The Orders Of St. John Care Trust

Hayward Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the previous inspection in October 2016 we found breaches of Regulation 9 because staff were not following guidance to ensure people's needs were met. Guidance to staff on meeting people's needs had not improved and we repeated the breach.

This is the third time this service has been rated as Requires Improvement since 2015 and we are considering what further action will be taken in response. Full details of CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

This inspection took place on 21 and 22 March 2018 and was unannounced. The registered manager was aware of the visit arranged for the second day of the inspection.

Hayward Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hayward Care Centre is registered to provide accommodation for up to 80 persons who require personal care. The service is arranged over four units Avebury, Bromham, Keevil and Potterne. Specialist dementia care is provided to people accommodated in Potterne. At the time of the inspection there were 68 people living at the service.

A registered manager was not in post. The current manager told us they will be applying to register as manager. '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.'

Risk management systems were mostly effective. The staff we spoke with were knowledgeable about people's individual risks and the actions needed to minimise the risks. Risks were assessed and for some people risk assessments were developed but lacked detail on how to minimise the risk.

There were people who expressed their anxiety and frustration using behaviours that staff found difficult to manage and placed others at risk of harm. Staff told us they had attended training to develop their understanding of people living with dementia. Emotional plans did not give staff guidance on how to respond to people when they became anxious. For example, staff were to give encouragement but did not specify how this was to be provided to gain the desired outcome.

The safety of the living environment was regularly checked to support people to stay safe. For example, fire risk assessments, fire safety equipment checks and fire training for staff. Some people on the first floor said

their access to the garden would be better if their accommodation was in the ground floor. Currently people depended on staff to access the garden.

Steps were taken to ensure medicine systems were safe. People told us staff administered their medicines. Medicine profiles included a photograph of the person and essential information such as known allergies and how the person preferred to take their medicines. However, for some people photographs were not updated. Members of staff were not always signing records to indicate the medicines administered. Procedures on the administration of medicines to be prescribed "when required" were not always person centred.

Staffing rotas were designed using dependency tools. However, feedback from relatives was that at times there were staff shortages and there was reliance on agency staff. We observed some people needed high levels of attention which limited the time staff spent with others. This meant people's preferences were not always considered. At times people in Keevil and Rowde were left in lounges without staff supervision and engagement was task focussed.

The staff we spoke with were knowledgeable about the day to day decisions people made. Mental capacity assessments for some people lacked detail on the best interest decision. There were inconsistencies with the assessments of capacity for restricting people's freedom. Mental capacity and best interests for people in Avebury and Bromham were in place and correctly assessed. Some relatives expressed concerns about how staff managed situations for people that resisted personal care or to take their medicines when they lacked capacity to make these decisions.

Care plans were not person centred and were not reflective of people's preferences. We found inconsistencies with the monthly evaluation and identified need. Plans in relation to people's emotional needs lacked detail and were missing for some people. Advanced Care plans were not detailed about people's future wishes and priorities of care.

While there were resources for activities there was limited capacity for one to one time. Most group activities occured on Avebury and Bronham. Outings were organised weekly but the number of people that could join the trips was limited to 11 people.

Quality Assurance systems were in place. While infection control audits had taken place and shortfalls were identified we found some areas were in need of better cleaning regimes. A health and safety inspection checklist was used to audit that procedures were followed. The findings of this inspection were consistent with some areas identified in the improvement plan. However, not all areas identified at this inspection were part of the improvement plan.

The views of people about the service were gathered and action was taken in response to their feedback. Where relatives raised concerns the manager responded in writing on the actions taken to resolve their complaints.

We saw people seeking staff attention and reassurance. People made positive comments about the staff and their skills. We observed staff approaching people in a caring manner but on occasions we overheard staff using language that was not respectful to people.

The staff were knowledgeable about the aims of the organization. They knew how these values were embedded into practice. Staff told us the team was stable and they worked well together. They told us the manager was approachable.

Safeguarding processes were in place and ensured people at the service were safeguarded from abuse. Staff's knowledge was good on the types of abuse and the actions needed where there were concerns of abuse.

The training records provided showed staff had attended training which the provider had set as mandatory.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were not following medicine procedures. Medicine records were not signed to indicate the medicines administered.

Risks were identified but for some people the action plans lacked detail on minimising the risk. Member of staff were knowledgeable on actions necessary to reduce risks.

Where people used behaviours that staff found difficult to manage guidance lacked detail on how staff were to respond when people became anxious and distressed.

The deployment of staff did not provide sufficient staff in all units. We saw there were times when people living with dementia were left unsupervised in lounges and dining areas. Relatives raised concerns about staffing levels in some units.

People said they felt safe and were able to describe what safe meant to them. Staff attended safeguarding of vulnerable adults training which meant they knew how to recognise the types of abuse and how to report their concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff enabled people to make choices. People's capacity to make complex decisions was not assessed. Where people's mental capacity was assessed the best interest decision reached was not clear.

The needs of people was assessed before their admission to the home.

The staff had the skills and knowledge needed to meet the changing needs of people.

People's dietary requirements were catered for.

Is the service caring?

Good

The service was caring

People were mostly treated with kindness and with compassion. We saw positive interactions between staff and people using the service. Staff knew people's needs well and how to reassure them when they became distressed.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Requires Improvement

The service was not responsive

For some people care plans were not person centred. Care plans action plans did not reflect the areas of need. Where reviews had taken place the same statement was written over periods of several months.

Some people had access to in-house activities and there were visits from external entertainers. People were supported to maintain contact with relatives.

People said they felt confident to approach staff with their complaints

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems and processes for assessing the delivery of care were in place. However, not all the findings of this inspection were identified for improvement.

The views of people were gathered from feedback received and action taken to improve their experience in relation to meals.

Staff were aware of the values of the organisation. They said the team worked well together and the registered manager had introduced improvements.

Hayward Care Centre

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 21 and 22 March 2018 and was unannounced. The registered manager was aware of the visit arranged for the second day of the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

This inspection was undertaken by two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with five people. There were people that were not able to tell us about their experiences of living at the service and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us." During the inspection we spoke with 11 relatives, two visitors and three social and healthcare professionals. We spoke with the manager, head of care, chef and the head house keeper. We also spoke with four senior support workers, nine support workers and the activities coordinator.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 17 care and support plans, staff matrix records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection dated October 2016 we rated this key question as Requires Improvement. We found that systems introduced for managing risk were not consistently followed by the staff. On this inspection we found improvements in risk management systems were inconsistent.

When risks had been identified, some plans provided clear guidance for staff on how to reduce the risks. However, this was not seen consistently. For example, some people had been assessed as having a high risk of falls. The assessment form guided staff that if the risk was classed as high, that a falls prevention plan should be developed. However, fall prevention care plans were in place for only one of the four people assessed at high risk of falls.

When staff needed to use equipment to assist people with transferring this was written within some plans. We observed staff using the equipment to move people and this was done in a safe way. Risk assessments for one person were confusing and did not give clear guidance to staff on whether to use a wheelchair when supporting this person to move around the home. A moving and handling risk assessment was not in place for one person who we observed staff using equipment to assist with transfers. A member of staff told us this person did not always need assistance with moving and handling. However, a moving and handling risk assessment was not in place on how staff were to support the person when assistance was needed with transfers.

When people had been assessed as having a high risk of developing pressure sores, the plans provided clear guidance for staff on how to prevent this happening. For example, details of any pressure relieving equipment in use was listed, and the frequency people should have their positions changed. Position change charts had been completed in full.

There were people assessed at risk of malnutrition and the management guidelines depended on the level of risk. For example, weight monitoring and dietician referrals for people at high risk of malnutrition. For one person at high risk of weight loss the eating and drinking care plan detailed that enriched meals and supplements were to be served. Their daily food intake was monitored and weight checks were fortnightly. Some relatives said their family member had lost weight and stated "The staff were concerned about my [family member] as they are very low weight and I know they weigh [family member] regularly and monitor food intake. [family member] has always been very slight, but I feel reassured that they take notice". "[family member] as lost weight and they do keep an eye on that and let me know".

Some people living with dementia expressed their frustrations and anxiety with behaviours that staff found difficult to manage. During the inspection we observed one person become anxious and distressed. We observed staff use a sensitive manner although they struggled to console this person and a member of staff working on another unit took the decision to contact relatives. The daily reports confirmed that on 11 days in March 2018 this person was "unsettled, anxious or distressed". However, care plans lacked detail on how staff were to manage the situation. The emotional care plan only described the person's personality and medical condition. In the review section of the care plan staff had recorded that relatives were to be

contacted when the person presented with high levels of anxiety. Care plans did not detail the actions to take in sequence when the person became anxious. This meant staff were not given guidance on when to use distraction techniques, when it was appropriate to contact relatives or to administer medicines to reduce levels of anxiety.

For another person the emotional care plan detailed the behaviours that were presented when they became frustrated. The guidance included using simple sentences, providing reassurance and giving the person time. The personal care plan also made reference to this person becoming distressed during personal care. Action plans did not give specific detail on actions to take. For example, how to provide reassurance and the simple sentences that gained agreement from the person to have personal care.

The majority of the staff we spoke with said they did not think there was enough staff on duty to meet people's needs. In Keevil unit we observed that some people spent all day in bed. When we asked staff the reason for this, they said that people didn't always choose to stay in bed. Some staff said people had "rest days" if they had been out of bed the day before. Three members of staff said people didn't always get offered choice, especially in relation to getting up each morning or having bedrest. They said staff chose for people with the best of intentions, but that staffing levels influenced them.

On the second day of the inspection in Rowde unit we observed three staff on duty. A member of staff told us there were three support workers on duty and a senior working across two units. During the visit we noted that a member of staff accompanied one person on a shopping trip. This meant there were two staff on duty for 15 people living with dementia. The second member of staff on duty said they had recently transferred from another unit to work in Rowde. The third member of staff was employed in February 2018. This meant two inexperienced staff were working in the unit with people living with dementia. We saw people were left unsupervised in the lounge and dining area also one person become distressed while the two staff on duty delivered personal care in bedrooms and administered medicines. We drew this to the attention of senior managers. A member of staff said "I am not experienced enough to understand some tasks. [Staff member] is really good and has helped me a lot. It's all about respect and taking your time". This meant people were not receiving continuity of care from staff that knew them.

Other staff on the first floor said that staffing levels were ok. One said "The staffing levels are based on people's dependency needs; but they don't take into consideration the layout of the building". One person using the service said "I would say there is enough staff. They work their socks off."

Medicines were not always managed safely. We looked at medicine administration records (MARs) and saw eight gaps where staff had not signed to confirm they had given people their medicines as prescribed. These gaps went back as far as 28/02/2018. There was nothing documented to indicate that staff had noticed the gaps or that any action had been taken to investigate whether the medication had been given.

Some entries in the MARs had been transcribed by staff. Best practise recommends that handwritten entries are checked by a second member of staff in order to confirm accuracy. The provider's Medicines Policy stated "All handwritten entries must have two employee signatures who have both checked it is correct." Despite this, we saw handwritten entries that had not been countersigned. Additionally, two of these entries had been transcribed incorrectly because the dose was written in milligrams rather than micrograms. This meant there was a risk that the person could be given a significantly higher dose than was prescribed. Staff had signed to indicate they had administered seven doses, but there was nothing documented to indicate that staff had noted during their checking process that the MAR instructions were incorrect. Another handwritten entry was for an opioid patch; again there was no second signature to confirm the accuracy of the dose.

On one MAR the printed instructions were for one tablet twice a day. Staff had amended this to two tablets twice a day, but the change had not been signed. Staff had written "see fax" but there was no fax in the MAR folder from the GP to confirm the dose change.

Although there were photographs of people at the front of the MARs some of these were dated, but not all. Additionally, some of these dated back as far as 2014. Having an up to date photograph in place enables staff to easily recognise people they are administering medicines to.

Some people were prescribed additional medicines (PRN). In these instances, there were PRN protocols in place. Some of these were personalised and provided staff with information about when and why people might require these medicines. Examples included "to treat pain in knees and hips, particularly during transfers" and "will say if in pain." Other protocols were not as personalised, and instead the information for staff was generic. Protocols for the use of anti-anxiety medicines did not always describe how people might present when anxious or agitated and did not describe the steps staff should take before resorting to the use of medicines.

Some people had been prescribed creams and lotions. The topical MARs (TMARs) we looked at had not always been completed in full. Instructions for staff were clear and there were shaded body maps also in place to inform staff where creams needed to be applied. However, although some of the charts we looked at had been signed in full by staff, this was not seen consistently across all three floors. For example, one person had been prescribed a gel. The instructions for staff were "apply at least once a day to prevent legs drying". The chart had not been signed on 12 days during March 2018. This meant there was a risk that people did not always have their creams and lotions applied as prescribed.

Staff administering medicines asked people if they were happy to take their medicines. They made sure they had a drink and waited until the person had swallowed everything before signing the MAR. We heard staff asking people if they had any pain and did they want any pain killers.

Medicines were stored safely, including medicines that required specific arrangements. Regular stock checks were carried out. The temperature of the clinical rooms and the medicines fridges were monitored.

Some medicine incidents had been reported. We looked at the latest report which showed that investigations had been undertaken and actions taken to reduce recurrence. However, not all incidents had been reported because the issues we noted such as transcription errors and gaps on MARs had not been reported. We discussed all of the issues we noted during the inspection with the manager and the head of care.

Effective arrangements that protect people from the spread of infection by the prevention and control of infection were not in place. We found areas of the home were not clean and there was debris in between doors and in the tracking of the lift doors. At times we noted odours in areas of the home. The upholstery of some chairs and underneath tables in Rowde and Potterne needed cleaning. We also noted that dishwashers in two units were in need of repair which meant support staff had to queue to wash dishes in the café area of the home. A member of staff said "we take the dishes to the café. It takes a lot to time. We queue with the staff from the other units to wash dishes". We drew this to the attention of the manager. The staff we spoke with agreed with our findings. The head of care told us easy chairs were to be replaced as they were too low for people with mobility needs to sit or rise unaided.

The head housekeeper told us there was one vacancy and recruitment was in progress for housekeeping staff. They also said as some housekeeping staff were on leave they were working "short staffed". The

cleaning schedules for bedrooms and communal areas were separated into daily, weekly and monthly tasks. We also noted that caring staff were responsible for cleaning parts of the home. For example, sluice rooms.

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

Systems were in place to monitor safeguarding referrals. Safeguarding systems, processes and practices were developed and implemented to safeguard people from abuse. Staff attended safeguarding of adults training and records confirmed this. The staff we asked knew the types of abuse and were aware of their responsibility to report allegations of abuse.

The people we spoke with said they felt safe and the staff gave them a sense of safety. One person told us "we all like it here, we like the company, the staff are very good, and they can't do enough for us". Another person said "Why shouldn't we feel safe? It's something we don't think of. It's nice here inside and out and the gardens are fantastic".

Relatives we asked said their family members were safe living at the home. Comments from relatives included "I feel my [family member] is safe, there's always someone in the communal areas keeping an eye on people, and I'm kept informed straight away of any changes". "I'm very, very happy with this place, I feel that my [family member] is totally safe because [family member] can wander up and down without getting outside, and the staff are here to keep an eye".

The safety of the living environment was regularly checked to support people to stay safe. For example, fire risk assessments, fire safety equipment checks and fire training for staff. Some people on the first floor said their access to the garden would be better if their accommodation was in the ground floor. Currently people depended on staff to access the garden.

Personal Emergency Evacuation Plans (PEEP) were in place for people. We saw recorded the person's ability to leave the building safely, the assistance needed from the staff and the number of staff needed.

Requires Improvement

Is the service effective?

Our findings

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.

Consent to care and treatment was not always sought in line with legislation and guidance. Some people had sensor mats, either on the floor or under chair cushions to alert staff when they moved. When these were used, the reasons were documented in the care plans. For example, "Fell out of bed. Pressure mat now in place." However, people had not always been assessed for their ability to consent to their use. We looked at the plan for one person on the first floor who had sensor mats in place. A mental capacity assessment had been completed. The person had been assessed as lacking capacity and a best interest decision had been made in conjunction with staff and the person's relatives. However, on the second floor we looked at the plans for three people with sensor mats in place. Mental capacity assessments had not been undertaken and people had not consented to the use of the mats.

Mental capacity assessments were in place for people living with dementia and related to living at the home and for continuous supervision. Overarching capacity assessments were not in place for care and treatment. For example, taking photographs and for administering medicines. Mental capacity assessments for specific decisions included sensor mats, lap belts for wheelchairs and for floor beds. However, capacity assessments did not make clear the best interest decision taken.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for continuous supervision and for living at the home were made and authorisation was in progress.

Some people were able to tell us about their ability to make decisions and who helped them take complex decisions. Their comments included "My daughter does a lot for me." "I have the odd deep discussion with my son and then we come to decision." The relatives we spoke with said they were consulted with decision making. Their comments included "I'm always kept up to date and we discuss any changes needed on an ongoing basis and I'm consulted about any decisions that need to be made." "I've been involved in making best interests decisions, for example whether to investigate a potential health condition. "I'm consulted about everything, I have lasting power of attorney (LPA) including health and welfare decisions and that's been absolutely crucial….. I've often needed to be an advocate for medical care."

Staff understood that people living with dementia also had capacity to make day to day decisions. We saw

staff offer people choices and asking their consent before delivering care and treatment. A member of staff said "[People] can choose the clothes they wear. We show the meal options to people for them to choose their meals."

Systems were in place for people to receive consistent support when they were referred for admission to the home. People's needs and choices were assessed before moving to the service. Personal assessments forms were based on all areas of need. For example, physical, social and emotional needs. The content of pre-assessments formed the basis of care plans. People and their relatives told us they'd had the opportunity to explain their own or their family member's needs before or when they first came to the home. A relative said "They came to my home and saw me there and asked me all about my likes and dislikes and needs before I came in."

New staff received an induction into the role they were employed for. Staff told us their induction included shadowing new staff and additional training to develop their skills. For example, the care certificate. A member of staff said they were re-employed and their induction included shadowing more experienced staff to reacquaint themselves with people's routines. Another new staff said "I am still learning. The staff have been brilliant they show me and talk me through things."

People received effective care and support from staff with the appropriate skills, knowledge and experience. Staff said they had access to training and personal development. All the staff we spoke with said they had completed mandatory training and had attended refresher training. Comments included "The training is really good" and "The training is brilliant." One person using the service said "I think the staff are well trained." The training matrix provided confirmed that staff attended training set by the provider as mandatory.

There were opportunities for staff to discuss concerns and to receive guidance from their line manager on their performance. The manager told us "Trusting Conversations" reinforced the values of the organisation. These one to one meetings were requested by the staff and were based on "how valued the staff felt." This was to create an opportunity for staff to discuss the action needed to make progress with their development plan. For example, attending specific training to achieve the desired outcome.

People were supported to maintain a balanced diet. People's nutritional needs were assessed. People's weights were monitored. When people lost weight staff sought advice and support. For example, we saw some people were having food supplements. In some of the plans people's food and drink preferences had been documented, but this was not seen consistently. Some people were having their food or fluid intake monitored. In these cases, the charts generally had the target intake recorded on them. The charts we looked at had all been completed in full.

Overall people told us the food was good, there was plenty to eat and choices of meals were available at every mealtime. People told us their preferred meals and that snacks were available outside mealtimes including at night. For example, one person said "Yes the food is good, and I like roast dinners and fish and chips with mushy peas. I never get hungry at night I always have a warm drink."

People were helped to choose their preferred meals. There was also a menu on the wall and in addition to meal times, staff regularly offered hot or cold choices of drinks and biscuits throughout the day. At mealtimes we observed staff on some units show each person sample meals of the choices available. We saw that people in Keevil were not always offered a choice of food to eat. For example, one staff member approached one person with their lunch and said "Would you like some chicken stew?" They didn't offer the

person an alternative, even though there were two options available. Other people were offered a choice although this wasn't shown to them. One staff member took a cup of a liquid to one person and said "I'll just let that cool down." They later asked if the person wanted a drink and picked the cup up saying "Would you like a drink? Its tea." They did not ask if the person preferred a hot or cold drink.

Comments from relatives included "My [family member] certainly gets enough to eat, eats well, and really seems to enjoy the food." "Whenever I'm here at lunchtime my [family member] eats very well and finishes everything."

Several people mentioned that having access to the kitchens in each unit, and to the ground floor café, was valued as they could make drinks for themselves and their visitors. Their comments included "Being able to get a drink for myself and the person I'm visiting is really good as we can go and sit in any of the sitting rooms and have a chat like we would at home."

The chef told us the menus were devised by catering staff. They said new menus with pictures and words were being devised and once laminated they were to be on display in all units. Also consideration was being given to serving the main meal in the evening and at lunchtime a lighter meal. It had been discussed that older people living with dementia may be more orientated with time as prior to their admission they would have eating their main meal in the evening.

Dietary forms which included people's likes and dislikes were completed and provided to the catering staff which gave them advice on people's dietary requirements. The whiteboard in the kitchen detailed people's food preferences and dietary requirements.

People were supported with their ongoing healthcare needs. Records showed people were reviewed by the GP, the district nurse, the care home liaison team and the occupational therapist for example. Staff said people were registered with different GP practises and that some were easier to access advice and support from others. People were supported to attend hospital appointments.

The premises were arranged to meet people's diverse care needs such as people living with dementia and mobility needs. For example, the toilets and bathroom had red frames and doors which made them more visible and recognisable. There was pictorial signage although these were quite small and not very prominent. Enlarged photographs of people were on their bedroom doors with items placed around the environment which encouraged reminiscence or to stimulate discussion, such as old advertising posters, an old fashioned pram or sewing machine. Walls were decorated with themed items such as bees, bird boxes and butterflies to assist people recognise different areas.

The walls in the entrance to Potterne were painted in primary colours which made doors and walls more visible to people. A member of staff told us from the analysis of falls it was evident accidents were occurring in this area. They said falls had reduced since then as people were more able to distinguish the doors. A member of staff told us the televisions and audio systems were to change locations. This was because of the levels of noise between the audio system and television. This meant people that listened to music were not interrupted by others that watched the television.

There were noticeboards with information in all areas about the home. All bedrooms were single and en-suite. Corridors were wide and toilets were accessible to people with mobility needs.

Good

Is the service caring?

Our findings

People generally spoke positively about the staff and their kindness. Comments made by people included "The staff are kind and helpful, they're approachable and they communicate well with my family member and us". "The staff are kind, they're patient and understanding. You can see that when they're dealing with people who can be a bit difficult. They are always welcoming and I've never seen anything to concern me". Some people also mentioned that not all of the staff met this high standard; "There are a few staff, naming no names, who aren't very interested or committed and I know they've had trouble getting and keeping good staff. It's not the best paid job in the world".

A relative told us "The regular staff are very kind and the senior staff definitely go the extra mile. I was on holiday when my [family member] became unwell and was admitted to hospital. I couldn't get back immediately so the clinical lead stayed with [family member] all night until I came back that was just so lovely."

We observed on several occasions staff and people interacting with warmth and affection. For example a member of staff who had been on leave was greeted by one person with a delighted smile and kiss. Another member of staff arriving on duty was asked by another person "Where have you been, I've missed you." A member of agency staff had formed good relationships with one person they were providing one to one care. We observed them were chatting easily together throughout the day.

In Keevil we also saw some positive interactions between people and staff but this was not seen consistently. People using the service did seem relaxed around staff and we saw that some people were laughing and joking with them. We heard one person greet a member of staff with "Hello my darling" and the staff member replied "Hello my love, how are you?" On other occasions we heard staff use terms of endearment such as "sweetheart" and "darling" and people responded positively to this. They smiled and did not seem offended in any way. However, we also heard staff call people "babe" which did not feel age appropriate for the people using the service.

On one occasion we heard a member of staff say to another "She's driving me mad. I'm going to put her in a chair and take her back to her room." We informed the senior support worker of this.

Staff spoke highly of their roles. Comments included "I like my job. I believe I make a difference to people" and "I treat people the way I would want to be treated." All of the staff said they would recommend the home to a friend or relative.

Compassion and respectful care was generally promoted. The registered manager said they "Observed what the staff were doing. I walk around the home and speak to people and their relatives." This was to gather their feedback on how people experienced care from the staff. The registered manager also said that one shift per week was with the team delivering care to people.

The staff respected the people they were caring for and supporting, including their preferences, personal

histories and backgrounds. Members of staff explained how they got to know people and built relationships with them. A member of staff said they listened to people, had patience and spent time with them. They talked to families and "picked up on people's characters." Another member of staff explained how people were made to feel they mattered. They said "I don't talk down to people; I give them reassurance and be approachable".

Visitors to the home were made to feel welcome and visiting times were not restricted. One person said "My family and friends can come in when they want to." The comments from relatives and friends included "I always feel welcome, I'm like part of the furniture here now and just come in and make drinks and sometimes only stay half an hour, sometimes longer." "I like to come in and help my [family member] with their dinner and I'm welcomed and able to take part in looking after [family member]".

Staff knew how to maintain people's dignity. They said they provided personal care behind closed doors, made sure curtains were drawn and kept people covered up. One member of staff said explained personal care was delivered "in the correct place to ensure they received care that was discreet." On public notice boards were posters informing people of "Dignity Champions" whose role it was to promote the uniqueness of every individual.

People were each treated with dignity and respect. The service worked within the principles of the Equality Act (2010), in ensuring that equality, diversity and human rights were reflected throughout all aspects of the care and support received. People were treated with fairness in decisions that were made in their best interests and their decisions were also respected. Staff gave examples of how they had provided support to meet the diverse needs of people using the service. These needs were recorded in care plans and all staff we spoke with knew the needs of each person well. One person using the service said "The staff help me to look the way I want to look." This person told us it was their preference to wear clothing that crossed traditional genders.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection dated October 2016 we found a breach relating to person centred care. We found that members of staff were not following the care plans to ensure people's needs were met. At this inspection there was little evidence that there had been improvements to care planning processes.

Some people and those acting on their behalf told us they were involved in the planning of their care and support. Comments from people included "No, I haven't seen my care plan, not sure what that is. I am happy with the care I get here."

There were variable comments from relatives about their involvement in the planning of their family members care. Some relatives told us they hadn't seen a care plan for their family member and others said they had, but everyone said they'd contributed to planning and reviewing care in some way. Their comments included "Yes I've seen the care plan and agreed it, and I meet with my [family member's] key worker regularly to review things." "I have regular meetings and feel fully involved." "We've never had a meeting at all, and although we can raise things informally anytime, I have to say that a formal meeting say every six months to talk about things would make a big difference." "I've never got involved in that side of things, looking at the care plan documents, or had a formal review, but I'm very involved and I contribute and suggest things and changes all the time."

Care plans did not provide staff with clear guidance on people's choices and preferences in relation to how they wanted to be supported. Although "This is Me" documents were available within the care plans and the majority contained detailed information about what was important the information had not always been embedded within the care plans. For example, personal hygiene plans did not always state people's preferred toiletries, whether the men preferred a wet or dry shave or which clothes people preferred to wear. For one person their "This is Me" document was not complete.

People's emotional and mental health care plans lacked detail and for some people the action plans did not give guidance on how to respond to the area of need identified. For example, in the plan for one person who experienced episodes of anxiety and agitation, the only guidance was for staff was to provide "support and reassurance". For another person living with Alzheimer's the "Emotional Wellbeing" care plan detailed the trigger of frustrations and how the person expressed this. However, the action plan was for staff to provide reassurance but didn't state how this was to be done.

Where people had mental health care needs the care plans lacked detail. For example, it was recorded that one person experienced periods of depression and "can become agitated about where she is." Medicines to be administered as required were prescribed in June 2017 to reduce their levels of anxiety. Guidance was not provided on how staff were to respond when the person became agitated and when medicines to reduce anxiety were necessary. The signs of deteriorating mental health and how to care for the person during these periods was not included in the action plans.

Communication care plans were developed demonstrating that steps were taken to support people with

additional needs around communication in line with The Accessible Information Standard (AIS, introduced by the Government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand). While communication care plans mostly detailed the areas of needs action plans lacked detail. For example, the communication care plan for one person stated "can express feelings and wishes effectively". At times "misinterprets situations and can become verbally and physically challenging". The action plan was for staff to "make eye contact, compliment the person" and for staff to ensure the environment was quiet during conversations. The action plan did not give staff guidance on how to convey information in a way the person was able to understand.

The communication care plan for one person detailed that at times they "became confused, muddled which lead to frustration." The review notes dated January 2018 stated "can occasionally become confused and muddled leading to frustration. When this happens will revert to "Italian". The action plans did not give staff guidance on how to communicate with the person during these periods. For example, how to manage periods of confusion and key words in Italian which may reassure the person. During the inspection we observed this person become anxious and used Italian to express their anxiety.

Advanced care plans were not always in place and had not always been completed in full. The information within the plans we looked at was limited and did not always detail people's preferences in relation to their end of life care. We looked at the plan for one person whose health had deteriorated recently. Earlier in the month staff had documented "Religion has been important to [person's name] and especially now as health has deteriorated." Despite this there was nothing within the person's advanced care plan about their spiritual needs during their end of life care.

Records showed that care plans were regularly reviewed. However, many of the reviews we looked at contained the same statement written by staff over periods of several months. People and their relatives had been included in some of these reviews. For some people the review notes were not reflective of people's needs. For example, although the emotional care plan for one person stated a close relative was important there other areas identified. There were episode of anxiety and during these occasions other people were at risk of harm. The review notes stated that the person enjoyed visits from the close relative. The review did not assess if the actions for responding to anxiety remained appropriate. For another person the review notes for the communication care plan stated "can be frustrated" and staff were to give the person time and patience. This meant staff were not reviewing the identified need.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014".

Care plans for people's health needs were detailed. Diabetes plans had clear guidance for staff on how the diabetes was managed. The signs and symptoms of a low blood sugar were documented and the action staff should take in these instances.

Eating and drinking care plans gave staff detailed guidance on the textured meals to be served and meals to be avoided. Where thickeners were prescribed the consistency of fluids to be served and the assistance needed from staff with eating. For one person Speech and Language Therapist (SaLT) guidance was attached and was reflected in the care plans.

While care plans were not always individual to the person and were focused on the task when we asked staff about people's needs, they demonstrated they did know the support people needed. When we asked how they knew, they said they knew from experience. One new member of staff said "I don't understand but I look at the books."

Two activities coordinators were employed to support the activities programme. While these coordinators had not attended any specific training for people living with dementia, they were supported by an Admiral Nurse. The activities coordinators told us the types of activities organised. Other comments about activities included "We are also opening a little shop which we are just waiting for and we have volunteers offering to work it. The hairdressers were open up three days a week and that's Monday Tuesday and Wednesday." There was a specific hairdresser for the people living with dementia.

There is a daily programme of activities was displayed on notice boards in each unit. This included two main items per day, including games, craft sessions, a knitting group, singing sessions and a weekly local news session. There was a weekly visit to the market, a weekly music and movement session, and monthly church services and visit from the local library service.

There were some resources for people living with dementia, such as rummage boxes and sensory packs. For example, a seaside smells, sights and sounds resource. There were also some picture books borrowed from the library, which are designed for people living with dementia. One to One sessions such as hand massage, painting nails or reading poetry were the responsibility of the part-time activities coordinator.

The main activities were taking place on the first floor and those on the ground and second floor didn't attend. People in Avery told us activities were taking place and told us they types of activities organised. Two people from a ground floor unit went on the market trip with one person needing care staff to accompany them. We heard the Activities Co-ordinator asking people on Rowde if they wanted to go to Bingo upstairs, but no-one agreed to go. Except for one afternoon of baking there were no organised activities in three units. We observed a small group of people with staff baking cakes to celebrate one person's birthday. Some people were able to actively take part in this and seemed to enjoy the social element.

Relatives said their family members found it difficult to take part in the general programme because many of the activities weren't matched to their cognitive function, or they couldn't get to the area where it was taking place. Their comments included "There's a lot going on but I don't think my [family member] is able to engage very much now. The staff have tried with things [family member] used to like such as needlework, with very simple sewing but it wasn't successful". "My [family member] loves music and movement in the café on a Friday but because we haven't got a suitable wheelchair, we can't take them". " I don't think my [family member] can really take part in anything now but seems happy enough and it's quiet and calm up here (top floor)."

People said they hadn't seen a complaints policy but said they knew how to make a complaint. Most people said they'd deal with any concerns directly with staff because they felt comfortable to speak to them. Comments from people and relatives included "I know how to raise a concern and on the occasions when I've needed to bring up an issue, the staff were approachable and tried their best to sort it out my [family members] lost their glasses and they didn't find them but they did everything in their power to look for them". "I've only once had to make a complaint, and that was because there were no staff in the sitting areas, the residents need to be overseen so I complained and it was dealt with." "I haven't got any complaints but if I did, I'd speak to one of the senior. I know them well and trust them to act on things we discuss".

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post. The current manager told us they were applying to CQC to become the registered manager. The manager said their management style was inclusive, they worked as part of the team and there was an "open door policy". They said when the staff team felt "valued it was reflected in the care people receive. I always say thank you and I appreciate what they [staff] do." The manager also said the aim was to create an environment where staff "feel able to problem solve whilst knowing I am there to support them." The intention was to "increase staff confidence because I am not here every day all day".

Systems were in place to assess and monitor the delivery of care. There was an overarching improvement plan that related to the training matrix, care planning, recruitment, mental capacity assessments and medicine errors. Action plans listed the shortfall and the progress on meeting the outcomes was listed and colour coded. Some actions were not in the order that met good practice and principles of legislation. For example, applications for Deprivation of Liberty Safeguards were made before mental capacity assessments were completed. The action plans for reviewing care plans stated that "10% care plans to be audited" by home manager, head of care and dementia lead. However, there was little evidence that care plans gave detailed guidance or were individual to the person.

The findings of this inspection were similar to the outcomes identified in the improvement plan. However, improvement had not taken place in some areas. For example, although medicine audits had been undertaken regularly, the issues we noted had not been identified. We looked at the latest pharmacist advice visit dated 10/01/2018. One of the recommendations recorded was "Photos need reviewing yearly or add a date to acknowledge same likeness". However, this had yet to be addressed. Records viewed were not always accurate and up to date. For example, care plans and risk assessments.

The manager had detailed within improvement plans the progress being made to meet outcomes. However, there were areas of care not included in the improvement plan. For example, staffing levels. Action had not been taken for shortfalls identified in the cleaning schedules. Some infection control audits were not taking place within the six month timescale.

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

The manager told us a meeting with seniors took place to discuss the improvement plans. They said the purpose was for senior staff to develop an understanding of their responsibilities to improve the service. Also that improvement plans were in place to address shortfalls and staff were "trusted" to take ownership of the plan. At this meeting senior staff established the most appropriate staff to complete the actions.

Staff received feedback from the manager in a constructive and motivating way. Staff told us team meetings had taken place. The manager said there were daily 10 at 10 meetings with all seniors. This was to discuss team issues on each unit and concerns to create confidence in the staff's skills.

Where risks were identified the manager ensured the level of potential harm was identified and monitored to ensure the care people received was not compromised. For example, the weight of people at high risk of malnutrition was monitored. Falls were investigated and assessed for patterns and trends. The manager told us continuous learning took place through reflective meetings. For example, accidents and incidents were discussed to prevent them from reoccurring. They said "we all make mistakes and in an emergency we do what is right. It's important to learn."

The staff said they were supported, respected and valued. The staff knew the values and expectations of their roles. A member of staff said the values of the organisation included "empowering and caring." These values were on display within the home.

Staff said the manager had made a "difference" was approachable and maintained a presence in the units. A member of staff said "The new manager has stabilised things. She's very approachable and very hands on." Another member of staff said "The new manager is fantastic". They said we know her and everybody [staff and people] is happy with her.

Staff said the team worked well and that "everybody gets on." Another member of staff said "I want to learn and ask a lot of questions".

The manager said maintaining a stable staff team ensured sustainability of the service. They said "I interview weekly. I am picky when I recruit as the right staff have to be in post". "A balance of experience is needed. I am passionate about getting it right".

There was open communication with all people who use the service, their family and other stakeholders. The social and health care professionals we spoke with gave positive feedback about the service. The comments from community nurses included "Good team work, well organised and requests for visits were made in a timely manner". Staff from the Care Liaison team said "referrals were made on time and their guidance was actioned". They said the staff were very "caring and passionate". They said the staff "reflected on practice".

The views of people were recently gathered and themed in relations to the feedback and concerns received. The questionnaires were in pictures and words. The manager told us from the feedback received consideration was being given to changing the meals served. The menus for display in units were to be in pictures and words format.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and action plans did not give staff guidance on how to meet people's needs. Reviews and monitoring notes did not reflect an assessment of the need identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not completed for complex decisions where people had cognitive impairments. Where capacity assessments were in place the best interest decision taken for some people were not clear. Deprivation of Liberty Safeguards were applied before mental capacity assessments were completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of harm because: Risk assessments for some people lacked detail. Guidance for staff to manage difficult behaviors were not always detailed in the order of action staff must take. Medicine systems were not always safe. Staff were not always signing administration records to show they had administered the medicines.

Some procedures for when required medicines were not detailed on when to administer these medicines.

There were areas of the home that would benefit from better cleaning regimes.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Improvement plans in place did not always reflect the finding of the inspection. Some records were not always up to date and accurate.

The enforcement action we took:

Positive conditions