervention. Another is when a safeguarding incident occurs.

The registered manager had delegated the management of notifications to a senior member of the management team. The registered manager and the delegated person had failed to send some notifications to the CQC and one following a safeguarding incident did not reflect the incident correctly. For example, no notification was sent for two accidents in February when one person fell and sustained a large wound to the head and another person sustained a fracture. One incident recorded in the home involved a safeguarding incident, no notification of this incident was sent to CQC. A safeguarding incident which had been notified failed to describe the incident correctly and was worded differently to the incident report in the home. Although some notifications had not been sent there was evidence that appropriate action, such as suspending staff and reporting to the local authority safeguarding team, had been carried out.

This is a breach of Regulation 18: of the Care Quality Commission (Registration) Regulations 2009 (part4). Notification of other incidents.

Although audits were being carried out some issues had been overlooked which resulted in delegated roles not being fulfilled. For example, the delegated duty of checking the falls audit in the home had not been completed correctly. The person had identified the number of falls on the 'monthly accident/incidents monitoring form' as 32. However, when reporting this on the organisations 'monthly accident/incident audit form', they failed to record the correct number of falls indicating only five. There was no evidence to show an audit of accidents/incidents in November or December 2015 had been carried out. When we asked for the audit of the accident/incident forms for January the registered manager handed us a box file thinking it contained the audit, however this only contained the forms with no audit completed.

We discussed the management of CQC notifications and the falls audits with the registered manager and the

regional manager. The registered manager thought all notifications had been sent in as required and agreed to send the outstanding notifications to the CQC. They also confirmed a meeting would be held later in the week and action taken to address the shortfalls.

There were quality assurance systems in place to monitor care, staff development, accidents and incidents. Audits and checks were in place to monitor safety and quality of care. However these audits had failed to pick up issues such as the lists of staff and people in the emergency grab file which were 11 months out of date, and the lack of a dementia friendly environment in the new unit. They had also failed to identify the failure to send notifications to CQC and incorrect monitoring of accidents/incidents by a delegated member of staff.

The regional manager explained the organisation was now being managed by a new provider. They had introduced their policies and procedures which had been shared with staff along with their own quality auditing system. The registered manager confirmed she would be using all the new auditing systems in future. The regional manager also confirmed the registered manager would receive support and they would be carrying out quality auditing visits to ensure the new systems were firmly embedded into the management of the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the last quality audit records for care plans and found shortfalls in the care plans had been identified. We checked against the issues raised and whether action had been taken. We saw the care plans identified had been corrected, reviewed and up dated as required following the audit. This meant the audit system for this area worked well. Other audits in place included such areas as: a monthly weight loss plan, pressure relieving equipment, bed rails, skin tear incidents, pressure area care, catheter care and any new infections. All these audits had been completed and any actions noted had been completed in a timely manner. For example pressure cushions had been provided or replaced and any concerns regarding people's weight had been referred to the local GP surgery.

Everybody spoken with said the registered manager was open and approachable, they showed a presence in the home through the day by visiting each unit and talking with people and staff. We observed very relaxed open and cheerful interactions with people, staff and visitors. The visiting healthcare professionals all said they felt the manager was open and ready to listen to suggestions for improvement. One person said, "Oh, I know her she's the boss always coming round, nice lady." One visitor said, "Communication is excellent I am always kept informed and involved the manager is always there to talk to."

Staff all confirmed and records showed staff received regular supervisions. These were either through regular one to one meetings or team meetings. This enabled staff to discuss working practices, training needs, and to make suggestions with regard to ways they might improve the service they provided. For example, one unit manager was making suggestions on how to improve the care plan format. Staff told us they had managed to discuss what training they wanted to do and had been supported to attend.

The registered manager had a clear vision for the home on their website they said, "Our philosophy is simple; we want everyone to enjoy life to the full. We never forget that all our residents are individuals and we treat them with dignity, privacy and respect while offering freedom of choice and as much independence as possible". We could see through staff meeting minutes this philosophy had been shared with staff, and staff we spoke with said they aimed to provide care support in a dignified manner. Observations throughout the inspection, with the exception of the new unit, supported the aim to provide an environment where

people could maintain some independence when able and enjoy themselves with meaningful activities.

People were supported by a service in which the registered manager kept their skills and knowledge up to date by on-going training, research and reading. They shared the knowledge they gained with staff on a daily basis or at staff meetings/supervision. The home also encouraged staff to obtain further qualifications, for example care workers had been supported to obtain their level two and three diploma in health and social care.

People were supported to share their views of the way the service was run. A customer satisfaction survey had been sent out in March and the registered manager was waiting for them to be returned.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Care Quality Commission of incidents which resulted in specific injury to people requiring medical intervention, and when safeguarding incidents occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for assessing and monitoring the quality of the service had not effectively identified the shortfalls relating to CQC notifications, an effective dementia environment, and the completion of falls audits17 (1) (2) (a), (f)