Larchwood Care Homes (North) Limited

Ravenstone

Inspection report

7a St Andrews Road
Droitwich
Worcestershire
WR9 8DJ

Tel: 01905773265

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was undertaken on 28 and 29 June 2017 and was unannounced.

The provider of Ravenstone is registered to provide accommodation and nursing care for up to 43 people who have nursing needs. At the time of this inspection 37 people lived at the home. Bedrooms, bathrooms and toilets are situated over two floors with stairs and passenger lift access to the first floor. People have use of communal areas including lounges, conservatory and dining room.

The provider did not have a registered manager in place. 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. A new manager had commenced their employment on 21 June 2017.

Our last inspection took place on 22 and 23 August 2016 where we found the provider was in breach of two regulations. The staffing arrangements did not reduce risks of people care needs being met in a safe and timely way. Staff did not respond to people's needs in a way which promoted care was centred on their needs to enhance their welfare.

At this inspection we found staffing arrangements were being managed more positively and responses to people's needs did not significantly impact upon their welfare as at our previous inspection. Although legal requirements had been met in these areas further work was needed to ensure improvements were consistent in how staffing arrangements and care centred on people was responded to so this did not impact upon people's preferences and individual needs.

People told us they felt safe in the home and staff showed an awareness of how to recognise and report potential abuse so actions could be taken to reduce risks of people being harmed. However, people were not supported by staff to reduce the risks of avoidable accidents when using wheelchairs and in making sure potential environmental hazards had been reduced in a timely manner.

People were confident staff supported them to take their medicines when they needed these so risks to their safety and health was reduced. Where people required time specific medicines staff had prioritised these in line with people's prescribed health needs.

Staff reflected their skills and knowledge to meet people's needs in effective ways. The provider had arrangements in place to equip staff with the induction, training and support they required in order to carry out their caring roles. Staff were provided with support during one to one meetings but staff expressed how there were some behaviours within the staff team which required managing as these had impacted upon staff morale.

Staff assisted people with their choices and decisions. There were improved arrangements in place which supported people who lacked the mental capacity to make specific decisions which reflected only people with the legal authority to do so were involved in best interests decisions. Staff had the basic knowledge to inform their practices so people were not restricted unlawfully and staff had knowledge of these so they were able to support people's safety and meet their needs.

People mostly enjoyed the food which was prepared and cooked. However, for some people there were occasions when they felt unable to eat their meals and enjoy these due to how these were cooked. The former management team had been made aware of this aspect of people's meal experiences which required improving but no action had been taken to remedy this.

People were supported by the arrangements in place to monitor and identify when people did not eat and or drink sufficient amounts to meet their needs. Healthcare professionals were consulted so staff had the best possible advice and guidance in order to support people to remain healthy and well.

Staff's caring approaches did not consistently support people in gaining positive care experiences. On occasions this impacted upon the assistance people required to maintain their dignity and privacy.

People had opportunities to have fun and interesting things to do were planned. However, staff missed opportunities to introduce into their caring roles time to spend enhancing people's social wellbeing and having spontaneous moments of fun.

The provider had a complaints procedure and people believed if they raised any complaints action would be taken to resolve these. Learning would also be taken from complaints made so similar issues were reduced for people.

The management team had arrangements in place to support staff. However, we heard from staff how the inconsistencies in the management of the home had impacted upon staff morale. Staff did not feel wholly supported to work as a team as there were behaviours within the staff team which continued to need improving and managing. Staff were hopeful the new manager would support them in their roles so they were able to provide consistently good quality care.

We found the inconsistencies in management of the home together with the provider's quality checking arrangements had not always been consistently effective in monitoring people's care experiences, and driving through improvement actions in a timely manner.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People had not always been helped to avoid the risk of accidents.

Further consideration was required to ensure the staffing arrangements worked effectively to consistently meet people's safety and welfare needs. Background checks had been completed before new staff commenced working with people.

Staff knew how to keep people safe from the risk of abuse.

People were supported with their medicines to make sure these were available as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who reflected their skills and knowledge into their caring roles so people's needs were effectively met.

Staff knew how to assist people in making everyday choices and where bigger decisions were needed there were arrangements in place to consistently support people who lacked mental capacity in their best interests.

People had the involvement of healthcare professionals to support them to remain healthy and well.

Although people were helped to eat and drink enough to stay well some of the catering arrangements meant people did not always enjoy the way their meals were cooked on occasion.

Is the service caring?

Requires Improvement

The service was not consistently effective.

People were supported by staff who reflected their skills and knowledge into their caring roles so people's needs were

effectively met.

Staff knew how to assist people in making everyday choices and where bigger decisions were needed there were arrangements in place to consistently support people who lacked mental capacity in their best interests.

People had the involvement of healthcare professionals to support them to remain healthy and well.

Although people were helped to eat and drink enough to stay well some of the catering arrangements meant people did not always enjoy the way their meals were cooked on occasion.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People believed they were involved in how their care needs were responded to but there were inconsistencies in how timely care was provided.

People were supported to pursue their interests but there was a reliance on the activities co-ordinator being at work so when they were not people did not always have enough assistance to do fun things.

People were actively assisted to have contact with their relatives and friends.

People were aware of how to raise a complaint and where this had happened the management team had taken action to resolve the issues to people's satisfaction.

Is the service well-led?

Inadequate

The service was not consistently well led.

There were systems in place to monitor the quality of the service but these had not always led to improvements being made in a timely way which had impacted upon people's experiences of care.

Steps had been taken to promote good team work however the impact of certain behaviours had not consistently helped to support people in receiving care which was timely and responsive.

People who lived at the home, relatives and staff were hopeful

stability to the leadership team would be positive in driving through consistent improvements. This was so people's views were listened to with action taken which was firmly embedded.□

Ravenstone

Detailed findings

Background to this inspection

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

This inspection took place on 28 June 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was an advanced nurse practitioner and an expert by experience. The specialist advisor had the knowledge, skills and experience of managing people's health needs. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector returned to the home to continue the inspection on 29 June 2017.

We looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidents of abuse. These help us to plan our inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

We sought information from the local authority and the clinical commissioning group in order to obtain their views about the quality of care provided at the home. These are commissioners who have responsibilities for funding care and monitoring the quality of this. In addition, we made contact with Healthwatch who are who are an independent consumer champion who promote the views and experiences of people who use health and social care.

We spoke with 14 people who lived at the home and six relatives about their care experiences. In addition, we spent time with people looking at how staff provided care to help us better understand their experiences of the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We also spoke with the manager, the peripatetic manager, deputy manager, regional manager; six members of the care staff team, two nurses, the housekeeper, maintenance person, activities co-ordinator, laundry staff member and head chef.

We looked at a range of documents and written records. This included sampling three people's care records, staff training and complaints. We also looked at information relating to the administration of medicines, maintenance records and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they had various reasons as to why they felt safe living at the home. One person told us, "I'm pleased I haven't fallen at all here. I feel safe here; I kept falling at home you see." Another person said, "I feel safe when they move me with the hoist. I don't think there is a security problem." Relatives we spoke with were confident their family members were safe.

Staff we spoke with knew how to recognise different types of abuse and how to report any incidents of potential abuse and or harm so action could be taken to keep people as safe as possible. Staff had received training in abuse and policies and procedures were in place to provide additional guidance.

However, we found there were shortfalls in the arrangements which had been made to prevent people from experiencing avoidable accidents. An example of this was some people did not have their feet on the footrests in place when they were being moved in wheelchairs. This could potentially place people at risk from injuries to their legs and/or feet. Another example was one person did not have the break on their wheelchair and was at risk of this tipping over. Although this person declined to have their brakes applied on their wheelchair when they were asked. However, the specific risks to people were not identified in people's care records alongside strategies to reduce avoidable harm. When we spoke with staff they acknowledged the potential risks to people but this did not change practices we saw happening.

During the inspection the regional manager took action to assess the risks to one person so these could be managed safely. The regional manager did this following our discussions about the management of specific risks to people. In addition, we spoke with the nurse about similar risks to other people. The nurse was aware of these specific risks to some people but what they could not show us was how these had been assessed. This included guidance recorded for staff to follow to support people's needs as safely as possible.

In addition, we found the flooring in the conservatory, which was frequently used to access the garden area and for people to choose to sit in, was lifting making this loose in places. This defect increased the risk of people falling and injuring themselves. Although this had been recognised by the management team some time had elapsed without the necessary action being taken to replace this. When we discussed the reasons for the delay the management team told us it could be due to funding, but other than this they were unsure.

This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff had identified other potential risks which could result in people experiencing accidents. For example, people agreed to have bedrails in position to support them in being more comfortable and decreased the worry to people of rolling out of bed. Another example was people being assisted to keep their skin healthy by having the necessary equipment in place to support people's wellbeing.

We heard varied views from people about staffing availability. Some people believed staff responded to their call bell so their needs and safety were met. One person told us, "They [staff] always come when I use this [their call bell]." Unlike our previous inspection we did not see call bells consistently sounding for long periods of time, which could place people at risk of their needs and safety not being met. Other people told us while their safety and basic needs were being met, care was not always provided in a timely way with one person telling us, "I use the bell system but I'm afraid you wait a long time sometimes; they're [staff] overwhelmed with everyone else."

Staff we spoke with said they felt the staffing numbers supported people's safety. Although staff did acknowledge there were busy times during the day but they had not impacted upon people's safety. One staff member told us, "There is no time to always talk with residents [people who lived at the home]." We have reported on this in the responsive section of our report.

The management team told us they reviewed staffing levels in line with the needs of people living at the home. As part of this process a staffing levels risk assessment tool was used. However, they acknowledged further work was required to make sure staff worked as a team with the deployment of staff in each part of the home based on a mixture of skills and knowledge.

In addition, people who lived at the home, relatives and staff told us how there was a reliance on agency nursing staff as there were not enough directly employed to cover the shifts. On the first day of our inspection one nurse was on duty as opposed to two to cover the morning shift until the deputy manager came into work at 11am. Although the nurse prioritised medicines to ensure people who required their medicines at specific times had these there were other impacts. For example, one person became distressed because they had expectations of receiving their medicine at a certain time.

The management team had taken action to recruit nursing staff but this had been difficult and the management team referred to a national shortage of nurses. The management team covered shifts wherever possible with agency nurses but there were occasions when there was a shortage. The management team had notified us when staffing numbers were below what the provider expected them to be with the actions they had taken to meet people's needs safely.

At our previous inspection in August 2016 we found the provider's staffing considerations had not addressed the shortfalls which increased the risk people would not safely received all the care they needed. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing. At this inspection we still found the provider required further improvements, particularly in consistently deploying staff to make people's needs were responded to in a planned way at each shift.

Therefore at this inspection we found there was a continuation of a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

The provider had recruitment arrangements to assure themselves staff had background checks on their suitability to work with people who lived at the home. One staff member described how they had been required to produce names of their previous employers so the provider was able to gain references. Another staff member told us how a check had been made to see if they had any criminal convictions which meant they were unsuitable to work at the home.

At our previous inspection we found two people had not received their medicine at times specific to meet their health requirements. For one person this had a significant impact on their emotional wellbeing and health. However, at this inspection this did not occur due to the nurses prioritisation of people's time

specific medicines.

People who lived at the home and relatives told us medicines were administered as prescribed. One person who lived at the home told us, "Medicines come when I need them. The duty nurses are very good." We saw staff supported people to take their medicines during the morning and found people received their medicines safely as prescribed to meet their needs. For example, we saw a nurse, checked people's medicines against their medicine administration records to make sure they offered people the correct type of medicine and dose. Systems were in place to ensure medicines were ordered, stored and administered to protect people from the risks associated with them. For example the provider had arrangements whereby medicines were checked and any discrepancies identified with actions in place to remedy these. In addition a visit had been made by a pharmacist to audit medicine arrangements and their check had been a positive one.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in August 2016 we found the provider needed to make improvements because staff did not consistently put the knowledge and skills they had gained from training into practice. During this inspection we saw examples whereby staff still did not reflect their knowledge and skills into their everyday practices to effectively care for people. One example was how staff did not consistently use their communication skills and knowledge about people's specific needs in an effective way. For one person this had impacted upon their sense of wellbeing and their self-worth.

People told us they were given choices of what food and drink they would like. One person told us, "The food is good and if you don't like it they'll get something else." Another person said, ""The food is fine. He's a good chef." We saw staff supported people with their meal choices. However, if people didn't want either of the two main options the chef was happy to prepare alternatives.

We noted there were measures in place to ensure people had enough food and drinks to meet their needs, so they remained healthy and well. People had been offered the opportunity to have their body weight regularly checked and records showed these weights had been monitored by staff to ensure any significant weight losses and or gains were identified. This arrangement helped staff to make sure they could quickly identify any significant changes which needed to be brought to the attention of a healthcare professional. We saw staff used methods such as their daily sharing of information to check whether people were considered to be at risk of not eating and or drinking sufficient amounts to meet their individual needs. Records showed as a result of this where one person had been referred to their doctor who had prescribed a food supplement to support the person in maintaining their health.

However, some aspects of the catering arrangements did not always support people to enjoy their meals. This was because some people told us they were unable to eat their meals and enjoy these due to how they were cooked. This increased the risk people would not eat enough to promote their good health. The head chef told us they had spoken with the former registered manager about this but due to the different changes in management improvement actions by the management team had not been taken. We have further reported on this in the well led part of this report.

People we spoke with told us they were supported with their health needs. One person told us, "They (staff) will call a doctor if I ever was taken ill." Another person told us the doctor visited the home regularly and staff would arrange for them to see the doctor if they wanted to. People told us if they needed an optician this was arranged for them. Relatives confirmed this as they were appreciative of how staff supported their family member's with their health and wellbeing needs. A relative told us, "I have no worries about how [person's name] health is reviewed by the staff and I am very reassured by staff who I know would get the doctor or call for an ambulance if this was needed without any delay." We saw established staff practices where they shared changes in people's health needs daily which included the shift handover meetings where they discussed any follow up health treatments for people and/or where the doctor needed to be consulted. During our inspection the doctor visited and discussions of the most effective treatments for a person were held to ensure the person's needs were met in the best possible way for them.

People told us staff were skilled in meeting their needs. One person said, "The care I get is good so this must be due to their [staff] training." Another person told us, "The staff are good and they know exactly how to help me." One relative told us, "The carers [staff] are satisfactory. They [staff] do their job as well as they can."

The management team had made improvements to the induction staff received, such as developing the detail of this and including the national care certificate which sets out common induction standards for social care staff. In the Provider Information Request [PIR] it was confirmed, 'The new staff induction is to be completed by them within the six-month probationary period. If new carer is employed who did not work in care before, this is to complete the Care Certificate within 12 weeks.' One staff member told us during their induction, "I was encouraged to ask if there was anything I was unsure of or needed help with."

Following staff's induction the provider had arrangements in place which included a detailed record of their training needs. This provided the management and staff team with knowledge about where training and refresher courses were required. The management team told us they used the detailed training records to assure themselves people received care from staff who were provided with support to gain the knowledge and skills they required.

Staff told us they felt they had the skills and knowledge required to provide effective care and support to meet people's needs. One staff member described how they had undertaken training courses which were relevant to their role. They had particularly found the course about how to support people in moving, as it gave them knowledge about the different techniques to use.

In addition, the nurse was able to provide examples which showed they knew how to correctly support people to manage their particular health care needs. Other examples were staff knowing how to correctly assist people who needed support in order to promote their continence. Another example was staff knowing how best to help people to keep their skin healthy. Staff were aware of how to identify if someone was developing sore skin. They understood the importance of quickly seeking advice from an external healthcare professional if they were concerned about how well someone's treatment was progressing.

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).

We checked whether staff were working within the principles of the MCA and saw they sought people's consent before assisting or supporting them. One person told us, "They [staff] ask me for my views before they help me with my care." Staff had received training in relation to the MCA and DoLS and showed they had a basic understanding of the need to consider people's ability to give consent. One staff member told us, "Residents [people who lived at the home] are encouraged to make choices about what they need and would like to do on a day to day basis."

We found work had been undertaken and was progressing so improvements were continuing to be made following our previous inspection, where we found inconsistencies in the best interests decision processes. For example at our previous inspection staff had not always been certain if the person involved in making the best interests decision on behalf of the person who lacked mental capacity had the legal authority to do

this. During this inspection we saw records were maintained where people's mental capacity had been recorded upon an assessment of this and documents we checked reflected where people's representatives had legal authority to make specific decisions.

In the PIR it was confirmed, 'Application for DoLS to continue to be submitted for the clients [people who lived at the home] who are assessed as needing it." At the time of our inspection we saw arrangements were in place to make sure DoLS applications had been made where required to the local authority. Additionally, we saw examples of staff practicing in a way, which was least restrictive when any decisions people made jeopardised their safety.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in August 2016 we found people had mixed experiences of care and their dignity was not always maintained. This was particularly found to be the case during people's lunchtime experiences. At this inspection we saw people's lunchtime experiences had improved and staff were available to support people in a dignified way when this was required. For example, when people required staff assistance this was provided so people did not struggle to eat their meals.

People who lived at the home and relatives were mostly positive in their views about the care provided, but some told us there were some staff they did not feel were as good. One person said, "They are very kind to me here. Certain individuals are caring." Another person told us, "Some carers are lovely and nothing is too much trouble but some carers have more of a (negative) attitude." One relative said, "It is excellent care. The staff are pleasant and helpful." Another relative told us, "They [staff] are very kind to me here. Certain individuals [staff] are caring."

We identified for some people staff did not consistently support them in a considerate and thoughtful way. For example, we heard a staff member having conversations with two people on different occasions which did not support people to feel valued. We heard the staff member said to one person, "Come on lady you have got to wake yourself up a little bit. You will be bad" and to another person, "You have not drunk that drink you are naughty." The one person was unable to tell us about their care experiences. However, the other person told us they felt they were sometimes a nuisance to staff who appeared to be rushed and did not have time to chat with them.

In addition, we saw two occasions where staff did not assist people by showing caring approaches towards people's privacy and or dignity. One person had items of food scattered on their floor. This was a person who needed staff support due to the sensory impairments. This did not reflect caring practices were maintained as two staff members passed by this person's room but did not ensure the items were picked up and disposed of. We spoke with one staff member about this and they told us they were busy at the time supporting other people but they had not considered sharing what they saw with other staff so they could assist the person. We spoke with the manager who acknowledged what we saw and arranged for a staff member to assist in removing the items from the person's floor.

For another person their privacy was not supported, whilst using their toileting aid as they sat opposite their room door which was wide open. A staff member who passed by the person's door said this often happened but had not considered how ways could be found to support the person further with their privacy. However, we saw and heard other more positive examples whereby staff ensured they respected people's right to privacy when they assisted them with personal care. We saw examples where staff spoke with people discretely and assisted them to the toilet or their room. One person who lived at the home told us, "They [staff] always make sure doors are shut if I'm having a wash.

The failure of staff to consistently support and respect people's dignity is a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.

We saw examples of how staff knew people well and used this knowledge and their relationships with people when chatting with people about how they would like their everyday needs met. We consistently heard from people at times staff appeared to be rushed and some people said it would be good if staff had more time to chat with them during the day. We saw some examples of staff sharing conversations with people about topics which interested them, such as their relatives who visited, events in the news and television programmes.

People confirmed they were involved in making decisions about their care and treatment. For example, one person told us they preferred female staff to assist them with their intimate personal care and this was respected. We saw another person who needed staff assistance to continue with something they chose to do was supported by different staff at different times so their choices were met. If people needed an advocate there was accessible information about these services to make sure people had opportunities to voice their views as they chose to. Advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes.

In addition, a system known as 'resident of the day' had been introduced which meant on one specific day each month a person and/or their representative met with designated staff at the home who checked whether they were receiving care in the way they wanted. This included housekeeping staff, the head chef, activities co-ordinator, nursing and care staff.

Staff told us they encouraged people to maintain their independence. One person told us how staff had made sure they had the appropriate cup to drink, so they were able to drink with comfort and independently. Another person told us, "I can do certain things for myself; the staff will always check if I am okay but they let me do what I can." We saw staff did look for opportunities for people to do things independently; for example we saw a member of staff assisting a person with their meal so the person was then able to eat this with ease and independently.

People who lived at the home and their relatives told us visitors were made welcome. One person told us their relatives could visit when they wished and there were no restrictions placed upon the, such as the length of their visits. One relative told us, "We've lunched here a couple of times and it's great. They even catered for us when a friend came over from Canada."

The management team were aware of the need to maintain confidentiality in relation to people's personal information. We saw personal files were stored securely. Staff conducted daily meetings where people's care and treatment needs were discussed in private to make sure people's rights to confidentiality were upheld.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in August 2016 we found the provider was not meeting their legal requirements and were in breach of Regulation 9 Person centred care. This was because people's individual needs were not consistently responded to which impacted upon their wellbeing. At this inspection we found the provider was still not meeting the requirements and remained in breach of Regulation 9 Person Centred Care.

During this inspection people had mixed views about how staff responded to their support and care needs. One person said, "Staff do come when I need them but they are very busy." Another person told us, "They [staff] don't always come straightaway when I call them." A further person said they would, "Appreciate if staff would make time to pop in and have a chat with me."

We saw some improvements in how staff responded to people's individual needs to make sure they had assistance when they needed this. For example, when one person needed support with their needs the call alarm was used to summons staff who responded in a timely manner. Another example was of how staff responded to people's needs over meal times so people had the support they required to eat their meals.

However, we saw and heard how one person's needs were not responded to in their preferred way. This had an impact upon how the person felt at the time. For example, the person told us, "I think they're half soaked. I don't like the taste left on these. It is not nice at all, I think they do it on purpose." A staff member had assisted the person with their oral care but had not done this in the way the person preferred. We spoke with the manager about the person's needs and they acknowledged the staff member's practice did not reflect care was centred on the person's individual needs. The manager made sure the staff member remedied the action they had taken so the person's needs were responded to. When we spoke with the staff member they told us they did not have time to always get to know people's individual needs including reading people's care plans to assist people in receiving the care which positively met their individual needs.

Another person told us how an agency staff member had not been responsive to their needs. This was because they had wiped the person's face with the same cloth as they had wiped their lower body parts. This did not reflect people were kept at the heart of their care together with reducing the risks of infections. The management team gave assurances this practice would not be tolerated and would take action to make sure it did not happen again. The peripatetic manager has now taken action.

We noticed people continued to sit in wheelchairs for long periods of time as they had at our previous inspection. The former management team had advised us they would be working alongside people as they had recognised this could impact upon people's wellbeing. When we spoke with people about their views around sitting for long periods in wheelchairs at this inspection we received comments, such as, "I won't sit in a comfy chair as staff won't come when I call them" and "I feel safer in a wheelchair. Carers do walk me occasionally but it comes back to staffing levels. There's no spare labour." People's comments reflected a culture had developed whereby people did not feel their needs would be responded to if they moved to more comfortable seating. This was because of their past experiences of waiting for staff support. The

management team were aware of people sitting in wheelchairs for long periods of time. We saw records where the management team showed through their own observations of staff practices they were working to improve the responsiveness of staff to meeting people's needs. In addition we saw the peripatetic manager encouraged a person to move from their wheelchair into an armchair. When the person declined their wishes were respected

We saw care plans were continuing to be improved upon to make sure they accurately held information to guide staff in providing care centred on each person. This was being undertaken through auditing procedures with notes for nurses where amendments and or inclusions were required. Staff we spoke with told us they tried to read people's care plans but sometimes they did not feel they had the time to do this and relied upon sharing people's needs and the changes in these on a daily basis at shift handover meetings. In addition, the management team had introduced meetings known as '10 at 10' whereby information was shared as another way to try to improve communication to support people in having their needs met in a consistent manner.

While it was positive to see the things for people to do for fun and interest were continuing to be developed following our previous inspections. People reflected in their conversations with us about what they particularly enjoyed with one person telling us, "I rather like the quizzes and sometimes the singing." Another person said, "Listening to the music and the occasional outing is really enjoyable." We saw people a variety of things for people to participate in, such as listening to music, singing, artwork and joining in to complete phrases from different sayings. In addition, we spent time with the activities co-ordinator who was passionate about creating a number of opportunities to support people in following their different interests. This included reflecting on whether increasing the numbers of volunteers from the one already supporting people to bring additional social opportunities for people.

However, we heard from people who lived at the home and staff when the activities co-ordinator was not at work people's social wellbeing needs were not consistently provided for. We heard examples of people sitting in front of the television at weekends watching programmes such as the motor racing when they were not interested in this. One staff member said, "They [people who lived at the home] get bored and start arguing with each other."

At our last inspection we did speak with the previous management team about the consistency in meeting people's social wellbeing and how care staff had a role to play in this. The management team gave their assurances at the time improvements would be made so staff practices were not solely centred on care tasks, such as personal care and meals. However, actions taken to drive improvements to ensure staff were supported to respond to people's social wellbeing had not been fully implemented. Staff we spoke with welcomed the opportunity to spend more time with people but felt they did not consistently have the chance to do this due to meeting people's other care needs. Throughout our inspection we saw staff were focused upon tasks.

We heard a radio which was on in a corridor area by people's rooms. The manager recognised this did not support personalised care practices and had the potential to impact upon people with a sensory impairment. The manager had intentions following our discussions to remove the radio.

In the PIR the provider informed us, 'Complaints procedure available in the reception area." We found this was the case and we looked at how complaints were managed. The management team investigated all complaints they were made aware of, whether they were formal written complaints, or verbal concerns people who lived at the home and relatives had shared. The complaints were investigated in line with the provider's complaints procedure and the outcome of the complaint communicated to the person who had

shared their issues.

People told us they felt comfortable raising concerns if they were unhappy about any aspect of their care. A person told us, "I can talk about anything which is worrying me or if I have a complaint, with the management who I am sure would take action. If they didn't I would involve my family." Another person described to us how they did have a concern about a staff member and the management team made sure this was resolved. A relative said, "If I have any worries, I can talk to anyone here. I know they'll call me straightaway if there were any problems."

Inadequate

Is the service well-led?

Our findings

There had been further changes in the management positions following our previous inspection when the manager at the time had left the provider's employment. We acknowledged the provider had taken steps to recruit a new manager who registered with us, but they left their position in May 2017. A peripatetic manager was allocated to provide a daily management oversight while the provider recruited a new manager. At this inspection the peripatetic manager was present and a new manager had started working at the home on 21June 2017. The new manager would be submitting an application to become the registered manager. This was to ensure the provider fulfilled their responsibilities in having a registered manager at this home

We found the provider was required to make improvements at our previous inspection in July 2016 to how the home was led and to ensure the quality checking arrangements were effective in driving through improvements. The management at the time pledged to make the required improvements which included supporting people to receive personalised care which was consistently safe, caring and responsive to their needs. However, we found gaps in the provider's mechanisms to check people's care experiences and ensure the leadership of the home was effective even through the inconsistencies of managers.

While at this inspection we found some improvements had been made there continued to be areas which had not improved consistently with the action which had been put in place. One example was to support staff in promoting personalised care. This included reducing the care task focused approached and embrace opportunities to respond to and enhance people's social wellbeing. However, we heard from people who lived at the home and staff when the activities coordinator was not at work people were not encouraged and supported in a consistent way with things to do for fun and interest. One person told us they were, "Often bored at weekends" as there was little to do. Another person said, "I wish I could go out more often but there is only one [activities co-ordinator]." One relative commented the opportunities to support their family member in going out with them had been rare and this was a goal they had wanted to achieve for some time. The management team said with good planning this could be arranged with support in place to meet the person's goal. Another relative told us the former management team had implemented actions to bring about improvements but these were not always sustained. For example, staff consistently responding to people's individual needs in a timely manner.

Although the peripatetic manager had arrangements in place which included gaining people's views we received different responses from people about their care experiences. We heard from people who lived at the home and staff about how the management and provider oversight of the home had been ineffective. This was because people's feedback had not always been acted upon to drive and embed improvements in care. For example, one person told us how they struggled to eat some of their meals. This was due to what they described as the cooking standard of these. Another person also told us they did not like eating their meals due to how these were cooked on occasions. When we spoke with the head chef they were aware of people's complaints about the standard of some of their meals and knew the reasons for people's complaints. They had provided the previous management team with people's views about their meals but told us, "They [managers] then leave" without steps taken to address the standard of some meals. When we spoke with the new manager they were aware of people's issues with their food at certain times and gave

assurances they would take steps to make improvements now they had come into post.

Another example from our previous inspection was to improve the culture within the staff team. This was because there was a lack of nurse leadership to provide staff with guidance and direction so people's care needs were consistently met. At this inspection we heard similar themes from staff about how some staff behaviours impacted upon the staff team working together and being happy in their work. Staff gave us examples of how some staff did not want to work with others which had the potential to lead to changes in the deployment of staff. At the previous inspection the former management acknowledged there were tensions in the staff team. At the time we were provided with assurances staff morale and behaviours would be improved so these did not impact upon people's care experiences. However, pledges made at the time had not been fully implemented at this inspection and/or been effective to reflect people were supported and cared for by staff who were happy in their work and well led.

Staff told us they had one to one meetings to support them in their caring roles. However, staff also spoke about how they found it unsettling due to the changes of managers. Additionally, staff spoke about how behaviours in the staff team needed to be improved as they impacted upon how staff effectively worked as a team. The management team were aware and showed they were committed in promoting positive teamwork. Shift handover meetings, a communications book, written notes and regular staff meetings were used to ensure staff kept up to date with changes in people's care needs and any important events

At our previous inspection we found there was a lack of nurse leadership to provide staff with guidance and direction so people's care needs were consistently met. At this inspection we heard similar themes from staff about how some staff behaviours impacted upon the staff team working together and being happy in their work. Staff gave us examples of how some staff did not want to work with others which had the potential to lead to changes in the deployment of staff. The former management acknowledged there were tensions in the staff team. We were provided with assurances at our previous inspection that staff morale and the behaviours within the staff team would be improved so these did not impact upon people's care experiences. However, pledges made at the time had not been fully implemented and or been effective to reflect people were supported and cared for by staff who were happy in their work and well led.

At the time of our previous inspection, the former regional manager was regularly visiting the home to speak with people, staff and their relatives, and listening to, and responding to their views about the service and the care provided. Another regional manager was now visiting the home to support the leadership team and they were there on the first day of our inspection. The regional manager was adding to reports and development plans this included considering, health and safety, staff recruitment, records and documentation. However, we were concerned that as indicated by the examples given throughout this report the provider's quality checking arrangements had been ineffective in fully driving through improvements from our previous inspection and consistently embedding these into practices.

We asked the management team about the provider's action plan which had been produced following our previous inspection. They advised us they had not seen this due to the previous managers leaving the provider's employment. However, they were able to show us a development plan they had which the new management team including the regional manager were working on to drive through improvements. They pledged to implement improvements and check over time whether these were effective and then sustain these. Additionally, the management team showed they were honest and accountable in their approaches to the inspection and supported this throughout. We provided feedback at the end of our inspection on what we found and where improvements were required which was received positively by the management team.

This was a breach of Regulation 17,(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the new manager who gave assurances actions would be taken to drive through the environmental improvements, such as the signage for the benefit of people who lived at the home and visitors.

Staff told us morale was low in the staff team with one staff member commenting, "They [staff] do care and are kind but we have no time." However, staff were hopeful of consistency in the management oversight of the home to support them in their caring roles with another staff member stating, "The new manager is supportive as was [former registered manager], did not want her to leave."

Although staff were still getting to know the new manager they told us they were appreciative of the manager's 'hands on' approach. One example staff shared with us was how the manager had supported a person with their needs and assisted staff when they were busy.

Staff were able to tell us how they would report any concerns or poor practice if they witnessed it and were aware of the provider's whistleblowing policy. They knew how to raise any concerns to external organisations if people's care or safety was compromised.

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
Treatment of disease, disorder or injury	The registered provider did not ensure that the care and treatment was appropriate, met the needs and reflected people's preference. Regulation 9(1)(a)(b)(c)(3)(a)(b)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	10(1) Service users must be treated with dignity and respect. (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular;- a. ensuring the privacy of the service user; b. supporting the autonomy, independence and involvement in the community of the service user; c. having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure safe care and treatment for people because risks to people's welfare were not always identified or acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust processes in place to ensure the safety and quality of the service was adequately monitored and improved, and to ensure known risks were acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staffing levels and deployment of staff were sufficient to meet people's needs.