Four Crest Care (Watton) Limited

Lancaster House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

The inspection took place over two separate dates 27 February 2018 and 15 March 2018. A second day was scheduled, as severe weather meant not all the inspection team could be present on the first day of inspection. The first day of inspection was unannounced the second day was announced.

The service was last inspected 17 January 2017 and was found to be providing a good service and meeting all of the associated regulations. We brought forward a planned inspection to this service because of concerns raised by the local authority. We also received a higher number of safeguarding concerns and incidents between people using the service than expected for a service of this size. We wrote to the provider last year after concerns were raised with us about staffing levels, insufficient activities and whether the registered manager was being adequately supported. The provider sent us a suitable response and the local authority quality improvement team have been working with the service to help them identify and carry out improvements.

At our inspection, 27 February and 15 March 2018, we found the service had made some improvement and was addressing the concerns raised since our last inspection. We have rated the service as Requires improvement in responsive and well led because people have not always received good outcomes of care and at times had not been safe in the service.

Lancaster House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided. The service does not offer nursing care. Lancaster House is a service registered for 31 people following an application last year to extend the service from 17 to 31 people. The homes registration includes caring for people with dementia, mental health, older people, and younger adults. At our inspection on the 27 February there were 27 people using the service. Whenever possible the service considered where people's needs could best be met. The annex was predominantly for younger adults with mental health needs. The other unit was mainly but not predominantly for older people with mental health or living with dementia. Some people had a dual diagnosis of mental health and dementia.

The home is situated in the town of Watton within easy reach of amenities and had adequate parking.

The service has a registered manager who had a background in mental health. They have been registered since 2015. 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.

At our most recent inspection on 27 February and 15 March 2018, we found improvements were being made but not firmly embedded. Undoubtedly, there had been a number of concerns with this service since the change of their registration to increase their bed numbers. The increase in numbers is likely to have had an

impact on the stability of the service and we found some people's needs were not compatible with others. This was being addressed by the service and some people had moved on or were being supported to find an alternative service. Effectively the registered manager's workload had increased and they did not have any administrative support or a deputy manager. They were working long hours including being permanently on call for this service with insufficient support from the registered provider. This put a strain on the service. This situation has since improved. The registered manager is supported informally by the registered provider and has extended networks of support. They have in place two senior staff who they have sufficient confident in and able to share some of the responsibilities and on-call so they can have some time off. This needs to be developed further to ensure staff are competent and can work independently and carry increased responsibilities. Staffing levels should also be kept under review as the needs and likely input each person requires could vary significantly particularly when some people receive a transitional service.

The safety of people using the service is paramount and this at times had been compromised by people living together who did not always get on and had incompatible needs. The registered manager had been proactive in meeting with health care professionals and local authority to ensure where needs could not be met they were supported to find somewhere else to live which was more appropriate. Safeguarding concerns had not always been dealt with effectively but lessons have been learnt and we found staff had sufficient knowledge and confidence in the registered manager to report concerns. The registered manager had worked closely with the local authority developing and working towards action plans to improve the service for people using it.

We found the service was not yet sufficiently responsive to people's needs both in terms of providing enough social stimulation or demonstrating individualised care and support. Some of which could be attributed to staffing levels. We found records although reviewed did not always clearly demonstrate how risks had been monitored or reflective of the care provided.

There were safe systems in place to ensure people received their medicines as required and staff had the necessary training and skill to do this. Staff monitored people's health care needs and sought advice and guidance when necessary. People received appropriate end of life care.

Staff recruitment processes were sufficiently robust and new staff were clearly supported throughout their induction period. There was a regular programme of training and support for all staff.

The Commission is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found people's rights were being upheld and staff supported people in lawfully and in line with legislation around mental capacity and deprivation of liberties.

People were supported to eat and drink in sufficient quantities for their needs and any concern about this was monitored to help ensure risks were managed. However, records did not always clearly reflect this.

Staff demonstrated good interpersonal skills and communicated with people effectively. They adopted a calm approach with people and exercised tolerance and understanding. People's independence was facilitated and staff respected their dignity.

Feedback from people was asked for but this needs to be developed further to ensure everyone's views was known and taken into account when planning the service.

The service had an adequate complaints procedure and gave people opportunity to raise concerns/suggestions about the service.

The premises were being refurbished and were suitable for purpose but lacked sufficient space to help ensure people's privacy.

The registered manager had worked hard to bring about stability and improvement. They kept their practices up to date and provided effective leadership. They were knowledgeable and supportive. The service had effective quality assurance systems and improvements were being made to the service.

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 enough staff to meet people's assessed needs and keep them safe. .

Risks were mostly well managed but there were gaps in reviews and paperwork. Staff knew how to respond to allegations of abuse and were confident in reporting concerns.

Medicines were administered as intended by staff qualified to do so.

Staff recruitment processes were sufficiently robust.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and supported in their role.

People were supported to eat and drink in sufficient quantities but the monitoring of this was not always adequately recorded.

Staff supported people lawfully and promoted their choice and well- being.

Staff supported people with their health care needs and to access services as needed.

Is the service caring?

Good

The service was caring.

People were supported to be independent and staff provided respectful care.

People's needs were known by staff who supported them.

People were consulted about their needs and the care provided.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People's needs were not always compatible leading to incidents between them.

Staffing was not always sufficient to meet people's needs in regards to their individual interests and hobbies.

Care plans were not always up to date and records did not always provide a detailed contemporaneous note.

There was an established complaints procedure and people's feedback was considered in terms of service delivery.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements needed were being addressed by the service but were not fully embedded.

The service benefitted from an experienced manager who provided necessary leadership and direction. Staff competencies and skills needed further development to ensure people received a seamless service in the absence of the registered manager.

Audits and quality assurance processes were sufficient in identifying areas for improved service delivery but more account needed to be taken of the service user's experience.

Lancaster House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. We also received some concerns from the Local Authority about this service. We also received a higher number of notifications than we might expect from a service of this size. We brought forward a planned, comprehensive inspection to assure ourselves that the provider has mitigated risks appropriately.

The inspection was unannounced and took place on 27 February 2018 but was hampered by poor weather. We were unable to finish the inspection so arranged to go back and this did not take place until 15 March 2018. The inspection was undertaken on the first day by one inspector 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. On the second day, one inspector undertook the inspection.

Before the inspection we reviewed information already held about the service including past inspection reports, notifications which are important events the service are required to tell us and feedback from other health care professionals. We also received a provider information return. 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.

During the inspection, we spoke with three care staff, a senior member of care staff, the cook and the registered manager. We also spoke with twelve people who used the service, three sets of their relatives and a visiting healthcare professional. We have spoken regularly with the Local Authority prior to our inspection.

Throughout the day we carried out observations of care. We looked at four care plans and we reviewed medication records, staffing records and other records relating to the management and running of the service.

Good

Is the service safe?

Our findings

At the last inspection on 17 January 2017, we found this service was good in this key question and people received safe care. At our most recent inspection on 27 February and 15 March 2018, we found the service remained safe.

People spoken with told us they felt safe living at the service and safe when being assisted by care staff. Everyone spoken with felt there were sufficient staff to help them when needed.. One person said, "I feel well looked after here; staff come fairly quickly when you need them." Another said, "All I have to do is ring and they'll come and help you."

One family spoken with could not praise the home highly enough. They said their relative's behaviour had changed dramatically and they no longer had outbursts and became distressed. They said the environment was good with consistent staff members who were caring. They said on occasion there had been minor incidents involving others but they were always notified so did not have any concerns about what happened when they were not there.

Staff had a good understanding of risk.There were some restrictions on people using the service but these had been agreed. Individual risks assessments showed the involvement of the relevant people particularly where a person had no or fluctuating capacity. Risks were assessed in relation to people's mental health, physical health and any risk from the environment. For example, some people smoked and were not considered safe to be left with cigarettes and lighters. There were agreed protocols around this.

Staff had received training to enable them to respond adequately to suspected abuse and report it as required. Staff knew how to raise concerns and whom they should raise them to. They were confident they would be responded to. The local authority raised concerns with us before our inspection about a specific allegation of abuse, which had not been reported adequately so the correct actions could be taken. This allegation has subsequently been reported and investigated. Staff disciplinary action was taken in relation to this incident as it was poorly managed and not reported as an incident at the time. Lessons learnt have been shared with staff to ensure they have sufficient awareness of reporting any incident as required and keeping adequate records.

Prior to the inspection, we noted a high number of incidents occurring at the service. We have attributed this in part to an increase in resident numbers and a change to the services statement of purpose. The service now provided support to younger people with mental health issues in a separate, newly built annex. The registered manager told us they had reviewed people's needs taking into account any recorded incident, compatibility with others using the service and environmental and social issues. They told us a number of people had moved. For example one young person who was not sufficiently socially stimulated. The level of incidents has significantly reduced and staff were more confident in dealing with people and diffusing situations before they resulted in a significant incident.

We reviewed all the recent notifications. They were sufficiently recorded, well managed and reported to the

safeguarding team and local authority where appropriate to decide on the course of action. The registered manager sought advice and updated documentation accordingly. For example, we saw one person pushed another over, both were deemed to lack capacity so no criminal element was considered. This resulted in a safeguarding notification and CQC notification so actions could be reviewed. The incident had been discussed with relevant social workers and families and risk assessments updated.

Staff received regular one to one support and met as a group, minutes of their meetings were viewed. This demonstrated how staff were kept up to date and incidents were reviewed to see if actions taken were appropriate to risk. This helped ensure this was a learning organisation and staff learnt from mistakes in a positive, supportive way.

We reviewed peoples care plans, which included risk assessments and risk management plans around people's behaviours. They also detailed how to support people with anxiety, self- harming behaviours of conflicts arising between people. Individual risk in relation to people's manual handling needs, nutritional needs, skin integrity and managing of long term conditions such as diabetes were recorded. Falls were monitored to ensure actions taken were least restrictive and appropriate to risk.

Checks on the environment and equipment used were carried out regularly to ensure the service was safe and any risk had been assessed to help ensure risks were mitigated as far as reasonably possible. We looked at a sample of records such as fire safety records in relation to drills, fire alarms, emergency lighting and fire - fighting equipment. Individual evacuation plans and risk assessments for paraffin-based creams were in place.

There were regular tests to ensure there was no presence of legionnaire's disease and water was at the right temperature to avoid scalding. Electrical testing both five yearly and individual portable appliance testing was completed. We saw gas safety checks and tests on hoists and slings and a programme of planned and routine testing and maintenance to ensure its safety.

Before the inspection, we received information of concern about the staffing levels in the annex. We found at this inspection staffing levels were at times compromised, for example at meal times and when staff were taking their planned breaks. Staff in the annex worked in pairs but told us when they took their break the other staff member was on their own but could summons assistance if needed. In addition the manager was at the service during the week and provided regular support to staff. Staff told us how unpredictable some people's behaviour could be and said there were times when they needed three staff to ensure they could meet every-ones needs and keep everyone safe. This was possible within current staffing levels. Staff told us they could do with more staff in terms of activities.

The registered manager was confident there were enough staff and had increased activity hours but we felt they should also review whether additional staff were needed at peak times of the day. On both days of our inspection, there were enough staff to meet people's needs in a timely, responsive way. There were five care staff, one of whom was a senior and leading the shift on the day of our inspection. The registered manager's hours were supernumerary but they were there most of the time and worked tirelessly to support staff on shift. There was also kitchen and domestic staff. Staff roles were being reorganised after the departure of one senior staff and the recruitment of another who was still on probation and studying for a care qualification. The registered manager said there was only one vacancy for a night post, but day staff were covering this and they were recruiting for occasional bank workers. The service had introduced a dependency tool, which helped them identify staffing hours required according to the needs and likely support people might need. The registered manager said this was reviewed regularly and adapted to the needs of the people using the service.

There were safe systems in place for the management and administration of people's medicines. We observed staff administering people's medicines and they did this safely. Staff took their time to explain to people what medicines they were administering and gave people time to take it.

Staff administrating medication told us they had received training and had regular updates. When first administering medicines staff observed and then were observed giving medicines to assure they did it in line with the medicines policy. The number of observed observations of practice was dependent on staffs confidence and competencies. Should an error occur staff would refrain from medication administration and be retrained and observations completed.

A designated senior staff member ordered all the medicines and carried out audits. They told us audits were done monthly where every single medicines administration record was checked against the available stock and for any inaccurate recording. The supplying pharmacist had carried out a recent audit and this identified a number of minor issues, which staff told us had been addressed immediately. The senior staff member told us other staff were able to do this if they were off. They were knowledgeable about all aspects of medicines storage and safe administration. They told us no one currently administered their own medicines but there was a protocol in place and this was discussed as part of the admission process. They said one person administered their own creams and there were body maps showing where cream should be applied.

The senior staff member confirmed that 90% of staff were trained to administer medicines and that on each day this was carried out by two staff members .One member of staff for each unit so this did not take an onerous amount of time and helped ensure people received their medicines as intended. They were able to tell us what medicines people were taken and if medicines were time critical.

We reviewed records which clearly identified what medicines people were prescribed, what it was for and when it should be taken. People who were prescribed as and when required medicines (PRN) had protocols for their safe use in place. One person had their medicines covertly, this had been discussed with their GP and a best interests meeting held. There was clear guidance in place to ensure staff acted lawfully. Where medication had been refused, this was recorded and staff said this would be discussed with the persons GP when necessary.

We checked some medicines in stock and found they tallied with what the records said they should have. We saw creams and drops were dated when opened and medicines were securely stored at correct temperatures. The service did not have a returns book for medicines taken back to the pharmacist. They said this was kept at the pharmacist. The home needs to retain a copy of all medicines returned. This was fed back to the senior.

We found the service to be clean, and hazard free with no obvious odours in the main part of the home but some isolated odours, which were being regularly addressed by domestic staff. We observed good infection control procedures throughout the home. Cleaning audits and schedules were in place and adequate staffing levels ensured good cleaning standards.

Staff records were secured safely. They provided evidence of robust recruitment checks to ensure staff were of good character and had the necessary attributes to work in the care setting. Staff records included an application form with work and employment history, references, a disclosure and barring check to ensure they were not barred to work in care or had committed any offence, which might make them unsuitable to work in care. There was documentary evidence of their identification and proof of address and interview notes.

Good

Is the service effective?

Our findings

At the last inspection on 17 January 2017, we found this service was good in this key question and people received effective care. At our most recent inspection on 27 February and 15 March 2018, we found the service remains effective.

People spoken with were confident with the staff. One said, "I felt safe with them. Staff here seem to know what they're doing." Another said, "The staff seem to be well enough trained." We were confident that the registered manager had good knowledge about the care sector and underpinning best practice and legislative requirements. They were able to demonstrate that they kept staff up to date with best practice through the sharing of information and training up dates. They networked with other professionals to share their experiences and reflect on best practice.

The registered manager did not have a deputy manager but there were two senior staff in place, one was very experienced and both seniors worked alternative weekends and shared the out of hours on call. Senior staff were observed as highly competent and the registered manager provided good direction and leadership. The registered manager was a train the trainer for multiple subjects and did the bulk of the training in house and when required. Some staff had specific roles and oversight for different areas of health and social care. There was a dignity and respect champion, an oral hygiene champion and an infection control champion. The manual handling champion had left and the registered manager said they would be replaced. Champions were chosen because of their specific knowledge, experience or special interest and would support staff and promote good practice in the workplace. New staff completed the care certificate or equivalent and over half the staff had additional qualifications in care. The registered manager was engaging with the relevant organisations including the local authority to help ensure training was relevant, up to date and reflected best practice.

Staff received regular training updates to help them support people in the service. Training included supporting people who behaviours could put themselves or others at risk. Staff were confident in their approach with people and one family told us how their relative no longer had, 'regular outbursts.' However, some staff told us they did not get specific training around mental health and this would be useful given the people they were supporting. The registered manager told us training did include a bit about mental health and training included case studies, which helped staff focus on the needs of people they were supporting. Some staff were more confident than others depending on their level of experience.

Records showed that all staff had received a recent one to one supervision, the registered manager had scheduled staff supervisions in advance, and this included an annual appraisal of their performance. Staff were subject to a probationary period, which could be extended, and staffs performance was reviewed at the end of their probationary period. Staff were monitored in an ongoing way whilst on probation. The registered manager had previously completed all staff supervision but had now delegated this to senior staff. The registered manager supervised ancillary and senior staff.

We reviewed staff records. They provided evidence of training undertaken and evidence of induction and

ongoing support throughout their employment. The induction process covered the environment, health and safety, and key policies. Staff then completed the care certificate, which is a standardised nationally recognised induction for care staff, particularly those new to the care sector. The registered manager confirmed new staff shadowed staff that were more experienced and this could be demonstrated by staffing rotas. However, there was no evidence of shadow shifts or what new staff had been observed doing or any gaps in their practice. A record of this would be helpful particularly when evaluating staff performance as part of their probationary review.

We observed the lunchtime meal on both of the units. This was well managed in the first unit where we observed 11 people eating lunch in the dining room. There were three care staff and the registered manager serving meals, taking meals to people in their rooms and assisting people who needed assistance with eating and drinking. In the second unit, (the annex) there were only two staff, and although people received adequate support around their needs we found the atmosphere poor. There was a joint living and dining area and people were unable to all sit together should they want to. There were no condiments on the table, which hindered people's choice. Food was served on plastic plates without first assessing if this met with people's preferences. These factors did not support a good dining experience.

The lunch menu was varied and had been discussed with people in terms of their preferences and meal choice. Everyone spoken with said that they liked the food. One person said, "It's very good; you'd love it." Another said, "The food is very good. You can choose your breakfast in the morning; the roasts are very good; you can get drinks whenever you want."

People were encouraged with their food and fluid intake but staff were not always flexible in their approach. People were all offered same size portions with little variation. One person was asking for more and was told they had already had their desert. The nature of this person's personality was to make continuous demands on staff. However, staff did not check if the person was actually hungry and denied them more food.

Through our observations, we saw staff asked people what they wanted to eat. Information was given verbally and some people struggled to make a choice. For example, one person said, "I will eat whatever you give me." The chef told us they were in the process of completing picture menus to enhance people's choice. We noted with the drinks trolley people were offered choices of tea, coffee, hot chocolate, biscuits and apples. Staff told us snacks were available for people.

Any concern about people's eating and drinking would be referred to the GP and they would be prescribed supplements or food and drink with a higher calorie content. No one was currently on weekly weight monitoring or identified as experiencing unintentional weight loss. It was difficult for us to assess how staff were adequately monitoring people who might be reluctant to eat regular meals due to an absence of clear reporting on this by the service.

We met a person newly admitted to the service who was very active and anxious in their new surroundings. The service did not have detailed recordings of what they were eating and drinking which would help them to establish a baseline of their routines around food and drink and whether their intake was good, adequate or poor. This would enable the service to assess the person's needs and taken action if necessary.

All staff understood people's nutritional needs. The registered manager was trained in using the malnutrition universal screening tool, (MUST) and had signed up for quarterly meetings with the dietician to keep up to date with best practice. They regularly cascaded information to staff.

We spoke with a visiting health care professional who did not have any concerns and reported some

improved practice particularly around the management of pressure care. One person had acquired a skin tear on the day of our inspection. A reasonable explanation was provided for this and the district nurses who were on site daily offered timely treatment. One person had a pressure ulcer but there was an effective treatment plan in place.

People had their health care needs met and staff were proactive in monitoring people's needs and flagging up any changes with the relevant health care professionals. One person told us, "They'll get a GP for you if you have an accident like a fall or an infection, but when it's something minor they've told me I'll have to get my daughter to take me to the doctor".

Staff raised concern about ordering the medicines and said there were sometimes issues with new medications being put on the medication script and they had to follow this up but said things had improved. They told us they had met with the practice manager and the home was supported by a nurse practionner so any issues like this could be flagged at the earliest opportunity and resolved quickly. They were new to post and had helped ensure people received continuity and were seen in a timely way. Prior to this staff reported some delays and fragmentation in terms of people's health care needs. The service had a GP book in which they recorded anyone needing an appointment or any one seen by the GP or the nurse and this included regularly assessing people where there might be a suspected infection. Staff had access to relevant health care guidance and best practice in care for older people and in mental health. People's records evidenced recent involvement and appropriate referrals to other health care professionals Weight records viewed showed people had static or increasing weights, although one person had weight loss and was still on monthly weights despite a falling body mass index.

The registered manager said it could be difficult to access a domiciliary dentist to visit the home so the expectation was for people to visit their own dentist.

The building was appropriate to the needs of the people using the service. On the second day of our inspection, we noted much of the home had been painted and there was ongoing refurbishment. There were two units and the doors between were key coded. The annex was all on one level with bedrooms going of the main lounge and dining room. The bedrooms were adequately furnished and personalised to people's taste. The dining room and lounge were open plan with a number of lounge chairs situated around the perimeter of the room. In the annex, there were not enough lounge chairs for everyone to sit together if they wished. There were limited private areas for people to use to meet their friends or relatives other than their bedrooms. There was a small room they could use but this was also used by staff to meet and to store confidential records. We spoke with relatives who were visiting their family member in their bedroom. The relatives were standing up as there was nowhere for them to sit other than the person's bed. People had access to a secure courtyard garden.

The registered manager clearly understood the MCA and DoLS and ensured people were supported lawfully. Where people lacked consent to make specific decisions around their care, welfare and treatment others were consulted about their care to decide what was in their best interest. Consultation and collective decision making was articulated in best interest decisions. Where there was a doubt about a person's capacity an assessment was conducted to establish capacity.

The registered manager told us a number of people have a Deprivation of Liberty Safeguard in place and these had been authorised by the Local Authority to help keep people safe. The manager provided an up to date list, which included dates DoLS had been applied for, and granted, and those outstanding. Most people were considered unsafe to go out unescorted and were restricted in the sense that there was not always staff to go out with people, as they may like.

Good

Is the service caring?

Our findings

At the last inspection on 17 January 2017, we found this service was good in this key question and the service was caring. At our most recent inspection on 27 February and 15 March 2018, we found the service remained caring.

Staff received induction, training and support to help them provide good care which respected the rights and dignity of each person using the service. Enhanced training was provided around meeting the needs of people living with dementia and how it might affect each person. This helped ensure staff could support the person effectively and reduce any emotional distress. Staff were also trained in providing end of life care so they could support the person at the appropriate time. We observed staff delivering kind and compassionate care to people they were supporting. They were responsive to people which enhanced people's well- being.

People spoken with all said they were happy with their care. For example, one person said, "This is a lovely home. They're lovely people." Another said, "They are very kind and nice." Another said, "They're very friendly and sociable here. At the moment things are going alright and I'm quite satisfied". One person said "I prefer living here, (than in my previous home) because they seem to understand mental health issues better than where I was before."

Changes were being implemented at the service, which would enhance people's emotional well- being. This included changes to the environment so it was more harmonious with people's needs. The registered manager said they wanted to create a dignity tree or memory board where they celebrate the uniqueness of people using the service. The service need to demonstrate how the service is provided to individuals based on the unique characteristics, gender, age and personal preferences.

A number of people had struck up friendships with each other and staff supported this. One person had moved rooms to be next to another and we saw people sitting together and chatting. There was a mix of ages, which appeared to work well and enhance people's experience. We saw staff enhancing people's well-being and striking up conversation. One person reported to being fed up, staff immediately acknowledged them and started to talk to them about things that interested them and things they liked to do. This had a positive effect on the person's behaviour who clearly enjoyed the interaction of staff. We spoke to visiting relatives who felt it was a lovely service with kind staff. One told us there were no restrictions and they could visit when they wanted. They said they were very happy there and had built good relationships with staff.

We noted one person had been involved in a number of alleged safeguarding incidents some of which were around them thinking people were stealing from them. They did not have access to their own money and we discussed this with the registered manager to see how they could reduce the person's anxiety. Peoples' care plans generally stated how staff could increase people's independence by enabling them to continue to do what they could do for themselves and developing the confident and skills to move on to more independent accommodation where appropriate. We saw the support provided to people was based on their individual need and staff were sensitive to each person and the support they required.

Staff confirmed routines were flexible to suit people's needs and their preferred routines. Staff said there was a key worker system, which meant people had continuity around their care needs and a key person to refer to.

Families reported being involved in reviews and consulted about their family members care and any adverse event. Staff confirmed there were resident/relative meetings and one to one reviews.

People reported that staff did respect their privacy and always knocked before entering their room and gave them choices about what they wanted to do.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 17 January 2017, we found this service was good in this key question and people received care that was responsive to their needs. At our most recent inspection on 27 February and 15 March 2018, we found the service was not always responsive to people's individual needs. We have rated this key question 'Requires improvement.'

Staff spoken with were aware of people's needs but we observed that staff practice was not always consistent. For example, a person who was very hard of hearing was supported to their feet by staff. They were confused and unable to hear staff. Several staff tried to assist the person without clearly explaining and communicating with the person about what they wanted them to do. This resulted in the person sitting down again. Another staff member took over and was clear and direct and said 'up on the count of three,' this was much more successful.

Throughout the day we saw that there was limited activity for people to engage in. We spoke with people about this. We noted the names of "quiz champions" were displayed on a downstairs notice board with the same four people's names appearing over the previous six-week period. One person told us. "Yesterday we played monopoly and we have quizzes, sing a longs and a religious service usually each week. I enjoy the sing a longs and I like reading. There are a lot of books in the library downstairs."

One person was observed sitting by themselves all morning, staff interacted with them at times to offer encouragement with drinks and meals and to assist with their medication. They were considerably younger than other people on the unit. They told us, "I would like more activities like bingo and games and I would like somebody, (staff) to have more time to talk to me". Another younger person told us, "Living here is good apart from the age gap with the other people here. There is not a lot for me to do downstairs so after breakfast I come back upstairs to bed. While I am asleep, I am not bothering any one."

One person went out independently, however most were reliant on staff or family to go out. Staff said they could not take people out in their own cars, as they were not insured to drive them but said they had hired a minibus and went to the pantomime. Some people sat in the same position for a long period of time and were falling asleep. Staff were very attentive to people and constantly stopped to chat and joke with people. However, we noted staff tended to interact with the same people because they were easier to interact with or their proximity to the door. This resulted in a differential experience for people. The registered manager told us some people liked to initiate conversation but others did not.

We discussed the lack of regular activities with the registered manager as we were aware the local authority had raised concerns about this also. The registered manager had pulled together an action plan stating how they were going to address this. They told us one person was employed specifically to provide activities and they worked ten hours per week. They subsequently confirmed following our inspection a second person had been appointed to assist with activities. The registered manager had some ideas to enhance people's social opportunities and support their emotional well- being. They told us about things they had tried like paying for a therapy dog and they were waiting for insurance to host a mother and baby group, sing and sign

session which has known benefits to older people. They spoke of getting pet rabbits and having games and technology, which was suitable for the needs of people using the service. For example, sound bingo. They told us at Christmas a choir had visited to perform and there was a person who regularly played the organ. They said there was a regular church service. They also told us they were going to plan a couple of trips for the summer, although did not have designated home transport to do this.

We have rated responsive as requires improvement, as the improvements planned by the provider were not fully implemented or firmly embedded within the service. We found people's experiences were limited. However, we were encouraged by the ideas the registered manager was considering which were suitable for people's cognitive and sensory needs. Some of the ideas involved creating interactive boards, and breaking up the physical space within the home in interesting ways and developing the outdoor space. This involved creating a sensory garden.

The registered manager told us there used to be an activity planner but they no longer used this but asked people on the day what they wanted to do. Most people spoken with were not able to tell us if they participated in anything recently or regularly. The registered manager said resident/relatives meetings were not regularly held and where they had were not successful. They said they provided opportunities for one to one meetings. The service did not have a newsletter so it was difficult to see what had taken place or what was planned and any recent changes within the service.

Relatives raised a concern about their family member and the level of activity provided particularly as they liked to stay active. They were just settling in and we observed them constantly seeking out staff and being involved in house hold chores such as folding laundry. Staff were doing their best to support them but could not always keep them suitably engaged.

We reviewed a care plan in relation to a person who we had received a statutory notification for. Following an incident, they were admitted to hospital but subsequently discharged and then readmitted. The person's health was failing and they required more care but we found their care plan did not reflect the changes in their needs. A more robust response is needed in relation to assessment and review.

Similarly we had concern about records not being updated in a timely way to demonstrate a change in need or risk. In relation to the person above we identified that their medication had been changed. This information was not reviewed in line with their falls risk assessment and could have increased their risk of falls. Neither did their risk assessment record their poor vision which is a significant factor in the increased risk of falls.

Weight monitoring was also a concern by the fact that everyone was weighed monthly and changes in people's health or circumstances did not always result in the person being weighed again such as after an illness or discharge from hospital. Being weighed monthly is a long gap for people at their most vulnerable and weight loss measurements could act as an early indicator that the person's health is changing.

We reviewed care plans, which were in sufficient detail, but they were difficult to navigate for staff who did not know the person and might not know how to support them. A summary of peoples care and support needs such as a one- page profile would help ensure all essential information was stored in one place. The registered manager took our feedback on board and by the second day of our inspection showed us how they had started to review and reshape the care plans. The information was person centred and focused on what was important to the person and what people's preferences were in terms of preferred routines, and any specific considerations such as gender specific care, favourite clothing and food preferences. The registered manager said people were involved in their care plan, support, and review of their needs where

they were able to contribute. Family and other health care professionals were also engaged with to ensure people's needs were being met as accurately as possible. We saw samples on one to one reviews. Care plans included what people could do for themselves and what support they needed. This helped ensure staff could promote their independence and autonomy.

Some people had complex mental health needs. There were risk assessments, support plans and for some people crisis intervention plans to help staff know about people's negative behaviours and how they should support them with these. Plans gave step-to-step actions staff might consider including the use of medication to calm people's anxiety but this was only to be considered after other strategies had not worked.

People's daily notes included if people had done any activities or if they had refused. Some records were poorly kept, for example, staff were not always using the correct form but sometimes recording information on blank paper and not always remembering to sign and date records, which meant that in the future these records would not necessarily provide an adequate audit trail. Gaps in recording information were identified for example in food and fluid records. These were put in place where there was a concern about a person's weight or erratic eating habits due to poor mental or physical health. However, several records seen did not accurately record what people had or had been offered and did not provide a thorough record. One relative reported that their family member sometimes appeared lethargic and wondered if they were always getting enough to drink. They were reported to eat and drink well but needed encouragement. They were not on a fluid chart.

We reviewed end of life care information in people's records. There was a thinking ahead document which in some cases was recorded and asked people about their wishes around their death. For example would they wish to be resuscitated, where would they liked to be cared for and any special wishes or considerations in terms of family to be contacted or any religious considerations. Details of where people were not for resuscitation were in place where appropriate and drawn up with consultation of relevant professionals. Staff were supported to provide good end of life care and knew how and when to contact relevant health care professionals and worked in partnership with them.

The service took into account feedback from people who used the service, although this was poorly documented as part of the provider audit. The audits had only just started to be recorded and did not report on who had been spoken with or their feedback. All those spoken with said that if they had any complaints they would feel free to raise them. One said, "The manager is quite approachable and nice to speak to." An open session from 2pm to 4pm every Wednesday was advertised on the notice board when anyone was invited to meet with the registered manager and raise any issue they might have.

We reviewed the complaints procedure and saw that complaints were responded to appropriately and within the given time scales. We also saw complimentary letters and cards in the support of the service. Relatives recalled being asked to fill in surveys to give their view on the home but could not recall seeing a newsletter or regular programme of activities.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 17 January 2017, we found this service was good in this key question and the service was well led. At our most recent inspection on 27 February and 15 March 2018, we found the service had experienced recent challenges but had responded to this and taken necessary actions. However, some of these changes were not clearly embedded in the service. Some people had experienced poor outcomes in relation to their personal safety and others did not have sufficient occupation or structure to their day.

We found the registered manager very knowledgeable about people's needs and a good advocate. They supported staff and were observed correcting or questioning staff when appropriate to do so in a supportive way. We discussed with the registered manager concerns that had been raised with us about staffing levels and the overall management of the service particularly in the registered manager's absence. The registered manager said they use to be on call seven days a week but now this was shared between the senior staff so they had every other weekend off. They said the provider was giving regular support but did not have a care background. They did however respond to anything to do with the building and provided practical support. They said they were responsive to any requests they made.

The provider visited the service regularly to support the registered manager and audit the service. However they had not been carrying out audits for a short time and neither had they been recording these to show how they were running an effective service and evidence or actions taken. The provider was unable to demonstrate that audits were linked to the key lines of enquiry we use as part of our inspection or that audits reflected people's experiences. The registered manager told us they had received some recent support from the Local Authority and were working through an action plan to address improvements identified. We were provided a copy of this.

Staff told us the registered manager was supportive, knowledgeable and hands on. They said they tried different approaches to adequately support people. By this they referred to problem solving and identifying what the person responded to.

We spoke with the registered manager about their work load after their recent time off. We felt the wide range of needs and dependency of people in the home was likely to pose particular challenges for both staff and management. The present structure placed significant reliance on the manager's availability, and potentially provide an unduly stressful working environment for the registered manager. They told us they had a good team in place but liked to be there to oversee the care being provided. We were concerned that the registered manager was carrying a lot of responsibility herself including most of the staff training. They were also supporting staff on shift and balancing all the administrative tasks required. This put a lot of pressure of them and the service supported people with complex needs. Staff could be supported more to develop the necessary competencies and skills to take on more roles currently done by the registered manager. Additional staffing at peak times of the day and more staff to help support the setting up and carrying out a robust activity programme would enhance people's well- being.

The service had a quality assurance system in which they asked and collated feedback for people using the

service. In the entrance was a suggestions box. They also sent out surveys, the latest being 1 November to 31 December 2017. These were left at reception. They had been completed by a social worker, a physiotherapist, a contractor, two relatives and two people using the service. There were no comments of concern other than the level and range of activities. Most people had not recently been asked or completed a satisfaction survey so we were not assured the current quality assurance systems was as effective as they could be. However, people had regular reviews of their needs and weekly surgeries were held.

The registered manager explained that since changing their statement of purpose to include a separate unit and a service for younger adults they have had an increase of incidents as people adapt to their new environment. They explained some people had moved from very restrictive environments so had to do a lot of adjustment. This had resulted in person centred reviews to look at where people's needs could best be met. Several people had moved and this had resulted in a reduction of incidents. Incidents/accidents, falls and other risks were closely monitored and reported and appropriate actions taken including lessons learnt.

The registered manager told us they were an accredited dementia coach and linked regularly with other care home managers for support and to share best practice. They told us they kept up to date so they could cascade their knowledge to other staff. For example in their role as a dementia coach. They attended Local Authority training when they could which gave them further opportunity to network.

We looked at a sample of records, which showed how the registered manager was overseeing the service to ensure it was safe for people to use and staff had the necessary training to support people. Checks on environment and equipment were regularly made to ensure these were safe. The registered manager sent a weekly report to the provider, which highlighted any risks or gaps in service provision including staffing vacancies. They also included a list of any accidents, incidents and falls, which had occurred at the service. The relevant paperwork was in the service but on the collated document, we could not see all the actions taken. For example, where a person fell out of bed, an ambulance was called but the outcome of this was not detailed. The registered manager was able to tell us but this should have been clearly recorded. The registered manager agreed to add an outcomes column to this record.

The registered manager took necessary action to reduce the risk of people developing pressure ulcers. They completed a pressure ulcer audit and acted on the advice of district nursing services to help ensure people got appropriate care.