AMS Care Wiltshire Limited

Bassett House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bassett House provides accommodation which includes nursing and personal care for up to 63 older people, some of who are living with dementia. At the time of our visit 56 people were using the service. Rooms are arranged over three floors .There were communal lounges and dining areas with satellite kitchens on each floor with a central kitchen and laundry. The home is situated in a residential area on the outskirts of Wootton Bassett.

We carried out this inspection over two days on the 13 and 14 July 2016. The first day of the inspection was unannounced. Two inspectors and a pharmacist inspector attended the inspection on the 13 July 2016. The same two inspectors and an expert by experience attended the inspection on the 14 July 2016. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last inspection in May 2015 we found the provider did not meet some of the legal requirements in the areas that we looked at.

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.

Medicines were not always managed safely. Records pertaining to the safe administration of medicines were not always completed correctly. Medicine administration records did not always contain all relevant protocols and advice for administration, including detailed 'as necessary' (PRN) protocols.

Staffing rotas reflected the staffing levels identified by the dependency tool. However, some staff members, people and relatives said there were on occasions not enough staff present and this concerned them.

Whilst people were supported to eat and drink food and fluid charts were not always completed which meant it was not always possible to determine whether people had received sufficient fluids and food.

Staff showed concern for people's wellbeing in a caring and meaningful way and they responded to people's needs when required. People were treated with kindness and compassion in the day to day care. People and their relatives were mostly positive regarding the care and support provided by staff.

People and their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. However some care plans did not contain up to date assessments. This meant people's care plans were not always in line with their needs.

The staff had received appropriate training and supervision to develop the skills and knowledge needed to provide people with the necessary care and support. Staff received regular refresher training and attended a range of training which included training specific to the needs of people using the service, for example

dementia awareness. Safe recruitment practices were followed before new staff were employed to with people.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Senior management and staff had a good understanding of supporting people to make decisions and choices.

There were systems in place to monitor the quality and safety of the service provided. Where required actions to improve the service had been identified and acted upon. People, relatives and staff were encouraged to share their views on the quality of the service they received.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Records pertaining to the safe administration of medicines were not always completed correctly. Medicine administration records did not always contain all relevant protocols and advice for administration, including detailed 'as necessary' (PRN) protocols.

Staffing rotas reflected the staffing levels identified by the dependency tool. However, some staff members, people and relatives said there were on occasions not enough staff present and this concerned them.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe.

Is the service effective?

Requires Improvement

This service was not always effective.

Whilst people were supported to eat and drink, food and fluid charts were not always completed which meant it was not always possible to determine if people had received sufficient food and fluids.

The staff had received appropriate training and supervision to develop the skills and knowledge needed to provide people with the necessary care and support

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Senior management and staff had a good understanding of supporting people to make decisions and choices.

People had access to healthcare services to maintain good health.

Is the service caring?

Good

This was caring.

People were able to make their own choices and decisions about their daily care.

Staff showed concern for people's wellbeing in a caring and meaningful way and they responded to people's needs when required.

People were treated with kindness and compassion in their day to day care.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People and their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. However some care plans did not contain up to date assessments. This meant people's care plans were not always in line with their needs.

People were supported to follow their interests and take part in social activities.

People's concerns and complaints were investigated and responded to in a timely manner.

Is the service well-led?

Good

This service was well-led.

There were systems in place to monitor the quality and safety of the service provided. Where required, actions to improve the service had been identified and acted upon.

People, relatives and staff were encouraged to share their views on the quality of the service they received.

People benefitted from staff who understood and were confident about using the whistleblowing procedure.

Bassett House

Detailed findings

Background to this inspection

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

We carried out this inspection over two days on the 13 and 14 July 2016. The first day of the inspection was unannounced. Two inspectors and a pharmacist inspector attended the inspection on the 13 July 2016. The two inspectors and an expert by experience attended the inspection on the 14 July 2016. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last inspection in May 2015 we found the provider did not meet some of the legal requirements in the areas that we looked at.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with 13 people who use the service and 12 relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 13 care and support plans, medicine administration charts and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with two directors, the registered manager, three registered nurses, 15 staff, and the activity co-ordinator. This included speaking with housekeeping staff and staff from the catering department. We also spoke with five health and social care professionals who work alongside the service and two visiting healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

During our inspection we looked at the systems in place for managing and administering medicines. We spoke to nursing staff involved in the administration of medicines, and reviewed 13 people's medicines charts. We found that medicines were not always managed safely.

Arrangements for ordering and receiving people's medicines from both the GP and pharmacy were appropriate. There were also arrangements to obtain medicines that might be needed urgently, such as antibiotics. Medicines were supplied against prescriptions for named patients from a local pharmacy. The pharmacy supplied most medicines using a monthly Monitored Dosage System (MDS) in blister packs. This is a storage system designed to simplify the administration of solid, oral dose medicines. The medicines are dispensed into the MDS under the supervision of a pharmacist, which reduces the risk of error. We checked any medicines that could not be packed into the blister packs and these were found to be correctly labelled.

Medicines were stored safely and securely and room temperatures were monitored daily. A medicines refrigerator was available and records showed this was normally kept at a safe temperature for storing medicines. Records showed that the temperature had gone slightly out of the correct temperature range for three days in June and we were told that maintenance had been informed. However, there were no records to state what action had been taken. Suitable storage was available for medicines which need additional security. Staff made regular checks of these medicines to make sure they were looked after safely and each transaction was countersigned. Processes were in place for ensuring waste medicines were disposed of correctly.

Medicines trolleys were secure and not left unattended. Medicines stored in the trolley were in date, labelled with the residents' name and date of when it was opened. Creams and ointments were kept in peoples rooms on top of bedside cabinets and applied by care staff. We looked at the creams and ointments kept in two people's rooms. Containers were labelled for the correct person and staff had dated the container on opening to ensure that the medicine remains within its shelf life.

Staff supported people to take their medicines correctly. On the day of the inspection no people were being given their medicines covertly (without their knowledge, mixed with food and/or drink). However, there was a policy in place to support this practice and protocols were in place for two people if required, assessed and signed by a GP.

We observed medicines being administered on the morning and lunchtime medicine round in a safe and respectful way and the nurse stayed with people to ensure they had swallowed the medicines and drinks safely. However, when some patients refused their medicine the staff did not always record the reason why. The medicine round took a long time so that people received their medicines at the times they were prescribed.

We looked at the current medicines administration records in the nursing home. The pharmacy provided

printed Medicine Administration Records (MAR) for staff to complete when they gave residents their medicines. Medicines were prescribed on the MAR in line with national guidelines and some relevant protocols were attached. For example, one person with diabetes had been reviewed by the nurse and the treatment protocol in line with this had been followed. Details of allergies were also available with each person's MAR.

Medicines were not always administered safely or in line with the medicines policy. Systems were in place for staff to record missed doses on the MAR but this was not always completed and some missed doses did not have an explanation as to why they had not been administered. In addition to this, on more than one occasion the MAR was either signed before administration or at the end of the medicine round. The amounts remaining in blister packs did not always match what had been recorded as having been administered. In addition, topical and transdermal patch application records were not always fully completed and therefore it was not possible to tell whether patches had been removed or applied as instructed. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. This meant it was not possible to tell from the records whether people had received everything they had been prescribed.

Some people were prescribed medicines to be given 'when required' (PRN). During the medicine rounds, staff asked people if they needed these medicines. We saw protocols were in place for the majority of medicines but lacked detailed additional information to help staff give medicines in a safe and consistent way. For example, one person's protocol had directions to be given 'when constipated' but this did not provide enough guidance for staff on how to make this clinical judgement.

There was a protocol for six "homely remedies" (medicines that would normally be purchased over the counter and therefore given under certain circumstances without being prescribed) developed with the GP to provide guidance to staff on when to give the medicines. Staff were able to describe when they would give people these additional medicines and we were satisfied that people received these medicines when they needed them.

Staff were able to access up to date information and advice from their local pharmacy on the safe use of medicines, although out of date reference sources were seen in clinical areas. We were told that medical alerts were received and managed by the care manager. There was a system to record and report incidents to the GP and care home management but we were not shown any historical written records of errors or near misses, or any analysis and learning as a result of these. However, we were told that these were rare. An example was provided where two people were prescribed warfarin and their warfarin cards had been mistakenly put into the wrong resident notes. Procedures had been changed to ensure the correct information was in the right notes.

Records showed staff had received training on medicines using an online training package. There were records to demonstrate that checks had been undertaken to ensure they were competent to administer medicines.

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

Staff had received training in how to keep people safe and had the knowledge and confidence to identify safeguarding concerns and act on these to keep people safe. Members of staff we spoke with knew the types of abuse and what actions they must take should they suspect abuse was taking place. They were confident that any allegations of abuse would be taken seriously and acted upon by senior management. Staff were

also aware they could take concerns to agencies outside the service if they felt they were not being dealt with. We spoke with the registered manager and directors about when to report concerns and the processes to be followed to inform the local authority, police and CQC.

Risks to people's safety had been assessed and actions taken to mitigate these risks. This included risks in relation to falls, the use of bedrails, nutrition and developing pressure ulceration. There was clear information in people's care plans which provided staff with guidance on how to reduce these risks. The staff we spoke with were able to demonstrate what they needed to do to keep people safe. Comments from staff included "It is our job to make sure residents are safe. This includes making sure they have the right equipment" and "We are very aware of people's needs and how to keep them safe. For example ensuring people have thickeners for their drinks when needed".

We spoke with the registered manager and directors who explained how they used a dependency tool to ensure appropriate staff were deployed at all times. We saw staffing rotas reflected the staffing levels identified by the dependency tool. However, some staff members, people and relatives said there were on occasions not enough staff present. One staff member told us they often didn't get chance to have a break and another said there were not always enough staff especially at weekends and due to this it could take a long time to get help from other staff when required. Another member of staff said that although staff were "Very hardworking", the time they had available to support people's needs and preferences was limited. They explained as most people liked to be up for their breakfast by 9am and these people often required support by two carers this meant there was only 45 minutes following handover at the start of their shift to assist people to be up by this time and meant care became task focussed rather than person centred. One person said that despite staff being very concerned and caring, at times, due to there not being enough staff, their call bell was not always answered very quickly and sometimes they waited more than five minutes for assistance. This person said they liked to get up at 9am for breakfast although when we spoke to them it was 10.15am and they were still in bed. One relative said to staff following lunch "Where have all the staff gone? I asked them a quarter of an hour ago for some help but everyone has disappeared".

We received feedback from a health and social care professional that had regular contact with the service. They stated "The carers do not have enough time to cover the needs and preferences of the residents in a person centred way. At night time there are only two staff per floor and one member of nursing staff covering all floors administering medication. A lot of the residents are in need of assistance from the carers and unfortunately a lot need to use the hoist, this means two members of staff are in a residents room for the required time, (and sometimes this can be a little rushed due to the pressure the staff feel under) and the alarms are ringing from other residents needs assistance and there is no one on the floor".

One staff member said during busy times, they were concerned people may not be safe as they were not able to keep an eye on what was happening when they were assisting other people. The service had recently tried to address this by introducing a hostess service where two members of staff offered help to people with drinks and meals to enable care staff to have more time to spend ensuring people's safety. It was also planned that additional activities coordinators would be recruited to support this too. Despite concerns raised during the inspection, we saw staff were calm and unhurried and people looked well cared for.

Comments from people and their relatives included "Staff are always rushed off their feet and this impacts on the care they are able to deliver to residents. When there is a change of shift at 8pm there are only two carers on this floor" and "Staff pop in but never seem to have any time to stop".

Agency staff had been deployed when sufficient numbers of permanent staff were not available. The service tried to ensure the same agency staff were deployed in order to ensure continuity of care for people. One

agency worker who had worked at the service on a number of occasions told us they were well informed about people's likes and dislikes and said they had received a comprehensive handover at the start of their shift which gave them the necessary knowledge to provide the care people needed.

We saw safe recruitment and selection processes were in place. We looked at the files for five of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Incident and accident forms were completed where appropriate and detailed what actions and care had taken place up to 48 hours after an incident or accident had been identified. Upon review of the accident/incident file, incident and accident forms had been filed except for three forms which could not be located. However, staff confirmed these had been completed and we saw supporting documentation relating to these incidents had been filed in people's care plans. It was suggested by one of the nurses during the inspection that they would like to have a copy of accident and incident forms filed in people's care plans to ensure these have been completed and are available and when this was raised with management they said this would be incorporated into their incident and accident reporting process.

Requires Improvement

Is the service effective?

Our findings

Whilst people were supported to eat and drink, information recorded on fluid charts was confusing and staff were unable to tell us when people had received fluids and how they would monitor people's hydration and nutritional needs. Food and fluid charts were not always completed, tallied or evaluated which meant that it was not always possible to determine whether people had received sufficient fluids and food. The dietary intake of one person was recorded on a chart to enable monitoring of this. However, although dietary intake had been recorded on this chart, there was no evidence this was being monitored or that where dietary intake was poor, action had been taken to address this. On a fluid chart for the same person, it showed on some days, a fortified drink had been given. However on most days when this person had not eaten due to them refusing meals, there was no evidence that these fortified drinks had been offered to support this person's nutritional needs and on most occasions only water had been offered. The weight of this person had been recorded on a weekly basis however, this had decreased by 10.3kg over the last 49 days and there was no care plan in place to address this.

Staff told us they were not satisfied that when people were left with drinks that they are being supported to have these fluids. They did not feel that they always had enough time to support people to have drinks outside of meal times.

We observed the lunchtime meal on the first floor on the first day of our inspection. Some people were supported to access the dining room whilst others had their meal in their rooms. Those people who required assistance to eat their meal were supported at a pace appropriate to them with staff checking if they wanted to continue eating. However, we observed in the dining area there was not enough staff to support those people requiring assistance to eat their meal at the same time. The lunch trolley was brought to the dining room at 12.40pm and we saw one person who required assistance with their lunch had still not received it by 1.10pm due staff supporting other people. This meant the person had to sit and wait for their lunch whilst others ate theirs. We spoke with the director and registered manager regarding this. They told us they had recently introduced two sittings at lunchtime to support people to be able to eat at the same time. They didn't understand why everyone was in the dining area if they could not be supported to eat. They assured us they would follow this up with staff.

We saw people being asked if they wanted a drink by an agency staff member. However they did not ask people their preferences and just poured the juice available. The meal time was very task focused on this floor with no real social conversation.

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

We observed the lunchtime meal on the ground floor on the second day of our inspection. This was a different experience to the previous day's observation. Staff explained what choices were available to people and asked what exactly people wanted to eat. For example, the available vegetables were explained and people were asked what specific vegetables they wanted. People were asked about portion size such as

one piece of broccoli or two. People were offered a choice of where they wanted to sit and were asked if they required assistance with cutting up their meal.

People told us they liked the food. One person told us "The food is very good. We get a choice and never go hungry". Another person told us "The staff will bring me crumpets if I ask".

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering department; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes. They explained that people had a choice of meals. They said if people did not like what was on the menu then they were able to request alternatives. The chef told us that they liaised with staff about nutritional requirements. We saw records of meeting they had recently attended which included a nutritionist and the person's family members. They had discussed the person's nutritional requirements and put together an action plan of how best to meet this person's nutritional needs. The kitchen was clean and tidy and had appropriate colour coded equipment and utensils to ensure that food was prepared in line with food safety guidance.

At our last inspection which took place on 18 May 2015 the provider was not meeting the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not taken appropriate steps to ensure that they acted in accordance with the Mental Capacity Act 2005 when assessing people's capacity to consent to care and treatment. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken all the necessary improvements required to fully meet people's needs.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Consent to care was sought in line with legislation and guidance. Mental capacity assessments had been completed and where people had been assessed as not having capacity, best interest decision meetings had taken place. Where needed the registered manager had made applications for DoLS authorisations. Applications had been submitted by the provider to the local authority. More urgent DoLS had been authorised, whilst others were awaiting a response. Where DoLS applications were in place we discussed with the registered manager about regularly reviewing these to ensure what was in place remained the least restrictive option.

The registered manager and staff had good knowledge of the Mental Capacity Act 2005. Training in this subject had been undertaken by staff. During our inspection we observed staff supporting people to make decisions about their daily living and care. For example, people were supported to make choices about what they ate, what activities they wished to be involved in and where they wanted to spend their time. Comments from staff included "You must assume people have capacity and whatever decisions they can make we must support them to makes choices for themselves" and "People are encouraged to make choices about what food they would like to eat, clothes they want to wear and their bedtime". Comments from people included "They (staff) allow me to choose what I like" and "It's my choice to have a lie in today

as I'm tired".

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Staff told us they had the training and skills they needed to meet the needs of the people they were supporting. Staff told us they had access to training when they started working at the home and were able to shadow more experienced members of staff before working independently. There was a training matrix in place which recorded the training staff had completed and staff said they were supported to refresh their training as required. Training undertaken by staff included safeguarding of vulnerable adults, fire safety, infection control and moving & handling. On the day of the inspection, staff had training in using a defibrillator. The management team told us this training was offered to all staff.

Staff told us they received regular supervisions and annual appraisals which supported them in their role. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. Staff said they felt well supported by the registered manager ad directors. Comments included "I get the opportunity to talk about any concerns. Yes I feel supported" and "I can raise concerns even with the director who is very good".

People were supported to maintain good health and had access to healthcare and other services to meet their needs. There were records of treatments relating to chiropody, eye care and dental care in people's records. A GP visited all residents on a weekly basis and more frequently as requested by staff in response to people's medical needs. One health professional told us "I feel that staff are very adept at spotting if a patient has become unwell and acting on this appropriately".

Good

Is the service caring?

Our findings

People and relatives mostly spoke positively about the care and support they or their relative received. Comments from relatives included "They treat us like friends. Staff don't just provide care for (name of relative using service) but extend this to the whole family" and "The staff are very caring. They ask if we need anything and always keep us updated if there are any concerns". Comments from people using the service on the care they received included; "They (the staff) are very nice. They look after me very well" and "I get well looked after, they (the staff) are very good".

One person who was staying at the home short-term told us "It is faultless. The standard of care has been wonderful from every member of staff. Very kind, courteous; a home from home. The catering is faultless. Food quality is excellent and range is faultless. It is very clean and staff are attentive. The management engage and talk to us. I get my medicines on time and at the time I take them at home. Staff are very thorough, nice to be with. It has been a pleasant stay. They allow me to have as much independence as possible. Can bath and shower when I want. Beautifully run by friendly, sociable staff, genuinely caring people".

We received positive feedback from health and social care professionals who regularly visited the home. Comments included "The staff always treat patients with the utmost respect. I have seen excellent relationships between staff and patients. The care staff and nurses work compassionately towards patients, "I am really impressed with staff who are also keen to learn about caring for people appropriately. My impression of the carers is that they are very caring" and "Staff are very patient with people and always treat them with dignity".

One person told us "Most staff are friendly" but said some staff were a bit abrupt in the way they spoke. One visitor told us staff worked hard to ensure the care was of a high quality but there were some staff who meant well but their manner sometimes appeared dismissive.

The relationships between staff and people receiving support demonstrated dignity and respect at all times. During a mealtime observation, we saw sociable interactions between people and the staff who were supporting them. For example, one staff member who was supporting a person with their lunch had a conversation which included how well the runner beans were progressing in the home's communal garden. The conversation was light and informal. When the same member of staff offered mashed potato to this person and they refused it the staff member jovially responded by saying "Don't you like mashed potato? No, I don't either; I'd much prefer it in chip form". The person they were talking to was unable to respond however, the member of staff continued to chat in an informal and kind manner and from their facial expression the person looked happy with this.

Staff were aware of the importance in respecting people's rights to privacy and dignity. People were addressed by staff using their preferred names and staff knocked on people's doors before entering their rooms. When people received personal care staff ensured this was done behind closed doors. One member of staff told us "I will always ask a relative to leave the room to protect the person's dignity. I talk to people

and tell them what I am doing and make sure they are covered by a towel when doing their personal care". Another staff member told us "I always make sure I have everything and we are in a private area when I do personal care. I will always close the curtains and doors".

Staff showed concern for people's wellbeing in a caring and meaningful way. People looked comfortable in the presence of staff and did not hesitate to seek assistance and support when required. Any requests for assistance were responded to quickly. We observed staff supporting one person who had become anxious. Staff took the time to offer them reassurance, explaining to them what was happening. We observed another person become confused during their lunch time meal. They requested to leave the dining room and staff supported the person to leave. They then explained it was lunch time and encouraged the person to "Come and chose their lunch" to which the person responded and came and ate their lunch.

Staff knew people's individual communication needs abilities and preferences. People were given time to communicate with staff and where people were unable to communicate verbally, aids were used to support them. For example staff told us how they used a white board to communicate with a person and this enabled them to make conversation with them and also discuss their preferences and choices. Guidance for staff relating to one person whose first language was not English included that the person understood more English than they spoke and staff needed to take the time to explain things clearly or to show the person things to support their decision making and choices. Access to an interpreter was noted should staff require it.

People's records included information about their personal circumstances and how they wished to be supported. People's care plans contained a one page profile which detailed people's routines and preferences. It included information on what was important to the person and things they enjoyed doing such as listening to wartime music, receiving visits from their relatives and hobbies and interests.

People and their relatives told us that permanent staff knew them well. They did not always feel that some agency staff knew their needs. Comments included "The service is very patchy. Agencies are the problem, permanent staff know the residents and do it so well but the agency staff just don't have that knowledge and staff here don't have time to read the care plan", "Agency carers don't know the residents as well as permanent staff" and "The regular carers are brilliant and always treat residents with dignity". A visiting health professional told us that consistency of agency nurses could be an issue on the ground floor whereby, communication from their previous visits aren't always known by agency staff. They said nurses on the other floors knew residents well and they had no concerns about the care nurses and staff provided.

People were able to make their own choices and decisions about their daily care. At mealtimes we saw people being offered choices. Staff comments included: "Would you like me to see what the pudding is?", "Would you like fish or toad in the hole?" and "Would you like me to cut the fish for you?". When being supported to access communal areas people were offered the choice of where they wanted to sit. People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as books, ornaments and photographs. People could spend time in their room if they did not want to join other people in the communal areas.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection which took place on 18 May 2015 the provider was not meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not taken appropriate steps to ensure that care plans contained accurate information about how people wished to be supported. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had undertaken some the necessary improvements required to fully meet people's needs.

Since our last inspection the service has been updating the information held in people's care plans. Care plans were still in the process of being updated. We saw that the updated care plans contained detailed information. People and their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person.

Where people were unable express their preferences, likes and dislikes, staff had liaised with people's relatives to gather this information. This information was available in people's care plan files. However some care plans did not contain up to date assessments. This meant people's care plans were not always in line with their needs. For example, one person had an assessment to determine what risk they were at of developing pressure ulcers. This assessment had last been completed three months ago and had not been reviewed since. The health of this person whose care plan this related to had since worsened however, no re-assessment had been completed in response to this. Therefore, although at the time of the inspection this person's skin was intact, there was a risk that this person was not receiving the right care appropriate to their needs due to this reassessment not being completed.

Although some care plans were detailed and provided the necessary information for staff to know what care people required, others were not quite as detailed. For example, the guidance in one person's care plan suggested a person who was at risk of falls should be monitored to avoid falls but did not specify how or when they should be monitored and when they were most at risk of falling. The care plan for another person stated they were at risk of pain and should therefore have their pain assessed so that pain relief could be administered as appropriate yet there was no tool in place or details to provide staff with guidance on how to do this.

People who had a catheter did not have their urine output recorded on the available fluid charts and there was not a robust system in place to ensure catheter care was given as required. This meant people who had an indwelling catheter were at increased risk of urinary tract infection.

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

People were supported to follow their interests and take part in social activities. One person told us the service provided a good activities program. They said enjoyed participating in a choir group once a week, gardening, quizzes and painting and weekend activities were also available.

The activities coordinators had arranged events in line with residents' request, such as a garden party. An activities calendar was on display in communal areas of the home. This detailed the forthcoming daily activities on offer to people using the service. These included music and movement therapy, sewing, gardening, card games and 1:1 sessions. Some activities were supported by volunteers which included them hosting coffee mornings, a whist club and sherry mornings. The activities coordinators were praised by people and relatives. Comments included "I hate sitting and getting bored. The activity coordinators are brilliant" and "The activities are good. Always something going on in the lounge like concerts and flower arranging".

There was a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. People and relatives told us they felt comfortable with raising a complaint if they needed to and were confident these would be listened to and acted on. Comments included "I feel I could raise my concerns. I would feel comfortable seeing the manager" and "We are encouraged to chat about any concerns and they will always respond".

People and their relatives were invited to share their views of the service. Relatives told us management and staff sought regular feedback. A suggestion box was available in the reception area inviting people and their relatives to make comments about the service.

Good

Is the service well-led?

Our findings

There was a registered manager employed by the service who had responsibility for the day to day running of the home. People, their relatives and staff we spoke with said they receive support from management. One relative told us when they had concerns these were taken seriously and action was taken to resolve the issues. For example, when their relative had started using the service, they noticed daily charts were not being completed and were inaccurate. This was promptly addressed and the daily charts were now being completed as required.

Staff told us management were approachable and open to suggestions and feedback to continually improve the service. One staff member told us they had suggested having typed care plans instead of them being handwritten to improve clarity and time management. The management team had been open to this suggestion and at the time of the inspection we saw these changes had begun to be implemented. Comments from staff included "The management are really nice and they are approachable", "There is lots of support. Staff are finding the directors more approachable. They have good relationships with staff, residents and families" and "I can raise issues or problems with senior staff or the director. He is good".

Staff we spoke with said they were happy working at Bassett House. They told us this was because they felt part of a supportive team where everyone strived to do the best they could to support people. When we asked one member of staff what they would change about the service if they were able to, they responded by telling us there was nothing they could think of as the management team always responded to their requests and everything was provided as required. Another staff member said "I enjoy working here. The care home is lovely and staff are all very caring".

One person using the service said they did not see the manager very often but said they knew who they were and that they could speak to her if they were concerned about anything.
One member of staff said management are supportive on an individual basis but at times they felt there was not enough active presence by the manager. For example, they said there used to be more frequent staff meetings but these had recently not taken place which meant staff were not always offered the opportunity to express their concerns as a team.

Staff were supported to question the practice of other staff members. Staff had access to the company's Whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities.

The registered manager, quality assurance lead and directors carried out audits to assure themselves of the quality and safety of the service people received. Whenever necessary, action plans were put in place to address the improvements needed. The registered manager understood their responsibilities of registration with us and notified us of important events that affected the service.

Staff members' training was monitored by the registered manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles.

People and their family were regularly involved with the service and their feedback was sought by the registered manager. Relatives and resident meetings took place periodically throughout the year. During these meetings people and their relatives were provided with updates and could make suggestions about how they felt the service could be improved. People and their relatives also received newsletters throughout the year. The newsletter contained information on new staff joining the service, events that had taken place and forthcoming events. We saw the results of an annual survey carried out by the service. The results showed that overall people were happy with the service they or their relative received. Comments included "Individually staff are generally friendly, welcoming and helpful", "The staff are always responsive and engaging and they try to provide the best caring environment for the residents", "They (staff) are never too busy to stop and discuss things with you. Nothing is too much trouble" and "Due to shortages of staff, the carers are often too busy but they are helpful and supportive when time allows".

The service had appropriate arrangements in place for managing emergencies which included fire procedures. There was a contingency plan which contained information about what staff should do if an unexpected event occurred, such as loss of utilities or fire. The management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported to have enough to eat and drink. Staff told us they were not satisfied that when people were left with drinks that they are being supported to have these fluids. They did not feel that they always had enough time to support people to have drinks outside of meal times. Some care plans did not contain up to date assessments. This meant people's care plans were not always in line with their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Records pertaining to the safe administration of medicines were not always completed correctly. Medicine administration records did not always contain all relevant protocols and advice for administration, including detailed 'as necessary' (PRN) protocols.