Chasewood Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 5, 6 and 7 December 2016. The inspection was unannounced.

The service provides accommodation and personal care for up to 107 older people who may live with dementia. Forty-nine people were living at the home in 6 units on the day of our inspection.

There was a registered manager in post. 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. The registered manager told us they planned to retire in December 2016. The provider had already appointed a new manager in the expectation they would register with CQC at the end of their probationary period. We have referred to the new manager as the 'service delivery manager' throughout this report.

At our previous inspection in April 2016, we found breaches of the regulations related to managing risks to people's safe care and treatment and the governance of the home. We gave the home an overall rating of requires improvement. We added a condition to the provider's registration, to ensure they regularly monitored the quality of the service and shared the results of their quality monitoring audits with us every month.

This was because the provider had not taken sufficient improvements since our prior inspection in November 2015, when we had rated the service as inadequate overall and had served a warning notice to the provider and the registered manager. The service was placed in 'Special Measures' in November 2015, and continued to be in 'special measures' in April 2016, because the requirements of the warning notices served on the provider and registered manager had not been met. There were ongoing breaches in the regulations.

At this inspection, we found sufficient improvements had been made to meet the regulations, and to take the service out of 'special measures'. However, further improvements were needed and the provider, registered manager and service delivery manager told us about their ongoing plans to improve.

Since our previous inspection, the provider had recruited a new manager, which meant there was more management time available to deliver a quality service. The registered manager continued to provide business support and had oversight of the service and the new manager was responsible for the quality of delivery of the service.

The provider's plans to improve how the service was managed included maintaining a separation of responsibilities between business support and service delivery, to ensure there will be sufficient management time make further improvements.

The provider had ensured people were supported by a consistent group of staff. No-one else had moved into the home since February 2016, so staff had had time to get to know everyone well.

Improvements had been made in managing and administering people's medicines and the protocols in place ensured people received 'when required' medicines appropriately and consistently. Regular checks were made of staff's competency to administer medicines and to ensure they were stored safely, in line with professional guidance.

The premises were regularly checked to ensure risks to people's safety were minimised through safe infection control practice and monitoring the condition of the building, the furniture and equipment. The provider had agreed contracts with external professional services to service and maintain essential supplies and equipment.

People were safe from the risks of harm, because staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies.

People were supported by staff who understood the risks to their individual health and wellbeing and knew how to minimise the risks. The new manager had already identified that improvements were required in recording staff's knowledge about how best to support people, to ensure their knowledge was available to be shared with new and relief staff.

Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence for the individual, but improvements were required in the overall analysis of accidents and incidents to identify any service wide contributory factors.

People's needs were met effectively because staff had the necessary skills and experience and received appropriate training and support. Staff understood people's needs and abilities because they worked with experienced staff until they knew people well. Staff had recently been encouraged to reflect on their practice and to consider how to develop their skills and knowledge, to improve people's experience of care. The service delivery manager planned to ensure new staff worked towards obtaining the Care Certificate, once they had taken over the full responsibilities of a registered manager.

The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority to restrict people's rights, choices or liberty in their best interests. Staff understood and acted within the principles of the Act to support people to make their own decisions.

Improvements were required in supporting people to maintain a balanced diet that was suitable for their individual dietary needs and met their preferences. Staff did not all demonstrate an awareness of, or work to, the provider's policy of ensuring people were offered a choice of meals and second helpings. Staff did not appear to have sufficient time to ensure people were supported and encouraged to eat a wide variety of foods, when they wanted them. People at risk of poor nutrition or hydration were supported by healthcare professionals, and staff followed their advice. However, improvements were needed in analysing the food monitoring records that staff kept, to identify any actions that could be taken to support people to maintain a healthy weight and appetite.

People were cared for by kind and thoughtful staff who knew their individual preferences for care and their likes and dislikes. People were able to choose how they spent their day and were supported to socialise or

spend time alone, according to their preferences. People enjoyed spending time with staff who took an interest in them as individuals.

Care was planned to meet people's individual needs and abilities and care plans were regularly reviewed and updated when people's needs changed. The new manager had already identified that care plan reviews needed to include staff's up-to-date knowledge about how people responded to their support.

Staff were guided and supported in their practice by a management team that they liked and respected. Staff spoke enthusiastically about the improvements already made in the quality of the service. Staff were looking forward to being informed and involved in implementing further improvements because they shared the same values and vision for the service. Staff recognised that people who lived at the home would benefit from all staff being listened to and feeling valued, because they recognised the importance of creating a happy atmosphere at the home.

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 people's health and wellbeing were minimised, because staff knew people well. People's written care plans did not always record the actions staff should take to minimise their individual risks. People were safe from the risks of abuse, because staff understood their responsibilities to keep people safe from harm. People's medicines were managed and administered safely. The premises, equipment and supplies were managed and maintained to provide a safe environment, but improvements were needed in the fire risk assessment and the plan to keep people safe in the event of a fire.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff had the training, skills and experience to meet people's needs effectively. The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and acted in accordance with the Act. Improvements had been made in ensuring appropriate information was available to support people with referrals to healthcare professionals. Improvements were required in supporting people to eat enough to maintain a balanced diet that met their needs and preferences.

Is the service caring?

Good

The service was caring. People were supported by kind and caring staff who knew them well as individuals and who connected with them emotionally. Staff were mindful of and responsive to people's unspoken need for friendship. Staff respected people's personal needs and preferences for care and support. People were treated with respect and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Staff knew people well and understood how to respond to their individual needs, moods and temperament. Improvements were needed in transferring staff's knowledge to people's care plans each time they were reviewed. Staff supported people to spend time engaging with staff, socialising with others or alone, according to

people's needs and preferred routines. People were supported to engage in pastimes that suited them. Improvements were needed in training or coaching for some staff, because they did not all demonstrate they were able to see the world from the person's point of view.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Improvements had been made to ensure more management capacity was available to provide leadership to staff. The management team were making progress in agreeing their current and future roles and responsibilities. Staff were encouraged by improvements the provider had made and were enthusiastic about the potential to continue to improve the quality of the service. Some improvements had been made in the effectiveness of the quality monitoring system and in support for staff. Further improvement was required in analysing the results of the quality monitoring audits, to ensure appropriate action was taken to minimise risks to people's health and wellbeing. Improvements were planned to ensure people, relatives and staff had the opportunity to make their views known, to ensure improvements focused on what was important to them.

Chasewood Care Limited

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.

The inspection took place on 5, 6 and 7 December 2016 and was unannounced. The inspection was undertaken by three inspectors, an inspection manager and an expert-by-experience on 5 and 6 December 2016. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service. A CQC pharmacist inspector visited the service on 7 December 2016, to check whether medicines were managed and administered safely. .

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

The local authority imposed a placement stop on the provider on 12 February 2016. This meant the provider was not permitted to admit any further people to live at the home. The Environmental Health Officer (EHO) shared an Improvement Notice with us that had been served on the provider on 18 December 2015, for environmental health and safety improvements that were legally required at the home. At the time of this inspection, EHO's Improvement notice was still in force.

We spoke with nine people and four relatives about what it was like to live at the home. We spoke with eighteen care staff about what it was like to work at the home. We spoke with the provider, registered manager and the recently appointed service delivery manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Most of the people who lived at the home were not able to tell us in detail, about how they were cared for

and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed six people's care plans and daily records and nine additional daily monitoring records to see how care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection in November 2015, the provider had not been providing safe care to people, and we judged they were in breach of Regulation 12. At our inspection in April 2016, we judged the provider had not taken sufficient action to meet the regulations. At this inspection, we found the actions they had taken, along with actions by the local authority, had been effective in minimising risks to people's health and wellbeing. The provider had ensured people were supported by a consistent group of staff, and, because no-one had moved into the home since February 2016, staff had time to get to know the people who lived there well. The provider had recently recruited a new service delivery manager. This meant there was more management time available to provide separate and dedicated oversight of the business management and service delivery.

People were supported by regular staff who knew them well and who understood their individual risks. Staff told us, "We are all responsible for making sure people are not at risk", "We identify different risks such as trip hazards and put plans in place to manage that risk" and "We get told at handover and everything is written down to make sure we don't miss anything." Staff's knowledge of how to support people to minimise risks was evident in their actions and in the explanations they gave to us about how they managed risks. We saw staff were consistent in their actions, so people received the same level and type of support whichever staff supported them. This demonstrated that people received support from a regular group of staff and that staff shared important information between them to minimise risks.

Care staff told us, "If I'm not sure about something I always ask. We have to be very careful so it's important to check with the seniors if I'm not sure." One member of staff told us, "All the seniors are trained to do risk assessments, so if I saw something I would tell them." Staff told us they monitored the number and frequency of accidents and incidents, to ensure people were supported appropriately to minimise the risks of a re-occurrence. A member of staff told us, "Depending on how many falls they have, if they have had frequent falls we will refer them to the GP and ask for a referral to the falls clinic."

However, some of the care plans we looked at did not include detailed risk assessments, or detailed explanations for staff about how to support people safely. Staff had kept daily records of how people were supported, but this had not always been captured and added to the care plans when they were reviewed. The provider was no longer in breach of the Regulation, because individual risks to people's safety were being managed. However, we reminded the provider we expected to see a continuous improvement in records of risk assessments and personalised care plans, to ensure any new staff had access to the same detailed information as current staff.

The newly recruited service delivery manager, who had been in post for a month at the time of our inspection, told us they had already identified that care plans were not sufficiently detailed or accurately updated with new information. They told us their first priority was to review and update people's care plans to ensure staff's knowledge and insight, into how to support people safely, was adequately recorded. A member of staff told us the service delivery manager was, "Re-organising the care plans, that is in progress at the moment. There is a lot more information there so they (staff) can deal with the (people) better."

At our previous inspection in April 2016, we acknowledged the provider had made improvements in medicines management and administration since November 2015, but we identified further improvement could be made. We had identified the guidance and training for staff to safely manage and administer people's 'as and when required' (PRN) medicines was not sufficiently detailed, and the registered manager had not sought advice from a pharmacist about the suitability of crushing medicines into people's food or drinks to give them covertly.

At this inspection, a CQC pharmacist inspector found that significant improvements had been made to ensure the safe management of medicines. We looked at how medicines were handled which included looking at 11 people's Medicine Administration Record (MAR) charts. Supporting information for staff to administer medicines safely was available. We looked at medicines prescribed to be given 'when required' or 'when needed' for agitation or anxiety. We found that although supporting information was available it could be more person centred, for example, it could describe an individual's facial expression when they were in pain. We discussed this with the service delivery manager, who agreed to make the available information more detailed and specific to the person. This would help to enable care staff to make a decision as to when to give the medicine safely and consistently.

People's medicines were available in accordance with their prescription, including suitable arrangements for accurate medicine stock checks. MAR charts were completed to document when people had been given their prescribed medicines or a code was used to record a reason why the medicine had not been given. A member of staff told us, "We have got new medication protocols and new charts." A senior member of care staff told us they had appropriate training and that the service and delivery manager had last observed their practice, to check their competency, two weeks prior to our inspection.

The provider took action to minimise risks of abuse, harm or neglect. Since our previous inspection in April 2016, all staff had attended training in safeguarding and protecting people from the risk of abuse. Staff understood the different types of abuse a person may experience and understood their responsibilities to record and report any concerns. Most staff remembered and knew about the provider's whistleblowing policy, which supported them to report any concerns about other staff's practice. Staff told us, "I would tell the senior on duty, straightaway, if I saw something" and "If it wasn't actioned I would report it to CQC." The service delivery manager had worked alongside staff, on the day and on the night shifts, which enabled them to check staff's understanding of and practice in keeping people safe from the risks of harm.

People told us there were enough staff to support them, which made them feel safe. People said, "I feel quite safe here, I've never felt unsafe, ever" and, "It's always nice here, always seems enough staff." Two relatives told us staff had taken the action they had requested to keep their relation safe from the risks of other people entering their room. Both people were cared for in bed, but liked to have their doors open so they felt included in the day-to-day events at the home. Staff had put stairgates outside both people's rooms, to stop other people from entering the room. Staff told us, "They [people] are safe here. We are always with them, watching and assisting."

Staff told us they felt there were enough staff on duty to keep people safe and to meet their needs. Staff told us they had enough time to support everyone, they were not stressed or rushed and there was always good cover and support. One member of staff said, "Staffing is fine because our numbers are low. We hardly ever work short because we ring around to get cover if staff are off sick. But sickness levels are good here." Another member of staff told us, "The new manager is very hands on. She comes and helps out on the floor. We can go and ask her for help and she will come out and help out."

However, we found the number of staff on duty was not always relevant to an analysis of people's needs. A relative told us, "It takes two to turn [Name] and there is usually only one on this corridor and they have to go and get another off another corridor." We found the number of staff on duty on the first floor varied between five and six members of staff for the same shift. Staff were not able to explain why the number of staff on a shift varied, while the number of people needing support did not vary. Staff's explanation was that it probably 'depended on the rota'.

We saw the inconsistency in staffing had an impact on the time available for staff to support people's wellbeing. On the first day of our inspection, when five staff were on duty upstairs, we saw people were sat in a lounge unobserved by staff for up to 20 minutes, despite the fact that two of those people were known to sometimes display behaviours that could cause anxiety or concern to others. Records showed, and staff confirmed, that one person had not been supported with personal care for almost five hours. The person was at risk of sore skin, and their care plan said it was 'important' they received 'regular pressure relief', but they had sat in a wheelchair from 9:45am until almost 2:30pm. A member of staff told us they were 'waiting for another member of staff to come and help', because the person required two staff members to mobilise. Records showed, and staff confirmed, that a second person had not been supported to go to the bathroom for almost 6 hours.

On the second day of our inspection, when one of the six staff on duty had to leave due to sickness, we again saw having only five staff on duty impacted on people's care and support. One member of staff had to serve meals and drinks to five people. They also had to answer the phone and respond to another member of staff, while simultaneously assisting one person to eat, encouraging a second person to eat and drink, observing two people who were known to present behaviour that challenged and carry on a conversation with a fifth person. The member of staff was admirably successful in multitasking, but no-one received the individual attention that supports making a mealtime a pleasurable experience.

The service delivery manager told us they were aware of the inconsistencies in staffing levels and had already shared a proposal with staff to completely transform the rota to ensure staffing levels were consistent and relevant to people's needs. Staff told us they had discussed the plan and thought it would suit them personally and work well for the home.

At our previous inspection, we had found the provider had kept accurate records of the checks they made before staff worked at the service. At this inspection, the provider was not able to demonstrate they consistently followed safe recruitment procedures. One member of staff told us, "I had to wait for my DBS check to come back before I could start work." The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

However, neither of the two staff recruitment records we looked at demonstrated the provider had maintained the previous level of consistency in ensuring staff were suitable for their roles. Records showed that two members of staff had started work before the results of checks on their suitability for the role had been completed. The provider had not kept a record of their own assessment of the risks of employing the two staff, or their plans to minimise the risks, before they started work. Although one of the two recruitment files included a contract for a 'trial' period, it was not signed by the provider or employee.

The provider had minimised risks related to the premises by contracting with specialist suppliers to test, service and maintain essential supplies and equipment. Records showed, for example, that the water and electrical supply and installation had been checked earlier this year, and that the lift and hoists were regularly serviced.

However, improvements were required in managing risks in the event of an emergency. Staff had all attended training that should have given them the skills and confidence in responding to and dealing with emergencies, such as health and safety, first aid and fire safety awareness. Their training meant they should all have the same knowledge of the provider's policies and procedures for responding in the event of the fire alarm sounding. However, we found staff's knowledge about what to do in such an emergency was variable and the actions they said they would take were inconsistent. A senior member of care staff was aware of the need to evacuate people to a 'safe zone', that is, behind the protection of fire resistant doors, and gave a detailed explanation of the actions they would take. However, two care staff only told us they would 'get out of the building' and did not know who the appointed fire marshal was. Although staff thought the fire marshal's name should be displayed in the entrance hall, it was not. The protocol for fire evacuation was not displayed around the home for people or visitors to see.

A plan of the building was available in the 'fire file' located in the provider's office, but was not displayed in the hallway for the safety of people or visitors. During our inspection visit, the provider added a copy of the plan of the building to the 'Fire safety' document folders in the main reception area. People's care plans included personal emergency evacuation plans (PEEPS), which described the support they would need to evacuate the building in the event of an emergency. There was a condensed version of PEEPs in the three 'Fire safety document folders' around the home. One folder was located by the front door, a second by the kitchen door and a third by the lift on the first floor. We saw this document was regularly updated, but the size of the print was too small to read quickly, in the event of an emergency.

We found improvements were needed because the provider had not acted in accordance with The Regulatory Reform (Fire Safety Order) 2005 or the associated guidance for fire safety risk assessments in residential care premises. The most recent fire risk assessment of the premises had been undertaken by the provider in March 2015, but the document we were shown contained only a fire evacuation procedure. We shared our concerns about risks to people's safety in the event of a fire with the local fire protection officer. The provider told us they would make immediate arrangements for an expert in the field of fire safety to conduct a risk assessment of the premises, to ensure their plans for managing the service in the event of a fire were adequate and minimised risks to people's safety.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in April 2016, we found improvements had been made in obtaining people's consent to how they were cared for and supported, in line with The Mental Capacity Act 2005. The provider had told us they would continue to make improvements in ensuring people understood and accepted the terms and conditions of living at the home. They told us they would update their 'service user guide' to include the fact that communal rooms and communal areas were monitored by CCTV cameras. At this inspection visit, we found the service user guide was no longer available, but people and relatives had signed an agreement to the use of CCTV in communal areas, and the signed agreements were included in people's care plans.

The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards.

The registered manager understood their obligations under the Act and had applied to the Supervisory body for the legal authority to deprive people of their liberty. This was because the home operated a 'locked door' policy. No-one went out of the home independently and no-one had the capacity to adequately understand the risks of going out independently. For example, one person told us they went into town twice a week and liked going out with staff. They had not identified this was because they would be at risk by going out on their own, but said they preferred and enjoyed staff's company. At the time of our inspection visit, none of the applications had been approved, but the manager was confident they would be because they had obtained advice from the supervisory body before submitting the applications.

The lists of training completed by staff as at November 2016 did not include information about which staff had been trained in The Mental Capacity Act 2005. Although some staff told us they found the information in the training was 'too much to remember', they remembered the principles of the Act. Some people's care plans included an assessment of their capacity and understanding, but the assessments did not identify exactly which decisions should be made in their best interests or who should make them.

However, staff understood and acted in accordance with the principles of the Act. We saw staff encouraged people to make everyday decisions, supported them according to their known preferences if they were unable to state their decision, and consulted with people's families or healthcare professionals to make sure decisions were made in a person's best interests. Staff told us, "We know the residents, so we know what they like and don't like and we can read the care plans so we can make decisions" and "We just have to offer them. If they turn their face away, they don't want it. If they don't want it, you can't force them."

Staff understood that people's capacity to make a decision could fluctuate and varied depending on the

complexity of the information they needed to understand. A member of staff said, "If we needed to make a decision about medicines, for example, we would have a best interest meeting with their family" and "For some decisions, we get in touch with their advocate or with a family member."

People told us the staff were effective because they understood their needs and offered them the support they needed, when they needed it. People told us, "If you need help they are there straight away" and, "I think they do know how to look after you. I'm more than happy with them." Two relatives told us they were confident their relations received the support they needed. We saw a senior care staff had set an alarm on their phone to ensure they made regular checks on the wellbeing of one person who was cared for in bed. They told us, "It is my unit and I am in charge of my residents."

Staff told us they felt well prepared to start work because they completed an induction programme, which included reading the provider's policies and procedures, learning about the paperwork, working with experienced staff and training. One member of staff told us new staff were not counted as 'on shift' during their induction period, because they were learning from experienced staff. One member of staff told us although the most important part of their induction was getting to know people's individual needs and abilities, they 'needed' the knowledge they obtained through formal training. Staff told us they had training in, for example, moving and handling, food hygiene, dementia awareness and falls prevention. A member of staff told us, "Training gives me a whole world of new ideas. We are supported by the management to do training. The manager asks if we want any extra training and we are told when refresher training is due."

The registered manager kept a list of the training staff attended to make sure it was appropriate to their role and responsibilities. Although some staff were currently studying for nationally recognised qualifications in health and social care, no staff had been invited to study for the Care Certificate, despite the fact that several new staff had not worked in the care sector previously. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life. It was launched in April 2015 and providers regulated by the CQC are expected to ensure that the standards of the Care Certificate are covered in their induction of new staff. The service delivery manager told us they were aware of this expectation and planned to work towards implementing this level of training once they had taken over the full responsibilities of a registered manager.

Staff told us they felt supported by the management team because they had regular opportunities to meet with the manager at team meetings. They told us the one-to-one meetings with a line manager had also been re-instated since our previous inspection. Staff told us they felt confident to raise any concerns, make suggestions and to discuss any training needs at their one-to-one supervision meetings. One member of staff told us they were confident they would continue to be held regularly. They told us they felt comfortable at their recent one-to-one because it was, "thorough and in-depth" and met their expectations of a supervision meeting with a manager.

Improvements were required in supporting people to maintain a balanced diet that met their needs, preferences, likes and dislikes. People told us the food was, "Fairly good here", "Is as good as it gets" and "Nice, we get a choice."

Meals were delivered to the home by a specialist catering supplier and included a range of meals to meet people's dietary requirements, such as diabetic and gluten free foods. The cook used a special oven to heat meals according to the supplier's guidance. The registered manager told us the menu was decided on a, "Rolling programme, on a points system." They told us, "There is a huge range available. I just do it on the computer and book well in advance. I get regular feedback from the cook about what they do and don't like and the cook will take regular feedback from staff and their families." They told us very little was wasted and

said, "There is always extras, so you could always put a single dish in the microwave." Staff's actions in delivering, serving and clearing away the lunchtime meal, demonstrated this policy was not understood or followed by staff.

A relative told us their relation had 'special food' and had 'some choice', "But not always." We observed how people were supported to maintain a balanced diet that met their needs in four separate dining areas at lunchtime. We saw people's experience of the mealtime, the amount of choice they were offered and the level of encouragement and support they received to eat sufficient for their needs, was inconsistent. The inconsistencies were not due to their different needs, but in staff's skills and approach to supporting people and their knowledge of the provider's policy about how to ensure people had choice and options for second helpings.

The registered manager did not check staff's practice to ensure they understood the provider's policy to take appropriate action in encouraging people to eat well. For example, serving pre-plated meals did not encourage people to choose their preferred foods, or to choose how much was on their plate, and did not make it easy for staff to offer people second helpings.

On both days of our inspection visit, we saw there was a choice shown on the menu that the cook sent around in advance on lunch. Two different main meals were delivered to each dining area, but the meals were already plated up in the kitchen out of people's view. This meant there was no choice of which vegetables people would prefer or the size of the meal. We also saw that the number of plates brought to each dining area matched the number of people in each area, and no extra food was available for second helpings. We saw one out of seven people were offered a choice or main meal and two people were given a choice of pudding. Everyone else had a pre-plated meal put in front of them, with no opportunity to say which they preferred, or which they liked the look of.

A member of staff told us they were confident that people were served a meal that met their expressed preferences, in accordance with staff's acquired knowledge of which foods people ate well and appeared to enjoy. Despite staff's assurance, on the second day of our inspection visit, we saw three who ate independently left most of the meal they had been served. One of the three people's care plans said, "I sometimes need prompting to finish my meal", but there were not enough staff to prompt or encourage them. The one member of staff on duty in this dining area was not able to maintain a sustained interest in whether each person ate well, or needed encouragement, because they needed to physically assist one person to eat.

One person told us they could have a second helping, but only if another person did not want their meal or pudding. We saw the person ate all of their main meal and pudding, but the staff did not offer them a second helping of either. We saw everyone ate their pudding, but no more pudding was available on the unit. There was no opportunity to maximise on people's preferences for sweet food, to improve their overall calorific intake, because no more puddings were available. Some staff told us they would ask the kitchen for a second helping, but other staff said they would not, but they would ask around the other units.

Records showed staff monitored whether people ate well. They recorded, 'ate ¼, ½ or all' of their main meals and their puddings', which meant staff could monitor who was at risk of poor nutrition. Although people were referred to a dietician, when they were identified as 'at risk', staff had not followed the provider's policy to ensure people were offered a balanced and varied diet that met their preferences. We looked at one person's nutrition records over a four-day period. According to the records, the person had lamb stew, lamb casserole or shepherd's pie at five out of six mealtimes. On another day, they had beef stew and beef casserole at different meal times. This did not support the provider's policy of making the most of

the "huge range available" from their supplier.

We asked staff what snacks were available in between meals. One member of staff told us people could have biscuits, yoghurt, toast and jam or porridge. The only snacks we saw being offered were biscuits in the middle of the morning and afternoon. On one occasion, we saw people were not even offered a choice of biscuits. We saw a member of staff take two biscuits out of a box and put them down on a table or armrest next to each person in turn. On another occasion when a person said they were hungry in the middle of the afternoon, a member of staff found there was nothing available in the fridge, although they had been expecting to find a sandwich to offer the person.

We saw there was some choice at teatime, but the choice was limited by what the cook chose to deliver to each unit. During the afternoon, the kitchen assistant delivered bread, butter, grated and soft cheese, meat paste, eggs and a choice of cold drinks to each dining area for staff to make tea for people. Apart from a microwave, there was no facility in the dining areas to cook, and the kitchen was locked, which meant staff were not able to make people a hot snack, such as an omelette, if they wanted one. Staff told us if people who needed a soft diet wanted a snack between meals, they would offer them snacks of cereals, yoghurt or scrambled egg.

Everyone was regularly weighed, which enabled staff to identify those people 'at risk of poor nutrition' or of not drinking enough. For those people identified as 'at risk', staff asked their GP to visit and for the GP to refer the person to specialist services, such as a dietician.

Staff were confident they followed advice from the dietician, but records for one person did not reflect staff's confidence. For example, one person's 'eating and drinking' plan had a handwritten note dated mid-October which read, 'update needed due to weight loss', but the care plan had not been updated. Records showed a referral to a dietician had been made, and noted that 'weekly weight monitoring' should commence, but the person's weight monitoring chart showed the person had been weighed at the end of October and not again until almost the end of November. A letter on file from the dietician, also dated mid-October, recommended, 'high calorie, high-protein foods' and 'frequent snacks and nourishing drinks'.

The dietician had requested a prescription for one week's trial of a nourishing drink to supplement the person's diet, and to repeat if the drink was 'well tolerated'. There was some confusion among staff as to whether the repeat prescription had been requested, chased up or delivered. The nourishing drinks were not recorded on MARs charts in the same way that prescription medicines were charted. There was a risk the person was not offered the nourishing drinks consistently and as prescribed. The service delivery manager told us the registered manager had recently changed GP surgery and they were concerned that GP visits, prescriptions and follow up visits were not consistently known about across the staff team. The service delivery manager had appointed two senior care staff to co-ordinate GP visits and cascade information about health professionals' visits to their individual staff teams. We saw a senior care staff gathering and collating that information during our inspection visit.

People told us they were supported to maintain their health and a relative told us they were happy with their relation's healthcare. One person told us, "I haven't needed to see the doctor recently. I have seen a chiropodist and had an eye test a while ago." Records showed people were supported to access to healthcare specialists, such as opticians and district nurses, when needed.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. People said, "They sit with you if you want to talk about your troubles" and "[Staff are] very nice indeed, quite respectful." Another person said, "Anything you want, someone [staff] will get it for you. I'm lucky with them." A member of staff told us, "If you see a smile on their face, you know you are doing a good job."

Another member of staff told us, "I absolutely love the job. It's not about yourself, it's about them (people). I love it. You can't help getting connected with people" and "I like how the staff respond to people. If [Name] is upset, 10-15 minutes with staff and they are happy again. [Name] cries sometimes, we give them a hug and they stop crying."

Staff told us they recognised it was the 'small things' that made a difference to people's emotional wellbeing. One member of staff said, "For me it's really getting to know people. Give them what they want. It could be a drink or it could be a hug." Staff understood that spending time with people could lift their mood. For example, when they identified one person appeared 'sad', they spent 10 minutes chatting with the person. They told us, "[Name] smiled at me and said 'thank you I needed that chat'." Another care worker told us they were always thinking about how they would like a member of their family to be treated. They said, "If I would be happy for my family to be cared for like this, then I know it's okay."

We saw staff were thoughtful in their interaction with people. For example, a member of staff asked if they could fetch a cardigan from one person's room, after asking whether they were cold. The member of staff returned with the cardigan and assisted the person to put it on while saying, "Is that better. You should warm up quickly now." The person said, "That's lovely, thank you." Staff told us they got to know people because they took time to sit and chat, to make sure they are okay." They told us, if a person was cared for in bed, they would, "Go into their bedroom and sit and talk to them. I will read the newspaper to them. It is still an activity (engaging with the person)."

Some care plans included more detailed information about people's previous lives and histories. For example, one communication care plan said, "Be patient, talk about fishing, cars, [Name of] football club." This enabled staff to quickly establish a rapport with the person and engage them in topics they enjoyed talking about. Staff told us, if the person or their relatives had not been able to describe their lives at the assessment of needs meeting, they found out about people's lives through conversation with them. For one person, for example, staff did not know what the person had previously done for a living, but they had established the person was knowledgeable about milking cows and was very interested in watches and shoes. We saw staff's knowledge of this person was accurate, because they became more animated when staff asked them relevant questions about their experiences.

Staff understood people's preferences for engaging with staff, for spending time alone and for engaging with other people who lived at the home. A member of staff told us, "I was just playing ball in Bluebell. It makes them laugh to see me running for the ball and messing about. Some people just like to listen to what is going on."

People were able to move from room to room, dependent on their individual mood, to choose where they wanted to spend time, chatting with staff in passing. We saw one person preferred to chat with staff and to assist staff with domestic tasks for most of the day. Staff understood the person's need to maintain their independence and to feel useful and staff thanked them for their assistance. A member of care staff told us, "We have a lot of people who like to walk around. They like to visit different lounges. To them they are going somewhere. They are quite happy. That is what they like doing, you can't stop them doing that." The member of staff understood that people were walking with a purpose and if a person believed they had been shopping, for example, they should listen to them.

We saw staff sat and talked with people a way that supported their need to maintain a sense of independence, although they shared their home with others. For example, a member of staff asked people individually whether they had put up festive decorations yet and whether they had finished their festive season shopping. We saw people became animated at having their own festive plans and preparations as a topic for discussion.

We saw staff greeted visitors warmly, like old and well-known friends. Staff shared relatives' pleasure in seemingly small changes in their relations, for example, when a person responded to their relative's presence or ate well. We heard a member of staff say, "That is lovely. I am so pleased for you."

Relatives told us they had been pleased with how care had been delivered since our previous inspection. One relative told us they had been a visitor at the home for years, and had raised issues in the past, but not recently. Another relative told us they were pleased their relation had moved to this home, because the design and layout particularly enabled their relation to walk around for long periods at a time, without coming up against a dead end, and this was the person's current preferred way to spend their time. The relative was pleased the registered manager had made the move so easy to achieve, and told us their relation had settled in well and was 'happier'. We saw most people had a 'memory box', containing items that were significant to them, on the wall outside of their bedroom doors, as a reminder that this was their own room, which supported them to feel at home.

People were supported to maintain their dignity and staff respected their privacy. People's hair, clothes and nails were clean and manicured. Staff did not disturb people unnecessarily if they chose to spend time in their own room. When staff did go to people's rooms, they knocked first and called out to let them know who was at the door, before entering.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in April 2016, we identified that improvements were required in responding to people's individual needs. At this inspection, we saw some improvements had been made, because people were supported by a consistent staff team who knew them well. All the staff gave us similar descriptions of people's needs and abilities, and how they supported them. During the first two days of our inspection visit, we saw people were supported in the same way, whichever staff supported them. Staff told us they had time to get to know people because no-one new had moved into the home since February 2016.

However, further improvements were required in capturing staff's knowledge of people and recording it in their care plans, to ensure any new staff were enabled to quickly understand each person's individual needs, abilities and responses to staff's support. For example, in one person's care plan, we read their ability to walk was affected by an underlying health condition and that the impact of their reduced mobility could lead to frustration, particularly in the evenings. The actions for staff included, 'support to walk' and 'use a wheelchair for distances', but the guidance was not focused on the person's individual needs or responses. For example, the person's previous occupation and interests were also recorded in the care plan, but, apart from 'walk with, chat and watch TV', there was little guidance for staff in how to use this personal information to reduce the person's agitation.

All the staff we saw supporting the person knew and followed the guidance in the care plan and the person was supported to walk safely around the home, on most of the occasions they stood up. However, there was no guidance for staff about how to distract the person from their need to walk about, by engaging their interest, while they waited for a member of staff to become available. A member of staff told us, "You get to know (people's) mannerisms. You do a lot of people watching and you can learn a lot." The service delivery manager told us they had already identified that care plans could be more person centred. They told us their first priority was to review and update people's care plans to ensure staff's knowledge and insight, into how to deliver person centred care was adequately recorded.

People were supported to engage in activities and events at home. Most of the people we spoke with told us they did not have any particular hobbies or interests they wished to pursue. They could not remember how staff supported them to remain active, interested in the world around them or engage with staff or other people. All the people we spoke with told us they could not remember 'going out' of the home. Staff assured us they did encourage people to take part in activities such as music, sewing, knitting, flower arrangements, board games and to walk in the park, when the weather was suitable.

Staff told us, 'Staff do activities. They try to cover everyone" and "We spend time with people, chatting, watching TV, walking, reading. Other activities include drawing, painting, puzzles. I never take people outside, but seniors might." A member of staff told us, "I can adapt my approach. Not everyone wants to joke around. For example, I can just put on music and people respond by moving around in time to it." A member of staff told us people could choose whether they used the home's own minibus or a taxi, when they went out shopping.

During the two days of our inspection visit, we saw staff variously engaged with people in playing a board game, some craft work and pampering sessions, such as, a manicure and nail painting. We saw one person was engaged in sorting craftwork materials and another person happily engaged in household tasks. Two people who lived at the home showed us their newly painted nails with obvious pleasure in how their hands looked. Staff were knowledgeable about how to support one person with their favourite television programme and in another lounge, people were watching an old movie.

Improvements were required in some staff's understanding of how people who lived with dementia understood verbal information and for staff to understand how people who lived with dementia understood the world around them. For example, some staff did and some staff turned the television off in the various communal areas before lunch. Not all staff checked whether people wanted the television off, while they concentrated on eating their meal. A member of staff brought cups of tea to people that were too hot to drink straight away. On one occasion, a member of staff took the cup away and added more milk. On another occasion, a member of staff put the cup of hot tea on the arm of the person's chair and then on the windowsill 'to cool', but where it was out of the person's reach.

The service delivery manager told us they had observed variation in staff's understanding and practice and they planned to address this through observation and supervision of staff. The service delivery manager told us they were skilled at using the Alzheimer's Society 'observation of people's wellbeing' template and had shared this with staff to support them to understand what 'good dementia practice' looks like and how to deliver it. The service delivery manager told us, "It's not about being in the office, but implementing changes and ensuring good practice. I need to know their [staff's] understanding, so we can implement changes together."

People told us they did not have any complaints about the quality of the service. Relatives told us if they had any complaints they were confident to raise them straight away with the staff or manager, whichever they felt appropriate at the time. They told us any complaints were usually resolved promptly and to their satisfaction. During our inspection visit, we saw the provider responded immediately when a visitor complained about the lack of lights around the front entrance and car park. The automatic lights had not come on and it was dark outside. The provider went out straight away to reset the timer, to ensure the lights came on at dusk, which minimised the risk of anyone tripping over steps or bumps in the shadow.

Requires Improvement

Is the service well-led?

Our findings

During a previous inspection in November 2015, we found the provider was in breach of the regulations related to governance of the home. Our judgement that the service was inadequate, resulted in the home being placed in special measures and we issued a warning notice to the provider. During our follow up inspection in April 2016, we found some improvement had been made overall, but insufficient improvement had been made in monitoring and maintaining the quality of the service to fully meet the requirements of the warning notice. The service was kept in 'special measures'.

During this inspection we found sufficient improvements, and effective plans to improve, were in place to remove the service from 'special measures'. The service continues to be rated as 'requires improvement', because, although some action had been taken, other actions had been planned, but not yet fully implemented. We will schedule a follow up inspection to check that all planned actions to improve have been implemented and are effective.

We found recent changes to the structure of the management team had resulted in an increase in management capacity, which had allowed sufficient time to make and plan improvements. The provider told us they had separated the registered manager's service delivery responsibilities from their business support responsibilities. The provider had recruited a second manager to take responsibility for and oversight of service delivery. At the time of our inspection, the registered manager retained responsibility for business support. The registered manager was due to retire in December 2016. The provider was making plans for how business support would best be obtained when the registered manager retired.

Some improvements had already been made in the quality of management audits. Medication audits and the medicines competency assessment framework had both been revised to reflect the needs and responsibilities of staff in a residential care home. The service delivery manager had checked staff's competency against the revised framework and conducted medicines audits on each unit. No issues had been identified by the manager. The CQC pharmacist inspector reported they had no concerns with the management and administration of people's medicines. The issues in medicines management we had identified at our previous audit, had been resolved by obtaining advice from a pharmacist about 'covert' medicines and implementing effective protocols for 'when required' medicines.

A relative told us the quality of care was, "Improving gradually". Improvements had been made in the management and oversight of staff. The most recent audit of staff training showed that all staff had attended training in safeguarding since our previous inspection. Records showed the service delivery manager had held one-to-one meetings with staff and had scheduled regular meetings in future. Staff told us their one-to-one meetings were useful and had identified what they could do to improve their practice and any training or coaching they felt would support them. The service delivery manager planned to invite all staff to appraise their own skills and interests and to identify the support they needed to improve their skills and develop their careers.

The service delivery manager had spent time working with day and night shift staff in supporting people and

they had organised team meetings. Staff told us this gave them an opportunity to get to know the service delivery manager, to understand what needed to improve, how improvements would be made and the support available for them. Staff told us improvements had already been made, because the service delivery manager had spent time 'on the floor' to observe, monitor and suggest and implement changes to support them in improving the service. Staff said, "I feel like there are positive changes since the new manager", "The new manager is doing her best. She is putting lots of changes in place. They are good (changes, such as), nutrition charts, care plan changes, and medication records. It's going to take some time to settle in but it's good" and "I feel this time we have improved overall. We know we have things to do, but we will work together with the new manager. It was the management bit, (in the CQC report), that gave us inadequate. It's better now."

Staff shared the service delivery manager's enthusiasm for making improvements and felt encouraged by their honesty and vision. Staff told us, "[Name of service delivery manager] is dynamic, has good ideas. I want it (the service) to be successful" and "We get more support. More input and information. This helps us and we are working together to help each other." The service delivery manager told us they recognised they had had the 'luxury of time' during their first few weeks at the service, because they had not yet adopted all the responsibilities of a manager. They were clear that responsibility for managing the business would stay with the provider, but knew they would adopt the administrative side of delivery of the service. They had already appointed senior staff to lead on specific aspects, such as medicines management and organising GP visits. They planned to continue to identify staff's key skills and interests and appoint additional leads and 'champions', to make sure key aspects of the service continued to improve when delegated to skilled staff.

The service delivery manager had conducted the most recent infection control audit of the home themselves. This had been followed-up by issuing new guidance for staff in the frequency and robustness of regular checks of equipment, such as pressure relieving mattresses and slings. The new guidance had been issued on the day of our inspection. Additional actions, such as 'replacing some worn furniture' and ensuring mixer taps in kitchens and bathrooms were thermostatically controlled', did not name the individual responsible for taking action, or the date by which action should be taken. The service delivery manager told us they had pointed out to the provider which chairs needed replacing and anticipated they would take the appropriate action to make the improvements.

Improvements had been made in supporting people to eat and drink sufficient for their needs, but further improvements were required. We found food and fluid monitoring charts had been revised and improved to include a target amount and to show seven days in one view, which enabled more meaningful monitoring. We noted staff were keeping regular records, because they understood the purpose and benefit of accurate recording. A member of staff told us, "We now have separate food and fluid charts, which are kept in people's rooms if they are cared for in bed. I like the paperwork in people's bedrooms. You can write them up while you still remember accurately." A relative told us the food and fluid charts were new (to them). They said they felt more confident on seeing the new chart that their relation's nutrition and fluid intake was being recorded and monitored.

Nutrition audits, conducted by a senior member of staff showed that action was taken when risks to people's nutrition were identified. There were 'weight loss' plans in place for all those identified as 'at risk' of poor nutrition. For example, people were regularly weighed, referred to appropriate healthcare professionals and were prescribed nutritional supplements. We identified that further improvements were needed in analysis of the nutrition audits to check for themes in underlying causes of weight loss. For example, whether people were offered enough to eat, whether people were encouraged and supported appropriately to eat, and whether weight loss was a recognised symptom of an individual's health

condition. There were no specific plans in place to address potential service wide causes, for example improvements in the size of portions, availability of second helpings and snacks, staff's skills in supporting people to eat, staff time to support and encourage people to eat, or more obvious choice in menu planning to improve people's appetites.

Improvements had been made in accurately identifying how many accidents, incidents and falls had occurred in the previous month, including where and when they happened and the actions taken by staff. However, further improvements were needed in analysis of these events to identify any service wide factors that might contribute to accidents and incidents. For example, the number of accidents and incidents listed for November had been totalled accurately, but the numbers in the previous two months had not been totalled accurately. This resulted in a significantly lower total in the quarter than the number of accidents or incidents that had actually occurred. This did not support effective analysis of any contributing factors, or plans to mitigate the contributing factors.

The provider showed some understanding of their responsibilities as a provider of a regulated service, but more improvements were required. For example, they had added the rating and a link to the latest inspection report to their website and continued to display the latest CQC rating in the entrance hall. However, the ratings poster displayed in the entrance hall was not displayed conspicuously, because it was obscured by a flower arrangement on two days of our inspection visit. The service delivery manager told us they would ensure it was displayed conspicuously in future.

Records showed the provider had commissioned professional services to check and maintain the safety of essential supplies and equipment, such as water, electricity, the lift and hoists. After our inspection site visit, the provider sent us a copy of their supplier's latest report of their quarterly water tests, which had not identified any issues. At the time of our inspection site visit, the registered manager, new manager and provider were in still discussion about who would have future responsibility for weekly water temperature checks and monthly flushing of unused outlets.

The provider had not understood the need for a fire risk assessment to be undertaken by a qualified professional. We found the provider's fire safety measures and plans to evacuate people in an emergency needed improvement. The provider told us they would engage a qualified professional to undertake a fire risk assessment to make sure risks to people's safety in the event of a fire were minimised

The provider's policies for obtaining feedback from people and visitors included surveys, resident and relatives' meetings and care plan review meetings. At our previous inspection, the registered manager told us the survey results were being analysed to sort out the priorities for action. People we spoke with could not remember attending any meetings, but a member of staff remembered one had been arranged for October. One relative remembered attending a meeting at which they discussed the food, and another relative told us they had been unable to attend the last one. The registered manager told us meetings were not always well attended.

The service delivery manager told us they had plans to revise the survey for people who lived at the home and to produce it in picture format, to make it easier for them to respond. They told us they planned to introduce a survey for staff, to support monitoring the quality of the service from staff's point of view. They told us they would keep an 'open door' policy to encourage feedback and plan coffee mornings for relatives who were reluctant to attend formal 'relatives meetings' with an agenda. The service delivery manager told us they would, "Speak with all interested relatives when conducting care reviews", to ensure everyone had the opportunity to make their views known.