Wilton Rest Homes Limited

Beacon House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 11 and 12 December 2017 and was unannounced. Beacon House provides accommodation and care without nursing for up to 23 people some of whom are living with dementia. There were 10 people living at the service during our inspection. Accommodation was provided over three floors of a converted residential dwelling, with a passenger lift that provided access to the second floor and a stair lift to the top floor, the stair lift was out of use at the time of the inspection. The service also has six bungalows on site but at the time of our inspection, no one living in the bungalows was being provided with the regulated activity of personal care.

Beacon House did not have a registered manager in place as required on the day of the inspection; the interim manager had left their post on 30 November 2017. There was an assistant manager and a head of care in post, whilst the provider recruited to the role of registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we previously inspected this service in May 2017, we found four continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and identified one new breach. We again rated the service as 'Inadequate' overall. The service remained in special measures and the provider was required to continue to undertake regular audits to monitor quality and risks in relation to the management of the service and staff, and support of people. They had to send a monthly report to CQC detailing the audit dates, the outcomes of these audits and any actions taken or to be taken as a result, which they have provided.

This service remains in Special Measures as although the key question of safe is no longer inadequate the key question of well-led remains inadequate. 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.

The provider had ensured that the required pre-employment information was available for new staff recruited. However, they had not ensured that all of this information was available for each of the longer-term staff in post as required to demonstrate their suitability for their role with people.

Measures had been taken in relation to the safety of the environment. However, the light fittings in the bathrooms did not all conform to legal requirements to ensure people's safety nor did all of the windows. Although the provider has started the process to rectify these issues since the inspection, they have yet to complete the works to ensure people's safety.

Not all notifications of reportable incidents had been submitted to CQC as required. We had not been

informed of four medicine errors, which staff had correctly reported to the local authority under safeguarding procedures.

At this inspection, we found improvements had been made to the processes used to assess, monitor and mitigate risks to people's health and safety and to identify issues that required improvement. However, not all audits were fully effective; data gathered on the service was not always consistently used to monitor trends over time and to identify areas for improvement. Where actions were identified, there was not always written evidence to demonstrate the required actions had actually been completed to improve the service for people.

Safeguarding systems, processes and staff training were in place to safeguard people from the risk of abuse. The provider had made the relevant alerts to the local authority as required when they suspected a person might have been experienced abuse. Legal requirements in relation to safeguarding people had been met.

Risks to people had been assessed and measures were in place to manage identified risks. Legal requirements in relation to moving and handling people and post-falls management had been met.

Sufficient improvement had been made in relation to medicines to meet legal requirements but staff medicine competency assessments which had been started, still needed to be completed, for people's safety.

Sufficient staff were rostered to provide people's care in a safe and timely manner. The provider tried to ensure continuity for people when agency staff were booked to cover vacant staff shifts.

Processes and staff training were in place to protect people from the risk of acquiring an infection.

Processes were in place to inform staff about any incidents and to ensure any required changes were made for people's safety. Staff were kept updated about safety information received from outside the service.

Staff had been provided with training and support relevant to the care needs of the people they were caring for, to ensure they had the correct knowledge and skills to support people effectively.

The service remains subject to a voluntary agreement not to admit new people to the service without the prior agreement of CQC; no one new has been admitted since the last inspection. The service has obtained and was using evidence-based guidance to deliver effective outcomes for people. For example, recognised guidance tools were used to identify and manage potential risks to people.

People were supported to ensure their eating and drinking needs were met. Any risks to them from weight loss or dehydration were assessed and addressed. People were supported to retain their independence with eating and staff supported those who required this assistance.

Professionals we spoke with told us there were good working relationships with the service and that staff sought their guidance as required. People had been supported by staff to ensure their healthcare needs were met.

The adaptation and design of the environment was suitable to meet the needs of the people currently accommodated.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service supported this practice. Further work is required to ensure staff have a sound understanding of the application of the mental capacity act in relation to the completion of assessments and their day-to-day work.

Staff treated people kindly and compassionately, and cared about their welfare. Staff had supported people to dress in the manner to which they were accustomed and which reflected them as an individual. People were involved in making decisions about their care and their decisions were respected by staff. People received their care at their pace. People were able to have visitors come to see them as they wished. People's privacy and dignity were upheld during the provision of their care.

People received personalised care that was responsive to their individually identified needs. People and their representatives were involved in planning their care and care plans were kept under regular review. People were supported to take part in a range of activities.

Processes were in place to enable people to make a complaint where required. No written complaints had been received since the last inspection, so we could not assess how effectively they had been managed.

People had been consulted about their wishes for their end of life care and relevant documentation had been obtained with regards to their wishes.

Staff and professionals spoken with felt significant improvements had been made to the service for the benefit of people under the leadership of the interim manager. However, there were anxieties about the future leadership of the service and how consistency in management of the service could be assured for people.

A recent staff meeting set out the expectations of staff and their responsibilities. Further work is required to ensure staff receive instruction on the provider's purpose and values.

There were processes to engage people and staff. However, there was not always clear written evidence of how peoples' feedback had been acted upon to improve the service provided.

The service has worked closely with health and social care quality teams in order to address the areas of improvement required from the previous two inspections. However, they need to be able to demonstrate in the longer term their resilience and capacity to embed the changes made to date and to manage without this level of input from external quality teams. The service is now looking outwards and is working closely with a variety of healthcare professionals to improve people's care.

At this inspection, we found improvements had been made and three of the previous breaches in Regulations had been met. However, the service had not yet managed to fully meet the legal requirements of two of the other Regulations and we identified two new breaches.

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.

Not all staff had undergone relevant pre-employment checks to ensure their suitability for the role.

Some light fittings in the bathrooms and windows did not conform to legal requirements to ensure people's safety.

There were some staff requiring their medicine administration competence to be assessed.

People were safeguarded from the risk of abuse.

Risks to people were assessed and their safety monitored and managed.

Sufficient staff were rostered to provide people's care in a safe and timely manner.

People were protected from the risk of acquiring an infection.

Processes were in place to inform staff about any incidents and to ensure any required changes were made for people's safety.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service had ensured staff had the correct skills, knowledge and experience to deliver effective care and support to people.

We shall assess the effectiveness of the provider's admission process once the service admits new people in accordance with their current voluntary agreement to obtain CQC approval prior to any new admissions.

Further work is required to ensure staff have a sound understanding of the application of the Mental Capacity Act in relation to the completion of both assessments and their day-to-day work with people.

The service had obtained and was using evidence-based guidance to deliver effective outcomes for people.

People were appropriately supported to ensure their eating and drinking needs were met.

The service worked with other services to deliver effective, care, support and treatment.

People were supported by staff to ensure their healthcare needs were met.

The environment was suitable to meet the needs of the people currently accommodated.

Is the service caring?

Good

The service was caring.

Staff treated people kindly and compassionately and cared about their welfare.

People were supported to express their views and to participate in decisions about their care.

People's privacy, dignity and independence was respected and promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their individually identified needs.

Processes were in place to enable people to make a complaint where required.

People had been consulted about their wishes for their end of life care.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Whilst improvements had been made to processes to assess, monitor and improve the service for people further work was required to embed them and to make them fully effective in driving improvements to the service for people.

Not all notifications of reportable incidents had been submitted to CQC as required.

There was not a registered manager in post as legally required. Whilst the interim manager had made improvements to the service, there was not a manager appointed to run the service at the time of the inspection.

Further work is required to ensure staff receive instruction on the provider's purpose and values.

People and staff were involved in the service through meetings; however, there was not always written evidence to demonstrate that their feedback had actually been acted upon.

The service currently receives a lot of support from professionals with regards to improving the quality of the service. In the longer term these improvements will need to be completed and sustained following the withdrawal of this support.

The service is working in partnership with healthcare professionals in order to provide staff training and introduce new initiatives for people's benefit.

Beacon House

Detailed findings

Background to this inspection

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

The inspection took place on 11 and 12 December 2017 and was unannounced. The inspection team included two adult social care inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

Prior to the inspection we spoke with a number of professionals who had been involved with the service including: four community and specialist nurses, a GP, an environmental health officer, a speech and language therapist and the quality lead from the clinical commissioning group. In addition, we received written feedback on the service from a Social Services team manager. Feedback received was positive overall with professionals feeling that the service was making progress. During the inspection, we spoke with five people and two people's relatives. We spoke with three care staff, the head of care, the activities co-ordinator and the maintenance person.

We reviewed records, which included five people's care plans, six staff recruitment and supervision records, and records relating to the management of the service.

The service was last inspected in May 2017 when a number of concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe within the service. Their comments included, "Yes I feel safe," Yes I think there are enough [staff]," "Oh yes it's very clean." People also confirmed they received their medicines, as they needed them.

At our previous inspection in May 2017, we found concerns in relation to the recording and administration of people's medicines. People's post-falls management was not always safe, staff were not sufficiently skilled in moving and handling people, or assessing their needs in this area, and care records were not always complete. Staff recruitment practices were not safe. Systems were not operated effectively to investigate, immediately, any allegation or evidence that abuse to people may have occurred. We found the provider continued to be in breach of Regulations 12, 17 and 19 and there was a new breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found one continuing breach and one new breach; the requirements of two of the previous breaches have now been met.

The two staff recruited since the last inspection had undergone all of the required recruitment checks prior to their recruitment to ensure their suitability for their role. These included checks to ensure they were of suitable character, confirmation of their identity, full employment history, explanations of employment gaps, criminal record checks, and declaration of their fitness to work.

Three of the longer-term staff files did not contain all of this information. Two had no written references and one only contained one written reference. Although we could see that for one staff member the provider had made efforts to obtain their references in September 2017, this action had not been followed up. There was no evidence that action had been taken in relation to the other two staff. We could not locate a recruitment policy, to check how many references the provider required. This was provided following the inspection and demonstrated the provider required a minimum of two references to determine applicants suitability for their role. Another staff member's file had an unexplained employment gap, which did not meet either the requirements of the Regulation or the provider's recruitment policy. The required information was not available, to demonstrate these staff were suitable for their role in working with people nor was there a satisfactory explanation for any missing evidence to demonstrate all reasonable efforts had been made to obtain it for people.

The registered provider had failed to protect people by ensuring that all of the evidence required within schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been obtained for all staff as required. This was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence that relevant measures had been taken in relation to the safety of the service. A person had been appointed to have oversight of health and safety. Records showed moving and handling equipment such as hoists had been inspected as required. Staff told us, which records confirmed, daily checks were completed on the safety of the hoists for people. Records showed fire equipment, alarms and

firefighting equipment was tested by competent contractors and actions taken as required, for example; new batteries for the fireboard system. Throughout the service, we observed appropriate fire signage and fire notices telling people what to do in case of a fire. Records showed us the maintenance staff checked fire alarms, fire door releases, door guards every week. The chimneys had been serviced as required. Gas safety and electrical safety checks had been completed as required. Checks had been completed in relation to the safety of the water system and water temperatures. Although we saw bathrooms had thermometers to check the water bathing temperatures for people in accordance with recognised professional bathing practice, there were no written records to enable the provider to be able to assure themselves that these checks had been completed. The head of care informed us they were in the process of introducing the required record sheet for people's safety, which they submitted following the inspection.

However, we noted the light fittings in the bathrooms did not all conform to legal requirements to ensure people's safety, which an electrician confirmed. We brought this to the provider's attention and they arranged to obtain a quote for the required works, which will need to be undertaken. We also noted that none of the windows had a British standards safety mark, windows of a certain size need to be fitted with safety glass or a film to ensure their safety if they break. Following the inspection the provider submitted evidence that they had started to make arrangements to ensure the safety of the windows, but these works have yet to be completed.

The provider's failure to ensure all aspect of the premises met health and safety legal requirements was a new breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an up to date safeguarding policy and a copy of the multi-agency policy. However there was a lack of written evidence to demonstrate staff had read and familiarised themselves with these policies. Following the inspection, evidence was provided that 10 of the 22 staff had read it, the remaining 12 staff also need to read and sign this policy and this work was underway. The training matrix showed all staff, except a chef who worked one day a week, had undertaken safeguarding training. We brought this to the attention of the provider for them to make the necessary arrangements for the Chef to undertake this required training. Following the inspection, the provider confirmed this training had been undertaken by the Chef. Records demonstrated safeguarding was also discussed with staff during their supervisions and staff meetings. Staff spoken with understood the purpose of safeguarding, the signs that might indicate that a person had been abused and their duty to report any concerns to senior staff. Records showed the provider had made the relevant alerts to the local authority as required when they suspected a person might have experienced abuse. The requirements of this Regulation had now been met.

Risks to people had been assessed and measures were in place to manage identified risks. We saw that where people required pressure relieving equipment such as pressure cushions or airflow mattresses to relieve the pressure on their skin these were provided. Staff checked people's potential pressure areas on a daily basis to ensure close monitoring of potential risks to people. There was guidance for staff in people's care plans directing them to report any concerns to senior staff and these were then shared with the relevant healthcare professional for people's safety.

Staff had undertaken training in moving and handling. The provider informed us that since June 2017, if people's moving and handling needs changed staff requested a re-assessment with an occupational therapist, which records confirmed. Assessing moving and handling risks can usually be done in-house, as long as staff are competent to identify and address the risks. The provider has informed us a member of staff will be booked on advanced training to enable them to do this in the New Year. The moving and handling needs of people currently accommodated can be met within staff's existing skills. However, if new people were accommodated, a staff member will need to have undertaken the advanced training or professional

guidance would need to be sought. Any particular information staff needed to hoist people safely was noted. We observed two staff supporting a person to mobilise from their wheelchair to a chair, which they did safely.

There was guidance for staff with regards to the measures to take to ensure people's safety in relation to falling, such as the removal of hazards. Staff ensured people had their mobility equipment such as walking frames located next to them to ensure they could access them as required. A person's risk assessments indicated they were at risk of falling. We saw that they were provided with equipment such as a sensor mat to alert staff when they got out of bed, a pendant alarm and a chair alarm to manage this risk to them. The sensor mat was documented in their care plan, but there was no mention of the chair alarm. Although staff understood the need to use this equipment to ensure the person's safety, the person's records needed to be updated to ensure they contained accurate up to date information. We brought this to the provider's attention and following the inspection evidence was provided that this work had been completed. People's moving and handling requirements were documented for staff on the shift handover sheet. This ensured all staff including agency had access to this information for people's safety.

When people experienced a fall staff followed the 'post-falls' protocol to ensure the person was monitored for any deterioration in their health. Relevant staff had undertaken training in falls prevention and the use of the protocol. Any falls were now reported to the person's GP to ensure they were kept informed. People's falls were documented on a 'falls register' with the time, date, cause, injuries, action taken to prevent repetition and whether the fall was witnessed. Relevant actions were taken to keep people safe when they experienced a fall. Legal requirements in relation to moving and handling people and post-falls management had been met.

Medicines were within their expiry dates and were stored safely and securely. Temperatures for areas where medicines were stored were monitored and within an appropriate range. Staff recorded medicines received into the service and any unwanted or expired medicines were documented and returned to the pharmacy for disposal.

Guidance was in place for staff to follow for people taking medicines on a 'when required basis.' This meant that staff would know when to give these medicines, what effects they should have and when to seek additional help. People's prescribed medicines had been reviewed to ensure they only took medicines they needed.

We observed medicines being administered to people safely. Staff had a good rapport with people and understood their needs. People were enabled to administer their own medicines if they wanted to be and were safe to do so. People's medicine administration records (MARs) were signed after medicines were given. Staff recorded the application of people's topical creams on separate charts and body maps were used to show where they should be applied. Staff recorded where on the body medicine patches had been applied. This meant that staff ensured patches were not continuously applied to the same area that could cause skin irritation.

The medicine policy required updating to reflect the requirements of the service and to include arrangements for when people were away from the service. Following the inspection, evidence was provided to demonstrate this had been done. However, it still requires a date for review to ensure the contents remain relevant.

Eight staff administered medicines and all had undergone relevant medicines training. Good practice requires that staff administering medicines should also have their competence assessed on an annual basis.

Although the head of care told us they had commenced this process, we were unable to locate the associated records. Following the inspection, evidence was provided that four staff had completed their competency assessments to date and a schedule was provided for the completion of the remaining four observations. Sufficient improvement had been made to meet legal requirements but all staff medicine competencies need to be completed.

In the morning there were three care staff allocated in addition to a senior, in the afternoon there were two staff plus a senior and at night two staff. In addition to care staff there was a chef, kitchen assistant, housekeeping staff, laundry staff, a part time activities co-ordinator and a maintenance person. The staffing rosters reviewed supported this level of staffing. Staff told us there were sufficient staff to provide people's care safely. Records showed that although there was regular use of agency staff to cover shifts, often the same agency staff were booked to ensure continuity for people.

Following the inspection the provider confirmed that they did not use a staffing dependency tool to determine the required level of staffing for people. Although staffing levels were adequate for the number of people currently accommodated the use of such a tool would enable the provider to be able to demonstrate how they had assessed the adequacy of the staffing levels and how they would continue to ensure adequate staffing levels when people's needs changed or when the number of people using the service increased.

The training matrix showed staff had undertaken training in infection control and food hygiene, which staff confirmed. Staff were observed to wear personal protective clothing when providing people's care. The service was seen to be clean throughout and there was an allocated cleaner daily. Sinks and baths were clean with minimal lime scale. However some of the tiling in some bathrooms needed re-fixing as this could harbour bacteria, which could cause infection.

Visitors to the service were provided with hand gel at the entrance, to clean their hands and reduce the risk of cross-infection. Hand gel dispensers were also located around the service. If people needed to be prompted with hand hygiene this was noted in their records to ensure staff were aware of the need to support the person, with this aspect of their care.

We noted that at the current level of occupation people had their own bathroom facilities, where they left their own toiletries and towels. However, when the number of people accommodated increases and people are sharing bathrooms, people's personal items will need to be removed in order to manage any potential risk of cross-contamination from towels or toiletries.

We noted that some bathrooms had a separate toilet, therefore there was a potential risk of cross-contamination as people went from the toilet to the bathroom to wash their hands. We have brought this to the provider's attention for them to consider if any actions are required to assess this risk and to minimise it for people.

The head of care told us staff were updated about any changes to people's care at the staff handover, which records and staff confirmed. When errors were made with people's medicines, we saw, this was reported to the local authority under safeguarding procedures and action had been taken to ensure staff underwent any required re-training. Records showed issues identified had been raised with staff both at meetings and through letters from the provider. Staff had been required to sign to demonstrate they had read the provider's letter and the issues raised for their attention. There was also a staff memo folder which contained staff updates alerting staff for example, to be vigilant following an outbreak of diarrhoea and vomiting at another service.

At this inspection, we found that the provider had acted on the risks and shortfalls that had been previously identified. Whilst we recognised that improvements were being made to safeguarding, risk management, moving and handling and medicines for people, many of the changes were still a work in progress and have not yet been sustained in the longer term to be fully embedded in practice.

The improvements that have already been made will need to be sustained to demonstrate that the service has improved and continues to do so without the additional provider support and oversight and any increase in placements at the service. At the time of this inspection the service was just under 50% occupied. It is too early to state that the improvements are sustainable.

Requires Improvement

Is the service effective?

Our findings

People told us the service was effective. A person told us about staffs' competency, "I would say the majority are." People enjoyed the meals provided. One person commented, "Most of the time they're very good. There is a choice and variety. There's always cups of tea and biscuits going around after meals." People told us they had good access to healthcare. A person told us, "No difficulties whatsoever. All I do ask." People felt the environment was suitable to meet their needs. People told us staff sought their consent. A person said, "Yes they do ask for my consent."

At our previous inspection in May 2017, we found staff had not all received the induction, supervision, training and appraisal necessary to enable them to carry out their duties. We found the provider was in continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found this Regulation had been met.

Relevant staff either had completed or were in the process of undertaking the Care Certificate, which is the industry standard induction for staff new to care. There was an induction file for agency staff to demonstrate the required checks had been made upon their suitability and that they had been made aware of the information they required in order to work on the staff shift with people safely and effectively.

In addition to the training requirements of the Care Certificate, some staff providing care had undertaken training in additional areas such as falls prevention, the use of the falls protocol and the use of the glucometer, which is a medical device for determining the approximate concentration of glucose in the blood. The staff training matrix showed that nine of the 12 staff providing care had completed a professional qualification in social care.

There was not an overall matrix to demonstrate what supervision staff had received and when. However, we saw from staff's individual records that they had been receiving regular supervisions which staff confirmed. Staff had also had an annual appraisal, to reflect upon their work over the past year. Staff had been provided with training and support relevant to the needs of the people they were caring for to ensure they had the knowledge and skills to support them effectively.

On 7 October 2016, the provider entered into a voluntary agreement not to admit anyone new without receiving prior written agreement from CQC and this agreement remains in place. The head of care confirmed there had not been any new admissions to the service. They had a good understanding of the type of person they felt capable of accommodating and were conscious of the need not to admit too many people too quickly and that any future admissions still required prior CQC approval. We were unable to assess the effectiveness of the assessment process at this point and will assess this when requests for new people to be admitted are received.

The clinical lead for quality in care homes told us staff were implementing best practice guidance. We saw staff were using nationally recognised assessment tools to monitor potential risks to people from weight loss and pressure ulcers. In addition, information had been provided for staff on clinical conditions such as

diabetes for example, to ensure staff had access to relevant guidance. We noted the provider's diabetes policy referenced national guidance in relation to effective diabetes care for people. The head of care told us and people's records confirmed their physical observations were taken monthly. These included a check on the person's urine, to monitor for any signs of urinary tract infection. This enabled staff to promote fluids with anyone identified as at risk in accordance with local protocols and thus avoid the unnecessary use of antibiotics. The service had obtained and was using evidence based guidance to deliver effective outcomes for people.

The head of care informed us no one was currently on a food or fluid chart; however, the service used them if required. To manage the risks of malnutrition to people and dehydration, people were weighed monthly and their Malnutrition Universal Screening Tool (MUST) score was calculated. MUST is a screening tool to identify adults who are at risk from either malnourishment or from being overweight. People were provided with a choice of drinks across the course of the day. The clinical lead for quality in care homes had noted in a recent report that this process was effective in monitoring the risks to people and that any risks identified for people were then discussed with the community matron for the service.

People's dietary preferences and needs were noted both in their records and in the kitchen. We saw that a person needed soft food and staff assistance with eating their meal and this was provided. People were provided with appropriate cutlery and crockery to promote their independence when eating and drinking, for example, people had adapted cups and crockery. People living with dementia were served their meals on red plates, as per research, as this provides a better colour contrast with the meal than white plates for people.

People were provided with their choice of breakfast, a three-course lunch, supper and snacks in addition if required. We saw at lunchtime people who chose to eat in the dining room sat around one big table, which encouraged them to interact with each other. Christmas music was played on the second day of the inspection and the tables were seasonally decorated. This created a convivial atmosphere within which people could enjoy their lunch, which they clearly did. People were supported to ensure their eating and drinking needs were met.

Health professionals told us there were good working relationships with the service and that staff sought their guidance as required. A district nurse told us, "They ring for advice". A GP said, "They do seem more proactive" and "Communications have improved." Records showed how staff had liaised with a person's GP to seek advice on the best way to support them to take their medicines as they were experiencing difficulty swallowing. Staff were aware of this guidance and applied it if required. A speech and language therapist (SALT) confirmed staff applied the guidance provided.

Records showed people had been supported to ensure their healthcare needs were met. For example, people had oral health care plans in place to support good dental healthcare. The GP confirmed staff had been proactive in chasing flu vaccinations for people. Staff knew when to seek support from the district nursing service and ensured this was done. People saw the chiropodist six weekly where required and had their eyes tested. Where required, people had seen specialists such as the SALT, dentist, optician, physiotherapist, community psychiatric nurse and occupational therapist.

The service is registered to accommodate people with a diagnosis of dementia, but the provider does not promote themselves as a dementia service. Staff can support people within the existing environment who later develop dementia whilst accommodated. The service is well lit, the carpets are plain so as not to confuse people and there is labelling of amenities such as bathrooms. Some people had 'memory boxes' outside their rooms filled with items of significance to them to help them to recognise their bedroom. The

external doors to the service are secure to ensure people cannot leave the service unnoticed. The grounds, however, are not secure and therefore people are able to leave them if they wish. Therefore, they are not suitable for anyone at potential risk of leaving them if left unsupervised. There was a metal ramp to the front door to enable access by wheelchair users. The chair lift to the third floor in the main house is not currently working and as this floor is not serviced by a lift, it would not be currently suitable to accommodate anyone who could not fully mobilise themselves. The environment was suitable to meet the needs of the people currently accommodated.

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 the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The training matrix showed relevant staff had either completed or were due to undertake training in the MCA 2005. Staff supervision records showed staff had also received additional support in understanding the MCA. However, not all staff spoken with demonstrated a sound working knowledge of the act as it applied to their role. People's DoLS status was documented for staff on the staff shift handover sheet. However, a member of staff was not aware of this information and therefore might not have been aware of the restrictions in place for two people accommodated.

One person had just had their DoLS application approved and a second was pending approval. In neither case was there a clear written record to demonstrate how the provider had assessed that the person lacked the capacity to consent to their care and treatment and the associated restrictions upon their liberty or the best interest discussions that had led to the DoLS application being made, as required. On the pending application, we saw evidence that this process had taken place, but it had not been fully documented. We have brought to the provider's attention that any future applications need to clearly demonstrate how and why the decision to make the application was made for the person in order to ensure legal requirements are met.

We noted that the person whose DoLS application had recently been authorised had a MCA assessment and associated risk assessment on their records for them to go outside alone. At present, the person had not been going out into the garden due to the weather. However, they had absconded from the service in March 2017; therefore, there was a potential risk of them doing so again if not supervised or monitored in the garden. We asked the provider to liaise with the authorising authority to determine what arrangements need to be made to manage any potential risks to the person, whilst not stopping them from enjoying the garden. Following the inspection evidence was provided that this person's records had been updated to ensure they did not access the garden alone and that relevant action had been taken to explore the options available to monitor the person when in the garden to ensure their safety and that legal requirements were met.

People's records demonstrated that where the person had a power of attorney in place to manage their affairs in the event they were unable to. The provider had requested a copy to enable staff to assure themselves of what decisions the donor was authorised to make on the person's behalf.

At this inspection we found that the provider had acted on the risks and shortfalls that had been previously

identified. Whilst we recognised that improvements were being made to staff induction, supervision, training and appraisal many of the changes were still a work in progress and have not yet been sustained in the longer term to be fully embedded in practice.

The improvements that have already been made will need to be sustained to demonstrate that the service has improved and continues to do so without the additional provider support and oversight and any increase in placements at the service. At the time of this inspection the service was just under 50% occupied. It is too early to state that the improvements are sustainable.

Good

Is the service caring?

Our findings

People told us staff were caring. Comments included, "I'm treated very well indeed. They look after me so well" and "She's [loved one] treated beautifully. They cater to her own preferences." With regards to privacy and dignity, a person said, "Yes, it is respected" and "Yes. When they're doing personal attention to you."

Staff were seen to bend down to people's level when communicating with them, which promoted better interaction with them. Staff spoke with people as they provided their care, chatting with them and providing reassurance as required. Staff kept people informed of what was happening. For example, staff informed a person they would be changing their sheets later. Staff used touch appropriately to communicate with people. We saw staff just gently place a hand on a person's back as they bent down next to them to ask them about what they wanted for their lunch. Staff treated people with kindness and compassion when providing their care.

Staff ensured people were warm and comfortable. A number of people had blankets on their knees to ensure they stayed warm. Staff asked a person if they were cold and assisted them to button their cardigan. Staff showed concern for people's comfort and welfare.

We observed people were well presented in clean, well-fitting clothes, suitable for the season. Women wore make-up if they preferred. Staff had supported people to dress in the manner to which they were accustomed and which reflected them as an individual.

People were provided with a comprehensive service user guide which provided them with information about the service, which they could use to make decisions about their care. The document set out people's rights within the service, which included the right to an anti-discriminatory service that was responsive to people's individual characteristics defined for example, by their gender, religion sexuality and disability. Information for people about the service was also displayed in the reception on the residents' information boards. This ensured people were kept informed about events at the service.

People's records noted what decisions they could or could not make for themselves. This ensured staff were aware of which decisions they should try and involve people in making. For example, staff were instructed to ensure a person was prompted to change their clothes daily as although they could dress themselves they would forget to change their clothes. This ensured the person was appropriately supported.

There was evidence people were involved in decisions that affected them, for example: although one person had a high MUST score indicating they needed nutritional intervention their records demonstrated why this was so, the fact that their weight was actually normal for them and that their GP was aware. This ensured the care the person received care that was tailored to them.

People's decisions were respected. We saw a person had declined to have a health screen, they had the capacity to make this decision and staff had respected and documented their wishes.

People's records provided staff with guidance about their communication needs, for example: one person's records informed staff they found it hard to verbally express themselves and therefore staff should give the person time to do so. We saw staff were familiar with this person's communication needs and gave the time they required.

Staff told people what dish they were putting in front of them if they required this information when serving lunch. This helped to inform people. Some people said they wanted a smaller meal and staff responded immediately and arranged this.

We observed people were able to exercise choice about how and where they spent their time. For example, some people liked to be in the communal areas whilst others preferred to stay in their bedroom. We saw some people liked to eat in the dining room and other people were served their meals in their bedroom.

We observed staff did not rush people. For example, a person was not sure about taking their medicines and staff were gentle, patient and encouraging. People received their care at their pace.

People's care plans provided guidance to staff about how to promote people's independence. A person's care plan told staff how to support the person to be as independent as possible when eating and staff were observed to apply the guidance when supporting the person with their lunch. If men could shave themselves this was noted, or the level of support they required to enable them to do as much of this task for themselves as they could. People were supported to retain their independence.

People's records noted if they had friends or family visiting, to ensure staff knew who to expect. A relative told us they visited their loved one daily and that there were no restrictions on visiting.

People's care records informed staff of how to promote people's dignity as an individual, for example; information was provided to staff about the physical signs that might indicate one person required assistance with a particular aspect of their care. If people preferred female staff to provide their personal care then this was noted on their records. Staff told us how they maintained people's dignity and privacy during personal care, for example; by ensuring doors and curtains were closed and keeping the person covered.

Good

Is the service responsive?

Our findings

People told us the service was responsive. A person said, "There's a list of things for people to do. I don't go because I can't walk. I'm happy with what I'm doing. I read a lot." A person told us with regards to complaints, "Yes I go to the office and it's always sorted out."

At our previous inspection in May 2017, we identified people's care plans were not sufficiently detailed to ensure staff that did not know people well, would know how to meet people's individual needs when referring to their care plans for guidance. We found the provider was in continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvements had been made to meet this Regulation.

Staff had received information about person centred care planning which is where a person's care is planned around their needs as an individual at the staff meeting held on 6 October 2017. People's care plans were individualised and reflected them as a person, their needs and how they wanted their care provided. People's care plans noted their preferences with regards to the provision of their care. For example, how often they liked to bathe or shower and their preferred toiletry products. There was also a note of what people liked to wear. People were asked to sign to demonstrate that they had been involved and consulted about their care plans.

People had a resident profile that provided a summary of key information about the person for staff, such as their mobility needs, personal care needs and personal preferences about their care provision. People's care plans outlined the aims and objectives of the provision of care so that staff knew what they were trying to achieve with or for the person. In addition to the daily verbal handover and written shift handover sheet staff had access to information about people's care in the person's bedroom, such as any medical needs or topical creams charts in use.

Records showed people's care plans were being reviewed monthly by staff or more often if required and updates added. Although people did not have 'formal' reviews of their care, records demonstrated staff regularly spoke with both people and or their relatives about their care and provided updates on any incidents. People and their relatives were spoken with about the care provided.

People's records contained their personal history or a 'This is me' form, which provided key information about the person's background for staff. The training matrix showed staff had undertaken training in dementia care, which a psychiatric nurse confirmed they had provided. People living with dementia had a care plan that identified their care needs in relation to their dementia. There was guidance for staff about specific behaviours the person might exhibit and how these were to be managed. For example, a person had been provided with a diary to aid their memory, although staff told us the person did not use it, we saw they carried it with them around the service, which indicated they derived a benefit. Staff understood how to support people living with dementia, for example; they showed people with dementia the choice of starters at lunch so they could see and smell them, whilst they told people who did not have dementia what the options were. Reminiscence sessions were held to stimulate those living with dementia and staff read

people the 'Daily Sparkle,' which is a reminiscence newspaper to promote discussions. The needs of people living with dementia were understood and met by staff.

The service ensured that people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Staff noted within people's records how the person was to be supported to access information, for example; a person could become frustrated so staff were guided to write things down for them. Another person had information about their external activity in an easy to read laminated format to aid their understanding. People's needs in this area were met.

People were provided with a programme of activities, which ran across the full week including the weekends. Some of the activities were run internally by the activity co-ordinator and staff, whilst others involved entertainers or external trips. Activities reflected the time of the year and this month included a Christmas cake competition, a Christmas party for people and a visit to the local pantomime. Staff had contacted a charity to set up a regular external social activity for a person. Peoples' religious denomination was documented and whether they were active in attending services. A church service was held at the service on a monthly basis. People's needs for social and spiritual stimulation were identified and had been met.

Staff were able to describe their role in supporting people to make a complaint if they wished. People were provided with information about how to make a complaint within the service user guide. The process set out, how to make a verbal or written complaint and the process by which their complaint would be processed. There were also details of how to progress the complaint in the event the person did not feel that it had been resolved to their satisfaction. No written complaints had been received since the last inspection, so we could not assess how effectively they had been managed.

Some people had an advanced care plan in place within their records; this is a process of discussion between the person and staff to make clear the person's wishes in the context of an anticipated deterioration in their condition in the future. If a person had an advance decision sometimes known as a living will refusing a specific type of treatment at some time in the future, then a copy of this was on the person's file to ensure their wishes were known and could be respected. People had a do not attempt cardiopulmonary resuscitation form in place where this intervention would not be successful. Either the person or where they lacked the capacity to understand the decision, relevant others had been informed as required. Staff had not undertaken any palliative care training yet; although the head of care told us this was an area they wanted staff to undertake training in. Palliative care is the care provided for people living with a terminal illness where a cure is no longer possible or at the end of their life. A palliative care nurse told us they had been happy with the care provided to people at the end of their life when they had visited the service.

Inadequate

Is the service well-led?

Our findings

People told us the service was well-led. Although people did not seem very familiar with the managers, one person said, "I can't think of anything against them. They're very willing. They give you plenty of written information."

At our previous inspection in May 2017, we found the systems in place to assess monitor and mitigate risks to people's health and safety, failed to identify issues that required improvement and where people may as a result be at increased risk. Planned improvements had not been implemented or sustained. We found the provider was in continuing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. A range of checks upon the quality and safety of the service were completed on a daily, weekly and monthly basis, in addition to audits against specific regulations of the Health and Social Care Act. Some were effective and others required further work to embed them and to make them fully effective.

Daily checks were completed, to ensure staff had signed people's medicine administration records and checks were made upon people's potential pressure areas and on the correct working of pressure relieving mattresses. The storage of medicines had been audited, to ensure this was safe. Maintenance safety checks were completed. Management completed a daily walk around the service. Records showed that when issues had been identified during the walk around they had been addressed with staff. Audits were completed in relation to infection control and the use of personal protective equipment by staff to ensure the risks of acquiring an infection were managed for people. The provider visited the service monthly and records showed that where they had identified issues they had addressed them for people.

However, not all audits were fully effective. Staff's completion of the monthly medicines audit had lapsed; the new head of care told us they would be reinstating it with effect from December 2017. This audit had not been embedded in practice over time as required. The staff recruitment audit had not been fully effective at addressing identified gaps in longer-term staff records. There was an electronic call bell system but no audits were completed to demonstrate how long people had to wait before they were responded to. Although no one raised the length of call bell responses as an issue with us, this would have provided a measure of the quality of care in this area.

Where issues were identified, it was not always clear that identified actions had actually been completed. An audit of Regulation 9 of the Health and Social Care Act completed on 13 June 2017 identified that that all policies needed to be reviewed, adapted to the service and put in a folder for staff within four weeks. However, we found at this inspection that the recruitment policy was missing, the medicines policy had not been tailored to the service and not all staff had read the policies as required. Although evidence was provided following the inspection that the recruitment policy had been located, this should have been to hand for staff's use. Evidence was provided that staff had begun to read and sign the policies but this work was not yet complete. A housekeeping check completed in October 2017 showed that an unidentified

bedroom needed a new radiator cover as soon as possible. There was a lack of written evidence to demonstrate if this work was completed and if so when. The head of care was not able to tell us if this work had been completed. An audit of Regulation 12 of the Health and Social Care Act in November 2017 identified that not all staff had been trained in completing risk assessments; there was no evidence that this training had yet been arranged for staff and the head of care did not think this training had yet been arranged.

Although there was a record, of the falls, people sustained each month and actions were taken to ensure each person's safety there lacked an overall written analysis of the data gathered, in order to demonstrate that either there were no overarching trends across the month, or longer term, or that any trends such as in the time of falls had been identified and addressed for people. The data gathered needed to be more robustly analysed in order to be able to demonstrate it was being used effectively to improve the service for people. There was a monthly record of safeguarding's raised, but again there was a lack of evidence to demonstrate that there had been any analysis of the data gathered, in terms of any emerging trends for people.

A customer survey had been circulated in July 2017 and a staff survey in November 2017, however there was no analysis of the results or evidence that either survey had been used to improve the service for people. For example, a person had indicated they were only, 'fairly satisfied' with the halls, corridor and bathroom, another person had indicated they were, 'not very satisfied' with the parking. A relative had written on the survey that they wanted their loved ones hair brushed daily and staff to ensure the person had their walking stick. There was no written evidence that any of these issues had either been identified or addressed. The staff survey showed that three staff were, 'not very satisfied' in relation to either whether they felt spoken to respectfully by other staff nor with the management of the service. There was no evidence that any of these issues had been either identified or addressed.

The failure to operate fully robust and effective systems to assess, monitor and improve the quality of the service provided was a continuing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all notifications of reportable incidents had been submitted to CQC as required. We noted that since the last inspection four medicine errors had been correctly reported to the local authority under safeguarding procedures, however, CQC had not received a statutory notification for any of them as required to keep us informed of these submissions.

The failure to report any abuse or allegation of abuse of a person without delay was a new breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. There was not a manager registered with CQC to manage the service. There had been an interim manager in post managing the service from June 2017 to the end of November 2017, however, they had now left. Staff and professionals spoken with felt significant improvements had been made to the service for the benefit of people under the interim manager's leadership, but there were anxieties both about the future leadership of the service and ensuring consistency. One staff member commented, "We are without a manager again." An assistant manager, head of care and senior care staff, all of whom remain in post, had supported the interim manager in their role. In order to build on the improvements made to date, the service requires clear, strong, consistent leadership to take it forward. Staff told us they had not been informed of the current management arrangements for the service. On the day of the inspection, the assistant manager was not available and the head of care was in charge.

The provider currently has a condition in place upon their registration, which requires them to provide CQC with monthly updates on their audits; which they have provided. This condition remains in place and enables CQC to have monthly oversight of progress within the service.

The aims and objectives of the service were set out in the providers Statement of Purpose. They aimed to provide, long-term, respite care and day care to people aged over 65 years of age. They aimed to promote a high standard of care and understanding of peoples' needs whilst respecting people's privacy and promoting their dignity. There was a lack of evidence to demonstrate how staff learnt about the provider's purpose and values. However, all staff were observed to be kind and caring towards the people they cared for. Staff told us there had been a lot of changes in terms of what was expected from them. The staff meeting of 6 October 2017 set out the expectations of staff and their responsibilities. Further work is required to ensure staff receive instruction on the provider's purpose and values.

Staff told us there were staff and resident meetings; however, we were unable to locate any minutes of these meetings during the inspection. Following the inspection, the provider supplied records for the residents meeting which took place on 6 November 2017 and staff meetings. All residents attended the residents' meeting. People were asked for their feedback and a number of issues were raised including: needing more parking, a hairdresser, more heating in the Oak Lounge, a visiting dentist, a newsletter and family social evenings. The follow up date agreed at the meeting was 4 December 2017. Although the head of care told us arrangements were in hand for a staff member to provide hairdressing, there was a lack of evidence to demonstrate that all of the required actions had all been followed up as agreed. There were processes to engage people and staff. However, there was not always clear written evidence of how peoples' feedback had been acted upon.

The service has worked closely with both the clinical commissioning group and social services quality assurance teams in order to address the areas of improvement required from the previous two inspections. They continue to receive a significant level of direct input and support from the clinical lead for quality in care homes, which we understand, will be extended until the new manager is in post. However, the service needs to be able to demonstrate in the longer term their resilience and capacity to embed the changes made to date and to manage without reliance on this continuing support.

At this inspection, we found that the provider had acted on the risks and shortfalls that had been previously identified. Whilst we recognised that improvements were being made to the service's systems and processes for maintaining standards and improving the service, many of the changes were still a work in progress and have not yet been sustained in the longer term to be fully embedded in practice. The improvements that have already been made will need to be sustained to demonstrate that the service has improved and continues to do so without the additional provider support and oversight and any increase in placements at the service. At the time of this inspection the service was just under 50% occupied. It is too early to state that the improvements are sustainable.

The service has been looking outwards and has sought to work closely with external healthcare professionals. Staff have worked proactively with the diabetes nurse regarding ensuring a person received safe and effective care for their diabetes. The diabetes nurse was also in the process of setting up a training session at the service in the New Year to be attended by staff both from the service and other services. This demonstrated staff's willingness to work in partnership with professionals.

The service was participating in the 'Red bag' initiative in conjunction with the local clinical commissioning group and national guidance. This scheme is where a red bag is used to transfer paperwork, medication and personal belongings when a person is admitted to hospital and stays with the person before being returned

home with them. Staff were working with other providers to improve people's experience of hospital admission.

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 18 Registration Regulations 2009 Notifications of other incidents The failure to inform CQC of any abuse or allegation of abuse of a person without delay was a new breach Regulation 18 (1)(2)(e) of the (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider's failure to ensure all aspects of the premises met health and safety legislative requirements was a new breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to operate fully robust and effective systems to assess, monitor and improve the quality of the service provided was a continuing breach of Regulation 17 (1)(2)(a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to protect people by ensuring that all of the evidence required within schedule 3

was a continuing breach of Regulation 19 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.