Baxendale

Baxendale 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7, 8 and 19 December 2017. The inspection was unannounced. The last inspection of the home was in December 2016 and the home was rated good at that time with no breaches of legal requirements.

This service 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.

Baxendale Care Home accommodates up to 57 people in one adapted building. This includes one separate six bed unit within the home for people living with dementia.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was absent so was not involved in this inspection. The rest of the management team; two deputy managers and a housekeeping manager were available and helped throughout the inspection.

The provider is a Charitable Trust. There is a board of Trustees, some of whom form a House committee to oversee the service provided at the care home.

This comprehensive inspection was prompted in part by concerns reported to the Commission that the home did not have enough staff employed, particularly at night and there were concerns about night time care. We found that some of the concerns about staffing were valid. We did not find evidence of poor care at night but we did find staff were working under pressure and found it difficult to manage people's needs at night.

People were safeguarded from abuse and felt safe in the home. They received their medicines safely and received support with their personal care. The home and equipment was well maintained, the standard of cleanliness was very good and people were protected from the risk of infection.

Staff training was good and equipped staff well to provide effective care. Staff worked hard, were committed to people living in the home and had formed good relationships with them. People told us that staff were kind and caring. People also felt their dignity and privacy was respected.

People received good support to access health services when they needed them. The food in the home was good and people said they were happy with their diet. They enjoyed some group activities. People with

dementia and those who stayed in their rooms had less opportunity for social interaction.

People said they felt able to raise concerns if they needed to and thought they would be listened to. They had appreciated a recent residents meeting where they could give their views. Relatives gave us very positive feedback about the home and the standard for care.

The charity charged reasonable fees and paid staff well. They had made continuous improvements to the facilities and had plans for further improvements. The Trustees met monthly and met with the registered manager.

We have made five recommendations in this report. We have made a recommendation to provide activities for people living with dementia and also to seek advice on person centred care. We also made a recommendation about seeking training in following correct best interest decisions practice when making decisions on behalf of people who did not have capacity to make the decision for themselves. This was because there was a lack of written evidence that this process had been followed for one person. We have made a recommendation to review the way that medicines are moved around the home, assessing the risks for people who manage their own medicines and reviewing whether the door to West Wing unit needs to be locked.

We found three breaches of regulations at this inspection. One was about staffing levels and supporting staff. This was because staffing levels, particularly at night, did not always meet people's needs fully. Another regulation breached was about safe care. Risks to the health and safety of people with high needs and those at risk of falling over had not been fully addressed. The monitoring of food and drink for those at risk of poor nutrition and/or dehydration was not effective. The deputy manager implemented some improvements in this when we raised it as a concern. The third breach of regulation was governance of the home as the quality monitoring by the provider and registered manager had not picked up the concerns we found. The monitoring of medicines and records of care provided had not been sufficiently regular or effective. Although the registered manager was away and not involved in the inspection the deputy managers were open and keen to make improvements. Some improvements were made immediately after the first day of the inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Risks to the health and safety of people at risk of pressure ulcers, poor nutrition and hydration were not addressed effectively. Staffing, particularly at night, was not deployed effectively to ensure there were always enough staff in the right places to provide safe care.

The home was safe, clean and well maintained. People felt safe in the home. People received their medicines in a safe way.

Is the service effective?

Good

The service was effective. There was a decision made without following and recording the correct process in a person's best interests and we have made a recommendation for the service to seek training in this. People received support from well trained staff. They enjoyed their food and most received good support with eating and drinking. People had support to access health care professionals when they needed them.

Is the service caring?

Good

The service was caring. People thought staff were very caring and kind. Staff showed a commitment to the residents and knew their needs and wishes well. People were very satisfied that their privacy and dignity was respected. Staff provided emotional support to people. Some cultural and religious needs were addressed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Although the management team responded to incidents and requests, some people told us they did not have enough choice in when they had a bath or shower, what time they got up and when they went to bed. Staff had written lists of people they should get up in the morning which was more institutional than person centred practice. People enjoyed a range of group activities but those people who had complex needs and those who did not like large group activities did not have individual activities offered which

were suitable for their needs and preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Staff morale was very low. The management team was very committed to the service and to continuous improvement but we found the standard of quality monitoring had not been robust. The provider and registered manager's monitoring systems did not pick up the concerns we found. However we were confident that this would improve as improvements were made as soon as we raised them.

Baxendale 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was prompted in part by concerns reported to us alleging that there were not enough staff employed, particularly at night and concerns about the care at night. The management team had carried out night time checks to look into these concerns and take their own action. This inspection examined those concerns and was also a comprehensive inspection.

Inspection site visit activity started on 7 December 2017 and ended on 19 December 2017. It included an unannounced visit during the night shift of 7 December to check on staffing, recordkeeping and care during the night shift. The inspection team comprised one inspector on 7 December, two inspectors for the morning of 8 December and one inspector on 19 December, a pharmacist inspector 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 all the information we held about the service including notifications of deaths and accidents, safeguarding alerts, whistleblowing concerns and contact from others sharing information about the home. There were 52 people living in the home at the time of this inspection.

During the inspection we talked to 28 people living in the home and ten of their relatives and friends. After the inspection we also spoke with eight relatives on the phone. We interviewed 20 staff in person and 11 staff on the phone. We spoke with five team leaders, eight daytime care assistants, ten night staff, two domestic staff, the training manager, head of night care and the activity coordinator. We met with the two deputy managers and housekeeping manager.

We looked at twelve people's care plans, carried out pathway tracking where we read the care plans, needs and risk assessments for five people then read the records of their daily care, met with them and spoke to staff and relatives about the person's needs to see if they were receiving good quality care. We looked at all

their care records including their food and fluid record charts and charts of their repositioning to prevent pressure ulcers for people who were unable to move unaided.

We observed two mealtimes in the main dining room and two mealtimes in the dementia unit and carried out observations of staff interaction with people in three communal lounges.

We inspected records. We looked at staff recruitment records for four recently employed staff, staff training records, and supervision records and staff meetings. We read minutes from a residents meeting. We inspected medicines in the home including reading 22 people's medicines administration charts. We checked health, safety and maintenance records.We read seven people's personal emergency evacuation plans. We looked at records relating to mental capacity and we checked financial records for one person.

We looked at staff rotas, shift plans and task allocation sheets and observed a staff handover. We read all quality monitoring records available from the management team and the Trustees for the home. We looked at safeguarding and complaints records. We also looked accidents and records of falls within the home.

Requires Improvement

Is the service safe?

Our findings

We had received concerns prior to the inspection about staffing levels in the home. We looked at staffing and discussed staffing levels with the management team, with individual team leaders and care assistants, temporary staff and some people living in the home and their relatives. Four people living in the home told us they believed the home was short staffed however they said that this didn't have a negative impact on them as staff responded to call bells quite quickly. People's comments included; "I just call out there is always somebody who comes to help me, "If I need help to go to the toilet or to go to bed I press the button and they come quickly" and, "they could not do more to help me they are very helpful." People told us that staff were kind and caring but very busy. Two people who spent most of their time upstairs by choice said they felt lonely and isolated as staff didn't have enough time to spend with them. We observed all staff to be busy with care tasks and not having time to spend quality time talking to people.

At night there was no consistent pattern of staff on duty. Inspection of the rota and talking to night staff indicated that some nights there were seven staff on duty, on other nights six or five or on one occasion four. On the night of our inspection an extra agency staff member arrived who had been booked earlier that day and who wasn't on the rota. They then had to leave and go to hospital with a person who had fallen over. Two night staff said they never knew how many staff would be working at night with them. We observed an evening up to 11pm and then early morning from 5.30am onwards. Night staff were rushing to carry out their duties. Where agency staff were covering vacant posts this put extra pressure on permanent staff as they had to advise agency staff on what to do. Two people had one to one staffing at night for safety reasons. We saw that one of these staff members played a role in supervising other people in the lounge as night staff were busy assisting people to bed. When we asked the staff member what they would do if their one to one person wanted to go to bed they said there would be nobody to supervise the other ten people they were supervising in the lounge and that they did this regularly. This meant that the person for whom the service received payment for one to one staffing at night may not always receive this level of support.

The deployment of staff on night shift had a negative impact on people. We saw three people got out of their chairs in the lounge and were asked by staff to sit down again. One of the three said they wanted to go to bed and another said they wanted a cup of tea. Staff asked both to wait as they were busy. A staff member said, "25 minutes until teatime" and "after the handover" when someone asked her for a cup of tea. We also observed a person ask to go to the toilet and staff told them they would need to wait for assistance. Three people fell asleep in the lounge shortly before 10pm whilst staff were assisting other people to bed. A lack of effectively deployed staff at night meant that people had to wait for their care.

Night staff helped a number of people to get up and dressed before day staff came on duty. There was a list of named people on the staff's list of tasks which stated who they should assist to get up and ready for the day. We saw that three people had been assisted to get dressed and fallen asleep again in their chair. Nobody complained to us that they had got up earlier than they wanted to but three people did say they couldn't choose to go to bed at their preferred time. The majority of staff
said that night staff were expected to assist a number of people to get up and ready for the day before day staff came on duty.

We looked at the record of falls in a nine week period and found more than 50% of the 27 falls happened during the night shift. Three people also told us they had fallen over in the bathroom or their bedroom during the night. Although the management team had been working on a dependency tool to determine staffing needs they said this had not yet determined what staffing levels were needed for the current resident group.

Although there appeared to be sufficient staff on duty in the mornings we observed that staff were very busy throughout and had little time to sit and talk to people. Team leaders allocated work to care assistants and oversaw the care, gave out all medicines, arranged and took part in any GP or other healthcare professional visits in the home. They were responsible for keeping care plans up to date and reviewing them monthly. We observed that team leaders all appeared rushed and constantly busy during the days of our inspection. We informed the deputy manager that team leaders appeared to be under pressure and that staffing levels should be reviewed. They told us that this was planned.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team told us that the Trustees had agreed an increase in staff on the third floor during the day so that there were two instead one staff member on duty there and this would be implemented in the near future.

All but one relative told us they thought the home was safe. One relative said their relative living in the home, " has a pressure mat on the carpet in case she gets up the alarm would be activated. I am 100 per cent happy and I don't feel that there is any more that could be done to make her feel safe."

People living in the home said they felt safe. Staff used equipment such as call pendants and sensor mats to support people at risk of falls. Some people said they knew they were at risk of falling and only moved from room to room when staff were present to assist them.

People had risk assessments to address the risks to their safety. Some people were at risk of developing pressure ulcers. The risk assessment tool used, the Waterlow score, was not used correctly for three people. Two of these risk assessments could not be completed properly as staff had not weighed the person for months and weight is needed in order to accurately assess the risk. Another person's assessment indicated they were of average Body Mass Index (BMI) every month for ten months and fully mobile. This meant they were assessed as not at risk of pressure ulcers despite spending their whole day sitting. This person was also assessed in their falls risk assessment as at medium risk of falls when staff told us they were at high risk and they had one to one staffing due to their risk of falling. This failure to carry out risk assessments correctly left people at risk of inappropriate care.

One person had a pressure mattress that was set incorrectly so was not effective. Staff and the management team were not aware of how to ensure a pressure relieving mattress was set to the person's weight and records showed there was no regular checking of pressure relieving equipment. There were no risk assessments or documented reasons found for three people who were cared for in bed at the time of the inspection. When we asked staff why one person had been in bed since a fall a few days previously we received three different answers. The other two people stayed in bed all the time. We gave feedback to the deputy manager on the first day of the inspection and they ensured the first person was supported to get up and by the time of our second visit they had designed a form for monitoring the beds and mattresses for people who were at risk of pressure ulcers.

There was a high level of falls in the home. We checked a sample of falls records and found there had been 27 falls in the last nine weeks before the inspection. We asked to see the accidents audits in the home but there was no auditing of falls and accidents other than responding to individual falls. People were referred to falls clinic appropriately but there was no overall action to address the reasons for the number of falls and no plan of action for reducing falls in the home. Between12 and 14 November 2017 there were six falls recorded which happened on the night shift but there was no record of any investigation to see why people had fallen and whether there had been enough staff available to help them. This showed a lack of learning from incidents.

There were a few people in the home for whom staff monitored their eating and drinking because they had been assessed as at risk of not eating or drinking enough. We reviewed the food and fluid records for these people and fund these were not adequate for assessing the food or fluid intake. This was a concern as it left people at risk of being dehydrated or malnourished. On 8 December 2017 we found one person's fluid chart had no entry of them having a drink since 12.50pm the previous day. One person's chart for the previous day recorded only 225ml of fluid all day but there was no record of what action was taken in response to this poor intake. Another person's chart on 25 November indicated they had only drunk 350ml of liquid but no action was recorded such as contacting the GP or staff being told to offer drinks more often. It was not possible to know whether this was due to staff not recording drinks or whether the person was not given enough to drink. There was no target fluid intake recorded on the charts to advise staff on how much the person should drink. There was no record that this issue has been picked up or addressed with staff. Most fluid charts we checked were not completed fully in the afternoons and evenings. Food recording was also not effective. Instead of recording what a person ate the chart asked staff to record whether they ate a quarter, half or three quarters, all or none of a meal and not what food they had. There was no evidence that any action was taken in response to monitoring of the records. In addition two people had not been weighed since July and September 2017 respectively despite the risk of weight loss. When we gave feedback to the deputy manager about this concern they devised a new and improved chart for more effective monitoring of the food and fluid intake of those few people at risk.

The above evidence amounted to a breach of Regulation 12 of the health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The service had a safeguarding procedure. Staff had completed their safeguarding training and those we asked all understood the signs of abuse.

Prescribed medicines were stored and managed safely. We saw evidence of people's currently prescribed medicines on the Medicines Administration Records (MAR). The allergy status of all people was recorded to prevent the risk of inappropriate prescribing, both on cover sheets and the MAR. We saw no gaps in the recording of administration of medicines which indicates that people received their medicines as prescribed. We noted the use of correction fluid to erase two records on the MAR of one person which contravenes best practice. We advised that this practice cease and staff agreed.

Several people living in the home were able to administer some or all of their own medicines and we saw that risk assessments were in place for only two people to ensure that this was carried out safely. We recommend that everybody looking after their own medicines has a risk assessment in place to ensure they are able to safely do so.

We counted 21 random samples of supplies of medicines over the three units and could reconcile all but one with the records of receipts, administration and disposal. Overall we were assured that medicines were administered as prescribed.

We observed medicines given at lunchtime to two people. We noticed that the medicines trolley taken to the dining room on three medicines rounds was loaded on the top with trays of boxed medicines. The trolley itself was kept locked but we had concerns that the security of the boxed medicines could not be maintained if the care worker was occupied with giving medicines or the dining room had to be evacuated in an emergency. Medicine trolleys were stored safely in the home in locked clinical rooms. A handle to one cupboard was broken and we were told that the maintenance manager had been informed about the broken handle the previous week. We recommend that the transporting of medicines around the home is reviewed to improve the security of medicines.

We noted from the MAR and GP record book that medicines were reviewed regularly and dosage changes were clearly documented on the MAR and the GP records. Some people were prescribed high risk medicines, such as Warfarin, which needed regular blood monitoring. Dates and results of blood tests were kept with the MAR and records showed that they were administered as prescribed. If people were prescribed medicines to be given as required (PRN) there were protocols in place so that staff knew when and how often they should be given. A separate record of administration and stock level was made on a PRN recording sheet. And when a variable dose such as one or two tablets was prescribed this was accurately recorded so that the prescriber could determine the effectiveness of the medicine.

One person was prescribed patches and oral medicines for pain relief and we saw from their care plan that they had capacity and could tell staff that they were in pain and that the GP regularly reviewed their pain relief. One person was prescribed anticipatory medicines for end of life care and we saw that there was a care plan in place. The instructions in the care plan and on the MAR were for the medicines to be initiated by the District nurse's instruction so staff could be confident on when to give these medicines.

Temperatures were recorded daily in the clinical rooms and for the medicines fridge so that the potency of the medicines could be maintained. Controlled drug records were not all accurate when we commenced our inspection. We noticed a large supply of morphine sulphate was recorded as being in stock but not available in the proper storage place. This stock was located in a separate insecure location at the time of the inspection and returned to the appropriate storage. All other supplies were recorded accurately. We recommend that the storage of controlled drugs is monitored in accordance with best practice.

The home had an up to date medicines policies and procedures available and we saw records of recent medicines training and competency assessments of staff trained to administer medicines. We asked to see monthly medicines audits for the last three months and noted that the last medicines audit been carried out on 25 September 2017. The lack of robust regular monthly audits suggested that best practice in medicines optimization was not being maintained. The deputy manager was able to show us her planned improvements for the more robust regular monitoring of medicines which was soon to be implemented.

The home was well maintained and the standard of safety in the building and the hygiene was very good. People had personal emergency evacuation plans for staff to follow in the event of a fire.

The kitchen was well maintained and staff recorded the temperatures of the fridges and freezers daily and stored food safely, including labelling food with the date it was opened. Staff had training in infection prevention and control and took appropriate precautions to prevent any spread of infection in the home. People living in the home were happy with the standard of cleanliness. One said the home was "spotless" and another told us, "The home is very clean and the staff do wear aprons and gloves."

Good

Is the service effective?

Our findings

Staff had the skills and the knowledge for the job. There was an induction programme for all staff and new staff completed the Care Certificate which is a nationally recognised training qualification for working in a care home. The provider employed a full time training manager who carried out much of the training and kept a record of staff training needs. Staff had the training necessary for the job and regular refresher training as required. The training manager was able to show us where training was booked for those who were waiting for refresher training.

Staff assessed people's needs to ensure they could provide effective care. A care plan was then devised. The care plan provided information on the person's needs.

People told us that they enjoyed the food in the home. Meals were provided in the large dining room for most people. People who lived in West Wing and on the third floor ate in their smaller dining rooms. There was a menu and the main meal was served at lunchtime and was three courses. The housekeeping manager told us that they planned to start making homemade soup for people. We observed part of two mealtimes in each dining room and saw that people were generally enjoying the food. People's dietary needs including special diets and allergies were recorded in the kitchen so that the chef could easily refer to them and all kitchen staff had completed training in food safety and food allergies.

Relatives said they were confident that the staff called out a GP whenever needed and made sure their relative went to hospital when they were unwell. People living in the home also agreed that they could see a GP when they asked. They felt that staff cared about their health and looked after them when they were unwell. A team leader accompanied the GP during their regular visits to the home to ensure staff were aware of the GP visit and the recommended treatment.

People who used hearing aids benefited from a charity who visited monthly to check people's hearing aids for them, change batteries and take their hearing aids to be repaired when necessary.

The premises was well maintained. A deputy manager showed us round and pointed out where planned improvements were going to take place. The top floor of the home had well designed larger ensuite bedrooms.

People could choose to spend their time in their rooms or in the main ground floor lounge .there was a lift in the home. People living on the third floor and West Wing had their own lounges. There were chairs on the landings where people could choose to sit quietly if they wished. There was a conservatory with lovely views where people could sit and we saw one person using the conservatory to entertain visitors for a meal. There was a garden and a lake which people enjoyed looking out on.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Where people were deprived of their liberty the service had made appropriate applications to the local authority for DoLS to be considered for authorisation. Ten people either had a DoLS authorisation or one had been applied for.

Where people lacked capacity, this had been documented within the care plan. Staff demonstrated understanding of the principles of the MCA and how this was to be applied when supporting people. We observed throughout the inspection that care staff always asked people's consent and permission prior to assisting them with care or giving medicines.

The West Wing was kept locked so the six people living there could not go into the main home alone. The door had a code lock and so staff had to enter a code to get out. On one of our visits the staff member on duty was from an agency and had forgotten the code. This meant that at one point the staff member and an inspector were trapped in the unit and had to press a call button to summon help to get out. We discussed this with the management team who felt a slope outside the door was a risk to people falling and so wanted to keep the unit door locked. We recommend reviewing the locking of this door in line with guidance that people should live in the least restrictive environment possible.

We saw in one person's file that a decision had been made about them but there was no record of how this decision had been reached in their best interests. This contravened the MCA. There was no record of this decision in the care plan reflecting that it was needed and what the care worker should be doing in order to provide the appropriate care. The best interests decision is a legal requirement and needs to reflect who made the decision and the reasons for it. This was not in the person's file nor did the service provide it when we requested it. We recommend that the service seek training in making and recording best interests decisions.

Good

Is the service caring?

Our findings

People thought staff were very caring. They particularly praised the team leaders in the home whom they said were all very caring and good at their jobs. Comments included; "very kind and caring" "really good" and, "They are really nice and friendly" and, "I am friends with the staff, we talk to each other."

Relatives agreed that staff were caring. Relatives comments included; "Care is pretty good", "[X] is really well looked after" and, "The standard of care is amazing."

One relative told us, "The care is really good, there is plenty of activities , the staff are fantastic and the staff are excellent" and another said, "Carers are the best I've seen, X is so well looked after, we can go visit when we like and it all very inclusive." Relatives felt welcome to visit when they wanted and to stay as long as they liked. They also said staff kept them well informed of how their relative living in the home was.

Staff showed dedication and genuine affection towards people living in the home. We observed positive caring relationships with staff interacting very patiently and respectfully to people they were caring for. Comments from staff included; "I love my residents" "It's the people that keep me here, I love them" and, "I wish I had more time to spend talking to people. They are all so lovely and I look forward to seeing them when I come to work."

Staff knew people well and knew their histories. Team leaders in particular showed a good understanding of the person as a whole and how their life history affected their wellbeing. The team leaders were very popular with relatives and residents.Three people told us they were lonely and said that their favourite staff offered them emotional support but staff did not always have enough time to spend with them.

The home had a small lounge with an altar which was used for weekly church services for those who were Christian. People from other religious backgrounds said their religious needs were met by their family and friends. We saw one person's cultural dietary needs were addressed.

People told us that they had their first residents meeting in November and people were positive about the opportunity to make suggestions for improvements. People said their privacy and dignity was respected. We saw that staff were discreet when assisting people to the toilet and respected their privacy by keeping bedrooms and bathroom doors closed. In the 2016 residents survey 100% of people were satisfied that they were treated with dignity and respect and 93% of people said they were very satisfied.

Relatives said that people's independence was respected. Two people said they were satisfied that they were enabled to be independent within the home though thought they were not allowed to go out alone. We explained to them that they were allowed to do so if they wished. The majority of people said their choices were respected and there was no pressure to join in large group activity or eat meals in the dining room if they preferred to be in their own room.

Requires Improvement

Is the service responsive?

Our findings

Most people said they thought they received personalised care which met their needs and wishes. Some people said they were involved in their care but didn't think their care plans were discussed with them. In the 2016 survey that the provider sent to people using the service, 31% of people said they were not satisfied that they were regularly involved in planning their care. The results of the 2017 survey were not yet known so we do not know if there had been an improvement. The monthly review of care plans did not show whether people had been consulted about whether their needs and wishes had changed in the previous month. The care planning system did not encourage person centred care practice.

Although some people said they could follow their own preferred routines and get up and go to bed when they chose, this was not the case for everyone. A deputy manager told us that there was no expectation that night staff get anyone up and help them get dressed but staff said there was an expectation that a certain number of people were up before day staff came on duty. Night staff had a list of people that they were expected to provide personal care to before the day shift started. Two people in West Wing were assisted to get up and washed at the same time every day. All staff told us that this was because one night staff and one day staff had to help them with personal care.

Most people said they were happy with their routine. Two people told us they would like to stay up later than the time staff supported them to go to bed. Two said they would like to go to bed earlier. Two said they would like to sleep longer.Three said they would like to have a shower more often. We checked the bath and shower records for one person who was unable to speak for themselves and the record indicated they had not had a bath or shower in 2017. Although staff supported the person to wash it was of concern that no bath or shower was recorded. There was no reason for this person not having baths or showers recorded in their care plan. There was some choice as we saw from records that some people had a bath or shower every day and others between once and four times a week depending on their preference. When we discussed this with the deputy manager they said they would respond straightaway to ensure people were getting their care when they wanted it. We recommend that the service reviews with people in the home their personal care routines to ensure a more personcentred approach to personal care, getting up and going to bed times.

The home employed two activities coordinators to arrange and carry out activities with people. There was a programme of weekly activities including entertainers and musicians. People told us they liked the activities. Music and movement classes took place twice a week. Three people and two relatives told us that there were no activities at weekends and they would like something to do. There was lack of activity for people who stayed in their rooms. There was a lack of activities taking place during our inspection suitable for people with dementia such as sensory activities, reminiscence and individual activities. We noted from observations and reading care records that staff did not spend much time with people who stayed in their rooms other than when providing care such as personal care and food or drinks. Some people told us they would like staff to spend more time with them. We checked the daily activity record for one person for ten months and the only activities staff had recorded were TV, music, singing and chatting. The registered manager informed us after the inspection that there was a weekly activities programme for people living in

the West Wing. They also informed us that the activities coordinator went out with one person per day at 4pm and organised group outings. Some people did not have opportunities to go out of the home. Records showed some people had not left the home for several months.

We recommend that the provider seeks guidance on best practice on appropriate activities and a person centred approach to caring for people who live with dementia.

Relatives said they would be confident that any complaints would be addressed. Most people had never had reason to complain but said they know how to and would not be reluctant. The complaints procedure stated that a complaint would be acknowledged in three days and resolved within 28 days. Complaints were appropriately handled.

There was one person who staff told us was on end of life care. They had appropriate medicines in place to ensure their comfort at the end of their life. However there was no end of life care plan. The deputy manager called in healthcare professionals for this person after our inspection to ensure they were receiving appropriate care with appropriate equipment in place.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was absent at the time of the inspection so was not part of the inspection and we did not meet her. We found the rest of the management team; two deputy managers and the housekeeping manager to be committed to the service, open and helpful with the inspection.

There was mixed feedback about the management of the home. One relative said the registered manager was "excellent." Thirteen people, a mixture of people living in the home, their relatives and staff felt that the management team spent most of their time in the office, were not visible enough in the home and did not spend enough time talking with people, overseeing the care or helping staff when they were very busy. We received many comments about a large turnover of staff and staff feeling "under pressure" "exhausted "and "unfairly treated." The feedback from the majority of staff was that they felt unsupported and unable to speak up about their concerns.

The management team were open about the challenges the home faces and proud of their achievements. A challenge facing the home was use of agency staff to fill vacancies as this caused extra work. A "floating" night staff had been introduced to help out on all units at night since the last inspection. It had not been possible to provide this every night yet so staff did not always benefit from this.

There was a group of long serving staff including the registered manager, housekeeping manager and one of the deputy managers, who had worked at the home for years and were proud of the service. This helped to provide a consistent service.

There was a clear supervisory structure in the home. The management team held daily meetings and met with team leaders weekly. Staff were all clear about the day to day tasks expected of them and carried them out to the best of their abilities.

Staff did not feel well supported. We spoke with a large number of staff and our findings were that staff morale was low. Team leaders and care assistants worked hard but did not feel supported. Some said they did not feel able to tell the management team how they felt as they felt they would be "told off" instead of given more help and support.

There was a lack of quality monitoring in the home. No falls audit had been carried out so there was a lack of oversight of falls and no remedial action had been taken in terms of a whole service approach to falls. Individual people who had fallen were referred to falls clinics and had other appropriate action but the management team had not carried out any work to find out why the number of falls was high to identify key causes and take action to address the causes. The management team said they did not think the number of falls was high. There was no management oversight of the food and fluid charts for those people assessed as being at risk of dehydration and malnutrition. We found some people's charts to be incomplete and some to indicate insufficient nutrition and hydration. There was no regular oversight of pressure relieving mattresses to ensure these were working correctly to reduce the risk of pressure ulcers. The lack of oversight left those people with high needs at risk of unsafe care. There was also insufficient oversight of staffing levels.

Medicines audits had been of a basic standard at the time of the inspection. The management team were not auditing medicines records regularly. The audits were only taking place every two months and the number of records recorded checked (less than 10% of people's medicines) was not sufficient to find out if there had been any concerns about medicines.

The Trustees had a house committee that included Trustees and the manager who met monthly. One Trustee presented a monthly report to the committee which involved a few comments about the home. We saw minutes of the last three meetings. The visiting Trustee had looked at staff records but there was no evidence of checking on quality of care, care plans or care records. The visiting Trustee listed the number of accidents/falls in the month but there was no recorded discussion and no recommendations about trying to analyse the reason for these accidents and any action to reduce the number of falls. Two staff said that they didn't feel Trustees spent enough time with staff and people in the home to seek their views on the quality of care. There was no record in the meeting minutes of what they discussed with people other than that staff and residents were "very happy." This was a lack of evidence of effective auditing at provider level.

One relative and two staff told us that people living in the home were expected to eat lunch half an hour early on days when the Trustees had their meeting as Trustees did not eat lunch with residents but wanted to eat lunch on their own in the residents' dining room at a specific time. None of the people living in the home mentioned this so there was no evidence of this having a negative impact on people but this was a missed opportunity to seek more people's views and an example of a lack of person centred culture.

The above amounted to a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new deputy manager had improved the monitoring in the home. They had introduced care plan audits recently and were reviewing all care plans and advising staff on how to improve them. This was a very positive initiative. The management team improved food and fluid monitoring within days of us advising them that this was a concern on the first day of our inspection. The deputy manager also responded quickly to our concern that one person was at high risk of pressure ulcers due to their mattress being set wrongly for their weight. They referred this to the district nurse team who ordered a new bed.

The management team had introduced more comprehensive medicines audits. The new audits which were just about to start were much more appropriate and likely to pick up any errors. .

The two deputy managers had carried out some night time audits which was positive to check if people were receiving good care and had taken some action to effect improvements.

There was an annual quality assurance exercise where questionnaires were sent out to people and their relatives to seek their views on the home. The questionnaires for 2017 had not yet been analysed but the 2016 results were positive.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons were not doing all that was reasonably practicable to mitigate the risks to the health and safety of those people who were at risk of pressure ulcers, falls, poor nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not operate an effective quality monitoring of the service in order to assess and mitigate risks to people and to assess and improve quality and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to ensure people's needs were met at all times.