

Healthcare Homes Group Limited

The White 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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out this unannounced, comprehensive inspection on the 26 and 31 January 2017 to check that the provider had made the improvements required following our last comprehensive inspection on 15 & 20 June 2016 and focussed inspection on 8 September 2016.

During our June 2016 inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was placed into Special Measures. We told the provider to take urgent action and kept the service under review, with the expectation that significant improvements would have been made within a six month timeframe.

We also served a warning notice on the provider in relation to the staffing levels in the service which posed risks to people's safety. The warning notice included a timescale by when compliance with the legal requirements needed to be achieved. We undertook a focussed inspection on 8 September 2016 to check that the provider had made improvements to meet the legal requirements in the warning notice, within the given timescale. We found that staffing levels had improved.

You can read the reports from our last comprehensive and focussed inspections, by selecting the 'all reports' link for The White House on our website at www.cqc.org.uk.

The provider had acted on our concerns and at this inspection we found that there was a positive, open and inclusive culture in the service. There had been significant progress made in making the required improvements, however there were some aspects of the service provision where further work was needed to ensure that safe, effective and responsive care was delivered at all times.

The White House provides accommodation and care for up to 33 people who are elderly and frail some of whom are living with dementia. On the day of our inspection there were 23 people living at the service.

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

Staffing levels had improved but staff were not always effectively deployed to provide a holistic approach to people's care, ensuring all aspects of their well-being were being attended to.

Although progress had been made with the care plans we found that records continued to be inconsistent in areas. Parts of the care plans which were complete had been written in a person centred manner and included details which reflected people's personal preferences.

There had been some improvements with regard to the provision of activities. People were positive about

the planned activities which took place throughout the week. However, There was a lack of staff training and resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions.

People and their families were positive about the care they received from staff who respected their privacy, dignity and independence. Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. Additional training was now needed to equip them with a greater awareness and understanding with regards to supporting people living with dementia.

Improvements had been made to the environment following an extensive refurbishment project. This was also having a positive impact in the way in which infection control procedures could be followed. These had been further improved by additional guidance for staff and action taken by the management team when shortfalls were identified.

Improvement had been made to the way in which risk assessments relating to peoples care and support needs were recorded and reviewed. Suitable arrangements were in place for the management of medicines and staff had been trained to administer medicines safely.

People presented as relaxed and at ease in their surroundings and told us that they felt safe. Staff knew how to minimise risks and provide people with safe care. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. People knew how to raise concerns and were confident that any concerns would be listened and responded to.

Staff understood the importance of gaining people's consent to the support they were providing. The management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, although care plans contained mental capacity assessments where appropriate they did not always reflect how individuals were supported with individual decision making.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. The dining experience had improved but additional thought needed to be given to ensure that this was not determined by which dining area people were seated in.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

At our last comprehensive inspection we found that quality assurance mechanisms had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. At that inspection we found that the provider did not have robust oversight of the service's operations. The provider had acted on our concerns and at this inspection we found that there was a positive, open and inclusive culture in the service. A comprehensive development plan together with a robust quality assurance system meant that shortfalls were being identified, addressed and used as an opportunity to drive continuous improvement.

Where areas requiring further improvements were still needed, the management team were open and transparent and shared with us the provider's plans to continue to develop and make improvements within

the service.

Although significant progress had been made in improving the service it was not possible for the provider to fully demonstrate the impact of the changes because of the short time they had been implemented for. The provider now needs to demonstrate that the improvements will be sustained and embedded in practice so that people can be confident they are receiving safe, effective and responsive care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Staffing levels had improved but staff were not always effectively deployed to provide a holistic approach to people's care

Procedures were in place to safeguard people from the potential risk of abuse.

There were improvements in peoples risk assessments and the management of infection control.

People were provided with their medicines in a safe manner.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

Additional training was needed to equip staff with a greater awareness and understanding of supporting people living with dementia.

Staff understood the importance of gaining people's consent but care plans did not always reflect how individuals were supported with individual decision making.

Peoples' nutritional needs were monitored. People had access to healthcare services to maintain good health.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

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

People were supported to have choice, independence and control.

Good ●

Is the service responsive?

The service was not consistently responsive.

Care plans were not always consistent and fully reflect changes in people's support needs.

There were improvements in the provision of activities. However, there was a lack of staff training and resources to support people with physical or mental stimulation appropriate for people living with dementia.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Requires Improvement ●

Is the service well-led?

The service was well led.

The provider now needs to demonstrate that the improvements will be sustained and embedded in practice

At our last comprehensive inspection we found that the provider did not have robust oversight of the service's operations. The provider had acted on our concerns.

A comprehensive improvement plan together with a robust quality assurance system meant that shortfalls were being identified, addressed and used as an opportunity to drive continuous improvement.

Requires Improvement ●

The White 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 unannounced inspection took place on 26 and 31 January 2017 and was carried out by one inspector, a specialist advisor who had knowledge and experience in residential care, 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.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with 11 people who used the service, three relatives and two other visitors and received feedback from a health and social care professional who visited the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection. 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 may not be able to verbally communicate their experience of the service with us.

We spoke with the registered manager, deputy manager and regional manager. We also spoke with the activities co-ordinator and six other members of care, housekeeping and kitchen staff.

To help us assess how people's care and support needs were being met we reviewed nine people's care records and other information, for example their risk assessments and medicine administration records. We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Is the service safe?

Our findings

At our comprehensive last inspection in June 2016 we found breaches in regulation about how the provider was protecting people against the risk of unsafe care. We found that staffing levels were not sufficient to ensure people's needs were met at all times. At our focussed inspection on 8 September we found that improvements had been made in this area. At this inspection we found that although staffing levels continued to improve there were times of the day when staff were not effectively deployed throughout the service to support people safely.

There were mixed views about whether there were enough staff on duty at all times. One person said, "On the whole yes, I think that there are enough staff". A relative told us, "There is now [enough staff] There wasn't at one time. That's improved a lot. Since the last [CQC inspection] visit there are a lot more staff I think during the day." Another relative commented, "Since the new management took over I think there are enough staff but I only see it in the daytime." However one person commented, "At the weekends they are sometimes short of staff which means I cannot have a bath." A person who stayed in their bedroom all of the time told us that they often felt lonely. They explained that they were able to use their call bell if they required support and they felt, "Safe" however, they felt that, "There are not enough carers" as the carers were, "Often rushing."

The use of agency staff had decreased which staff felt was a positive step forward. One member of staff explained, "Agency staff come in still but quite a few come on a regular basis which is good because they get to know the residents and the staff. It's not as big a problem as it was."

Staff told us that staffing levels had improved but some days were better than others. One member of staff told us, "You do get some bad days when we are short staffed but the team here is good. There's usually four [care staff on duty] On a good day five. The fifth person does assisted feeds, makes sure people are drinking. There is a bit of flexibility. With four you are aware of the clock more. If I'm honest you rush more. Like maybe you don't spend so much time asking what kind of night they've had." Another staff member commented, "This morning has worked really well. We've had five staff. When there is only four on it's more difficult."

Despite this staff felt that the way in which they now worked meant that people had all of their physical care needs met. One member of staff explained, "The way that we work in the mornings is better. We work in pairs, it's a lot more efficient." Another staff member commented, "We cope with four [care staff] it's just a lot harder going but residents still get everything they need." A third member of staff said, "On my weekend we are pretty much always short. It's a treat to have five. We still do bathing [with four care staff on duty] it just slows things down.

However, we observed that there were times of the day when staff were not deployed effectively to meet all of people's needs. For example, on the first day of our inspection one person who required assistance with their meal remained on their own in the lounge during the lunch time period. They were becoming unsettled but had to wait until people in the dining room had been served before a member of staff was available to help them. Staff walked through the lounge on several occasions taking meals to other people who

remained in their bedrooms and the person seated in the lounge commented, "Oh don't worry about me, I'll just wait." However, this was said in a frustrated manner. Another person's care plan stated that they required prompting and supervision whilst eating due to a risk of choking and falling asleep. The manager explained that this person did not like to be supervised so staff check on them every few minutes. We observed that the person sat at a table on their own and a check was only carried out once during a 30 minute observation period. This put the person at risk as staff were not available to assist immediately should they begin to choke.

The service employed an activities co-ordinator who was on duty five days a week. However, they were not present on the second day of our inspection and people spent a large part of the day unoccupied in the lounge. Although staff were observed to walk backwards and forwards through the lounge they did not often stop to spend time with people. Later in the day two visitors provided musical entertainment however people did not appear to be engaging with what was going on and the absence of care staff in the lounge to encourage and assist people to get involved meant that people were not fully benefiting from the activity provided.

This demonstrated that staff were not effectively deployed to provide a holistic approach to people's care, ensuring all aspects of their well-being were being attended to.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the deployment of staff with the management team who told us that their priority had been to increase the number of staff on duty and reduce the use of agency staff. They were now looking at how they could support staff to work in a way which ensured people were provided with mental stimulation and that all of their physical and emotional needs were being met.

At our inspection in June 2016 we found that bathing equipment was unsafe for use and infection control procedures were not effective. At this inspection we saw that bathrooms had been completely refurbished including new equipment and new flooring. An extensive refurbishment project throughout the service including new furnishings and carpeting was also having a positive impact in the way in which infection control procedures could be followed. The management team had been working with the local infection control team to improve the way in which infection control was managed within the service and a new infection control auditing system had been implemented. Where there had been a need to re-train and prompt staff to carry out cleaning duties consistently and effectively this had been dealt with by the management team. For example, records of daily meetings with staff showed that these issues had been discussed. A member of staff confirmed, "With infection control things are all a lot tighter and stricter." The deputy manager explained how following concerns raised about beds not being changed when it was appropriate to do so the registered manager had spent time with each member of care staff on a one to one basis giving guidance as to what they should be aware of and how beds should be made properly.

Improvement had been made to the way in which risk assessments relating to people's care and support needs were recorded and reviewed. For example, falls risk assessments were regularly reviewed and intervention sought from the fall prevention team when appropriate. One person's assessment relating to the risk of them acquiring a pressure ulcer indicated that a particular type of cushion should be used and we saw that they were sitting on this throughout the day. There was nobody living in the service who currently had a pressure ulcer but records showed that staff were providing the appropriate support to people who were at risk and needed assistance to reposition themselves. However, some risk assessments needed additional detail to ensure that it was clear what action was being taken when a potential risk was

identified. A risk assessment for one person indicated that they were at high risk of choking however it was not clear what the specific risks were or details to guide staff as to how they should support this person to minimise the risk.

People presented as relaxed and at ease in their surroundings and with the staff. A person told us, "I feel safe. The staff are good and very supportive". People told us that they felt happy to talk to the staff about any concerns they may have. One person explained, "For practical matters I could talk to any of the staff but for more personal things I would talk to the senior staff." A relative commented, "I am sure [person] is safe because the staff are very attentive". Another relative told us, "I can leave [person] and not worry."

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received training in safeguarding adults from abuse. Staff understood the provider's policies and procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. A member of staff explained, "I'd go to a senior [carer] or to management. Hopefully I wouldn't have to go higher but I could go to head office or social services."

Equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire and there was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

Employment records confirmed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the vulnerable adults who used the service.

Suitable arrangements were in place for the management of medicines. People's medicines were stored safely but available to people when they were needed. Staff had been trained to administer medicines safely and they were observed to ensure that they were competent in this role. The Medicines administration records (MAR) charts were signed to show that medicines were administered regularly as prescribed. Protocols were used to manage medicines to be taken when needed, for example for pain or anxiety. This meant that staff had the appropriate guidance to ensure people received these medicines when they needed them.

MAR charts included allergy information, a photograph of the person to make sure they were correctly identified and guidance for staff on how each person preferred to take their medicines. This guidance was specific to each individual, for example, "Due to poor eyesight pills placed on coloured paper towel with glass of water. We observed another person being assisted with their medicines in line with the details given in their care plan. A person told us, "They've never been more than a little bit early or a little bit late [with bringing their medicines]. In the main they watch me take them but now and again they just leave them with me but they know I will take them". This demonstrated that people were being assisted to be involved in the administration of their medicines in a way which worked well for them.

There were improvements since our inspection of June 2016 in the way in which records were kept for creams prescribed for external application. People had specific cream charts and body maps in place so it was clear where the cream was to be applied and could therefore be monitored more effectively.

Is the service effective?

Our findings

At our inspection in June 2016 we found that staff did not always receive regular supervision sessions to support them to improve their practice and identify further training needs. There had been improvements in this and records showed that staff were regularly meeting together with a senior member of staff. A member of staff told us, "The past few months we've had them [supervisions] more regularly. I've had three or four since August." This demonstrated that the provider was working to provide a support system for staff that developed their knowledge and skills, and which motivated them to provide a quality service.

Staff were provided with a range of training to assist them to meet people's needs and preferences. However, training in dementia care was delivered via e-learning and our observations told us that this had not been completely effective in providing staff with the knowledge and understanding they needed in relation to the specific needs of people living with dementia. For example, we saw that communication with people could be improved by ensuring better eye contact, slowing down, taking time to be sure that people understood and being less task focussed. We discussed this with the management team who told us of their plans to engage all staff in additional dementia training. They told us that this would also include input from a dementia champion recently employed by the organisation to help staff to empathise more fully with people living with dementia and have a greater understanding of their specific needs.

The training programme was continuing to be developed to ensure that people's healthcare conditions were fully understood by staff. For example, there were several people with diabetes and although the senior care team had received some training in this the majority of the care staff had not been trained in this area. Additional training relating to specific healthcare conditions would support staff to recognise and meet people's needs effectively and safely.

The provider now needs to demonstrate that their staff training and supervision programmes are embedded and that this continues to be reflected in the positive way staff provide people with care and support.

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.

Care plans contained mental capacity assessments where appropriate but did not always reflect how individuals were supported with individual decision making. It was also unclear how some decisions had

been made in people's best interest. For example, for one person living with dementia it had been decided that the kitchen staff should decide what they would like to eat each day as the person was unable to communicate this for themselves. However staff told us that although this was usually the case there were times when the person could express an opinion. One member of staff said, "[Person] struggles a bit but sometimes can verbally communicate. It's about trying as much as possible to treat them the way you would want to be treated." The persons care plan did not make this clear so there was a risk that some staff would assume that the person always needed the decision made for them.

This person also sat on their own in the lounge over the lunchtime period. Their care plan had previously recorded that they like to sit in the dining room for lunch but this had been crossed out. However, it had not been recorded why the decision had been made for them to now sit in the lounge or how this new arrangement was being monitored to ensure that it was in the persons best interest. We discussed this with the manager and another member of staff who told us, "[Person] is a lot calmer in the lounge. [person] eats a lot better. We can talk and encourage [person.]"

We observed that staff sought people's consent and acted in accordance with their wishes. For example, we heard staff ask, "Is it alright if I just sit down for a minute?", "Would you like to be moved closer to the table?" and "Do you need any help?" This showed that staff were aware of the importance of allowing people to make their own choices and decisions.

At our inspection in June 2016 we found that the dining experience was not conducive to an enjoyable mealtime and did not give opportunity for social interactions. At this inspection we saw that an additional dining area had been created which meant that all who wished to could sit in these areas to eat their meal. The experience in the main dining room was positive, people chatted together and staff were attentive. Staff described to people what was available and offered choices. Sauces were served separately so that people could decide for themselves whether they would like them or not. People were still asked the day before what they would like for lunch the next day but staff told us that they were able to provide alternatives if people changed their minds or were unable to remember what they had ordered. We saw that one person's meal was quickly and pleasantly exchanged when it was not what they expected.

In the smaller dining area, the atmosphere was less positive and staff were less attentive as they walked backwards and forwards through it to take food to people in their bedrooms. One person was concerned that they were slipping in their chair and the person sitting next to them had to point this out to a member of staff who was walking through as this had not been noticed. This showed that although the service had moved forward in creating a positive mealtime experience for most people some additional thought needed to be given to ensure that this was not determined by which dining area people were seated in.

People were complimentary about the food and the choice available. One person said, "The food is usually very good. Mealtimes are enjoyable; we have a good laugh". Another person commented, "I must be the world's worst for food because there's a lot of things I don't like. I'm not really a meat eater but [the cook] will find me something I like." A relative told us, "When I have stayed for lunch with my [relative] the food has been delicious". They also added, "[Member of the kitchen staff] has been good at working out what my mother likes". Families were encouraged to have lunch together with people. One relative explained, "They [kitchen staff] have made arrangements for us to have lunch together in the dining room once a fortnight after the main lunch time period. We come in after lunch at 1.15pm. They suggested it. They have accommodated us."

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Records showed that guidance and support had been sought from

relevant professionals to ensure that all people's dietary needs were being met. The kitchen staff were knowledgeable about people's nutritional needs and preferences and were proactive in finding ways to support them. For example, a member of the kitchen staff had identified that one person with swallowing difficulties had a limited diet because only certain food could be prepared in the way they needed them. The member of staff had researched what may be able to help this person, their GP had been consulted and a prescription obtained for a food supplement which could be added to food to allow the person to have more choice. This demonstrated that people could be assured that changes in their nutritional needs were monitored and appropriate action would be taken if necessary to maintain their health and well-being.

People had access to health care services and received ongoing health care support where required. People were referred to appropriate health professionals such as speech and language therapists, dietitians and GPs. A visiting healthcare professional told us, "We have developed a relationship. We've taught them to do simple obs [clinical observations such as taking peoples blood pressure], it's a joint approach." They added, "I'm really impressed."

Is the service caring?

Our findings

The atmosphere within the service was relaxed and welcoming. One person told us "It's a family relationship with the staff. I'm treated as a real person: they are very respectful." A relative commented that their family member, "Loves it. [relative] is very happy." Another relative said, "The staff are lovely. They are fantastic."

People and their families were positive and complimentary about the care they received. A person told us, "The staff are very kind and helpful and they treat me with respect and dignity". A relative commented that staff were, "Very caring and compassionate. They treat [relative] with respect and quickly respond to [their] needs". A visiting healthcare professional said, "They [staff] are pro-active and certainly caring."

Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. A person commented, "I'm sure the staff know me as a person and they know what I like and what I don't like". Another person said, "I get on well with the staff. They treat me alright". Staff had built a rapport with people and this was demonstrated in the warmth they displayed when engaging with them.

Staff acknowledged that they didn't always have the time to fully read people's care plans to ensure they knew how best to support them. One member of staff said, "I made it a point to read as many of them [care plans] as I could. We write in them every day but I should spend more time looking at them, like at people's histories." However all the staff we spoke to felt they had a good understanding about people's needs. One member of staff told us, "Everyone has a pretty good idea of what people need." Another member of staff told us, "Anything we need to know that's changed we are told in handover." This demonstrated that good communication amongst the staff team meant that they knew people well and were aware of changes in people's needs. However, if these changes were not recorded in people's care plans or staff did not have time to read them there was a risk that important information could be missed.

There was still work to do to ensure that people and their relatives were involved with discussing their care and support needs and that this was recorded. People told us that they had not been involved in updating their care plans and we saw sections where important information about people's history and things which were important to them could be recorded had not been completed. However, a relative told us, "I have been involved and have made an input to [person's] care plan". People told us that they felt the staff and management team listened to their views and their care was provided in line with their preferences. They also had the opportunity to attend residents meeting which were held regularly. One person told us, "We have residents meetings. They really are quite helpful and meaningful".

People were encouraged to be independent. For example, we saw a member of staff say to a person, "When you are ready. In your own time. Can you try and stand?" They then gave them the time they needed to be able to stand up themselves and provided encouragement as they did this. A member of staff explained another way they encouraged people to be independent when assisting with personal care, "I say here you are, here's the flannel. I encourage [people] to use it. They say it's use it or lose it."

People were encouraged to make their own decisions relating to their daily routines, where they would like to be and what they would like to do. A member of staff told us, "We need to show people dignity and give them a choice. Like whether they want to stay in bed." They went on to say, "My philosophy is you need to say what you are hoping to happen then say 'is that ok?' Let them lead as much as they can. Asking them if that's ok." There were improvements in the way in which people were offered baths. A member of staff told us how people had a choice of when they would like a bath or shower, "We are asking everyone every day. Before it was very regimented." This demonstrated that staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

People told us that staff respected people's privacy and dignity. A person commented, "I'm certainly treated with respect." Another person said, "The staff are always kind and they respect my privacy." We observed that staff were aware of the need to respect people's privacy and dignity for the majority of the time. For example, they used privacy screens when assisting people to move using a hoist in the communal areas. However, on the first day of our inspection there were two occasions when people's dignity was compromised when staff were heard to enquire loudly about whether a person needed assistance with going to the toilet. We discussed this with the management team who acknowledged that this was in no way acceptable and told us they would address this with the staff involved.

Is the service responsive?

Our findings

At our last inspection we found that the level of information held in people's care plans was not consistent. Although progress had been made with the care plans we found that records continued to be inconsistent in areas. One member of staff talked to us about the information contained in the care plans and commented, "They could be better. Some of them have a different layout. It could do with being in the same place in each care plan." The care plans were regularly reviewed but information was not always updated when there were changes in people's needs. For example, one person was being cared for in bed and staff explained that this was because their health condition meant that they became unwell when they attempted to sit out of bed. However this information was not included in their care plan. The person had full mental capacity and was able to make decisions for themselves but there was no record of any discussion with the person to show that they were in agreement with the way care was being provided. There was also no reference to how a decision such as this may impact on the person's physical and mental health.

The main part of people's care plan was contained within a file which also held their daily records, risk assessments and information about their health. The part of the care plan which contained details about what was important to people and how they could best be supported was not easily identifiable within the file which meant it may not be easily accessible to staff, particularly when they were short on time. A member of staff commented, "We don't have a lot of time to stop and read them."

Daily records did not always make it clear what support was being provided. For example, one person's care plan stated that they needed to be checked every two hours throughout the night as they may need assistance with their continence aids. However this was being recorded as a single entry of, '2 hourly checks provided throughout the night.' This did not reflect details of the checks such as times, staff members involved, or assistance provided. The person was identified as being at high risk of developing pressure ulcers but the care records did not provide sufficient evidence that this risk were being appropriately managed or support was given when needed. The manager told us that this person was able to call for assistance but acknowledged that the records did not accurately reflect the support provided. By the second day of inspection an additional record sheet had been produced for all people who needed to be checked through the night to show the assistance they had been given. This meant that any changes in their support needs could be identified and monitored.

Additional work was also needed in relation to care planning to meet the specific needs of people living with dementia. The sections where people's life history, family details, hobbies and interests and things of importance to them could be recorded were not completed in some files. This meant that opportunities were being missed to discover how staff could support people to engage in meaningful activities to enhance their sense of well-being.

We discussed this with the management team who acknowledged that the care plans needed further attention. They had plans to re-format people care documentation to make it easier to complete and update. Support from the dementia champion recently employed by the organisation would assist staff to include meaningful details in people's care plans which would also reflect people's goals and aspirations

and guide staff in promoting independence, choice and control.

Parts of the care plans which were complete had been written in a person centred manner and included details which reflected people's personal preferences. For example an entry in one care plan read, "I prefer comfortable tops and trousers." The care plan also said, "I like it when people stop and talk to me and hold my hand." Staff were aware of this and we observed that this person was wearing trousers rather than a skirt and a member of staff told us how this person liked it when staff sat with them and held their hand.

People with diabetes had a specific care plan in relation to this which gave clear guidance to staff about how to assist people with diabetes should they become unwell due to unusually high or low blood sugar levels. However the care plans all referred to the same recommended blood glucose level which meant it was not clear what was normal for each individual and when staff should take action. We pointed this out to the management team and by the second day of our inspection all of these care plans had been updated to reflect each person's usual blood sugar level as well as specific guidance regarding the intervention and support they would need if these levels became too low or too high.

At our inspection in June 2016 we found that the approach to supporting people with their interests and to have meaningful and fulfilled days was not effective. At this inspection we found that there had been some improvements with regard to the provision of activities. People were positive about the planned activities which took place throughout the week. One person told us, "I join in because I spend nearly all my time in the lounge and it keeps me active." Another person said, "I like the quiz sessions but on the whole I don't join in although in the afternoon I often sit in the lounge for a while." A relative commented, "[Person] reacts well to the quizzes and joins in the music. The stimulation has been amazing." People also told us how they had also enjoyed trips out and one person told us, "I like the outings; we were taken up the river and my [relative] came as well". Another relative told us, "The activities are excellent. They have a new [activities co-ordinator]." The relative explained how the activities co-ordinator knew that her relative used to make wedding cakes and likes flower arranging and added "[Relative] does that here, baking and flower arranging."

A member of staff commented, "The [activities co-ordinator] is marvellous. [They] go round to people in their rooms, makes sure [they] visit them." A person confirmed that the activity co-ordinator did visit them in their bedroom, "[Activities co-ordinator] gets up here when [they] can and puts a record on for me." However, the person's daily records reflected sporadic contact time and they told us that they felt, "Lonely" due to being in their bedroom all of the time.

There was a lack of resources to support people with physical or mental stimulation appropriate for people living with dementia or other mental health conditions. This meant that there was not a holistic approach to people's care and support to ensure their general wellbeing. On the second day of our inspection the activities co-ordinator was not present in the home and people remained unoccupied for large parts of the day. The care plan of one resident living with dementia stated that, 'I need to have a lot of 1-1 time' and that they, 'Prefer activities such as listening to music or being able to work with my hands, touching things to stimulate my interests.' Although the person was encouraged to listen to music we saw no attempt to engage them with any activity they could do with their hands. This person became restless at times throughout the day and at times repeatedly clapped their hands. An understanding from all staff of how resources could be used to provide appropriate stimulation would mean this person could be better supported.

We spoke with the management team about the provision of meaningful activity throughout the day and they acknowledged that this was an area they needed to develop further. They had plans to work with staff

to guide them how to support people with daily living activities such as assisting with preparing vegetables or folding napkins if this was something they would like to do. The regional manager explained how it was hoped that a change in culture would encourage staff to be involved in the provision of activities so there was not an assumption that this was only the role of the activities co-ordinator. This would help to ensure that there was a holistic approach in the provision of peoples care and support.

There was a procedure in place which explained how people could raise a complaint. A person told us, "I've never had to make a complaint but if I had to I would speak to one of the senior staff." Records of complaints showed that they had been responded to appropriately and in a timely manner. A visiting healthcare professional told us about a concern they had previously raised with the provider. They explained, "It was responded to very quickly" and told us that appropriate action had been taken and changes made. This demonstrated that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right. The management team also used these concerns as an opportunity to learn how things could be done better in the future and shared what they had learnt with the staff in order to continually improve the standard of care provided.

Is the service well-led?

Our findings

At our inspection in June 2016 we found that while there were some quality assurance mechanisms in place, these had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. The service had been without a registered manager for four months at the time of that inspection.

There was now a registered manager in post supported by a deputy manager. The provider had acted on our concerns and there was a positive, open and inclusive culture in the service. A relative commented, "There have been big changes. A lot of things needed doing but I've seen a big big improvement." They went on to say, "I can't find any fault." A healthcare professional told us how impressed they were with the way the service was run and commented, "I have nothing but praise [for the staff]."

People and staff told us the management team was approachable and had implemented a lot of positive changes. One member of staff told us, "It's all positive now. It's going up instead of down. [Registered manager] has done a great job. Compared to the last management, you couldn't compare the two." Another staff member said, "I look forward to coming to work. I'm confident things are done as they should be."

Staff were confident in the ability of the management team and told us that they were a visible presence within the service. One member of staff told us, "[Registered manager] is a lot more involved with staff and residents and keeps you up to date." They added, "If I felt something was detrimental I feel confident that management here would listen and sort something out."

Staff felt that they were now being supported in their role and their opinions were valued. One member of staff told us, "We've had a lot of changes but it's all been for the better. It's been tough but I like having the extra responsibility." Another staff member said, "I've always been happy to go to a senior [carer]. [Registered manager] and [deputy manager] are very easy to talk to. I haven't had any issues but if I did they'd be happy to help out."

As part of the continuous monitoring of the service the management team had introduced a daily meeting which was attended by all care staff. This meeting covered all aspects of the services operation including any concerns about people and sharing of information. Where poor practice had been identified or improvements needed to be made this was also addressed with staff during these meetings and guidance and support was given to drive forward continuous improvement.

The management team monitored accidents and incidents which occurred in the service to ensure they were investigated and appropriate actions taken. For example, when one person had fallen steps had been taken to identify why they may be at higher risk such as testing for a urine infection and completing additional risk assessments. In addition, actions had been taken to reduce the risk of the person falling again such as a referral to the falls team for additional guidance and support. A relative told us they were confident that the management team would keep them informed of any incidents and commented, "They ring me, even if it's just a little knock and [relative] has a plaster on." This demonstrated that the service was

acting in line with their own duty of candour policy and was open and transparent regarding any incidents or accidents which may occur.

Following receipt of the warning notice we issued following our last inspection the provider was pro-active in sending us weekly action plans informing us of how they were working towards making the necessary improvements to the service. The provider had put together a development plan which was regularly updated as changes were being made within the service and as other areas requiring improvement were identified. This was a working document which the management team frequently consulted and actions were taken as a result of it.

To supplement the development plan, additional quality assurance systems had been put in place to identify shortfalls and to drive continuous improvement. These included monitoring by the registered manager as well as monthly monitoring of all areas of the service's operation by the regional manager. In addition, an external organisation had been commissioned to carry out a comprehensive review of all aspects of the services operation in order to obtain an independent view of the improvements which had been made. Further areas for improvement identified by this review, such as additional work required on protocols for medicines to be given 'as required', had been acknowledged and action taken.

The views of people, relatives and staff were sought through regular meetings. Minutes showed that action had been taken as a result of the discussions which had taken place. For example, people had expressed an interest in trips out, particularly a boat trip. Minutes of subsequent meetings recorded that a boat trip had taken place and had been very much enjoyed. This demonstrated that the service empowered people to voice their opinions and these were listened to and acted upon.

Where areas requiring further improvements were still needed, the management team were open and transparent throughout the inspection and responded immediately to the concerns we raised. The regional manager shared the providers plan to continue to develop and make improvements within the service. This included making improvements to peoples care plans and additional training and resources to enable staff to empathise more fully with people living with dementia and have a greater understanding of their specific needs.

The management team were continuing to work with the staff team to help them to understand and share the culture, vision and values of the service in its main objective to provide high quality care and continued positive life experiences to those who used it. A member of staff commented, "I like our trainer's philosophy. To take time management out of the job. I would like to see more focus on a person centred approach, putting the person first; get away from looking at our watches. You can see it happening a bit more when we are staffed up with five." The regional manager explained how they were advocating this person centred approach and were working on encouraging staff to be less task focused and take a holistic approach to peoples care and support.

Although significant progress had been made in improving the service it was not possible for the provider to fully demonstrate the impact of the changes because of the short time they had been in place. The provider now needs to demonstrate that the improvements will be sustained and embedded in practice so that people can be confident they are receiving safe, effective and responsive care.

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 HSCA RA Regulations 2014 Staffing Staff were not always deployed appropriately to meet all of people's needs.