

Cheriton Care Centre Limited

Badbury Care Home

Inspection report

8 Weymouth Avenue
Dorchester
Dorset
DT1 2EN

Tel: 01305265365
Website: www.agincare-homes.com

Date of inspection visit:
14 December 2017
15 December 2017

Date of publication:
19 February 2018

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 14 15 December 2017 and was unannounced.

Badbury Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 33 people across two floors, each of which has separate adapted facilities. At the time of our inspection there were 23 people living at the service.

At our last inspection on 13, 14, and 17 July and 22 August 2017 we found there was a lack of consistent, effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. People's identified risks in relation to skin damage had not been consistently managed or actions taken in order to minimise the risks.

Systems were not in place to ensure people received their medicines safely. Stocks were not always available to ensure people received their medicines when required. People were at risk of malnutrition because food and drink records were vague and did not reflect how much people had actually eaten or drank. Service users were not always treated with dignity and respect. Service users did not always receive personalised care that responded to their individual needs and reflected their preferences. Care records were not always completed accurately or consistently. Care plans and grab sheets did not reflect people's DNAR preferences. Systems and processes in place to assess, monitor and improve the service were ineffective. The provider had not notified us of all notifiable events.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well led. We found that during this inspection the action plan had been followed but although improvements had been made, some improvements were still required.

Fire procedures for visitors and signage was not clearly displayed in the home. The provider acknowledged this and told us they would address this as a priority. Following the inspection evidence was shown which identified measures had been taken to ensure signage was clear.

People, staff and relatives described that the home had been through a challenging period. They were all

confident that the provider had secured change and stability.

Although improvement had been made to ensure medicines were managed safely, there remained a risk that people may not receive their medicines when required as stock levels were not maintained. This meant people could be at risk of not receiving their medicines when required. Medicines were, securely stored, correctly recorded and only administered by staff that were trained and assessed as competent to give medicines.

People were happy with their care and they shared appreciation and confidence in the registered manager and staff team. Professionals confirmed that improvements had been made. Staff were able to tell us how they would report and recognise signs of abuse and had received training in safeguarding.

People felt safe. They were protected from harm because staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected the person's preferences. Staff knew how to identify and respond to abuse.

People described the food as good and there were systems in place to ensure people had enough to eat and drink. Where people changed their mind about what they wanted to eat they were offered alternatives. Where people needed support with fluid and food this was provided. The new on line care system alerted staff if identified needs such as turns or fluid intake were required.

There was mixed feedback regarding staffing. The provider informed us they had sufficient staff to meet individual needs. People and their relative told us although they felt there was sufficient staff they were "Busy". During the inspection staff were observed to be task led and busy which meant that there was limited time to spend with people on a one to one level.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check.

The service had a clear management structure. The registered manager reported to the provider. There were senior staff in place who made day to day management decisions. Staff told us communication had improved, one member of staff told us, "Handovers are much better now".

Staff were aware of the Mental Capacity Act and training records showed that they had received training in this. Improvements had been made in relation to the completion and assessment of capacity assessments and best interest decisions.

People were supported to access healthcare appointments as and when required and staff followed professional's advice when supporting people with on going care needs. Records we reviewed showed that people had recently seen the GP, district nurses and a chiropodist.

People and their relatives knew how to raise a concern or make a complaint. There were systems in place for people, staff and visiting professionals to give their feedback on the service. Staff felt able to approach their managers and raise any concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was mainly safe.

Fire procedures for visitors and signage of assembly points were not displayed within the home.

There was a risk that people may not receive their medicines safely as stock levels were not always maintained

People were supported by sufficient staff, however they told us staff were often task focused.

People were protected from the risk of infection.

Staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

Requires Improvement 

Is the service effective?

The service was mainly effective.

People were not supported by staff who had been deemed competent to provide their support. Not all staff had been assessed as competent following probation periods

The principles of the Mental Capacity Act 2005 were understood by staff and were consistently followed in making and recording best interest decisions.

People were cared for by staff who knew their needs, abilities, risks and preferences well. Staff understood their responsibility to support people to maintain their health and wellbeing.

People were supported to see relevant health professionals such as dentists when they needed to.

Requires Improvement 

Is the service caring?

The service was caring.

People were supported by staff that treated them with kindness, respect and compassion.

Good 

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected their privacy and dignity.

Is the service responsive?

Good ●

The service was responsive.

People were supported by staff that used person centred approaches to deliver the care and support they required.

People were supported by staff that recognised and responded to their changing needs.

People were supported to access the community and take part in activities within the home.

A complaints procedure was in place. Relatives, professionals and people told us they felt able to raise concerns with staff and/or the management.

Is the service well-led?

Requires Improvement ●

The service was mainly well led

The quality of the service provided to people was monitored and where there were shortfalls these were not always identified.

The home was led by a management team that was approachable and respected by the people, relatives and staff.

The home was continuously working to learn, improve and measure the delivery of care to people.

Staff received feedback from the management and felt recognised for their work

Badbury Care Home

Detailed findings

Background to this inspection

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

This inspection site visit took place on 14 and 15 December 2017 and was unannounced. The inspection was carried out by three inspectors on the first day and one inspector and two pharmacy inspectors on the second day.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also reviewed information from monthly reports sent by the provider as part of a condition of registration. We contacted the local authority quality improvement team and safeguarding triage to obtain their views about the service.

We did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection.

We spoke with 12 people who used the service and four relatives. We met with two health care professionals who had experience of working with the home and an independent activity worker. We had discussions with nine staff including the chef and activity coordinator.

We spoke with the registered manager, operations director, group chief executive and operations support manager. We reviewed six people's care files, policies, risk assessments, health and safety records, consent to care and treatment, quality audits and the 2017 resident and relative's survey results. We observed staff interactions with people. We looked at six staff files, the recruitment process, complaints, training, supervision and appraisal records.

We walked around the building and observed care practice and interaction between care staff and people

who live there. We used the Short Observational Framework for Inspection (SOFI) at meal times and during activities. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the operations director to send us information after the visit. This included policies and the staff rota. The operations director agreed to submit this by Friday 22 December 2017 and did so via email

Is the service safe?

Our findings

Our previous inspection in July and August 2017 found a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure care and treatment was provided to people in a safe way. We also found some aspects of people's medicines were not managed safely and there were not always enough staff deployed to meet people's needs. At this inspection we found improvements had been made, however we have rated this key question requires improvement as further time is needed to demonstrate the improvements can be sustained. For example, There remained a risk people may not receive their medicines as prescribed or that medicines would be available.

There was no procedures displayed for visitors to follow in the event of a fire or warning notices displayed informing people not to use the lift in the event of a fire. In addition to this the fire assembly point was not clearly identified with signage in the car park. The registered manager acknowledged this and told us that signage had been ordered. Following the inspection site visit the provider produced photographic evidence that showed new procedures and signage were now in place. For example, signage telling people not to use the lift in the event of a fire.

Staff were living in the home with people they were supporting. These staff informed us they were working 12 hour shifts six days in a row with one hours break during the day. This meant that these staff were working 66 hours per week. One of the staff said, "I work six days on and one day off. I do find myself tired by day six, more so at the beginning. I'm more used to it now". Another staff member said, "I work 12 hours a day. Not so easy but its ok. One day off. I was tired at the end of day six". This meant that there was a risk that staff member's judgment and performance could be compromised due to tiredness. The operations director told us that the organisation had reviewed this and had informed their management teams to ensure any live in staff did not work more than 60 hours per week over a five day period, and was unsure why it was still happening at Badbury. The operation director told us they would review the staff shift patterns. On the second day of the inspection this had been reviewed and we were informed staff would not work these long consecutive days.

The management team told us that live in staff would be moved to the first floor of the service next door where people receiving a service did not live. This meant there would be a reduced risk of sleep disturbance for staff. This action was taken with immediate effect during the inspection.

There was mixed feedback regarding staffing. A relative said, "I think there are just enough staff. I think they are sometimes rushed. Some staff don't have time to spend with people". A person told us, "There are sometimes enough staff. Night times can be bad especially when there is only two staff. Some people ring their bells all the time. Staff come to me when they can. I haven't had to wait a really long time". A staff member said, "We are just helping one person and then the alarm goes off so we are bouncing from one to another". Another staff member told us, "I think there are enough staff here to keep people safe". During the inspection staff were observed to be task led and busy which meant that there was limited time to spend with people on a one to one level. The service used an online care system which helped carer's plan, record,

report and co-ordinate care on the go via smart phones Staff told us they felt "Busy" learning to adapt to the new system but were also confident they would in time get used to it. We discussed staff comments with the registered manager who told us the staff were still learning the new system, and they had noticed improvements where staff were becoming more confident with the system.

Staffing levels were determined by a staff dependency tool. We reviewed staff rotas over a four week period which identified the assessed levels of staff as discussed with the registered manager. The registered manager told us they aimed to have seven staff on duty throughout the day which would include the deputy manager. They explained there had been changes within the staff team, however they were confident the staff team remained stable and reliable.

Recruitment was carried out safely. Checks were undertaken on staff suitability before they began working at the home. Checks included references, identification, employment history and criminal records checks with the Disclosure and Barring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people. Where gaps in employment history were apparent on the member of staff's application form, these gaps were explored and documented as part of the recruitment process.

Staff files identified health conditions for staff. Actions had been identified to complete risk assessments to ensure appropriate measures were in place to ensure the staff members wellbeing and safety to people they were supporting. Three files reviewed that identified risk to staff had not been reviewed or assessed by the registered manager. The registered manager told us that the other two staff members had not been completed, but agreed some had been missed. The registered manager told they would complete the risk assessments with immediate effect.

People received their medicines in a safe way. The service had safe arrangements for the ordering, storage and disposal of medicines. Staff responsible for the administration of medicines had undertaken training and had their competency assessed. Senior staff completed monthly audits. However there had been recent safeguarding concerns in regards medicine stocks. One person told us they were concerned they had not received their medicines for seven days. However they informed us following a meeting, "Everything has now been sorted out". Records showed that when there had been difficulties in obtaining a medicine for one person, action had been taken to obtain a replacement supply.

Another concern was raised in regards one person not receiving their medicines regularly as prescribed, due to them being asleep. This had been picked up through a medicines audit, and actions taken by contacting the prescriber changing the administration time. The deputy manager informed us lessons had been learnt and process were now in place to prevent the same medicine errors occurring. For example, either the registered manager or deputy manager would attend the handover meetings and question staff around any concerns in regards people medicines. They told us, "It is very important to communicate and I believe communication broke down. Our new on line monitoring of medicines will prevent this happening again alongside daily management checks on medicines and stock levels."

People with an identified risk of choking were supported to receive fluids safely. One senior care assistant told us that when using thickeners "I always follow the instructions on the tin" they informed us they had access to the directions of the speech and language therapy team about the recommended consistency of fluids for those people prescribed them.

People and relatives told us Badbury Care Home was safe and that the service had improved since our last inspection. One person told us, "I feel safe here. Staff help me. Things are better now". A relative said, "My

loved one has safety, warmth and comfort here. They are very settled and safe. There is continuity of care. It feels like a family and is homely. I feel that improvements have been made".

Following the last inspection the service had made effective arrangements for reviewing and investigating safeguarding incidents and events when things had gone wrong. The provider had identified themes, taken action to investigate and shared their learning with stakeholders, families and people.

The service had a safeguarding policy in place which detailed definitions, preventative measures, the investigation process, key contacts and record keeping. Advocate services were available to people and learning was shared in meetings. A number of safeguarding alerts had been recorded and investigated since our last inspection. We were told by the local safeguarding team that all safeguarding enquiries were now closed. A spread sheet was used to log and track all safeguarding alerts, incidents and accidents. It also recorded notifications sent to CQC, actions and outcomes. We reviewed recent incidents linked to falls. We noted that actions had been taken including referrals to occupational therapists and seeking aids such as sensor mats. The registered manager told us that this was an example of how information was analysed and trends identified.

Staff were able to tell us how they would recognise if someone was being abused. Staff told us that they would raise concerns with management. Staff were aware of external agencies they could contact if they had concerns including the local safeguarding team and CQC. A staff member told us, "Unexplained marks may indicate abuse, someone may complain about a staff member or other person, I may hear or see something. I would report it to my manager, head office or the CQC. I currently have no concerns". Staff told us that they had received safeguarding training and that it was regularly updated. Training records confirmed this.

Staff understood their responsibility to report incidents. A staff member told us, "We do regular checks and report incidents like falls and sores". Incident reports captured information for staff to complete such as; people involved, location, what happened, actions taken and body maps. Reports required managers to complete actions taken such as re-assessment, risk assessment review and complaint process opened. There was also a section to record staff debriefs in the event of any serious incident. Lessons were learned and shared amongst the staff team and measures put in place to reduce the likelihood of reoccurrence. A relative said, "When incidents take place I'm told about them. There was blood loss once, we were informed, it was monitored and it is now OK". The registered manager told us, "I am open to learning, it's important to me. One example is that we have had issues with contractures. [Contractures are the shortening or stiffening of muscles, skin, or connective tissues that results in decreased movement and range of motion]. My awareness was not good on this. We are now working closely with the community rehabilitation service to learn more and train the staff".

Risks to people's care and treatment were being managed and appropriate assessments completed. Care files identified people's individual risks, and detailed the control measures staff needed to follow to ensure risks were managed, and people were kept safe. For example, people had risk assessments for moving and handling, diabetes, nutrition and falls. Staff were aware of people's risks and controls in place to protect them from harm. Risk assessments we reviewed were up to date, securely stored and available to relevant staff. A person told us, "Staff help me keep safe. They advise me on how to reduce risks like falls".

The service had started to use an online care system which helped carer's plan, record, report and co-ordinate care in a timely way via smart phones. This was an effective system that ensured that staff had the information they required to deliver safe care, understand individual's assessed needs and how best to support them. Staff had received training in this and told us they found it useful, however were still gaining

their confidence in responding to alerts. For example an alert would inform staff if a person needed support to change position. As people's needs changed notifications could be sent out to staff via the system and would show to each staff member the next time they logged in. The service was in the process of uploading and reviewing care plans and assessments. A staff member told us that the new system helped them support people safely by sending alerts when people need turning or to drink more fluid.

People were protected from the risk of infection. We observed staff wearing Personal Protective Equipment (PPE) such as gloves and aprons throughout our inspection. There was a comprehensive infection control audit in place and up to date. We observed domestic staff regularly cleaning people's bedrooms and communal areas. Domestic staff worked around people and asked if they could enter people's rooms to clean them. The home was free from offensive odours. There were hand washing facilities throughout the building and signage around the home reminded people, staff and visitors to the home of the importance of maintaining good hygiene practices.

People had Personal Emergency Evacuation Plans (PEEPS) in place. These plans detailed how people should be supported in the event of a fire. We reviewed the fire safety record which recorded regular fire alarm, equipment tests and services.

Equipment owned or used by the registered provider, such as specialist chairs, adapted wheelchairs, hoists and stand aids were suitably maintained. Systems were in place to ensure equipment was regularly serviced and repaired as necessary. All electrical equipment had been tested to ensure its effective operation.

Is the service effective?

Our findings

Our previous inspection in July and August 2017 found concerns relating to the need for consent and staffing. The provider was not always acting in accordance with the Mental Capacity Act 2005 and staff did not receive appropriate support, supervision and training to carry out their duties.

At this inspection we found improvements had been made, however we have rated this key question requires improvement as further time is needed to demonstrate the improvements can be sustained. For example, improvement continued to be needed in regards the monitoring of staff competency.

Checks on new members of staff had not always been completed by the provider. New members of staff were informed formally in writing part of their condition of employment was to complete a successful probationary period. Records showed five recently appointed members of staff had not received first and final probation meetings or any form of supervision. Staff recently employed confirmed they had not received probation meetings or checks. This meant it would be difficult to determine the progress a new member of staff was making towards successful completion of their three month probationary period. We addressed our concerns with the registered manager. The registered manager was unaware that the checks had not been completed. We were informed following the inspection by the operations director all probation checks would be complete by the end of December 2017.

There was a clear induction programme for new staff to follow which included shadow shifts and practical competency checks in line with the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training.

People received support from staff who access to on going training and development. Training was delivered via workbooks and an online portal. Staff were given protected time to complete the training topics. The staff expressed satisfaction with the training they had received. One person living at the home told us "They know how to support me. I'm confident they have the right training."

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.

Staff spoke confidently about their understanding of capacity, the principles of the MCA and what they did to gain people's consent to care and support. Examples included the use of bed rails, medication administration, flu vaccination, personal care, accessing people's rooms, and specific dietary requirements such as pureed food or thickened fluids to reduce the risk of choking and aspiration. Assessments of people's capacity were completed in line with the principles of the MCA code of practice. Where people were assessed as lacking capacity there were records of best interest decisions made on their behalf including involvement from the people concerned or their legal representatives such as, independent advisors, power

of attorney or healthcare professionals. Records showed that best interest decisions were specific and were reviewed. A relative said, "I am involved in best interest decisions regarding my loved one. For example; intrusive surgery and covert medicine".

People were given choice and control over what happens in their lives. Care plans detailed where people could still be involved in decisions affecting their day to day lives. For example after a fall and hospital admission a person was asked if they would prefer to move to an available downstairs room. Records showed they had been consulted with the appropriate family representatives to agree to move downstairs. We observed staff asking for people's consent throughout our inspection and people confirmed staff sought consent to support them.

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). Where DoLS had expired these had been reapplied for. DoLS applications had been made where required and conditions attached to these were being met. For example there was evidence that a person was being consistently encouraged to spend time in the garden and that in another person's case they had 1-1 time in their room with the Activities Coordinator.

Care files demonstrated that people received comprehensive pre- admission assessments. Skin care, nutrition and hydration needs were assessed, monitored and regularly reviewed. Staff used a on line care system to keep informed of people's daily needs and record what support had been given or declined. This included how often and when people were supported to change position to maintain their skin integrity where required, equipment settings [such as air flow mattresses], and people's food and fluid intake against assessed targets. We observed staff supporting people with their re-positioning and hydration needs and system records confirmed this. The staff told us that the electronic system gave them more contact time with people. The admiral nurse who was the quality lead for the home said they felt the use of the on line system had improved support at the home. For example by facilitating efficient reporting, alerting staff to unmet need, and identifying staff who carried out their responsibilities well. The senior management advised that contingency plans were in place if the system failed to work.

People's care records and conversations with people living at the home confirmed that they had been referred to healthcare professionals promptly when required. This included opticians, speech and language therapist, dentist, podiatrist, cardiologist, dermatologist, diabetes nurse and district nurses from a leg ulcer clinic. A person told us, "I am being supported to the dentist today". Were people had specific health needs such as diabetes, up to date diabetic care plans were in place which included foot and eye care and their specific dietary needs, and guidance for staff to support them in how to respond in the event of a person in a diabetic emergency.

People's care plans detailed the food and drinks that people enjoyed and their preferred meal times. There was evidence that this is reviewed by staff. The on line system recorded how much people had eaten or drank. Where needed people had safe swallow plans in place, we observed staff supporting people in line with their safe swallow guidelines. This included the person's posture, an explanation of what was being offered, the pace, and positive interaction throughout. Where staff were concerned people were seen not to enjoy their food the staff re-referred to speech and language therapy to reassess. We observed people being given a choice of food and fluids and being offered alternatives if they changed their minds.

Where people were identified at risk of malnutrition, appropriate actions had been considered and taken to manage this risk. For example a person who had a very low MUST score was referred to a dietician, a speech and language therapist, and had been supplied with a palm protector and a pressure cushion to maintain

skin integrity. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. People were supported to have a balanced diet that supported their health and well-being. Some people had been identified as being at risk because they did not want to eat or drink enough. Food and drink records were in place and information shared at the daily handover if people needed more encouragement to eat or drink that day. People's intakes were monitored and their weight was regularly checked.

We observed people eating and found that there was a relaxed atmosphere. Food looked appetising, was plentiful and overall it appeared to be a pleasurable experience. Tables were nicely laid with mats serviettes and condiments. Different flavoured drinks were available to people. A relative said, "Menus have improved. There is always juice available now too. These are improvements". People requiring assistance were helped in a manner which respected dignity and appeared to demonstrate knowledge of individual dietary and food consistency needs. Another relative told us, "I see staff feeding my loved one. Staff seem competent in this". People choose whether to have their meals in their own rooms or the communal dining room.

We found that the kitchen had been awarded their five star food standards rating and that all kitchen staff had received food hygiene training. The menu was visual. There was a choice of three lunch time options on day one of the inspection which included; roast chicken, nut roast or omelette. Pudding choices included homemade trifle or yogurts. We were told that alternative options were also available.

There was evidence that staff work with outside healthcare professionals to support the health and wellbeing of people living at the home. For example on one person's tissue viability plan it stated 'monitor for red marks, bruising or wounds and report to any senior for liaison with district nurses.' The same person had been supported with appointments at a local hospital to receive pioneering diabetic leg ulcer therapy.

People told us they liked the physical environment. The service was on two levels and there was a working lift in place. Handrails were in place to enable people to move around independently. There was clear signage to indicate shared lounges and bathrooms and people's individual bedroom doors were painted different colours to enable people to easily recognise their rooms. This is important for people living with dementia who can become disorientated in their environment. There was access to secure, level outdoor spaces with seating and planting that provided a pleasant environment.

The accommodation and grounds were maintained to a high standard and provided a pleasant environment. People's bedroom doors were painted different colours and looked like front doors. Improvement had been made in regards signage and prompts for all people. For example clocks were displayed in all communal rooms and the menus had supporting photos, identifying food available.

Is the service caring?

Our findings

Our previous inspection in July and August 2017 found concerns in regards staff being able to spend time with people. At this inspection improvements had been made. People told us they were happy with the care they received, but felt that staff were still busy but happier in their roles. Comments from people and their relatives included: "It is very nice living here the staff are excellent. I like to be as independent as possible and they respect that, "Yes I do like living here, I am quite happy"; "They look after me the way I want them to".

At our previous inspection people told us they had not been able to participate in personal goals or interests. At this inspection we found improvement had been made. For example Staff were aware of people's likes dislikes and history and personal goals. One person told us they were now supported to maintain their interests where previously this had not been happening because staff did not have the time. They told us, "Some days staff offer me support. But if I don't want to do anything and I am happy with my own company, they [staff] respect that". Staff were able to demonstrate an awareness of people and their interests. Records reflected when people had been engaged with personal interests. The activity coordinator told us that they tried to encourage people to come into the communal areas or to have one to one time but respected their wishes not to.

People were treated with kindness and feedback we received about the caring attitude of staff was positive. We observed staff being respectful in their interactions with people. During the inspection there was a calm and welcoming atmosphere in the home, punctuated with moments of singing and laughter. A relative told us, "Staff are very kind and friendly to everyone. People are treated fairly". A person said, "Staff are very nice and kind to me. They are very cheerful which is nice to see".

People were treated with dignity and respect. Staff knocked on people's doors before entering and did not share personal information about people inappropriately. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. One person told us, "I like my room and all my things around me. The staff don't touch my things". Each door was painted a different colour to support people who may need extra help in identifying their rooms.

Families and friends were able to visit at whatever times they wished. People were supported to spend time with family outside of the home. Staff had a good knowledge of family and friends that were important to people. There were a number of relatives and friends visiting people in the home during the inspection. Relatives told us that they were always made to feel welcome. One relative told us, "[name] is happy living here, sometimes gets fed up but that is only to be expected".

People were communicated to in ways that promoted their diversity and history. For example one person was overheard having a conversation in their native language with an independent coordinator who visited the home on a weekly basis. The coordinator told us, "[person's name] always starts the conversation in their native language and really engages in the conversation it is so special for us both and is very important to them". This meant that people were supported to overcome communication barriers. It respected their

past histories kept memories alive and treated people with respect and diversity.

People were supported to make choices about how and where they received support. Care files held pen profiles of people, and recorded key professionals and relatives involved in their care. We were told that information about advocacy services, external bodies and community organisations was made available to people and relatives as and when required. They said that information would be discussed with people who had capacity and with relatives for those who may not be able to understand the information.

People were offered comfort and support when they found it hard to express themselves. We observed one person become very anxious and upset. Staff were seen to spend time reassuring the person offering drinks and spending time with them in their room.

Staff were polite, treated people in a dignified manner throughout the course of our visit and knocked on doors before entering people's rooms or communal bathrooms. We asked staff how they respected people's privacy and dignity. A staff member said, "I always respect people's wishes, needs and interests this helps me build relationships with people and shows I respect them as an individual".

People's cultural and spiritual needs were respected and reflected in their care plans. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent in privacy. A person said, "I often choose to stay in my room. I'm happy in my room I have my TV and radio". Staff were polite, treated people in a dignified manner throughout the course of our visit and knocked on doors before entering people's rooms or communal bathrooms. We asked staff how they respected people's privacy and dignity. A staff member said, "I always respect people's wishes, needs and interests this helps me build relationships with people and shows I respect them as an individual".

Records were stored securely. There were systems in place to ensure data security breaches were minimised. Staff used passwords to log into the online recording system and understood the importance of respecting confidentiality. When staff logged off they did not take the mobile phones out of the home.

Is the service responsive?

Our findings

Our previous inspection in July and August 2017 found that people did not always receive care that was responsive to all of their needs because care plans were not accurate or followed. During this inspection we found that improvements had been made.

People had their needs reviewed regularly. Reviews included contributions from people, relatives, staff and health care professionals. A relative said, "I'm involved in my loved one's care planning and reviews. When they were losing weight I was involved. We looked at different ways to help".

The provider told us people care plans reflected their physical, mental, emotional and social needs, including protected characteristics under the Equality Act. They told us, where changes were required to people support, staff were able to share and communicate through mobile phones. The admiral nurse supported the provider in a number of their establishments. They told us, "Regular audits take place by seniors, we employed office staff to support us transfer information from the old care plans onto the new systems. Reviews are now recorded on the system when they are due." The registered manager told us, "Each member of staff is allocated a phone when commencing their shift. They are able to contact and update the management team at any time of any concerns or changes to people's plans through confidential apps on their mobile phones, these apps are also linked to the office computers". They shared the example of informing staff that a person had requested they use a different name when addressing them with immediate effect.

An activity co-ordinator had been appointed. They worked to support group activities and one to one activities. People told us that the activity coordinator spent time with them and they enjoyed this. A relative told us, "Entertainment has improved. I see more now. When I came in [relative] was in conversation about what they would like to do. Trips out take place now. There is also an activity coordinator now". We also heard about musical entertainment provided. The home had a number of Christmas events planned including a staff pantomime. An activity programme of events was seen around the home, and people were positive in regards activities in the home and out in the community. One person told us, "I have been out to Weymouth and another bay. I really enjoyed it. The driver explained the villages and history we drove through. It was lovely". Another person told us, "In the summer I went to my sisters for a BBQ. A taxi was booked. I arrived at my sisters just in time for food. Very enjoyable".

People were encouraged to make friends and to join in with the activities to avoid social isolation. However some people told us they chose not to participate in activities. The activity coordinator told us, "I work five days a week, I really do try to encourage everyone to take part in activities particularly if I know there is a personal interest. I see everyone each day and try to engage and encourage them to have a little chat." They spoke of great progress getting one person to engage, they told us "Before they did not want to speak with me, they are a very private person. Now I knock on the door and [person's name] will have little chats with me". A person said, "Staff help me with exercises on Monday to Thursday". We reviewed this person's records and found that exercises had been recorded.

The service had an end of life care policy, guidance and procedure in place. At the time of our inspection staff told us there were no people with end of life care needs. We saw that care plans included advance care planning noting when people had expressed a wish not to be resuscitated. Staff were able to demonstrate they were aware of people who did not wish to be resuscitated and would make those wishes clear if needed. The care plans identified people's spiritual and religious needs including whether a person had expressed that they were practicing or non-practicing. Some of the staff told us they had previously supported people with end of life care needs. They were able to describe how they would respond and who they would involve if people at the service needed this support.

The service had a complaints, concerns and compliments management policy and produced a monthly report. Complaints were dealt with within the policy timescales and outcomes were shared with complainants. People and their relatives told us they knew how to raise a complaint and would do so if required. All were confident their concerns would be addressed.

Is the service well-led?

Our findings

Our previous inspection in July and August 2017 found concerns relating to notable events and good governance. Systems and processes in place to assess, monitor and improve the service were ineffective. We found continued regulatory breaches which demonstrate the quality and safety of the service had not improved.

At this inspection we found improvements had been made, we have rated this key question requires improvement as further time is needed to demonstrate the improvements can be sustained. Governance and performance management was not always reliable. Systems to monitor and assess new employees were not always effective.

Following our last inspection improvement had been made to the overall management of the service, this included the appointment of an operation support manager whose role was to support the registered manager in addressing concerns highlighted at our previous inspections. The group chief executive told us that from a corporate level an action plan was drawn up following the last inspection and that it was still in place. They informed us senior managers would continue to visit the home to complete audits however they would also have oversight of actions being completed at the home through the new on line system when not in the home. However we found some checks had not been completed such as probation periods and agreed guidelines for working hours of living staff. This meant improvements were not completely effective. Following our inspection the provider informed us action was taken with immediate effect to ensure all actions were complete.

The registered provider had a quality assurance process that included regular provider visits to the home by the operations director. They completed monthly audits and informed us the online care system helped them to monitor the service whenever they needed to, 24 hours a day if required. The operations director was in the home on a regular basis and completed on the spot checks where they reviewed safety and the experience of people and staff. The new on line recording system included the facility to monitor specific areas of care such as fluid intake or meaningful activity. These systems were developing and the provider had taken guidance from other professionals to improve their systems. For example during the inspection where concerns were raised in regards oral hygiene support, the operation director immediately added to the systems additional support process for staff to follow. The provider planned to utilise this facility to improve oversight. They were in regular contact with the provider of the system to ensure it met the needs of the home.

The approach to quality assurance also included completion of an annual survey by people and their relatives. The results of the most recent survey had been positive. Relatives and people told us they were able to comment on all aspects of the service with confidence.

The registered manager told us that they promoted an open door policy. The main office was located by the entrance door, visitors to the home were observed speaking to office and management staff throughout the inspection. Staff confirmed they were able to speak with the registered manager on many occasions

throughout the day.

The registered manager and deputy manager told us they did regular spot checks, by "Walking the floor". The registered manager informed us they were consistently out on the floor supporting staff where needed. The registered manager and deputy manager were also available on alternative weekends. The registered manager told us "We work well together, we're a good team". The deputy manager told us, "We have learnt from our past inspections, we now ask questions and don't wait to be told. I check our on line systems to ensure tasks have been completed as they should be. It is a much quicker way of checking".

Staff told us they were respected and valued by the senior managers, they confirmed they knew who was who and what their roles were. One member of staff told us, "There are always managers around the place". Staff confirmed they had supervisions and regular feedback in a constructive way, which enabled them to take the appropriate action and support when required. Staff told us they knew their roles and responsibilities and were confident to complete them. Staff were observed approaching the management team for advice and support throughout the inspection.

The registered manager told us the service promoted dignity and respect and would offer equal opportunities to everyone employed. They told us, "It has been a great achievement to maintain the staff we have. We are building back confidence and work alongside them to build up that confidence in regards our new monitoring systems".

Staff told us that they would support any new member to the team or person moving to the home in a non-discriminatory way and would ensure their rights, dignity and privacy were maintained at all times including if they wanted a partner to visit or stay over. They said if they observed the person experiencing discrimination from other people or staff they would raise this immediately with management and look to discreetly reassure the victim about what steps had been taken to protect them.

The registered manager said they thought relationships with other agencies were positive. Where appropriate the registered manager said they ensured suitable information, for example about safeguarding matters, was shared with relevant agencies.

Professionals informed us communication had improved with the service. The registered manager told us, "We encourage health professionals who visit the home to leave feedback following their visit. There are forms by the entrance door to enable them to give feedback. We have received lots of positive feedback." Health professionals told us they completed the forms and improvement had been made.

There were links with the local community. The operation manager told us, "It is very important that we raise our reputation within the local community". They explained they were currently working in close partnership with local education providers to provide real life experiences for students to work with people and get to see how a role in adult social care can be a rewarding career. They said, "By doing this we give students a great insight in this sector". They explained it helped to provide clear pathways into a career in adult social care, to support work placement, they said, "The ultimate aim is to show students that Health and social care for older persons is a viable and hugely rewarding career choice and to then support them in achieving the qualifications and experience they need to succeed."

The registered manager told us their future plans were to "Drive improvement forward and be a hub for the community and town. There have been a whole home review, we have built up positive relationships with our local GP's. I am confident in our ability to improve.

