HC-One Oval Limited

Chaseview Care Home

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of Chaseview Care Home on 5 and 6 February 2018. Chaseview Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Chaseview Care Home is a care home for up to 120 older adults. This included people with dementia and people who were at the home for a short stay. The home was split across four units and each unit was managed by a unit manager. There were 100 people living at the home on 5 February 2018, which had reduced to 99 people on the second day of the inspection.

The home had recently changed providers and this was the first inspection since the new provider took over.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Risk assessments for most people who lived in the home included information on how to mitigate identified risks. However, risks were not always robustly managed for some people to ensure they were safe at all times.

Some people, relatives and staff raised concerns about staffing levels. The way staff were deployed across the home meant there were sometimes delays in providing support to people who required it.

Some people who lived at the home were deprived of their liberty under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty applications had not been made for four people when their initial DoLS authorisation had expired. Staff were aware of the principles of the MCA and assessments had been carried out to determine people's ability to make decisions in certain areas.

Quality assurance systems were in place but were not always effective. The audits which the home carried out had not identified the shortfalls we found during the inspection to ensure people were safe at all times. Accurate and complete records had not been kept to ensure people received high quality care and support.

Medicines were managed safely. In general, we found that people's Medicine Administration Records (MAR) had been completed accurately. Medicines was being administered as instructed on people's MAR, or in accordance with the provider's policy.

Pre-employment checks had been carried out for new staff to ensure they were suitable to provide care and support to people safely. Staff we spoke to were aware of how to identify abuse and knew who to report abuse to, both within the organisation and externally.

Incident records were reviewed and these showed the provider took appropriate action following incidents that had been recorded. Systems were in place to analyse incidents for patterns and trends to ensure lessons were learnt and incidents were minimised.

Systems were in place to reduce the risk and spread of infection. Staff had access to personal protective equipment and used this when needed.

Staff had the skill and knowledge to provide support effectively. Records showed that some staff needed refresher training in some areas. This was being addressed by the management team. Staff were knowledgeable on how to support people. Supervisions were carried out regularly and staff told us that they were supported by the manager.

People had access to healthcare services and staff knew what to do if people felt unwell.

People in general told us that they enjoyed the food at the home and were given choices. However, people in one unit raised concerns with meals. People's weight and food intake was monitored when required and if there were concerns, action was taken, which resulted in people's health improving.

Care plans were inconsistent. Some people's current circumstances were not being reviewed effectively to achieve effective outcomes as although reviews were being undertaken, we found that they did not accurately reflect some people's current circumstances. Care plans contained information on how to communicate with people. Pre-assessment forms had been completed in full to assess people's needs and their background.

People's privacy and dignity were respected by staff. People told us that staff were caring and they had positive relationships with staff.

Complaints were being investigated and staff were aware of how to manage complaints.

Regular activities were being carried out. This involved group activities and individual activities. There was an activities lead for each unit.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Some risks had not been assessed to ensure people were safe at all times.

Staff were not deployed effectively to ensure people received safe care and support when required.

Medicines were being managed safely.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

Pre-employment checks had been carried out to ensure staff were suitable to care for people safely.

Appropriate infection control arrangements were in place.

Is the service effective?

Requires Improvement

The home was not always effective.

People were deprived of their liberty under the Mental Capacity Act 2005. However, applications had not been made for four people to deprive them of their liberty lawfully.

Staff had the knowledge and skills required to perform their roles effectively. Some staff required refresher training and this was being addressed by the management team.

Staff told us they were supported to carry out their roles.

Most people's nutritional needs were being met. However, people in one unit raised concerns with their meals.

People had access to healthcare services.

Is the service caring?

Good

The home was caring.

Staff had a good relationship with people and people told us that staff were caring.

People's privacy and dignity was respected.

People were encouraged to be independent, where possible.

Is the service responsive?

Good

The home was responsive.

Some care plans were inconsistent. However, staff were knowledgeable about the people they supported.

Care plans contained information on how to communicate with people.

People participated in regular activities.

Complaints were being investigated. Staff knew how to manage complaints.

Is the service well-led?

Requires Improvement

The home was not always well-led.

The systems in place to monitor and improve the quality of care provided were not robust. Shortfalls in the home were not always identified. Therefore necessary action was not always taken to rectify them to ensure people were safe at all times.

Accurate, complete and contemporaneous records had not been kept in regards to people's care and support.

Staff meetings and residents meeting were taking place regularly.

Chaseview Care Home

Detailed findings

Background to this inspection

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

The inspection was carried out on 5 and 6 February 2018 and was unannounced. The inspection was carried out by three inspectors, a specialist advisor in nursing care, a pharmacist 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 care service.

Before the inspection, we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events which the provider is required to tell us about by law. We also received a Provider Information Return (PIR) from the home. A PIR is a form that asks the provider to give some key information about the home, what it does well and any improvements they plan to make. We sought feedback from health and social professionals. We used this information to decide which areas to focus on during our inspection.

During the inspection, we spoke with 27 members of staff, which included the area director, registered manager, deputy manager, four unit managers, 14 care staff, two domestic staff, a laundry staff member, an activities coordinator and two maintenance staff. We also spoke with 23 people and 13 relatives. We carried out observations of people's interactions with staff and how they were supported. 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.

We reviewed documents and records that related to people's care and the management of the home. We reviewed 15 people's care plans, which included risk assessments and staff files which included pre-employment checks. We looked at other documents held at the home such as medicine, training, supervision and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Staff deployment was not always effective. During this inspection, some staff, relatives and people told us the home did not have enough staff. A person told us, "Just recently we haven't had sufficient staff. They are trying to do 3 or 4 jobs at once." A relative told us, "No, there is definitely not enough staff and there are always staff members off sick." One staff told us, "No never. Especially on a weekend. We are always short staffed. It looks good on paper. The nurses and the senior don't do the care. Morale is low, staff are crying." Another staff member also told us that the nurses did not support care staff with, "basic hands on care" and this was not taken into account when assessing staffing levels. For two units the rotas did not demonstrate there were enough staff on duty. They did not indicate who was in charge or who is a nurse, senior care staff and care assistant on each day. The rotas showed gaps in coverage on some days and extra staff on other days and at times was incomplete. For one unit, the rota showed there should be an allocated number of staff on duty for each day; however, this did not correspond with some entries on the rota.

On the first day of the inspection we heard a person calling for help and as there was no staff nearby, we had to locate a staff member to support the person. In one unit, we observed at times that staff members were in the lounge, not engaging with people or walking across the unit to see if people needed assistance. Information on one person's care plan included that staff should spend time with the person and help them engage with other people. We observed that the person was very agitated and wanted to go outside. However, staff did not support this person or facilitate a walk in the garden. Later, this person left the building on their own, through the fire exit which prompted the need for an incident form to be completed. The buzzer went and this was promptly identified by staff who then spent some time with the person.

One person told us, "If I ring my call bell at night they can take a long time to come, sometimes about 45 minutes." We checked the call bell records and found in general the response time was within two minutes. However, on the first day of the inspection, we tested the call bell in one person's room who was cared for in bed with the unit manager. The person's care plan included should the person need support they would use the call bell. We observed the person was holding their call bell but upon testing it, we found the call bell was not working. This was fixed by the unit manager and upon calling the buzzer, we had to wait six minutes before staff responded. The following day we tested the call bells across all the units and the response time was satisfactory in most cases. However, in one unit a person was in a bed with bed rails which meant that they could not mobilise without staff support. We tested the call bell response with a nurse and had to wait six minutes before the unit manager arrived. The unit manager told us that all staff were busy, hence the delay and that it was ok to wait 10-15 minutes to respond to a call bell. This potentially meant that there was a risk people may not receive immediate support and care when they needed it.

The above issues highlight that the home failed to ensure sufficient staff members were deployed at all times within the home to meet people's needs and ensure their safety. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Records showed that a risk management plan had been created for most people at risk of skin complications, which provided information on how to mitigate the risk. We saw good responsive care from

staff on two occasions regarding the management of a skin condition, which demonstrated robust responsive care such as referral to a health professional, updated risk assessments and regular evaluation leading to a good outcome. However, this was inconsistent as we found one person who was at very high risk of skin complication; a risk assessment had not been completed. Records showed the person was identified to have had skin complication previously and the care plans stated an additional risk assessment or support plan was required to manage this risk. However, this had not been completed. Records and body maps showed that the person had bruises and tears to their skins. However, there were no records of how this had been managed. Staff were unable to find the records and the registered manager told us that the records may have been lost. For another person, who was discharged from hospital on December 2017 with skin complications, the discharge summary stated that support was needed to treat the skin complication. However, upon speaking to staff, they were not aware of the information on the discharge summary and the person's risk assessments had not been updated to reflect the support required. These failings to consistently assess and document the risks in relation to skin complications may have placed people at risk of harm.

A staff member for this unit told us, "I'm getting to know them gradually. Some are really aggressive but nobody told me." One person told us, "For the most part within these walls I am fine. There is a resident that comes into our rooms at night. Everyone is talking about it today. It is just the anxiety it creates." Our observations confirmed a person occasionally walked around their unit, going into people's bedrooms. As we were speaking to one person and their relative in their bedroom, the person tried to get inside; this led to a confrontation with the relative. We checked the person's support plan. We found that there was no assessment in relation to the person's behaviour or that the person went into people's rooms and how this was to be managed. For another person we found that there was a behaviour chart in place that recorded the person may demonstrate behaviours that may challenge, for example hitting staff members. The unit manager confirmed this. However, a risk assessment had not been completed in this area to ensure the risk of re-occurrence was minimised. These failings to accurately assess and document the risks with behaviours, potentially placed people at risk of harm to themselves or others.

The above issues show the home failed to provide the proper and safe management of risks associated with their health and circumstances. The issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The remaining risk assessments we reviewed provided information on how to mitigate risks such as on smoking, nutrition, choking, mobility and medicines. The home also had a fall scoring methodology to determine people's risk of falling. Where there was a risk of a person falling, a falls risk management plan was in place. A nutrition assessment was also carried out to determine risks with nutrition and a risk management plan was in place for people at risk of malnutrition.

People and relatives told us that they did not have concerns about people's safety. A relative told us, "Mum has been here for 2 years. Overall I do feel that she is safe because it is a safe and secure environment." Another relative told us, "Overall, she is safe." Comments from people included, "Yes, I feel safe. All the bits and pieces are special", "I don't think any of them would do you any harm", "Yes, I do feel safe because I know everybody." and "Yes, I feel perfectly safe here because the system and the staff are generally very good." A staff member told us, "We do our best for people."

Staff we spoke to were aware of their responsibilities in relation to safeguarding people. Minutes showed that safeguarding was also discussed at internal meetings. Staff were able to explain what abuse was and who to report it to. They also understood how to whistle blow and knew they could report any concerns to outside organisations, such as the Care Quality Commission (CQC) and the police.

A person told us, "I receive my medication twice a day and the staff tell me what it is for and I can explain it to you." We reviewed medicines in each of the four units at the home. Medicines were stored securely in medicine trolleys and cupboards within the clinic room. Arrangements were in place for the collection and disposal of unused medicines. We reviewed a sample of 39 Medication Administration Record (MAR). All MAR charts included allergy status and a picture of the person. In general, we found that the MAR charts we reviewed had been accurately completed. Staff had been trained on medicine management and had received comprehensive competency based training before being signed off to administer medicines.

We saw that appropriate records were being maintained for controlled drugs (CDs) and this was stored securely. CDs are subject to legal requirements for recording and storage and were at a higher risk of diversion and abuse. We found that each record was witnessed by two members of staff as per the home's medicine policy.

Protocols were in place to support staff when administering PRN medicines. These are medicines that were given when needed, for example pain killers and reliever inhalers. Homely remedies were available for people who required them, a policy supported staff to administer these medicines.
People who were able and wished to do so, were supported to manage their own medicines. We saw documented evidence of self-administration assessments for people who were managing their medicines.

Incident records were reviewed and these showed the provider took appropriate action for incidents that had been recorded. The details of the incidents were recorded along with the actions taken. The area director also had oversight of incidents and accidents. The registered manager told us that they had identified a number of falls emanating from one unit and this had been analysed and action taken such as updating risk assessments, referring people to falls clinical and allocating more staff. As a result of these actions, falls had been significantly reduced. This meant that the home was committed to learning from incidents to ensure that there was continuous improvement and people living at the home were safe.

Pre-employment checks had been carried out to ensure staff that were recruited were suitable to provide care and support to people safely. The registered manager told us that staff did not start working at the home until all pre-employment checks had been completed. Records showed that relevant pre-employment checks such as criminal record checks, references and proof of the person's identity had been carried out as part of the recruitment process.

Checks had been carried out to ensure the premises were safe. Regular fire and evacuation tests were carried out. There were records on how to safely evacuate people. Staff were able to tell us what to do in an emergency, such as evacuating people, moving them to the assembly point and ensuring everyone was there and calling the emergency services. Fire evacuation equipment's such as slide mats, blankets and extinguishers were also installed throughout the home. Records showed that fire extinguishers had been serviced recently. We saw evidence that demonstrated appropriate gas, electrical, portable appliance, water safety checks had been carried out.

Staff were knowledgeable about their role in preventing the spread of infection and confirmed there was plenty of personal protective equipment (PPE). People told us that their rooms were clean and staff wore appropriate clothing when supporting them. Observation confirmed that the home was clean and staff used PPE's such as gloves, aprons and uniform when required. A staff member told us when asked if they had access to PPE, "Yes, there's loads. Since this company took over we always have them." A cleaning staff member told us, "There is plenty of PPE and products." Anti-bacterial lotion slots were available throughout the building for hand hygiene and we saw staff used these slots to clean their hands. One person had an infection at the time of the inspection, which had not spread. This had been dealt with according to

procedure and staff described the actions taken. Monthly and quarterly infection control audits were carried out that focused on cleanliness throughout the home.

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. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that the doors to each unit were kept locked and were informed some people did not go out by themselves without being supervised by staff. However, records showed that four DoLS authorisation had expired and an application had not been made and authorised for people whose liberty was being restricted for their own safety. One DoLS authorisation expired in August 2017, one in October 2017 and two in December 2017. This meant that some people's liberty was potentially being deprived without following a lawful process. We were subsequently informed by the area director that these applications had been completed and submitted.

The above issues related to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff were seen to seek consent from people about their daily routines. Staff spoke about how they supported people to make decisions and about the importance of offering people choice. A staff member told us, "You have to ask what they want to wear and if they need help going to the toilet." A person told us, "Yes, they do ask my permission. For example, they ask if I am ready to go into my wheelchair. They ask if I want to go bed, they don't just tell me." Staff were aware of the principles of the MCA and records showed that MCA assessments had been carried out to assess people's ability to make decisions on specific areas. Where a person did not have capacity to make a specific decision, then a best interest decision had been made on their behalf with family members where possible. A relative told us, "I have been involved in capacity assessment and best interests decisions in the past." One MCA assessment showed, "[Person] has variable capacity to make decisions over her care. Her son is involved in decision making in her best interest. Staff encourage her to make decisions. She likes to discuss in her room."

Pre-admission assessments had been completed prior to people receiving support and care from staff. Information was obtained on people's health conditions and background. Assessments were also carried out on the level of support people would require. Care plans were developed using this information. The home assessed people's needs and choices through regular review meetings. The review included reviewing all aspects of care and support people received. However, although reviews were being undertaken, we found that they did not accurately reflect people's current circumstances. For one person who was at risk of having seizures, monthly reviews showed that the person did not have seizures since May 2016. However,

during September and November 2017, records showed the person had seizures and had seen a health professional about this. For another person, their skin care plan included, "The SU (service user) is able, with encouragement, to change position." However, staff told us that the person was not able to change positions and relied on staff to do this every four hours. Records showed that the person was being re-positioned every four hours. This meant that people's current circumstances were not being reviewed effectively to achieve effective outcomes.

People and relatives told us staff were skilled, knowledgeable and able to provide care and support effectively. Comments from people included, "They know how to use all the equipment", "It is no problem here because the carers look after me", "I have wonderful staff to take care of me", "The staff are very good" and "The staff, they are excellent." One relative told us, "Overall yes, staff understand mum's support needs."

Staff confirmed they received an induction when they joined the home; and all staff spoken with said they had received training appropriate to their roles. One staff member said, "The induction was really good, an eye-opener to everything." Another staff member told us, "I observed for about a week until I was comfortable." Records showed new staff that had started employment had received an induction. Induction involved looking at care plans, training staff on roles and responsibilities and shadowing experienced members of staff.

Staff were positive about the training. One staff member told us, "The training is on-line and face to face. It's good." Training compliance was mixed but there was evidence the home was working to become compliant. We looked at the training matrix and analysis for 1 December 2017 and also training attendance records. Records showed that some staff were due refresher training on safeguarding, information matters, infection control and moving and handling as this had expired. However, there was a home improvement plan in place that detailed the new provider would be rolling out a training plan to ensure compliance with these training. Staff had also been trained in nutrition, handling complaints and MCA/DoLs. They had also received specialist training in positive behaviour and dementia.

Supervision of staff had been carried out regularly. Staff records showed that they received supervision to help them provide good quality care and to ensure a consistent approach. Topics discussed included care of people, safeguarding, training and staff member's performance. The registered manager also told us that she had a system of holding themed group supervisions to deal with specific issues. For example, recently there was medicines management group supervision. Staff told us that they were supported by the management team. A staff member told us, "I feel well supported."

Care records included the contact details of people's GP, so staff could contact them if they had concerns about a person's health. We found letters from hospitals and psychiatrist that showed appointments had been made with people to monitor their health. Records showed that people had seen GP's, dentists, optician's and chiropodist to ensure they were in the best of health. Staff had awareness of when people did not feel well and what to do if they were unwell. A person told us, "When I had a chest infection, the staff helped me." This meant that people were supported to ensure they were in the best of health.

The staff team worked together to deliver effective care and support. Staff told us there was a system of communicating people's change in needs with each other. A staff member told us, "There is good team work." There was a daily log sheet and communication book, which recorded information about people's daily activities, the support provided by staff and any health visits. This was used to communicate information between shifts on the overall care people received. This meant that staff could summarise the care needs of people on each shift and respond to any changing or immediate needs.

There was an eating and drinking section in people's care plan that detailed people's likes and dislikes, assistance required during meal times and any special diets. People's weight was monitored monthly and when needed, weekly. Records showed that people who had lost weight consistently had been referred to a health professional. For one person, records showed the home took prompt action to improve a person's health. The person had lost significant amount of weight and was at very high risk of malnutrition during admission to a hospital. The person was then referred to a dietician, kitchen staff were informed on dietary requirements such as fortified meals and regular review of the person weight took place. As a result the person's health had improved following the home's action.

The menu showed that people were given choices during meal times. We observed that the kitchen was clean and tidy. Cooked and uncooked meat was kept separately. Labels had been used that detailed when a food item had been opened. The kitchen had been awarded an environmental hygiene rating of five. We spoke to the chef, who was able to tell us which people had specific diets and the diet for people with specific health conditions such as diabetes. The chefs had records of people who were on specific diets in the kitchen and received daily updates on people's preference with meals.

People and relatives told us that people had choices and generally enjoyed the food. Comments from people included, "On the whole they do a good job", "It is very good. We have a good chef here", "The chef is pretty good", "You can eat what you like. You do get a choice." A relative told us, "Yeah, you can have what you want. Mum's food is cut up for her and she eats with her fingers. The food for mum is appetising." A staff member told us, "People get choices here, always." We were informed that people's choices on meals were taken the day before.

However, on one unit, a number of people raised concerns about their meals. Comments included, "The food use to be beautiful but it has all gone downhill", "We have made complaints e.g. the soup it is too watery, the food is bland. We were served mushroom when a lot of us can't eat mushroom", "The food could be better and I am not the only one who thinks that", "It is often not hot enough and sometimes it is different to what you have ordered" and "The food it is terrible."

In another unit, we found that the menus did not reflect the meal choice on the day. A person told us, "We are not served bread or butter with our meals." Another person told us, "They have a 'what you said and what we did board' but you can see that there was no bread or butter today like it says there should be with each meal." We saw that there was a 'You Said, We Did' board near the lounge area that indicated that people had requested that bread and butter was served with their meal and had been told this would be provided. Our observation on one unit during meal times confirmed that there were no bread and butter being served.

Some people raised concerns about receiving their meals late. One person told us, "I had breakfast in the dining room. It is supposed to start at 08:00 but is always closer to 09:00. Today was closer to 09:15. The hot food is in a trolley and that can be the reason for the delay." On the first day of the inspection, we observed that some people had to wait a long time for their meals to arrive while other people had received their meals and there was not much interaction between people and staff. We fed this back to the management team who informed us that improvements would be made. On the second day of the inspection we found improvements had been made across all the units. We observed staff offering people in the dining room, a choice of food prior to serving. Meals were provided in a timely manner for people in the lounge and for people that wanted to have their meals in their room. Staff sat with people they were supporting to eat. We observed friendly and cheerful conversations between staff and people during mealtimes.

People's rooms were personalised and contained an en-suite toilet. Bedroom doors were different colours

and in the style of a hall door to help people to recognise their room. Each person had a red, green or amber colour sticker to indicate their level of mobility. There was a board in the communal area in a dementia unit, which displayed the day, date and time with the season and the weather of the day to help people with dementia be orientated to time.

Good

Is the service caring?

Our findings

People told us staff were caring. They explained that staff spent time with them and treated them with kindness and compassion. One person said, "It is good care. Staff are always talkative." Another person told us, "The staff are kind and caring. There is nothing wrong with the staff, they are lovely." Relatives were also positive about the approach of staff at the home. A relative told us, "The ladies carers are helpful and kind, generally nice." Another relative told us, "In the main they are caring. We don't see any of the staff get stroppy."

Staff had positive relationships with people. Staff told us they maintained relationships with people by looking at their care plans and finding out about their interests and using this information to talk to them. A staff member told us, "I look at their care plan to see what they like and then start a conversation to build a rapport with them." A person told us, "I get on well with the staff. You treat them how you want to be treated yourself. They are all very jolly." Another person told us, "Oh yes, I have a very good relationship with staff." A third person told us, "Yes, I have a good relationship with staff they are lovely people." Staff were observed to interact with people in a caring manner. We observed multiple times during both inspection days that staff came down to people's level, spoke softly to people and checked with them regularly that they were okay and if they needed anything.

People were protected from discrimination within the home. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally. A staff member told us, "We make sure the residents are not discriminated against. Everyone's treated as individuals and not as a group." People and their relatives confirmed that they were treated equally and had no concerns about the way staff approached them. A person told us, "I think people are treated equally." Another person told us, "Yes, they treat people equally." Records showed that a priest visited the home to carry out a service. A staff member told us, "There's a priest that comes in for the Catholics and gives them Holy Communion. We have a lady here who is Jehovah's Witness." A person told us, "Yes, my spiritual needs are respected. I am fussy, I say my own prayers. If I want to go to church, it is always there." Another person told us, "They have a church service once a month in the other unit and we are all welcome."

A relative told us, "I have the opportunity to be involved. If I had concerns, I would be more involved. I get notification of reviews." Another relative told us, "Yes, there is one [reviews] every 3 months. I went once in December and the next one is in March." A person told us, "Yes, I am involved in decisions about my care and support. They do undertake care reviews." A staff member told us, "Yes, they have care reviews and the relatives are phoned." As far as possible, the home supported people to express their views and be actively involved in making decisions about their care and day to day living. Relatives were also involved with decisions on the support people would receive. Information on one care plan included that staff should encourage a person to choose their clothes. Another record stated that a person wanted the light left on in her en-suite at night and the door to the en-suite left open as her choice. We observed a staff member asking a person if they wanted to go to the communal area to see other people. The person said no and this was respected. Records showed that people were given the choice of using advocates.

Independence was encouraged and records showed that staff should encourage people to support themselves where possible. We observed that people were encouraged to be independent and saw people being encouraged to eat by themselves and to go to the toilet. A staff member told us, "We try to encourage them as much as we can to carry on their independence." A person told us, "Yes, I am encouraged to be independent for example I do knitting and crochet." Another person told us, "Yes, they encourage me to be as independent as possible."

Staff ensured people's privacy and dignity were respected. People told us that staff treated them with respect. One person told us, "Yes, they respect me." Another person told us, "They do respect my privacy and dignity." Staff told us that when providing particular support or treatment, it was done in private and people we spoke with confirmed this. A relative told us, "They also close the door when they are dressing her." A staff member told us, "When they are being washed and dressed, the door is shut, the curtains are closed." We did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. We observed that staff knocked on people's doors regularly before going inside. A person told us, "Yes, they do ask permission before they do things for example they knock on my door before they enter." A staff member told us, "We always knock on the door before we go in."

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity. We saw that confidential information such as people's care plans and medicines records were stored securely.

End of life care plans were completed for some of the people and the involvement of their relatives were clearly indicated. We saw correspondence between relatives and staff and evidence of meetings about end of life care.

Good

Is the service responsive?

Our findings

People and relatives told us that staff were knowledgeable of people they supported and were responsive. One person told us, "Yes, I expect they are knowledgeable as they always help me in here. They know me, they don't just walk by you." Another person commented, "I have come a long way since I came here. I couldn't walk when I came, now I can walk. The carers are very willing to help me stand up." A relative told us, "They know what Mum likes and dislikes." A staff member told us, "People get good care. We help them with feeding and changing positions." Staff we spoke to were aware of people's preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service.

Each person had an individual care plan which contained information about the support they needed from staff. One staff member told us, "We read their care plan about what they used to do, their dislikes so when we are giving them personal care we can talk to them about these things." Most care plans detailed the support people would require and people's medical condition. There was also an 'My day, My Life, My Story' care plan that gave a history of where a person had lived most of their life, childhood holidays, favourite childhood memories, favourite job, hobbies and interests. There was a 'Lifestyle' care plan that indicated people's likes and dislikes, what the person could do for themselves and what support the person needed from staff in terms of interaction. A person told us, "Yes, the staff are kind and caring in the way they look after me. They give me a body wash every day and occasionally they bath me. You can make a suggestion and they do it for you if they can." In one person's care plan, information included, "[Person] refused to sleep in bed. [Person] likes to sleep in her armchair at night. She dislikes getting on to her bed to sleep. [Person] likes to go to sleep around 10pm." In another person's care plan, information included what a person's preferred clothes to wear and they preferred to have a shower once a week and a strip wash on other days.

However, we found inconsistencies with care plans. For one person, their support plan for eating and drinking stated they should be weighed weekly but records showed they were weighed monthly. Staff told us that there had been a change following advice from the dietician in April 2017, but the care plan had not been updated to reflect this. We found inconsistencies with care plans for people who had diabetes. On some care plans information had not been included on hyperglycaemia and hypoglycaemia, which should have included the signs and what staff should do to ensure glucose levels were stable. On other care plans, we found that this information had been included. We fed this back to the registered manager who informed training had been booked for all clinical and care staff on diabetes and action would be taken to ensure care plans were consistent.

Care plans also included people's sensory abilities, allergies, nutritional information, mobility needs, and details of their next of kin, health professionals and whether people preferred male or female carers.

The home had a system called "Resident of the Day". This was a day where a resident was identified and something outside of the normal routine was done for the person such as a preferred activity. Staff told us that the person's family were involved and particularly encouraged to visit on this day and their care plans were reviewed.

A relative told us, "Yes, the [staff] communicate well with [person]." A person told us, "Yes, they do communicate well they do speak good English." All organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS) by law. The aim of the AIS is to make sure that people who have a disability, impairment or sensory loss receive information that they can access and understand. None of the staff we spoke to were aware what the AIS was but were able to tell us how they communicated with people. We spoke to the area director and registered manager about how people could receive information in a way that they could access and understand. The area director told us they were in the process of putting systems in place so people would have access to information that could be read easily and with pictures. After the inspection the registered manager sent us evidence on how information could be accessed through different formats such as easy read, audio tapes and Makaton formats. Records showed that communication needs had been identified and recorded in people's care plans with information on how to meet those needs. For example, one communication plan said, "At times staff need to prompt [person] to communicate her needs. When speaking to her staff to speak slowly and clearly and be at her eye level. Staff to give [person] time to express herself and listen to her."

People told us that activities were carried out regularly, which they enjoyed. One person told us, "I join in the family entertainment. I like the singers, arts and crafts and colouring. I like the greyhound dog that visits. A baby goat and some chickens came into visit. In the summer, I sit in the garden." Another person told us, "I join in a lot of the activities such as bingo, play your cards right, hoopla, cake decorating and we are knitting a blanket for the hospice. We have concerts and singers and have musical exercises. Animals come in and visit us such as rabbits, chicks and a black grey hound. In the summer, we have had a garden fete, bazaar, singer and stalls. They took about nine of us to the café in the local college for coffee." A staff member told us, "They do activities here like singing and music." There was an activities lead on each of the unit that organised group and one to one activities. During the inspection we observed a number of activities that took place. Photos and records in people's care plans showed that people participated in activities. This involved celebrations, choirs from primary school, going outside and arts and crafts.

There was a social section on each care plan that included information on people's likes and dislikes with activities. There was a timetable on each unit that displayed what activities would be taking place. Care records included an activity and interaction log for each person. In general, there was a good atmosphere at the home and people smiled, chatted and laughed along with the staff interactions. We observed that there was a good atmosphere in one unit during a birthday celebration. Other examples of activities offered included, pets as therapy, church service, music, dancing, cake decorating and crafts. The activities log showed that people who were cared for in bed or preferred to stay in their rooms had regular one to one from activities staff. An activities co-ordinator told us that work was in progress to support people access the community more readily. They also told us, "I asked for a suggestion box for residents and relatives to get ideas from people, it's been ordered for me."

We observed positive interactions between staff and people across the units. In one unit, we observed a person was sitting at a table with staff and other people were chatting amongst themselves. Another person was sitting away from other people with one staff member supporting them to have a drink. The staff member spoke softly to this person who responded in an equally soft voice. A third person was sitting in an armchair quietly looking at a book and a magazine. When a particular track came on, this person started singing and staff joined in; the person stood up and started dancing and laughing with the staff member.

The complaints log showed that complaints were dealt with according to procedure. A person told us, "I would complain to the person in charge but I have never had no problem." People and relative were aware on how to make complaints. A relative told us of a complaint she made regarding their family member and since she made the complaint, things had improved. Staff were aware on how to manage complaints. A staff

member told us, "Get them the complaints form if its family. If it's a resident I would take them to the unit manager or they can complain to me and I can go and tell them."

Requires Improvement

Is the service well-led?

Our findings

Regular audits were carried out to monitor the quality of the home such as; health and safety audits, quarterly night visits, medicines, infection control, catering, and care plan audits. There was also a first impressions audit, which involved members of the management team walking across the home to check standard of care and if there was any issues with the home. However, while some of these audits had been effective such as reducing falls in one unit and managing medicines safely, others had not identified issues of concern. The care plans audits had not identified some of the issues picked up during the inspection, for example, inconsistencies on some care plans and a lack of accurate risk assessments. Audits had not identified the concerns we found with staff deployment. Although the 'You Said, We Did' board indicated that people had requested bread and butter with their meals we observed this was not provided in one unit and some people raised concerns that this was not being provided. The catering audit had also indicated that menus should be made available; although menus were seen, they did not indicate the food offered on one unit. This indicated a lack of oversight in following actions through. Although regulatory requirements were understood by the management team, shortfalls were not identified in relation to DOLS monitoring. Some authorisations had expired and internal monitoring systems had not picked this up.

Records were not always kept up to date. Risk assessments had not been completed in full for some people and some care plans did not have information needed to support people effectively. Records could not be found in one care plan on how a person's skin conditions had been managed.

There was a home improvement plan in place that referred to documentation and the improvements required in this area. The improvement plan included a date that this would need to be completed by and the staff responsible for this.

The consequences of not having robust quality assurance processes and not keeping an accurate, complete and contemporaneous record of people who use the service, may impact on people's care and support if staff are not able to support people safely and meet their needs.

A staff survey had been carried out. This was positive overall and demonstrated an upward trend since the appointment of the registered manager. However, no recent resident surveys had been undertaken. We were informed that this would be carried out soon. Feedback was sought from residents and relatives meetings that were being held regularly. At these meetings relatives and people discussed activities, meals, staffing and were also introduced to new people and staff.

Staff told us that they enjoyed working at the home. One staff member told us, "I like my residents. I love helping people." Another staff member commented, "I like looking after people, I enjoy doing this."

In general staff said that they felt supported by senior staff and that team working was strong. One member of staff said, "The manager is good. She is very encouraging and respects everyone. She makes you feel comfortable." Another staff member said, "The manager is very helpful." An activities staff member told us, "The manager is very helpful. She joins in activities sometimes."

Staff meetings were held regularly. The meetings kept staff updated with any changes in the home and allowed them to discuss any issues. Minutes showed staff held discussions on staffing, infection control, change of provider and there was a question and answer session with the registered manager. A staff member told us, "These meetings are helpful to keep us updated and for us to talk as well." This meant that staff were able to discuss any ideas or areas of improvements as a team, to ensure people received high quality support and care. Staff also commented that systems in place such as daily flash meetings, weekly clinical risk meetings and shift handover reports were useful and relevant. A daily flash meeting took place with senior staff nurses, unit managers and activity staff. At these meetings staff were updated on issues such as with medicines, safeguarding, complaints and record keeping.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Deprivation of Liberty applications had not been made for some people to ensure they were being deprived of their liberty lawfully. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The home had not done all that was reasonably practicable to mitigate risks to service users to ensure they were safe at all times. Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The home did not comprehensively assess the needs of people to sufficiently deploy suitably qualified, competent, skilled and experienced persons. Regulation 18(1)(2)