

Caring Homes (Salisbury) Limited

Laverstock 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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection was unannounced and took place on 30 and 31 October 2018. At our last inspection in March 2018 Laverstock Care Centre was rated as 'Inadequate' in all key questions due to concerns about the safety and well-being of people who lived there. We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to these concerns the service was placed in 'Special measures' by CQC. Services that are placed in 'Special measures' are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

Following the last inspection, we met with the provider to confirm what they would do and by when to improve the service. We also asked them to provide us with a weekly action plan to keep us updated with the action they were taking. At this inspection we found significant improvements had been made. This service is no longer in 'Special measures', however, the rating reflects that further improvement is required.

Laverstock 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. Accommodation is provided over three floors for up to 80 people. Each floor had two separated units. Each unit had a separate lounge and dining room which included a small kitchenette. All rooms had en-suite facilities and there were communal bathrooms and toilets. At the time of our inspection 54 people were living at the home.

Following our previous inspection, the registered manager left the service. The provider appointed another manager who also left the service. A new manager was in post and in the process of registering with us. 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.

Risks had been identified but not all safety measures in place were robust. The provider had taken steps to reduce the risks we found at the last inspection. The environment was clean and cleaning schedules were being followed to maintain cleanliness.

People received their medicines as prescribed. Nursing staff administered medicines and had their competence assessed. Improvement were needed to how some medicines were stored.

Staff had been recruited safely as the provider had completed all necessary recruitment checks. Staff could identify the different types of abuse and knew how to report any concerns. There had been an improvement to the culture at the service so staff now felt more confident about reporting concerns.

Accidents and incidents were recorded and analysed by the clinical staff. Lessons had been learned and measures put into place to reduce the risks of reoccurrence.

People were being supported by staff who were trained. New staff received an induction and were allocated a mentor to support them with their learning. The provider had put key senior, experienced staff at the service to mentor and coach existing staff. This had improved staff confidence, skills and knowledge.

Where appropriate referrals to healthcare professionals had been made. Records demonstrated that people could access healthcare advice and support when needed. People received sufficient food and drink. Where people required additional monitoring of fluid this had been completed thoroughly.

People were being cared for by staff who were kind and caring. Overall people's dignity was promoted and privacy respected. We observed interactions between people and staff that were caring and demonstrated that staff knew people and their needs well.

Incidents of distress were supported by staff who demonstrated an understanding of people's needs. They followed identified strategies and recorded their actions. Behaviour support plans were in place which were person centred and positively written.

People had their own care plan which was personalised. Improvement had been made to how staff recorded daily information. Nurses reviewed care plans monthly or sooner if needs changed.

There was a range of activity available for people to engage with. The service had identified activity workers who co-ordinated activity provision and planned events for the whole home. People were able to have visitors without restriction.

Complaints were recorded and responded to within the providers timescales. Quality monitoring was realistic and transparent about how the service was provided. The new leadership at the service was appreciated by people, relatives, professionals and staff.

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 always safe.

Risks had been identified but safety measures were not always robust.

Medicines were being administered by nursing staff.
Improvement was required in how medicines were stored.

Staff had been recruited safely and understood their responsibility to safeguard people from harm.

There were sufficient staff deployed.

The environment was clean and improvements had been made to maintenance.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People were being supported by staff who had been trained and felt supported. Further training was required and had been planned.

People had sufficient to eat and drink. Meal times were relaxed and unhurried.

Referrals to healthcare professionals were made, they were appropriate and timely.

People were supported to make their own decisions, where people lacked capacity, assessments had been completed.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Whilst there had been improvements to how staff treated people, further improvement was needed to promote dignity at all times.

Relatives could visit without restriction.

People were supported by staff who were caring and knew them well. We saw kind and compassionate interactions between people and staff.

Is the service responsive?

The service was not always responsive.

Records did not always reflect the care given or the action needed to record the support given.

Care plans had improved and were personalised.

Activities were provided so that people could follow their interests and receive stimulation.

Complaints were responded to and recorded with all actions taken.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

People's views were sought but action plans had not been developed to act on feedback given.

Quality monitoring had improved. The provider had reviewed the audit tools used to monitor quality.

Management changes had been well received by people and staff.

There was a positive and open culture at the service, staff felt listened to and able to raise concerns.

Requires Improvement ●

Laverstock 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 30 and 31 October 2018 and was unannounced. The inspection was carried out by three inspectors, a pharmacy 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.

Before our inspection we reviewed the information we held about the service including the providers action plans and previous reports. We also looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us by law.

We spoke to 10 people, two relatives, the new home manager, the senior operations director, the clinical manager, 11 members of staff and one visiting care professional. We looked at six recruitment files, 10 care and support plans, medicines administration records, risk assessments and other records relating to the management of this service. We also 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.

Following our site visit we contacted a further seven healthcare professionals for their feedback about the service.

Is the service safe?

Our findings

At our last inspection in March 2018 we found that the provider was in breach of Regulations 12, 15 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the provider had made improvements in these areas, however the rating reflects that it will take time to see these improvements embedded in practice and the areas of improvement sustained.

At our last inspection we found that the environment was not clean. We also saw that some equipment and areas of the environment needed repair which prevented them from being sufficiently cleaned. Some members of staff had long nail extensions with brightly coloured nail varnish. This compromised infection prevention and control. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw that improvements had been made to the cleaning practice. A new head housekeeper had been recruited and had worked with the home manager to produce cleaning schedules. All areas of the home looked clean and there were no unpleasant odours. The kitchenettes all looked clean and there was no evidence of food debris or spills. Equipment seen in use was clean and in good working order. One person told us, "Recently it's got cleaner. I've had a spring clean in my room." A member of staff told us, "We have had lots of improvements with regards to maintenance and cleanliness."

Repairs to the environment had been carried out but there was still further work to complete. We saw the repairs to toilets and bathrooms had taken place and new equipment had been sourced. We saw that the sluice rooms still required maintenance. One sluice room had some flooring which had come away from the wall, this would prevent the floor and area from being thoroughly cleaned. The home manager was aware of this and told us the work was planned. We did not see any staff with nail extensions or brightly coloured nail varnish during our inspection.

At our last inspection we were concerned about the safety of people living at the service. We saw that risks had not always been identified and/or addressed. People did not have access to their call bells which meant they could not call for assistance if they needed it. Agency staff had not been given an induction. We saw stair gates were in use in people's rooms without sufficient risk assessments or safety measures in place. Where people had developed or were at risk of developing pressure ulcers the care and support was not consistently provided as it was recorded in the care plan. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had decided to remove all stair gates so this was no longer a risk. People had their call bells within reach so they could call for assistance if needed. Where people could not use their call bell there was a risk assessment in place and staff were aware of additional checks needed for those people. People's risks had been identified however, risk management plans were not always robust. We found one risk management plan which the staff were not aware of. One person had been involved in an incident with another person which had led to a distressed reaction. To support the people involved the service had put a risk management plan in place with safety measures. We asked the staff

about the safety measures, they were not aware of them. This meant that the risk of a further incident had not been managed. We discussed this with the home manager who told us they would review this risk management plan.

One person had been identified as being at risk of ingesting substances that may be harmful to their health. There was a risk assessment in place which referred to risks associated with the kitchen. We saw that chemicals were in locked cupboards in the kitchen where they lived, reducing the likelihood of the identified risks occurring. However, the risk assessment and care plan did not show consideration for the ingestion risks that may be present in other places, outside of the kitchen. We saw that the person had products that may be harmful to them if ingested, readily available in their bedroom. We also saw an incident form had been completed where the person had used antibacterial hand gel inappropriately. This risk had also not been recorded in the care plan. We discussed this with the home manager who told us the person was familiar with the products in their bedroom so they did not consider this a risk, however they would review the person's care plan.

We did see however, other risks that had been identified and did have comprehensive risk management plans in place. We saw that the provider had assessed people's risk of choking. In each nurse station there was equipment to support people in the event of them choking. The clinical manager explained that all staff had received training in using the equipment. This meant that should an incident of choking occur the staff would have the skills and equipment to deal with the situation promptly. Where people had incidents of distress the service had put into place detailed and personalised behaviour support plans. These gave staff clear strategies on how best to support people when they were distressed. We observed staff supporting people who were distressed and saw they followed the recorded strategies.

At the last inspection we had concerns about pressure area care. We had found that specialist mattresses that were in use were not always on the right setting for people. We also found people were not being re-positioned according to their care plans. At this inspection this area of care had improved. The provider had invested in more specialist mattresses to support skin care and reduce the risks of developing pressure ulcers. The clinical manager explained that the new mattresses were in place for most people who required this type of pressure relieving equipment. They told us that the mattresses did not require manual settings to be applied and instead adjust to the person. The mattresses could also be adjusted to provide further support at specific areas of the body, such as the left or right side, or at the ankles. Where mattresses required manual settings to be applied, these were checked daily by the nurse on each unit. We also saw that pressure relieving chair cushions were in place and being used in the lounges and people's rooms.

Accidents and incidents were reported and recorded on forms which were reviewed by the management team. Where CQC and the local authority safeguarding team needed to be notified, these notifications were made appropriately. There were monthly management meetings to review the number of falls in each unit. The meeting records showed that discussions included what could be done to reduce the likelihood of the fall recurring. Where action was required, the records showed what had been done to support people at risk of falls. For example, where a person required a sensor mat to alert staff when they were mobilising and may need support, it was recorded that this had been reviewed and implemented. Falls analysis reports demonstrated that incidents of falls had fallen significantly. In May 2018 there had been 30 falls whilst in October 2018, there were three falls.

At our last inspection we saw unsafe moving and handling techniques used by staff. At this inspection we saw safe techniques being used. One staff member had been appointed as the moving and handling lead. They told us they had attended a five-day training course and that this had taught them safe practice which had not been part of the training they had previously received. We saw the staff member supporting a senior

staff member to assess a person to use a mobility aid to help them stand. The moving and handling lead ensured that all practice was completed safely. The senior staff member provided clear guidance for the person and talked them through everything that was happening.

At our last inspection we were concerned that medicines were not being managed safely. At this inspection we found that whilst improvements had been made there were further improvements required. Medicines were stored in a locked treatment room; however, some medicated creams were kept insecurely in people's rooms and did not comply with the home's medicines policy which stated they should be kept in a locked cupboard. Following the inspection, they were locked away. Some people were looking after their own medicines if it had been assessed as safe for them to do so. We saw that risk assessments had been completed, however these medicines had not been stored securely. When identified at the inspection the service put appropriate arrangements in place.

Care staff applied creams and other topical preparations and recorded this on separate charts. We reviewed these records for six people and saw that creams were being regularly applied and body maps were filled in well so staff knew exactly where to apply them. However, two people we saw were prescribed a medicated cream and we saw that on some days it had been applied more often than it had been prescribed. We discussed this with the home manager who told us they would address this shortfall.

Fridge temperatures were being recorded daily however when we checked the maximum temperature it was outside the recommended range for all three fridges. It was not clear if staff had been resetting the fridge temperature. The home manager put an action plan in place during our inspection to correct this. When creams, eye drops and liquid medicines were opened the dates were not always recorded to ensure these were discarded within the required time range.

Staff had additional guidance to explain when to administer medicines which had been prescribed to be taken 'when required' (PRN), however some people who were prescribed medicines for anxiety/agitation did not have enough detail for staff to recognise when it would be appropriate to administer these medicines. This had been identified at the previous inspection.

There were appropriate arrangements for the ordering and disposal of medicines including medicines which required extra security. Nurses administered medicines and we saw that they were given in a safe and caring way. They recorded this on Medication Administration Records (MARs). We reviewed 17 MARs and saw medicines were being given as prescribed. Since the last inspection daily stock audits have been introduced and we saw they were being completed.

Staff that were responsible for the administration and management of medicines had their competencies regularly assessed. Competency records for one nurse showed that shortfalls in their knowledge had been identified. We saw that the nurse was then enrolled onto training courses to address the specific areas where refreshers were required.

At our last inspection we were concerned that agency staff did not always receive an induction when they worked at the home. Agency staff we spoke with were not aware of key information such as the fire procedure. At this inspection we found the service had improved. There had been a reduction in the reliance of agency staff to support the staff team numbers. The deputy manager explained that agency staff work with an experienced member of the team, "because they won't know the residents as well as the staff do." We saw the induction form used for all agency staff when they first worked at the service. This included information around fire safety and an overview of the relevant policies and procedures.

At our last inspection we were concerned about the service not having sufficient staff to provide the care and support people needed, when they needed it. We observed people calling for assistance, people being in various stages of distress and staff unable to respond. People, relatives and staff told us they thought there were not enough staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw that there were sufficient staff available to meet people's needs. Records demonstrated that staffing was consistent and the provider had notified us on occasions when staff numbers fell below a safe level. Despite our observations people told us they felt there was not always enough staff. Comments included, "Definitely understaffed", "They are very short staffed. Sometimes you wish you could see more of them", "A lot of girls have left" and "We could do with a few more staff."

All staff we spoke with told us that they felt there was enough staff to support people's needs. One staff member said, "We have had some really good new staff join the team. I think we have enough staff, I'm sure some others might not agree, but really, we have enough now and it's much better than it was." Another staff member told us, "I definitely think we have got the right number of staff. Sometimes we need to find smarter ways of working to make it feel like we have enough, but we're getting there." The clinical manager explained that they will cover staff shortfalls in the event of absence, along with the deputy manager. They said, "We have enough staff, previously there were so many problems with organising the staff, but now it is much better."

We spoke with the senior operations director and home manager about why people would think the service was short staffed when this was not the case. They told us that there had been a high number of staff who had left the service since the last inspection. This could have given people the impression that there were not as many staff available. They told us they would make sure people were aware that the service was fully staffed.

Recruitment drives had been successful, and the manager explained that they had been selective in who was appointed. We checked the recruitment files for six members of staff who had been appointed between May and October 2018 and found these to contain references, identity checks and a Disclosure and Barring Service Check (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable adults. One long-standing staff member explained, "We have had some fantastic new carers come in, you instantly know when someone cares from the heart and I get that feeling with them."

Staff told us that following the last inspection there had been a large staff turnover. Different staff members explained that during the changeover in managers, some staff had left because they were not on board with committing to making improvements to the service. One nurse told us, "A lot of staff left. It was very stressful at the time, but looking back, I think it was the right thing to happen because they were not doing things right and they didn't want to change. Some good staff left, but they quickly came back, and I am so glad they did, they are good for this home." A member of care staff said, "The staff that left were too set in their ways. They were not the right ways. The team now are mostly all the same mindset. I stayed following the last inspection because I couldn't leave the residents. I wanted to stay and make it right for them."

Staff understood their responsibility to identify and report any concerns they had. Staff told us they would feel comfortable raising concerns within the service by speaking with the nurse, deputy manager, or home manager. One staff member told us, "Absolutely, I wouldn't hesitate to speak out if I saw something that concerned me, or if I felt someone was at risk of abuse. I know I could go to [the home manager] or one of the nurses." Staff also knew they could contact the local authority safeguarding team and understood that

they could whistle-blow to CQC. 'Whistle-blowing' is the term used when an employee passes on information concerning wrongdoing or poor practice. Whistle-blowing procedures ensure that the whistle blower is protected from reprisals when they raise concerns of misconduct witnessed at work.

Is the service effective?

Our findings

At our last inspection in March 2018 we found that the provider was in breach of Regulations 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we were concerned people were not receiving sufficient fluids to ensure hydration. We were also concerned about staff induction, supervision and training. During this inspection we found that the provider had made improvements in these areas, however further improvement was required. The improvements that had been made need time to embed and become sustained.

At our last inspection we found that staff had not always had the training they needed to be effective in their roles. This was a particular concern with regard to dementia training. Staff did not have the skills required to support people who could present with behaviour that challenged. Staff had not always had the opportunity for supervision and many did not feel supported in their roles. This was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were being supported by staff that had the right skills. Comments included, "It has suffered from underfunding here and understaffing but there are some very capable nursing and care staff" and "Discounting the agency staff the others here are experienced."

There was a training plan in place which identified which staff required what training. There were gaps in the training the provider considered to be mandatory for staff. We saw that one nurse had worked at the service for five months, however had not completed training in four areas. This included training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), as well as emergency first aid at work. Another nurse, who had worked at the service since 2015, had not completed up to date training in five mandatory areas, including infection prevention and control, as well as health and safety. Seven staff had not been trained in manual handling. In addition, 12 staff had also not received food hygiene training. During the inspection we saw that training was taking place, this included catheterisation training for nurses, as well as MCA and DoLS training for ancillary staff. The home manager told us they knew this was an area of the service where improvements were required and had training planned to address the shortfalls.

Dementia training had been provided by both external and internal sources. The provider had placed a dementia specialist manager at the service to work with staff to improve this area of care. They had provided training and mentoring to staff to give them better skills and confidence when working with people with dementia. The provider also worked with a local dementia consultant who provided training sessions on a range of dementia related topics. They told us, "Staff here have a thirst for knowledge in dementia care." They had evaluated the training provided and told us that staff felt they had improved their skills and knowledge in this area.

New staff completed the Care Certificate, as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The home manager told us that the Care Certificate had not been completed as promptly as they would have hoped. They said this was going to become more of a focus for new staff

moving forward. Despite this shortfall staff were complimentary about the induction process.

Staff told us that the provider had introduced mentoring for staff which had improved practice. One member of staff said, "Caring Homes have taken the concerns raised in the last inspection very seriously and recognised the significant problems. The mentoring systems that have been introduced have been excellent and really helped staff to make the improvements needed." One member of care staff told us that when they started there had not been the required opportunity for shadowing as much as they felt they needed. They said, "When I started, I didn't have a buddy or mentor, I was expected to do things such as showering someone without being shown how. Having never done that before, it would have been better for me to have observed someone more experienced, but there wasn't that opportunity."

Staff told us that they felt there had been an investment in staff training, since the last inspection. One staff member said, "I didn't know I was doing things wrong before, because I just had never been shown the right way. Now I can look back and see that we didn't have it right when you last inspected. The training we've had since then has been so helpful and I now feel more confident that I'm supporting people to move properly. I would challenge anyone else if I didn't see them doing things in the right way."

At this inspection we found improvements had been made to make sure staff were able to have supervision meetings. Records demonstrated that staff received supervision meetings, either with the manager, or with a nurse. Performance was discussed with the staff member. We saw that where required, conversations took place about policies and procedures to refresh staff knowledge. Staff told us they felt better supported.

At our last inspection we were not assured that people were having enough to drink. People at risk of dehydration were having their fluid intake monitored but we found concerns with the recording on fluid charts. Relatives told us they found their family members were often thirsty and felt they needed more to drink. We observed people having drinks placed near to them but there was no support offered to help them to drink if needed. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we observed that people were offered drinks throughout the day. As there were sufficient staff deployed people had the support they needed to be able to drink. There had been an improvement to fluid monitoring. Records were now kept in a 'nurses file' in the care office and the responsibility of totalling fluids was delegated to the nursing staff. The clinical lead for the home completed daily checks to make sure people who were being monitored were receiving sufficient fluids.

We observed mealtimes throughout our inspection and saw that people had food that they had chosen. The food looked appetising and there were sufficient quantities. The chef was available over mealtimes to make sure that people were satisfied with their meal. Hospitality staff were employed to help over mealtimes. This meant the care staff could focus on supporting people to eat and drink whilst hospitality staff served and cleared away.

Overall people were satisfied with the food available. Comments included, "It's quite good", "It's alright. We have a good cook", "I love the fish days" and "I had spaghetti bolognaise yesterday. I told the chef 'that's just the job'." One person told us, "One lady wanted a bowl of fresh fruit, the chef sorted that out straight away. The chef is a nice pleasant chap which you need." Some people did think the food at times lacked flavour. Comments included, "Some food is ok, some of it is boring", "Often there is not enough flavour" and "They get salad cream for you and that sort of thing. I miss sauces from home."

Mealtimes were relaxed and unhurried. People had the support they needed which was provided in a

discreet way. Staff sat down next to people and talked to them throughout. They informed people what was on the fork or spoon before placing any food in people's mouths. Gentle encouragement was given to encourage people to eat well. People had a choice of where to sit to eat their meal and what to eat. If people did not want what was on the menu, alternatives were offered. We observed people ate meals in the dining rooms, lounges or their own rooms.

People's needs had been assessed in line with good practice guidance to make sure the service was effective in meeting their needs. Nurses used a range of nationally recognised assessment tools for skin assessment and nutrition. For example, the service used a Malnutrition Universal Screening Tool (MUST) to assess people's needs in relation to nutrition. Once a score had been calculated this information would form the basis for the care plan and support given.

Care plans contained a 'transfer booklet', with an overview of information about the person, to be used if they were admitted to hospital. The booklet contained information that could be used by healthcare professionals to understand how to support the person. For example, the transfer booklet for one person included an overview of what and who were important to them. There was a daily heads of department meeting where information was shared to all departments. This was information about people, events happening in the home that day and other communication. Staff present were encouraged to share views and participate in the meeting to make sure people's needs were known.

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. Staff were knowledgeable about applying the principles of the Mental Capacity Act (2005) (MCA) to their role. One staff member explained, "Just because someone has dementia, it doesn't automatically mean they can't make decisions. We offer people choices and different people can make different choices for different decisions."

It was not always clear from the care plans if people had appointed a Lasting Power of Attorney (LPoA). An LPoA is a legal document that lets a person appoint someone to make decisions on their behalf. LPoA can be for health and welfare, or for property and finances. We saw that relatives had been involved in decisions where people lacked mental capacity. However, mental capacity assessments also did not make it clear whether that relative held the legal authority to make decisions. We asked the manager if there was a record of copies of LPoA documentation. They advised us that this was in progress and had not yet been fully updated to ensure that all copies were held by the service.

At our last inspection we saw that a mental capacity assessment had been completed for a person with identified communication needs. There was no evidence to demonstrate that the person's preferred form of communication had been explored. At this inspection we saw the assessment had not been reviewed so it was still not clear if steps had been taken to communicate effectively with the person. We asked the home manager to review this with urgency.

People can only be deprived of their liberty so that they 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 are called the Deprivation of Liberty Safeguards (DoLS). We saw that the home manager maintained a file of all DoLS applications and correspondence sent to the local authority. When DoLS authorisations were in place, the conditions of the authorisation were reflected in the care the person received.

Is the service caring?

Our findings

At our last inspection in March 2018 we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we saw people being treated without dignity. Care routines and care practice did not promote people's dignity or person-centred care. During this inspection we found that the provider had made improvements in these areas and was no longer in breach. There were still areas that required improvement.

Most people were supported with dignity. However, we observed some practice that did not promote dignity. For example, one person did not receive attentive care and support by the staff member assisting them to eat. The staff member was not engaging with the person, but instead was occupied with speaking to other people and tending to their needs, despite other staff being available. This meant that the person they were supporting on a one to one basis was left five times during their lunch, for several minutes at a time, while the staff member completed other tasks. Another person was sat in a communal lounge area wearing a short skirt. They had fallen asleep in their chair and the skirt had risen well above the knee. They needed a cover over their legs to protect their modesty. Another person asked a member of staff to move out of their wheelchair. They were told they would receive help but then had to wait for over an hour. We shared these observations with the home manager during our inspection.

There was a staff member appointed as the dignity lead and a dignity team in place. The team consisted of people, relatives, staff members and management. The dignity lead explained that the team met to discuss how dignity at the home could be improved and to explore suggestions around this. People had a choice of a male or female care worker to support them with their personal care. One person told us, "You get a choice. I don't mind male or female but some of the women like female staff only."

We observed improvements in how staff were supporting people with dignity. Staff were sharing information about people with each other discreetly and using people's preferred names when communicating. Incidents of distress were responded to with kind and compassionate care.

We saw caring interactions between staff and the people they were supporting. One recently appointed staff member engaged people in conversations and clearly knew their interests well. They talked through the newspapers and the staff member said, "Shall we look for the football section? I know you are a football fan." This was well received by the person, who was engaged in the interaction and enjoying the staff members company. We saw the same staff member greet different people in the room with a warm smile before engaging them in conversation.

People told us they were happy with their care. Comments included, "The care is very satisfactory", "I'm quite happy here", "I'm happy with the standard of care", "A nice lot of people care for us", "The girls are very pleasant. Some you can joke with, it's very good" and "it is smashing here." People told us they thought the staff were kind. Comments included, "Couldn't have better staff, they do anything for you" and "The carers are very kind."

We saw other positive social interactions between people and staff which demonstrated that the staff had built up relationships with people. The service had obtained life histories from people to help staff to get to know people. Life history work for people with dementia can help staff to better understand people's needs and behaviour. We observed that all staff regardless of their role were able to talk to people easily. For example, we saw the chef interacting with people demonstrating their knowledge of people and their needs. People told us they enjoyed talking to the chef and appreciated them coming out of the kitchen to see them regularly. We saw housekeeping staff in people's rooms taking time to talk to people and respond to their needs.

Staff used different communication methods to try to engage with people. We saw that staff used dolls to communicate and provide people with comfort. Staff made sure they were on the same eye level as people, they touched people gently on their arm to let them know they were there. We saw the staff were more relaxed with people, they had time to sit and talk to them. One person was reading a magazine at a dining table. Staff had the time to sit and talk to them about what was in the magazine. Another person was walking around the home with a member of staff. As they were strolling along the member of staff was communicating with them in their preferred way, which was recorded in their care plan. The person looked happy and relaxed. One healthcare professional told us, "All the staff appear to know the residents really well. They appear to put themselves in their resident's position to provide better all-round care."

The home provided people and their relatives with a monthly newsletter. This reminded people and their relatives that they could leave feedback about the service in various ways. One method was by using an electronic tablet which was available in reception. The home also published dates in the newsletter to remind people and their relatives about activities and key dates. We saw that resident and relatives' meetings were advertised in the newsletters to encourage attendance.

People's relatives and friends could visit without any restrictions. We saw relatives visiting at various times during our inspection. We spoke to one relative who told us they came regularly over a mealtime so they could support their relative to eat. They told us they had no concerns with the care their relative received and were always kept informed by the staff of any changes.

Is the service responsive?

Our findings

At our last inspection in March 2018 we found that the provider was in breach of Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care being provided was not always person-centred. Daily records written by staff were task focused and did not reflect the person's well-being. We observed poor practice and saw that people were not receiving personalised care. During this inspection we found that the provider had made improvements in these areas and were no longer in breach of the Regulations.

At the last inspection we saw that daily records written by staff were task focused. This did not give the service an overview of people's well-being. At this inspection we saw that daily records had improved. Staff had recorded information about how the person was day to day, how they were feeling and what conversations had taken place. This was in addition to information about care and support given in areas such as personal care and eating and drinking. Recording was personalised and gave a good overview of care and support given.

Staff recognised and told us their record keeping practice had improved. One staff member explained, "We are more organised than we used to be. We have a lot more paperwork to complete now, but for some reason it doesn't feel like more. This is because we are doing things right and the paperwork helps us to keep everything up to date as it should be." We discussed with the home manager how the key information gathered and recorded would be transferred to the person's care plan. For example, we read in a person's daily notes that they enjoyed talking about a particular rock star and listening to their music. This had helped to keep the person calm and relaxed. We checked the person's care plan but this information had not been transferred. This meant that other staff may not learn this about the person, so they would not know to use this strategy if the person became anxious. The home manager recognised this and told us they were looking at how they could make sure this transfer of information happened.

Whilst there was an improvement to people's daily notes we saw that some other records still required improvement. The provider had charts in place which recorded when people received oral care. The charts did not allow staff to record how many times people had been offered oral care if they had declined. The chart only enabled staff to record once during the day which meant we could not be sure if staff had been successful later in the day. Charts demonstrated that for some people oral care was not being provided daily, but the record did not demonstrate what action had been taken. We checked the daily notes and observed this information was not recorded there. This was a concern at our last inspection.

There was a 'resident of the day' system in place which was used to review people's care and support plans. On each floor there was a person identified as the 'resident of the day'. As part of that process the nursing staff reviewed their care plan and risk assessments. This made sure that the review process happened at least monthly. Nursing staff told us they would update people's care plans if their needs changed in the interim.

At our last inspection care was not personalised and responsive to people's needs. At this inspection, we

observed there had been changes to the daily practice at the service. People were being supported to do what they wanted to do and when they wanted to do it. Staff were responding without delay to requests for help or incidents of distress. Emotional support was provided in a person-centred way. For example, one person was becoming anxious so a member of staff walked with them and held their hand. They talked to the person about their family and what they used to do for a living. This helped to reassure the person. Another person became distressed when receiving personal care. Staff ensured the person was safe and used the strategies in their care plan such as playing their favourite music. One healthcare professional told us they had been visiting the service since the last inspection and had seen improvements to the practice. They said, "I have noted a gradual and tangible change in the staff culture. Staff engage and respond quickly to requests for care. I have heard and witnessed interaction between staff and residents to be appropriate and respectful. It is an approach based on dignity and respect."

For incidents of distress the staff completed an 'ABC' behaviour form. This records the events leading up to the incident, the behaviour experienced and the action taken and events following the incident. We saw the 'ABC' charts had been filled out in full. The action taken by staff to support people were the strategies recorded in people's care plans. Where people's behaviour had caused concerns the service had involved dementia specialists for advice and guidance.

We saw that complaints had been received and investigated. Complaints had been raised by people and their relatives. One person had provided their feedback about the quality of their pureed meals. The concerns were responded to with visits from the home manager, to discuss how this could be improved. The chef also visited the person and an agreed set of standards were put in place. This included using a specific food processor to reduce the likelihood of lumps being present in the pureed meal. The person had raised a further complaint three weeks later explaining that the issues were still present and that their meal was often cold. We saw that this was again followed up with actions for the chef to improve the quality of the person's meals. The chef had worked with the person to create a menu based around their preferences. This included sourcing a specific type of fish that the person had requested.

Activities took place and everyone living at the service was invited to attend. Information was displayed around the home informing people and their relatives about what was happening on which days. We spoke to a member of the activities team and they said, "We try to do activities on different floors of the home. Before the session I go around everywhere and see who would like to join us. I try to include more sensory activities in the dementia care units and we also have the favourites everyone likes, such as bingo and quizzes. If they don't like something, they certainly tell me, and I take all their feedback on board."

The new home manager had encouraged all staff to provide activities regardless of their role. This meant that people had activities and stimulation more often from all of the team. We saw one person being supported to do some colouring. Other people went for walks with staff throughout the home, looking at the views from windows in different areas. There were records showing that people received engagement and interactions with staff, as well as attending outings. The records for one person stated, "[Person] appeared in excellent spirits at the pub, lots of laughs, lots of smiles and clear speech. When asked if he would like to go again, he said yes." We saw people decorating cakes for the Halloween party later in the day. There were also pumpkin carving sessions for people to attend. The home manager told us that they supported people to celebrate national festivals if they wished. People were also supported to participate in religious activities that were important to them.

We saw a poster on display informing people that a 'Pets as Therapy' (PAT) dog was visiting during our inspection. People told us they liked the dog and looked forward to their visit. We saw the PAT dog visiting people and saw people were happy to see it, they were able to smooth it which clearly gave people

pleasure. A member of staff told us that on their day off they brought in their parrot to see people. They told us there were people living at the home who used to own their own birds and took pleasure in talking to the parrot. Records demonstrated that people regularly enjoyed a visit from these animals.

Is the service well-led?

Our findings

At our last inspection in March 2018 we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's quality assurance systems had not identified the concerns that we found and were inadequate. In addition, there was a culture at the home which was not open and transparent, staff were worried about reporting concerns. During this inspection we found that the provider had made improvements in these areas, however further improvement was required. There also needs to be time for improvements to become embedded and be sustained.

At our last inspection we found that staff were concerned about coming forward with their concerns and did not feel supported. In the providers action plan, they told us they had set up 'listening groups' to support the staff team. A member of the HR department visited the home on a regular basis to talk to the staff and hear their concerns, and to also offer any HR support. At this inspection we found that staff felt the provider was listening to them and providing the support they needed. One staff member said, "After the last inspection, I didn't feel proud to work for Caring Homes. We were not where we should have been. I feel proud now because every day we are getting better." Another staff member told us, "We have had help from [the clinical manager], she has a massive amount of knowledge and immediately calls out poor practice. She then educates us about how to do things properly, things I had never been shown, such as mouth care and nail care."

There was a new home manager in post. Since our last inspection the registered manager had left and another manager had been recruited. We were told by the provider that they had also left and another manager was in post. This meant the service had been managed by three different people in six months. The current home manager told us they were in the process of registering and were committed to "stabilising the home". Staff told us they felt the home was being well managed with the current manager in post. Comments included, "[The manager] is great. She is really bubbly and supportive. I know that I can go to her with anything and she will support me to support my team", "[The home manager] is a delight to work for. She isn't stressed. She listens and if she can help you, she will" and "[The home manager] is a much-needed breath of fresh air here. She has also managed to bridge the gap between night and day staff so that we start working as one whole team. She is an inspiring lady who knows what she is talking about."

Staff told us they felt a change in the management had been beneficial to the home. One staff member said, "The atmosphere has completely changed, everybody was set in their ways and this wasn't being challenged by management. Now we are all working as a team to head towards the same goals." Another staff member said, "I think a change in manager has helped, it has meant we had to change what wasn't working and go back to basics to make sure we were doing things right." Another member of staff said, "The easy thing for me to do after the last inspection was to leave, but I didn't. Now I am pleased I stayed and feel proud to work here."

The culture of the home had become more positive, with staff feeling proud of what they had achieved in making improvements to the quality of care. One staff member told us, "I am positive, and it makes me

happy to see that other staff are also positive. I think we are now much more person-centred, we get to spend more time with people. I am really happy working here, I really believe we are going in the right direction." Another staff member explained, "This is the happiest I've ever been while working here. The way staff think has turned more positive. You can see carers smiling, even when we are busy there is still time for laughter and that is because we are now a happy team." A healthcare professional told us, "The current management team are empowering the staff and appear to be supporting their staff and residents well."

At our last inspection we found the provider's quality monitoring to be inadequate. At this inspection the senior operations director told us they had made changes to the provider's auditing tool. They told us they had reviewed their audit tools and made changes to make sure that improvements needed would be identified more robustly. The provider had been sending us a weekly action plan which had identified areas that required improvement and the action taken to address issues. The home manager was open and honest with us about where the service was in terms of improvement. They told us they recognised whilst the service had improved a lot, there was still work to do. One of the ways in which the provider was trying to continually improve was to recruit two senior positions at the home. It had been identified that a night manager and a dementia lead would be beneficial to the home. These posts would provide additional senior manager support and guidance. The provider was actively recruiting into these posts at the time of our inspection.

The management team completed night time checks, following on from concerns being highlighted at the previous inspection. We found that any concerns which were identified were recorded, along with the actions taken. For example, the deployment of staff at certain times of the evening. Plans were then put in place to introduce a twilight shift, which meant the staffing numbers were more proportionate to the number of people likely to still be awake. Staff told us the senior operations director often visited the home at night or phoned the night staff to check they were ok. They were appreciative of the support from senior management. A member of staff told us, "We have had so much support from head office, not just for maintenance and funding, but also for personal support. [The senior operations director] is here quite often and she always says if there are any problems just ring me, it is really nice."

People told us they were happy living at Laverstock Care Centre. Comments included, "I'm happy here and that's the main thing", "I wouldn't want to move anywhere else. I like it here", "I think I'm very fortunate to be here", "In the last fortnight I've seen an improvement in everything" and "The whole home is improving; the attitude is better." One relative told us "Things are better here now, more staff around."

The provider rewarded staff with a monthly 'caring stars' award. People, relatives and colleagues could nominate a member of staff to win a monetary shopping voucher. Staff were supported to do work based qualifications and encouraged to do courses which enabled them to start nurse training. Nursing staff told us they had more study days available to them now and the opportunity to develop their clinical skills. Staff could attend regular staff meetings. One staff member told us, "We have regular staff meetings and they are well attended. They didn't used to be, but the meetings are a good opportunity to air our views and ask if there is anything we need."

The service sought people's views using surveys. The most recent survey from May 2018 had no action plan produced in response to people's views. Whilst the survey demonstrated that overall people were satisfied with the service, with a score of 85% there was room for improvement. The home manager told us they would produce an action plan based on people's comments.

In addition to surveys the service also organised meetings for people, relatives and staff to share and discuss feedback. We saw that meetings had been held with people and their relatives on a regular basis. These

included discussions around the content of the previous CQC inspection report. We saw that the management team had communicated with people and their relatives regarding plans for improvements and how these had been progressing. The provider had taken action in response to feedback gained at meetings. For example, people and relatives had complained that the top floor of the service was very warm. In response the home manager organised for air conditioning to be installed to help regulate the temperature.