East Anglia Care Homes Limited

Halvergate House

Inspection report

58 Yarmouth Road
North Walsham
Norfolk
NR28 9AU
Tel: 01692 500100
Website: www.eachltd.co.uk

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was carried out on 3 and 11 November and was unannounced.

Halvergate House is registered to provide accommodation and support to a maximum of 50 people, some of whom also require nursing care. At the time of our inspection there were 32 people living in the home.

The manager had been in post since August 2015 and had submitted an application to become registered with the Care Quality Commission (CQC). We saw that this was currently being processed by CQC's registration team. A registered manager is a person who has registered with CQC 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 and associated Regulations about how the service is run.

At our last inspection on 13 October 2014, we asked the provider to take action to make improvements to staffing

Summary of findings

levels and deployment, meeting people's nutrition and hydration needs and to their systems for monitoring the service. During this inspection we saw that action had been taken and improvements had been made.

We also asked the provider to take action to make improvements to ensure staff treated people with dignity and respect. During this inspection we found that further improvements were still required.

This inspection identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the Mental Capacity Act and the appropriate application of Deprivation of Liberty Safeguards. There were also breaches relating to people's dignity and respect and record keeping.

Improvements had been made to the consistency of staffing levels and we found more appropriate deployment of staff. There were sufficient staff to meet people's needs and ensure their safety. Appropriate recruitment procedures were followed before people started working in the home, although there were gaps in some people's employment history.

Nurses and senior staff understood what constituted a safeguarding issue and knew how to contact the safeguarding team when necessary. Other care staff had received training on this subject, knew how to recognise signs of possible abuse and understood they needed to alert senior staff promptly.

Identified risks to people's safety were recorded on an individual basis, with guidance available for staff to refer to so they could support people safely and effectively.

Nurses and senior staff were proficient with regard to the safe handling and administration of people's medication and people were given their medication safely, as prescribed.

Staff were being supported well, although formal staff supervisions had not been carried out for many months. Annual appraisals had been completed by the previous manager.

Staff completed basic and mandatory training during their formal induction. Some of the junior staff were lacking in some basic training, with regard to fully respecting people and understanding how to interact and communicate effectively.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. These safeguards protect the rights of adults using the services by ensuring that, if there are restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is needed.

Not all staff had a clear understanding of the Mental Capacity Act. Best Interests assessments and applications for DoLS had not yet been completed for some people who were subject to some restrictions and whose capacity was in question.

People were provided with sufficient amounts to eat and drink and increased staffing levels meant that people were being supported more appropriately with regard to eating and drinking. People's weights were monitored, together with their intake of food and drink, although there were gaps in some people's food and fluid charts.

Prompt action and timely referrals were made to relevant healthcare professionals when any needs or concerns were identified.

Staff generally treated people kindly but they did not always knock on people's bedroom doors before entering and some staff did not acknowledge people or speak to them before moving them or carrying out a personal task.

Volunteers visited people in the home and people had access to support from independent advocacy services if needed. People could have visitors at any time.

Meaningful activities and social interactions had been limited for some people, due to the absence of the full time activities coordinator. However, people who were more physically able or independent had continued to follow pastimes of their choice.

Assessments were completed prior to admission, to ensure people's needs could be met and people were actively involved in compiling their care plans. However, although the contents of the care plans were personalised and gave a general description of each person's needs, they were difficult to follow and it was not easy to locate specific information quickly.

People were able to voice their concerns or make a complaint if needed and were listened to with appropriate responses and action taken where possible.

Summary of findings

Consistency and communication had improved throughout the service. The manager was 'hands on' and approachable and operated an open door policy. Staff meetings and 'Resident and Relatives' meetings were being held more often.

We found that a number of improvements had been made within the service. Other areas were noted to be 'work-in-progress' and since the appointment of the new manager, areas of concern were being addressed appropriately.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff to meet people's needs and ensure their safety. Appropriate recruitment procedures were followed, although there were gaps in some people's employment history.

Nurses and senior staff understood what constituted a safeguarding issue and knew how to contact the safeguarding team when necessary. Staff had received training on this subject and knew how to recognise signs of possible abuse.

Identified risks to people's safety were recorded on an individual basis, with guidance for staff to be able to know how to support people safely and effectively.

Medication was handled, stored and administered safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff were being supported well, although formal staff supervisions had not been carried out for many months. Some staff required additional training regarding respecting people and understanding how to interact and communicate effectively.

Not all staff had a clear understanding of the Mental Capacity Act. Best Interests assessments and applications for DoLS had not yet been completed for some people who were subject to some restrictions and whose capacity was in question.

People were provided with sufficient amounts to eat and drink, although there were gaps in some people's food and fluid charts.

Prompt action and timely referrals were made to relevant healthcare professionals when any needs or concerns were identified.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some staff demonstrated a lack of understanding about the need to engage with people in an appropriate way and staff did not always treat people with dignity and respect.

Summary of findings

Volunteers visited people in the home and people had access to support from independent advocacy services if needed. People could have visitors at any time.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not consistently supported to undertake meaningful activities or engage in social interaction.

Assessments were completed prior to admission, to ensure people's needs could be met and people were actively involved in compiling their care plans. However, care plans were difficult to follow and it was not easy to locate specific information quickly.

People were able to voice their concerns or make a complaint if needed.

Is the service well-led?

Requires improvement

The service was not yet consistently well led.

Some of the previously required remedial action had been completed but some areas were still work in progress.

At the time of this inspection, the manager's application to become registered with the Care Quality Commission had been submitted and was being processed.

Consistency and communication was much better throughout the service. Staff meetings and 'Resident and Relatives' meetings were being held more often.

Halvergate House

Detailed findings

Background to this inspection

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

This inspection was carried out by four inspectors on 3 and 11 November 2015 and was unannounced.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the provider's action plan that had been sent to us in April 2015.

During this inspection we met and spoke with 11 people living in the home two relatives, a person's friend, a volunteer and the visiting neurological nurse. In addition, we spoke with the provider, the manager and two other members of the provider's management team. We also spoke with the Nurse in Charge and seven members of care staff, including seniors.

Some people were living with dementia and not able to tell us in detail about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care records for seven people and a selection of medical and health related records.

We also looked at the records for five members of staff in respect of training, supervision, appraisals and recruitment and a selection of records that related to the management and day to day running of the service.

Good

Is the service safe?

Our findings

Our previous inspection of October 2014 identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that there were not always enough staff to meet people's needs or to keep them safe.

During this inspection we saw that improvements had been made to the consistency of staffing levels and the staff were more appropriately deployed. We determined that there were sufficient staff to meet people's needs and ensure their safety and concluded that the provider was no longer in breach of this regulation.

People told us they felt there were enough staff on duty to meet their needs. One person said, "It's a lot better now, there are more staff around." Another person's relative said, "There is now plenty of staff." A person who was visiting a friend at the service also agreed with this comment.

We saw from our observations and copies of the rotas that staffing levels had been increased since our last inspection. As a result, we saw that people's needs were being met in a more timely way. For example, staff were able to spend time with people without rushing and call bells were being answered more promptly.

The manager also informed us of a proposed restructure to further improve staff deployment. It was explained to us that there would be two registered nurses on each shift and seniors would be replaced by 'Healthcare Leads'. This would ensure that qualified clinical staff were more readily available to meet people's healthcare needs.

The manager also explained that he chose to work a couple of shifts per week as the 'Nurse in Charge' in order to oversee the day to day provision of care in the home. He told us that this helped enable him to identify and address any issues more quickly. We were satisfied that appropriate measures were in place to ensure any managerial demands continued to be met during the times that the manager was working a care shift.

Three members of staff we spoke with told us that there had been issues with staffing levels but that these were being addressed and things were improving. They also told us that recruitment of additional care staff was ongoing.

The recruitment files we looked at were mostly in good order but we found that some information was lacking, such as recent photographs and there were gaps in some people's employment history. For one member of staff there was no employment history, or explanation for the gap, for a nine year period. This meant that the provider would not be able to thoroughly check the person's suitability to work in a health and social care environment.

People we spoke with told us they felt safe living in the home. One person told us that they were totally reliant on the staff for support and would say something straight away if they didn't feel safe.

Senior staff and nurses showed a good understanding of keeping people safe, as well as how and who to report safeguarding concerns and incidents to. Three members of staff told us that they knew where to find the phone number if they needed to contact the local safeguarding authority.

Some of the junior care staff lacked confidence and full understanding of what constituted a safeguarding concern but they did say that they would report any concerns to the senior staff, nurses or manager without delay. All the staff we spoke with said they would 'whistle blow' if necessary.

We saw that any bruises, cuts or scratches were being recorded appropriately on body maps in people's care plans, which were kept in the nurses' office. The causes of these were also seen to be recorded or investigated where necessary.

Risks for people were being identified and managed appropriately. Risk assessments had been completed for people covering areas such as falls, pressure areas, choking, mobility and the use of bed rails. Some of these assessments were maintained in the care plans in people's rooms, whilst others could be found in the care records that were stored in the nurses' office. This meant that, although staff knew where to find the information relating to the support people required, it was not always readily available to all staff.

One person's care plan included an assessment to cover the risk of the person falling from their bed. We saw that, as this person did not want bed rails in place, the guidance for staff was that the bed should be lowered as much as possible when the person was in it. This reduced the risk of injury for the person, whilst still respecting their wishes.

Medication was managed, recorded and administered safely. The Nurse in Charge explained that although the

Good

Is the service safe?

registered nurses remained accountable, senior staff had been trained to administer people's medication, with the exception of insulin and a few medicines requiring specific administration methods. We also discussed the medication procedures with this person and looked at the method of storage which were found to be satisfactory.

We saw that medication was kept in a locked, designated medication room, which was clean and tidy. The fridge and room temperatures had been recorded daily and showed they were within the safe limits for storage. The controlled drugs cabinet was locked and we checked the register against one person's name picked at random. The tablets were counted out and the number corresponded with the number recorded in the controlled drugs register.

People with patches for pain relief had body maps held in the medication storage room, showing on each application where the patch had been placed on the body. All the daily medication was locked in two trolleys and also stored, when not in use, in the designated medication room.

Returns and disposals of medication were recorded in a separate book with a designated container in the locked room for all unused medication. We were told that medication audits were carried out monthly by the manager.

We observed the senior carer in one dining area administering the lunchtime medication and saw that this was carried out safely. Liquid medication was poured at eye level to ensure the correct dosage was given and tablets were pierced into pots and offered to people on a spoon, so they were not touched. The senior member of care staff watched to ensure people had taken their medication properly, before signing the medication administration records.

Requires improvement

Is the service effective?

Our findings

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.

We were told that only one person was currently subject to DoLS. We looked at this person's documentation and saw that the principles of the DoLS had been followed and that the application had been made in accordance with these principles. This ensured that any restrictions made to the person's freedom had been properly considered.

However, we identified that some other people were also subject to some restrictions but best interests assessments and applications for DoLS had not yet been completed. For example, some people had bed rails in place but it was unclear if or how they had consented to this. One person told us that they didn't really want the bed rails because it meant they could no longer get up and go to the toilet independently. Although this person said they had agreed to the bed rails being in place, following a recent fall, their care records reflected this as more of a decision by staff rather than through an appropriate best interests assessment and discussion.

We also noted from the care records we looked at that capacity assessments for people had not always been completed, where their capacity to consent was in question. For example, some people with dementia were unable to make informed decisions for themselves regarding all aspects of their care and treatment. Some people also had complex communication methods and it was unclear from their care records whether some of these people had capacity or not.

Staff told us that although they attended training and refresher courses, they had not received specific training on the MCA and did not have a clear understanding of how the Act affected how they went about their work. The manager confirmed that plans were in place to provide staff with more effective training regarding MCA and DoLS.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of October 2014 identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that people's nutritional and hydration needs were not always being met in a timely manner.

During this inspection we saw that people were provided with sufficient amounts to eat and drink. In addition, increased staffing levels meant that people were being supported more appropriately with regard to eating and drinking. We determined that improvements had been made and concluded that whilst the provider was no longer breaching this regulation, there were still some areas that would benefit from further improvements.

For example, during the lunch period, we saw a member of care staff use one tin of thickener to thicken five different people's drinks. We heard this member of staff ask one person, "Is it two scoops you have?" However, when reading the labels on some other tins that were stored away, we saw that they were all individually named and varying amounts of thickener were prescribed for each person. This meant that if people were given thickener from their own tins, they would be more assured of receiving drinks to the consistency recommended for them. The manager assured us that they would follow this up with staff to make sure people were given their thickener as prescribed.

We saw that risk assessments were in place for people regarding eating and drinking and records were being completed on the amounts consumed. However, we noted that there were gaps in some people's food and fluid charts.

Requires improvement

Is the service effective?

We observed that one person, with severe swallowing problems, had their liquids thickened but drank very little at lunchtime. We spoke with a member of staff about this but they said they were unsure of what the most suitable intake of fluid was to ensure hydration for this person. The records in the person's nutrition and fluids care plan stated that they should receive one and a half litres per day but only 700mls had been recorded as consumed for the day prior to this inspection. There was no follow up noted in the person's records for this apparent shortfall in fluid intake.

However, when we reviewed additional information for this person and spoke with a more senior member of staff, it was evident that this was an issue regarding record keeping and that the person was being supported to drink sufficient amounts.

One person we spoke with told us, "The food does vary, it's sometimes not all that great and there's often not enough; but you can ask for more though."

This person required full assistance from staff for eating and drinking and they told us that they were never left for long after being served with food or drink, before being supported to consume it. They said, "Staff normally come quickly – or I can ring and they come straight away. I don't have to wait when I ring the bell." We saw this to be the case during our inspection. A member of the kitchen staff brought the person a cup of tea and some apple slices and a member of care staff came to the room within a few minutes to support the person to eat and drink.

While we were speaking with another person, a member of staff brought their lunch to their room. The staff member asked if they wanted any assistance with eating it, to which the person replied that they did. This person told us, "I said I could do it myself the other day, but then found I couldn't manage – that's why they help me now." We noted that both the main meal and the dessert were of a pureed consistency. The person asked what the main meal was and the member of staff said it was broccoli and cauliflower cheese. The person acknowledged this with a smile and appeared happy to eat it. The person told us that although they were asked what they wanted to eat, they often couldn't remember what they had chosen.

Throughout the day we saw that people were offered regular drinks and snacks. We noted that one person, who only ate a little at lunchtime, had eaten a cake at 11am and also had another pudding at 3pm so was eating little and often.

Staff said they felt the care team worked well together and was supportive. They also said they felt supported by the new manager. Formal one-to-one staff supervisions had not been carried out for many months, although the manager told us that group supervisions were taking place, whilst they were establishing the new staffing structure and that general support was constantly available. Staff told us that annual appraisals had been completed by the previous manager.

One new staff member was shadowing their shift and said that they felt they were being supported well in the process of getting to know the job.

Staff completed basic and mandatory training during their formal induction and new staff were currently completing the Care Certificate. This certificate aims to equip health and social care support workers with the knowledge and skills they need to provide safe and compassionate care. However, we noted that some of the junior staff appeared to be lacking in some basic skills, particularly with regard to fully respecting people and understanding how to interact and communicate effectively. For example, not speaking with people before undertaking a task with them.

The manager told us that they were working on implementing a training audit tool, to be able to more quickly identify staff training needs and address any shortfalls. They also told us that by working care shifts, they were able to pick up on and take action to improve any areas of poor practice more promptly and effectively. In addition, the manager also told us how their ongoing recruitment drive would help enable them to 'overstaff' the rotas on a regular basis, to ensure staff could more frequently attend training sessions as needed.

We observed the handover that was completed in the nurse's office at 2pm. We noted that each person was discussed in detail, although the details were mostly focused on the clinical needs of each person. It was clear the nurses and staff knew each person well but little information was shared about supporting people with their social wellbeing.

Requires improvement

Is the service effective?

People had regular access to external healthcare professionals. We received positive feedback regarding improvements in the way the service worked with healthcare professionals to provide good outcomes for people.

One person told us, "I had a pressure sore on my foot which was nearly healed but then it got worse again. It's been dealt with since and it's almost healed again."

Another person told us that they liked to read but needed to get their eyes tested. They said, "I can make an appointment for someone to come and see me here because the optician does come to the home."

We noted that the GP had a regular surgery each Thursday in the home. Dieticians and speech and language therapists also visited regularly and we saw a speech and language therapist completing assessments with people on the day of this inspection. This demonstrated that appropriate referrals and follow up action was taken for identified risks to people's welfare.

A neurological nurse said that the home had improved in recent weeks and told us that staff now had more time to discuss issues with them. They also told us that they were kept fully informed of progress by telephone and that staff followed the action required for people's wellbeing. The nurse said that staff recognised changes in people's health and wellbeing and quickly reported any concerns appropriately.

The nurse gave us an example of one person with Parkinson's disease who had been unresponsive prior to admission to the home. They told us how the work within the home and the recommended action applied, meant this person had improved and was now responding in a more positive way. They also told us that people's families were fully involved in the decision making processes and that their views were listened to. We heard another nurse talking with a family member about the benefits of PEG (Percutaneous Endoscopic Gastrostomy) feeding (this is often used when a person has difficulties swallowing), and the respect and consideration given to the relative's feelings and concerns were evident.

Requires improvement

Is the service caring?

Our findings

Our previous inspection of October 2014 identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that people were not always treated with dignity and respect.

During this inspection we acknowledged that some improvements had been made since the appointment of the new manager and we were informed that further improvements were planned. However, the provider had not yet taken sufficient action and we found that they were still in breach of this regulation.

Although we saw that senior staff and nurses generally treated people with dignity and respect, we saw a number of examples of staff providing care and support in a way that was not dignified or respectful.

Some staff did not knock on people's bedroom doors before entering and some did not acknowledge people or speak with them before moving them or carrying out a personal task. Some staff were also very task focused and passed by people on a number of occasions without acknowledging or interacting with them.

For example, one member of staff was seen entering someone's room without knocking because they believed the room was empty but the person was in fact in there. Whilst we were speaking with another person in their room, a member of staff brought a drink in but did not knock and, a few minutes later, another member of staff just walked in without knocking. A nurse had been to see this person earlier and did knock before entering.

We observed a member of care staff looking at a person who lived in the home but they did not respond to mucous running from their nose, which was detrimental to the person's dignity and self-respect.

We observed one person sitting by themselves in a communal area throughout the day. Many members of staff walked past the person but very few gave any verbal or visual signs of acknowledgement or support.

During meal and snack times, we noted that there was little or no conversation or stimulus offered to people. For example, while supporting one person to eat, we saw a member of staff just holding a spoon of food to the person's mouth, without talking to the person. On another occasion, a member of staff was observed putting additional food into a person's mouth, while they were still chewing their previous portion. 'Childlike' language was also sometimes heard being used by staff, to encourage people to eat.

People were not always given the choice with regard to wearing protective aprons during mealtimes. We saw that one person appeared unhappy, by way of their facial expression, for the apron to be placed on them and the care staff did not talk with the person about doing this. Another member of staff gave a person an apron to wear while they were eating. However this person did not want the apron and glared at the member of staff saying, "I don't want that!" The member of staff then left it on the table in case the person changed their mind.

We observed a member of staff moving someone away in their wheelchair, without first saying that they were taking them to another room, why they wished to do this or sought their agreement. We also saw a similar incident near the visitor's signing in book, where a person was moved backwards in their electric wheelchair by staff, because they were in the way. The member of staff did not explain what they were doing or hold any conversation with the person, until after they had already moved the person.

One person was having bed rest with their television on but staff had placed their large reclining chair directly in front of the screen so it could not be seen. Another person had their radio on that was not tuned in properly and was making static noises. A member of care staff who was in the room with the person did not notice this until we drew their attention to the issue.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager about our observations, who assured us that this was an area in which they had already begun taking steps to improve. For example, providing staff with further training in dignity and clearer guidance for staff to understand how to deliver 'person centred care'. The manager said he believed that the new staffing structure, with healthcare leads 'leading by example' would further

Is the service caring?

help to drive improvement. The manager also said that they felt the previous lack of clear leadership in the home and staff shortages had resulted in staff becoming 'task focused' rather than 'person centred'.

One particular improvement we noted was that the manager had stopped staff from using their personal mobile telephones whilst on duty, as they had identified it as being disrespectful and having a detrimental impact on the people being supported.

We did see some examples of compassionate care and people we spoke with said, of the staff, "Lovely", "Very pleasant", and, "Very dedicated".

One person said of one particular member of care staff, "If they were all like [Name], this place would be perfect. [Name] is brilliant! [Name] knows exactly what they're doing and always does all my care spot-on!" Another person told us, "The girls are all lovely and look after me."

We saw some letters of compliment and gratitude from people who had either stayed in the home themselves or whose relatives had lived there. One person was very complimentary about the care they had received and had promised to write to the Care Quality Commission to tell us about this. Another person said that they couldn't thank the home enough for the time and care provided for their relative.

We observed one member of care staff speaking gently and engaging at eye level with someone who could not communicate verbally, resting their hand on their arm. We noted that this person moved closer to the carer, smiling. We also heard another member of care staff explaining to someone about their medication and why they needed to take it; reassuring the person and waiting to make sure they were okay. A member of care staff told us, "To come here is not an end of someone's life but a continuation of it – it needs to be positive."

We were told that since the staffing levels had improved, there had been a positive impact on the care people living in the home received. One relative said, "The home was dreadful six months ago." This person told us that the family had been considering moving their relative but due to the improvements made they would now 'wait and see' what happened.

People we spoke with told us that they were fully involved in planning their care. For example, one person relied on staff totally to support them with all the physical aspects of their daily living but they were very clear about the way in which they wanted their personal care and support delivered. They said that staff provided their care and support in the way they had specified and that they were fully involved in any changes and the decision making processes.

Another person we spoke with gave us a detailed history of their previous working life and talked about how they came to move to Halvergate House. This person said they liked to speak with staff when they were passing their room and we observed that there was a lot of engagement as staff walked past. We observed a member of care staff come into the person's room to administer some medication and noted affection and positive interactions between the two people.

This person also spoke very positively about a volunteer who visited and supported them to pursue one of their hobbies. We also noted that other volunteers frequently visited the home and engaged with people with activities such as a game of dominoes. The manager told us that people were supported as needed to access support from independent advocacy services.

People we spoke with who were living in the home told us that they could have visitors at any time and people's friends and relatives told us that they felt welcome when they visited.

Requires improvement

Is the service responsive?

Our findings

Although people had care plans in place, these were not always easily accessible for all the staff providing care for people. Some records were incomplete, some were missing information and some were out of date.

For example, people's care documentation was predominantly divided into two main areas. One care plan was kept in each person's own room and contained information such as some risk assessments, daily records and details of the person's general care and support needs. More detailed and clinical information, such as pre-admission assessments, additional risk assessments, medical assessments, body maps and nursing notes were stored in the nurses' office.

The contents of the care plans were personalised and gave a general description of each person's needs, but we found they were difficult to follow and it was not easy to locate specific information quickly. Many of the care folders we looked at in people's rooms had loose pages and no clear indexing system. Specific care information was hand written on green paper, which was difficult to read and various topics were filed together in one section. For example, specific information regarding a person's mobility support requirements was stored together on the same coloured paper as the information regarding their personal care needs. This meant that clear guidance for staff to know how to support someone according to their individual needs, could not be found quickly or easily.

One person we met and spoke with required full assistance to eat and drink. However, we could not find specific guidance in their care plan to clarify what level of support this person needed. For example, although their night care plan stated that they needed help with their night time drink, the daily 'care plan activity' only stated to ensure a drink was to hand. There was no clear guidance to indicate the level of the person's independence or dependence or whether a particular design of cutlery or crockery would help enhance or maintain their independence.

At the front of the care plans that were stored in people's rooms, we saw that there was a 'care plan activity' sheet, which gave a snap shot of the care required, together with tick boxes for bowel movements and care staff or nurse accountability charts. However, we noted that these were not always updated as changes occurred and there were some gaps in the accountability charts. This meant that we could not be sure whether the person was receiving the care and support that met their current requirements.

One person had not had an air flow mattress since 17 September 2015, as they had stated that they 'did not like the noise'. As a result, this had been replaced with another mattress that did not require the same checks. Staff had recorded 'N/A' on the daily recording chart but the 'care plan activity' showed that checks for the air flow mattress were still required.

Although one person had clear information and positive recording regarding their catheter care and skin integrity, other records to show that care had been given were incomplete. For example, this person's records showed that they required some nursing intervention three days per week but on the week commencing 17 September, there were no signatures at all and on the week commencing 14 September, there were signatures for two days only. This meant that the manager could not be assured that people were receiving proper care by looking at the records. We were told that some staff didn't always remember to complete these records, as they had only recently been implemented and the manager said that this was another area that he was striving to improve on.

These concerns constituted a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments were completed for each person, prior to admission, to ensure their needs could be met within the home. We noted that these assessments were used to form the basis of people's care plans and risk assessments, before they moved in.

However, we noted that information that could help staff to support people with their preferences, social interests and activities, such as personal histories, hobbies and lifestyles was very limited for some people. This information would be particularly important for people who were unable to communicate verbally or were living with dementia, as it could help enable care staff interact with people in a more person centred and meaningful way.

One person, who could not communicate verbally, had a loose piece of paper in their care records regarding their social needs, which said they liked music and that their spouse visited regularly. One particular detail we saw in

Requires improvement

Is the service responsive?

their records was that they liked to lie and face the window when they were offered bed rest. However, the way in which we saw this person's bed was positioned, meant that this was not possible.

We saw that the general support for people, provided by care staff was still very task focused rather than being person centred, i.e. identifying with and acknowledging the person they were doing the task with or for. We had no concerns regarding the clinical care provided for people and saw that this was 'person specific' and individual to each person's needs.

On the first day of our inspection we acknowledged that the full time activities coordinator had been away for some time on sick leave. However, the part time activities person and some of the care staff needed some additional support, guidance and training in awareness of people's individual environments and understanding meaningful activities and positive interactions.

We heard staff speaking with some of the people in the communal lounge, although we noted that the conversations mostly revolved around general issues such as lunchtime. This did not demonstrate that staff had knowledge or understanding of people's individual interests.

The only organised social activity we observed on the first day of our inspection, was with a volunteer who came to play dominoes with a few people in the Tunstall lounge. Care staff did not seem aware of the lack of stimulation for people not wishing or able to join in. For example one person was left in the middle of the dining area of the Tunstall lounge, in their wheelchair, with nothing to do. This person was there for at least 15 minutes until we intervened.

We also noted that the television in this lounge was turned on but at a very low level. Another television down the corridor was on the same channel but broadcasting at a different frequency, such as satellite. This meant that there was an echo in the Tunstall Lounge, making it more difficult to hear the television properly. In addition, some people were seated in a position that was lower than the television's level and therefore couldn't see it properly if they wanted to.

On the second day of our inspection the manager confirmed that the full time activities coordinator had returned to work and that more structured and engaging activities had recommenced with people living in the home. The manager also told us that additional training for the part time activities person and other care staff was being arranged.

Meanwhile, one person we spent time speaking with told us how they enjoyed playing the organ and we observed them doing this in the Tunstall lounge after lunch. We looked at the person's care records and saw that although their personal history was limited in detail, it was well documented and matched what the person had told us about themselves. This person also told us about the regular visitors that came to see them, whose company they enjoyed very much. We also noted that this person's faith was very important to them and that staff were aware of this and respected the person's views.

During the first day of our inspection, one person told us that they had plans to start going out alone again when they were 'feeling better'. They explained that they had been a bit too unsteady on their feet recently. The person pointed to a wheelchair and two walking frames (one with a seat), which they told us they used around the home and said that they tried to have a walk around on most days. In addition, near to this person's room was an electric scooter, which they told us they used for going out into town.

Staff told us that the fireworks party at the home had gone very well and had been very much enjoyed by people living in the home, their friends and relatives.

We noted that there was a copy of the complaints procedure on display in the front foyer and further information was contained within the home's statement of purpose and service user guide.

People we spoke with told us they would talk to staff if they had any concerns and that they believed they would be listened to and that the necessary action would be taken. Everyone we spoke with told us they were happy in the home and were positive about living there. People's relatives told us they knew how to make a complaint when needed and one relative said that they felt more confident about doing this now, since the new manager had been in post.

Requires improvement

Is the service well-led?

Our findings

Our previous inspection of October 2014 identified a breach of Regulation 17(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that systems and process were not in place to effectively monitor risks and the quality of service provided to continually evaluate and improve the service. The views of staff were also not routinely sought to help improve the service.

During this inspection we determined that improvements had been made and concluded that this was no longer a breach. However, there were still some areas that required ongoing improvements, or improvements to be completed, in order to ensure compliance was sustained.

We noted that more effective systems to audit, monitor and evaluate the quality of the service had been implemented and we saw that the manager was taking steps to ensure appropriate follow up action was taken. For example, the manager explained that senior staff had begun auditing people's care plans on a monthly basis and that the manager was completing an overall audit, on alternate months, for each of the main house and the Tunstall unit.

We were also told that people living in the home and their relatives, were involved in reviews of their care. Where privately funded residents did not have input from social services, six monthly reviews of their care were being organised by the home. The manager also confirmed that any best interests' discussions involved people living in the home, as well as their family and relevant healthcare professionals.

Accidents and incidents were being reviewed and audited more effectively. We looked at the findings from the previous month and saw that a trend had been identified during the late shift. Action had been taken as a result and the manager told us that there had been a marked reduction in incidents as a result.

Medication audits were being carried out by the nursing staff on a continual basis and we noted that there were very few errors and no areas of concern were identified during this inspection.

The manager showed us the audits regarding pressure areas and skin care and told us that this area was being managed well, with good observations being carried out by the nurses and senior staff. Timely referrals were being made and appropriate action was being taken, where the risk of a person acquiring pressure sores had increased.

We also noted that corporate audits were being carried out by another member of the provider's management team, in order to identify any areas that required action to be taken and help to ensure the necessary improvements were made accordingly. The internal audit carried out in October 2015 had highlighted some areas that required remedial action to be taken and the manager confirmed that some action had since been completed, whilst a few areas were still work in progress. We noted that the manager was in the process of compiling a revised action plan and appropriate improvements were being made in a timely fashion.

We saw that improvements had been made to communications between the management and that care staff were being given the opportunity to be more involved in aspects regarding the day to day running of the service.

Staff, people living in the home and their relatives all told us that they had been involved more in discussing aspects regarding the way the home was being run and felt more able to raise issues or make suggestions.

For example, the manager had introduced a communication book for staff, to try and ensure more effective transmission of information. Staff confirmed when they had read the messages by adding their signatures to the messages. Staff we spoke with said that this was working well.

A communication book had also been introduced in people's rooms to enable information to be shared between staff and people's relatives, which was also proving to be effective.

We saw that a relatives' meeting had been held on 30 September 2015, during which the new manager had introduced themselves and explained the improvements they were making in the home, to enhance the quality of care provided for people. One relative told us that they felt the new manager was more approachable and interested in their views and comments.

Staff meetings had also been held since the new manager had begun working in the home and the manager told us

Requires improvement

Is the service well-led?

about the plans they had to complete a staff survey and that they were actively encouraging staff feedback and participation in driving the business forward. Staff we spoke with also confirmed this to be the case.

The new manager had already submitted an application at the time of this inspection, to become registered with CQC and this was currently being processed by CQC's registration team.

We raised a concern with the provider, regarding the fact that the previous manager had submitted an action plan to us in April 2015, stating that the majority improvements required from our last inspection had been completed, when in fact they had not. It was evident during this inspection that the issues had only begun to be addressed since the appointment of the new manager in August 2015.

We acknowledged that the new manager's plans for ongoing improvements were realistic and predominantly focused on the physical and emotional welfare of the people living in the home. We also saw that a number of improvements had already been made within the service, whilst others were noted to be 'work in progress'. It was evident that the manager had clearly been observing the day to day running of the home and where they identified elements of poor practice, they were taking appropriate action to eliminate these, with appropriate support from the provider and other senior management colleagues.

Our observations, together with notes from staff meetings and discussions with people living in the home, their relatives and staff, supported the fact that all previous areas of concern were currently being addressed appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People who use services were not fully protected against the risks associated with other people making decisions on their behalf, because formal mental capacity assessments and 'best interests' decisions were not always being carried out where needed and clearly recorded in people's care plans.** **Regulation 11 (1)(2)(3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.** **Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who use services were not fully protected against the risks associated with incomplete record keeping.** **Regulation 17 (2)(c)**