HC-One Limited

Cedar 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?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an unannounced inspection of Cedar House on 15 and 16 January 2018. The inspection was prompted in part by the notification of an incident relating to the administration of medicines and concerns raised by relatives and visitors to the service.

Cedar House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cedar House accommodates up to 42 people living with mental health support needs and dementia in a purpose-built building. There are two separate units, over two floors and each unit has two lounges and a dining room. At the time of the inspection there were 40 people using the service.

At out last inspection in September 2017 we rated the service as Requires Improvement and found a breach of Regulation 9 because the care provided did not always reflect the needs or preferences of people using the service. At this inspection, we found some improvements had been made in relation to the recording of personal care which met the wishes of the person and daily fluid intake.

At the time of the inspection there a registered manager in post and the provider had appointed a deputy manager since the last inspection. 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.'

People using the service and staff felt that at times there were not enough staff to provide the level of support people required. There were times during the day when people were left unsupervised and without appropriate support as staff were supporting people in other parts of the unit.

People felt staff were kind and caring but, at times, were focused on the care tasks they needed to complete which meant they were not always able to identify if a person required support or reassurance.

The provider had a range of quality assurance processes to monitor the service and identify areas for improvement but some of these were not effective.

There was a range of activities provided and people were supported to be involved with both one to one and group activities.

The provider had processes in place to help keep people safe and protect them from abuse. People told us they felt safe when they received care.

A robust recruitment process was used to identify if new staff were suitable to provide care for the people

using the service. Staff completed a range of training and regular supervision with annual appraisals to support them to provide care in an appropriate and safe way.

Incidents and accidents were recorded and reviewed to identify if there were any trends and actions required to prevent reoccurrence.

Medicines were managed and administered safely and people received their medicines as prescribed.

A detailed assessment of a person's support needs was completed before they moved into Cedar House to ensure their care requirements could be met.

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

People had a choice of food every day and their dietary needs had been identified and were met.

People told us they were happy with the care they received, they were treated with dignity and respect and they were supported to maintain their independence.

Care plans included information for staff in relation to the person's religious and cultural needs as well as their preferences for how they wanted their care provided.

Records were completed to identify incidents of behaviour which required additional support but the information was not used to inform future practice to ensure staff understood ways to appropriately support people.

An audit of care plans had identified areas where information was not consistent for example what type of equipment should be used when helping a person move. Action was being taken to resolve the issue.

Staff felt supported by the registered manager and said that the service was well-led. People and relatives could provide feedback on the care provided which was used to identify areas for improvement and they felt the service was well-led.

We found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were breaches of Regulation 17 (Good governance) and Regulation 18 (staffing). You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Sometimes there were not enough staff to provide the support and care to people in a timely manner and according to their care plans.

Medicines were managed and administered safely and people received their medicines as prescribed.

The provider had a robust recruitment process to ensure new staff had appropriate skills and knowledge.

Incidents and accidents were recorded and reviewed to identify if there were any trends and actions required to prevent reoccurrence.

Is the service effective?

Good

The service was effective.

A detailed assessment of a person's support needs was completed before they moved into Cedar House to ensure their care requirements could be met.

The provider had a policy in relation to the Mental Capacity Act 2005 that staff were familiar with. Processes were in place to ensure decisions were made in the person's best interests if they were assessed as not having capacity.

Staff completed a range of training and regular supervision with annual appraisals to support them to provide care to people in an appropriate and safe way.

People had a choice of food every day and their dietary needs had been identified and were met.

Is the service caring?

Requires Improvement

Some aspects of the service was not caring.

People felt the staff were kind and caring but, at times, were

focused on the care tasks they needed to complete which meant they were not always able to identify if a person required support or reassurance.

Care plans identified the person's cultural and religious needs as well as their preferred name.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans identified how people wanted their care provided and records reflected the care that was provided. Where information was identified as not being consistent in some care plans action was being taken to resolve the issue. Records were completed in relation to people's behaviour but the information was not used to inform practice.

The provider had a complaints process and people understood how to make a complaint.

Care plans identified the person's wishes for their end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Areas of concern were identified during the inspection which demonstrated some aspects of the service were not well-led.

The provider had a range of quality assurance processes to monitor the service and identify areas for improvement but some of these were not always effective.

People using the service and staff felt the service was well-led. There were regular staff meetings and staff felt supported by the manager.

Cedar 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.

The inspection was prompted in part by the notification of an incident relating to the administration of medicines and concerns raised by relatives and visitors to the service.

This comprehensive inspection took place on 15 and 16 January 2018 and was unannounced on the first day. The inspection was carried out by two inspectors, a pharmacy inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR) in June 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with the registered manager, the area director, six staff members and one volunteer. The expert by experience spoke with three people and four relatives of people using the service.

We also looked at records, including eight people's care plans, four staff records, medicine administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

After our last inspection in September 2017 we made a recommendation for the provider to review the deployment of staff throughout the day in line with national guidance on safe staffing levels to ensure people had the support and supervision they needed at all times.

During the inspection we asked people if they felt there were enough staff available to provide support. Their comments included, "I feel there are staff around but more are needed particularly at weekends and nights" and "There are not enough staff. The carers and staff have to work so hard." Relatives also told us they felt there were times when there were not enough staff. They said, "No, there isn't enough staff available, especially permanent staff", "The staffing is okay however they can do with more particularly in the morning and night" and "They have been understaffed due to illness which puts more pressure on the staff working."

All the staff we spoke with told us they felt there were times when there were not enough staff to provide the required support to people. Their comments included, "Depends, usually enough. If staff go sick we are short until agency cover can be found", "Yes we manage, we try our best. The wellbeing coordinator is helping a lot. More staff would be good", "Yes enough staff but not enough permanent staff. Today three agency and one permanent on the ground floor. When all permanent staff are on duty things run smoothly and efficiently. Particularly during toileting, lunch and meals times. Do need more staff at targeted times", "No, not enough permanent staff, not enough instructions for agency [staff]. Carers do their best but they just don't stay, always new ones and they don't always know what to do" and "No, 8am to 2pm extra person needed for personal care, breakfast and lunch. No difference weekdays to weekends."

The rotas indicated each unit had four care workers and a nurse allocated between 8am to 8pm. One nurse with one care worker was allocated from 8pm to 8am per unit with one additional care worker who worked across both units when additional support was required. During the day care workers were allocated specific people on the unit where they were based to care for and support. This was identified in the handover document reviewed at the start of each shift.

During the inspection we observed three incidents that indicated staff were still not deployed in a way that met the needs of the people using the service. We saw there were times where the staff were busy providing support for people in other parts of the unit which resulted in people being in the lounge for up to 20 minutes without any staff supervision to provide support if required. During the inspection we were asked by people in the lounges and in their bedrooms for assistance and we had to locate staff to provide support to the people.

When breakfast was being provided on one unit we saw two staff had been allocated to provide support. One person asked the staff if they could be supported to go to the bathroom. The staff replied that they still had to support people to eat their breakfast so were unable to support the person. The staff did not identify if anyone else could provide support at that time. The registered manager came into the dining room and we asked if there was anyone else who could support the person. Once footrests had been located for the

person's wheelchair, the person's received support from the registered manager.

We spoke to one person who told us they wanted to be supported to get out of bed and go to the lounge. We passed this information on to the staff on the unit and they informed us there would be a delay in providing support of up to 30 minutes as two of the staff were on a break and two other staff were busy with another task. The registered manager then arranged for staff to provide the required support to help the person join other people in the lounge as they had requested.

We saw one person was in the lounge and had been given a hot drink and a bottle of nutritional supplement drink. The person needed encouragement to drink and we saw staff were not able to spend time with the person to provide that support. Around two hours after the person was given both drinks they still had not drunk them. Another person then walked into the lounge and picked up the drink and we intervened to stop them spilling it over themselves.

During mealtimes we also observed that people were not always being supported appropriately with their meals because staff were not appropriately deployed. When we asked a member of staff to assist a person with their meals, they told us they were going on their break at a time when there was a greater demand for more staff to support people with their meals. They were therefore unable to help the person. Unable to locate another available member of staff we spoke with the registered manager who provided support for the person to eat their meal.

We asked if people received the support they needed from staff during meals. Most people we spoke with said they did not require support and one person told us, "Yes, there is not much they can do as there are not enough staff and other residents need more help than me."

The registered manager told us the staffing levels were based upon the assessment of each person's support needs which was reviewed monthly. Due to vacancies the service relied upon agency care workers and nurses to ensure the identified staffing levels were met. However, the evidence in the above paragraphs shows that the provider did not deploy appropriately skilled, competent and experienced staff to meet the needs of people using the service.

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

During the inspection we saw housekeeping staff cleaning communal areas and people's bedrooms. Staff completed training in infection control and used the appropriate personal protective equipment (PPE) when necessary. An infection control audit was carried out quarterly and an action plan was developed if any issues were identified.

People using the service were kept safe and were protected from abuse. We asked people if they felt safe and they told us, "Oh no, I don't feel unsafe due to abuse, the staff are good to all of us" and "I feel safe from abuse, I think they won't try any abuse because I will tell them my mind." Relatives we spoke with also told us they felt their family members were safe when receiving care and support. Their comments included, "Yes, I think he is safe and receives the best care", "Compared to other places I do feel [person's name] is safe in here from abuse and other harm", "I don't have any concerns about abuse for my family members. I visit the home at irregular times, in the morning mostly so I can tell" and "Yes I feel my family member is safe from abuse."

The provider had a procedure for the reporting, investigation and review of safeguarding concerns. We saw

the records relating to safeguarding concerns contained information regarding the concern, investigation, statements from staff and the outcomes. Records showed all staff had completed training in relation to safeguarding. Staff confirmed they had completed training and could explain what safeguarding meant and what they would do if they had any concerns.

Recruitment processes were robust to ensure new staff were suitable to work with people using the service. During the inspection we reviewed four staff files and saw they included application forms, references, proof of identify, a criminal record check and proof the person had the right to work in the United Kingdom. Information relating to care workers provided by an agency was available which indicated their previous experience, training and criminal record check outcome. The registered manager demonstrated a new system used when agency nurses were booked. The system provided up to date information regarding the nurse including training, criminal record check and NMC (Nursing and Midwifery Council) registration status.

The care plans we looked at included the assessment of possible risks to people and risk management plans which provided staff with guidance on how to mitigate the risks identified. We saw risks assessments had been completed for falls, mobility, choking, pressure ulcers and incontinence. The assessments and care plans included guidance for care workers on the action they needed to take to reduce risks.

There was a process for the reporting and reviewing of incidents and accidents. During the inspection we looked at the records of five incidents and accidents. The records included the outcome of any investigation, immediate actions taken, documents such as body maps and any long term actions including refresher training and monitoring of possible hazards to prevent reoccurrence and to ensure learning took place.

At this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people using the service. Medicines were stored securely in locked medicines cupboards or trolleys within the treatment areas, and immobilised when not in use.

Current fridge temperatures were taken each day, including minimum and maximum temperatures. During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. Room temperatures were also recorded on a daily basis. This help to assure us that medicines were stored at appropriate temperatures.

People received their medicines as prescribed. We looked at 16 MAR charts and found no gaps in the recording of medicines administered, which showed that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate charts for people who had patch medicines prescribed to them (such as pain relief patches), warfarin administration records and also topical medicines. These were filled out appropriately by staff. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this (in line with national guidance), along with people's allergies to medicines that were recorded appropriately. Running balances were kept for all medicines which had a variable dose (for example when one or two paracetamol) and there was a record of the exact amount given.

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with twice daily audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. For example, we saw 14 PRN forms for pain relief/laxative medicines. There were appropriate protocols in place which covered the reasons for giving the medicines, what to expect and what to do in the event the medicine does not have its intended benefit.

We looked at three MARs for people who were administered their medicines covertly. We found that they had a best interests meeting and the appropriate authorisation to enable them to have their medicines administered covertly.

Medicines were administered by nurses that had been trained in medicines administration. We saw a nurse giving medicines to a person with a caring attitude. For example, the person refused their medicines initially but the nurse was able to administer their medicines a short time afterwards.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including safe storage of medicines, fridge temperatures and stock quantities on a daily and monthly basis. We also saw examples where learning took place after medicines incidents to prevent similar incidents.

The provider had developed a business continuity plan which identified how the service would continue in case of an emergency such as a fire or flood.

Good

Is the service effective?

Our findings

People using the service benefitted from living in an environment that was maintained and suitable for them. The home was overall clean and in a good state of decoration. On the first day of the inspection we found a storage cupboard in one of the units which contained hoists, slings, wheelchairs and mattresses. This storage area was not tidy and we found the hoists and wheelchairs had not been cleaned. We saw the equipment stored in this area was in regular use by staff. We raised this with the registered manager who asked staff to sort out the storage area and the equipment was cleaned before the end of the first day of the inspection.

The sink in a kitchenette on one of the units was not in use and was covered in cardboard. This meant there was only a small sink designated for hand washing in the kitchen area. The registered manager explained this had been reported to the corporate maintenance team and they were developing plans to make the repair with the minimum impact on the bathroom next to the kitchen.

During the inspection we saw call bells were accessible in bathrooms and in the bedrooms of people who were identified as being able to use them. We asked people if they had access to the call bells and they told us, "Yes, I do have one at the wall. I only used it once by mistake, I have not used it since but I do hear the sound from other rooms" and "I have never used it for no reason. I don't know for others but I do hear bells go on for a while before it stops." A relative commented, "Yes he has a call bell he can reach when he is in bed but not when he is in his armchair."

Where people had been identified as not being able to use their call bell this was indicated in their care plan. Also if a person sat in the armchair in their bedroom the call bell could not always be used as this meant the cable would trail across the floor and be a trip hazard. The rooms could not be reconfigured as the location of the call bell point meant the cable would still be a trip hazard if the bed and chair were repositioned. The care plans indicated staff should check on them regularly but these checks were not recorded.

An assessment of a person's support needs was completed before moving into Cedar House. The registered manager explained if the person was in hospital they would be visited to assess their support needs and a healthcare professional would also be asked to provide additional information about the required care needs. The assessments included information on the person's preferences as to how their care should be provided to meet their needs and wishes. Whenever possible the person and their relatives were encouraged to visit the home and meet people and staff. The information from the assessment was used to develop an interim seven day care plan for the first week after the person moved in. Further assessments of support needs were carried out over this period from which the full care plan was developed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager demonstrated a clear understanding of the principles of the MCA. They showed us records indicating when applications for DoLS had been made to the supervising local authority, if authorised or not and when it needed to be reviewed and renewed. We saw some applications had been made to the authorising authorities a number of months before our inspection but had not yet been authorised. The registered manager explained they were in regular contact with the authorising authority to monitor the progress of the applications and were considering resubmitting them.

Where an application for a DoLS had been authorised by the local authority a care plan had been developed which included the reasons for the application, any conditions that had been imposed and how this effected the care provided. Best interests' decisions relating to specific decisions were also recorded as part of the care plan.

Staff had received the support and training they required to provide safe and effective care for people. The records we saw indicated that the majority of staff had completed a range of training identified as mandatory by the provider. These courses included manual handling, infection control, safeguarding, food safety and health and safety. We saw staff were scheduled to complete training in the coming months if their refresher was overdue. Staff we spoke with confirmed they felt they had the appropriate training to do their job and meet people's needs.

All the staff we spoke with told us they felt supported by their manager. One comment was "Approachable and very supportive, enabling and encourages idea. They offer guidance and practical information." Staff confirmed they had regular supervision meetings with their line manager with some staff describing the goals they were working towards which had been agreed in their supervision meetings. The registered manager told us staff had three supervision meetings per year and an annual appraisal. The records we saw supported this. There were also quarterly staff meetings which were held at 8am and 3pm to enable as many staff as possible to attend. Other monthly meetings were led by the deputy manager and each meeting was themed including MCA, dignity in dining, teamwork, meaningful activities and safeguarding.

New care workers were allocated a mentor and completed a period of shadowing as part of their induction. The registered manager told us new care workers completed the Care Certificate as part of the induction. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. Care workers completed the workbooks during their probation period which were signed by their mentor and reviewed by the registered manager and learning and development team. The registered manager said the probation period could be extended if they felt the care worker required additional training or support.

A volunteer, who was a relative of a person that had used the service, had completed induction and training before they started at the home which included safeguarding, introduction to dementia, MCA, infection control and dignity. This meant they had an understanding of how to provide support during activities in a safe and appropriate way.

The registered manager told us they worked closely with the local authority and other care providers to support people move to Cedar House if it had been identified that their current care provider could not support their specific needs. They developed transition plans with everyone involved in providing care and

ensured all appropriate safeguarding measures were in place.

The provider had a good relationship with a range of healthcare professionals to support people to meet their health needs. Care folders contained copies of reports from speech and language therapists as well as information from opticians and discharge summaries if the person had been in hospital. When a person was visited by a healthcare professional, a record was completed including any outcomes and directions related to the person's care. We saw consent forms had been completed in relation to the person receiving the flu vaccine.

People and relatives were encouraged and supported to personalise bedrooms with things that were important to them. Outside each bedroom there were memory boxes on the wall where items of importance or relevance to the person's life could be displayed.

People were asked their views on the food provided and if they were given a choice of food. We received a range of comments with some people enjoying the food and others not happy with the food options. Their commented included, "I don't like the food, it used to be nice earlier. That is the one thing that I will give you as a negative answer. Yes they give me a choice. On the menu I like fish, they do give me but it can be cooked more nicely", "I like the food. People's birthdays are celebrated. It's very nice, I do enjoy it. I do have a choice but if I have not been offered my choice of food, I do have choice on the menu" and "Not very good at times, like today. I do have choice but I don't eat what I don't want. I did not eat the food today because it was not nice." We also asked relatives for their view on the food offered at Cedar House and they told us, "I will say the food is nice but my family member will say it is disgusting. [Name] eats the main meal and is encouraged to go to the dining room. Yes, there is a choice for the meal. The choice does meet the requirements for their meal", "My mum does say the porridge is nice to a degree. I feel my relatives are supported with their meals."

There was a dining room in each unit where meals that were prepared in the kitchen were served. We saw people could choose to eat in the dining room, the lounge or in their bedroom. A copy of the menu was displayed outside the dining room and we saw people were shown each meal option to help them make a choice. There was a meat, fish or vegetarian option on the menu which was varied. We saw each person's care folder contained a record of their dietary needs including if they required a pureed, diabetic or fortified diet and if they had any allergies or religious requirements. This information was provided to the chef and a copy was kept in the kitchen and regularly updated.

Requires Improvement

Is the service caring?

Our findings

People said they were happy with the care provided and their comments included, "Yes very happy here, very happy as you could be at 80 years old", "The carers are very wonderful and good. The only problem is there are not enough staff due to funding", "Yes the carers are respectful and nice. I can't complain about them" and "Very happy here, not happy in other places I have been but here, it is very nice here." Relative also said they were happy with the care provided. "Yes, very happy enough", "Yes very happy with both the service and the support", "Yes the staff and care workers treat my family member with respect and dignity", "Yes I feel my relatives are safe" and "I do feel happy my family member is here and [about] the support given to him."

During the inspection we saw people generally received support from staff in a kind and caring manner but there were times where the staff were focused on the care tasks they were required to complete which meant they were not as caring as they could have been.

When observing people being supported in the lounge we noted a person's hot drink had gone cold because staff had not had time to help them drink it. A staff member approached them nearly two hours after the drinks had been given and encouraged them to drink it. We had to point out the drink was now cold and had food in it. The staff member then offered to get a hot drink for the person but the need for the drink to be replaced had not been identified by staff until that point.

We responded to a person who was asking for assistance when they asked for help to reach their evening meal. The person was unable to reposition themselves in bed and their meal had been left on a table which was located behind them. They therefore could not reach their meals to eat. We brought this to the attention of the manager who helped to resolve the situation

Throughout the inspection there were times when we heard people calling out from their bedrooms for support or in distress. One person had been calling out for more than 30 minutes and when we asked a staff member about the person they told us they called out all the time but did not need any help when the staff went to see them. We reviewed the care plan for the person and this indicated the person would call out and staff should go and reassure them. At the time the person was calling out the staff were busy updating records of care provided.

Notwithstanding the above, people thought the staff were kind and caring with comments that included, "Oh yes, the carers are nice, caring, kind and doing a very good job", "Yes the carers are kind and caring" and "They are very nice, although at times we don't see eye to eye they are very good." Relatives comments supported this view and included, "Yes they are very kind and caring and if they were not I will tell them", "Yes, very kind and caring" and "The carers are very kind and caring."

People felt the staff supported them to maintain their independence when they received support. They said "Yes, the support does help my independence and maintain my dignity" and "It does at times but I still need help with my care." Relatives told us, "Yes the support is sufficient for his needs" and "It doesn't help, my

family member needs more support and encouragement to dress and get out of bed."

Staff we spoke with demonstrated they knew how to ensure a person's dignity and privacy was maintained while they provided support. Their comments included, "Closing doors, always be polite and use preferred name", "Cover the person with towels during care and respect choices" and "Ask before undertaking any task."

Information including the contact details of a local advocacy service were displayed in communal areas in each unit to enable people and relatives to obtain additional support if required.

We saw the care plans identified the person's cultural and religious needs as well as their preferred name. The care plan also identified if the person had a preference in relation to the gender of staff member who provided their care. Where available, information about people's personal histories was included in the care plans to provide care workers with additional information about the people they were supporting. This meant care workers had information so they were aware of people's cultural or religious needs that could affect the way care should be provided.

Requires Improvement

Is the service responsive?

Our findings

During the previous inspection in September 2017 we saw the care people received was not according to the care records staff maintained and that was agreed with the person or their relatives. We found a breach of Regulation 9 and we asked the provider to send us an action plan to tell us how they were going to make improvements. The provider sent us an action plan indicating improvements would be made by 31 October 2017. At this inspection we saw improvements had been made in the recording of when personal care was offered in line with the person's wishes and in the recording of people's fluid intake.

We looked at records that indicated the person had either been offered or had been supported to have a shower in line with the preferences shown in their care plan. A shower/bath matrix had been developed to identify who should be offered a bath or shower each day. The care plans indicated when a person's fluid intake should be monitored. We saw this information was recorded and the total fluid intake was calculated and recorded on the handover notes at the end of each shift.

We saw some care plans did not provide information in relation to the person's support needs which was consistent with information in other documents relating to care. The resident profile page for one person indicated they required a hoist with full body sling and the support of two care workers. The person's care plan in relation to mobility stated they needed a standing aid with the support of two carer workers. This information was not consistent and did not provide up to date guidance for staff. We also saw that where a change in the person's support needs had been identified during the monthly review of their care plans this was recorded on the review document but the actual care plan was not updated with any changes. This meant the staff had to look at the monthly review document in addition to the care plan to identify if there had been any changes in the way care should be provided.

We raised this with the registered manager who explained that a change in the format of the care plans and other documents was being introduced. They also told us an audit had been carried out of all the care plans at the end of 2017. This audit had identified areas in people's care plans that needed to be updated or amended. We saw an action plan had been developed and the registered manager confirmed all they records would be updated by the end of January 2018.

Staff completed Antecedent Behaviour Consequence (ABC) charts to record people's behaviour where there was a concern or if additional support was required. We saw ABC charts had been completed for a number of people describing specific events which had occurred but not all of the records identified what action had been taken to deescalate the situation and if it had been successful. Where people had been identified as requiring additional support with their behaviour a stress and distress care plan was in place which indicated if an ABC chart should be completed. We saw the information from the ABC charts was not reflected in the care plan or the reviews. The care plans did not always provide staff with clear guidance as to how to support the person to reduce the occurrence of a specific behaviour. This was discussed with the registered manager and they confirmed this would be reviewed as part of the review of care plans.

People told us their care was provided in the way they wanted with their comments including, "Yes they do, I

have never asked for anything. I do have a bath and things required", "Yes, they get me out of bed with the hoist and I can go to the bathroom and toilet on my own" and "Yes they try, there is nothing wrong with the staff, they could do with a few more."

Care plans had a number of sections which identified the person's preferences of how they wished their care to be provided. These sections included communication, medicines, nutrition, mobility night time support and personal care needs, with information for staff on how they should provide support to meet the person's preferences and needs. A care plan was in place to identify the person's wishes in relation to their end of life care and where agreed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) document was in the front of the person's care folder. The care plans were reviewed monthly. Staff completed a detailed record of care and support provided during each shift.

People told us they were involved in making decisions about their care and their comments included, "Myself and family are involved in my care and needs decisions", "Yes, my family member and myself are totally involved in decision making about my care" and "Yes, myself and children are involved in my care decisions." All the relatives we spoke with confirmed they were involved in the decisions relating to their family member's care and support when required. One relative commented, "Yes I am involved in the decision making, I am an appointee. If I am not available they contact other family members." We saw, when appropriate, relatives were invited to take part in the monthly reviews of the care plans.

People confirmed they enjoyed the social and recreational activities provided at the service and one person commented, "Any activity, particularly singing in the activity room. I am always involved in singing and watching films." Relatives also commented about the activities, "Yes, he is involved in activities and encouraged to be involved in it. He loves dominoes, the carer comes in to do one to one and when the animals come in", "He loves to sing along and throwing the ball" and "They go to any activity provided if they are up to it."

Since the last inspection one staff member has been given the role to support the provision of activities at the home. The well-being coordinator told us they spent time every day providing one to one activity sessions with people who were in their bedrooms. They also organised a range of group activities in the afternoon. The volunteer also provided support with both group and one to one activities. During the inspection we saw people enjoyed taking part in activities which included exercises and bingo and that they were supported to visit the hairdresser at the salon facilities at the home. People said they looked forward to the activities and we saw the well-being coordinator had a good relationship with people, encouraged them to take part and interacted with them in a supportive way to help them understand the activity.

Each care plan had a section which identified the activities the person enjoyed. A record of each person's activities was completed every day to identify if staff needed to provide additional support to prevent isolation. Pictures of recent activities were displayed in each unit and a schedule of planned activities was also available. The well-being coordinator explained they were in the process of identifying other activities to add to the schedule including entertainers who could visit the home. They had spoken with staff providing support with activities who worked at other homes owned by the provider to get ideas and suggestions. They confirmed they had not attended any training in relation to activity provision in a care home setting but they felt this might be useful to extend their skills and increase the types of activity they could provide. This was discussed with the registered manager who confirmed specialist training was being identified in relation to providing activities.

People using the service and relatives knew how to make a complaint. Their comments included, "I know what to do if I have one", "Yes but I have no complaints yet" and "I have never made a complaint." The

provider had a procedure for the reporting and investigation of complaints. Guidance on how to raise a complaint was displayed at the home for people and relatives. Since the previous inspection two complaints had been received. We saw the records of each complaint which included details of investigations, statements, the outcome of the investigations and if the complainants were happy with the way their complaints were addressed.

Requires Improvement

Is the service well-led?

Our findings

During the inspection, we identified concerns in relation to the provider maintaining appropriate staffing levels to help ensure that people received the level of care they required. Although the provider used a tool to assess staffing levels, they had not taken into account other indicators that showed staffing levels were not adequate to meet people needs.

During our inspection, we also observed practices that staff were not always caring to people. These had not been noted by the provider so action could be taken to eliminate these, despite the various governance arrangements at the service, including the 'Dignity in dining' audit. This audit was carried out weekly to monitor people's experiences during meals.

The above concerns showed that some aspects of the service were not always well-led and the governance arrangements at the service were not always effective. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a range of other processes in place to monitor the quality of the service and make improvements. The registered manager showed us the system used for recording audits, which also provided prompts for when audits and action plans should be completed. Quarterly audits were completed in relation to falls and infection control. Monthly audits of clinical indicators, the environment around the home and medicines management were carried out. Where issues were identified from these audits the registered manager completed an action plan which was then monitored to ensure the actions were carried out.

A health and safety audit was completed every six months with an annual fire risk assessment to help ensure the premises were safe. An audit of the care plans had been completed and identified specific issues with the information in the records which needed to be amended. The registered manager confirmed the actions identified from this audit would be completed by the end of January 2018.

The registered manager had a daily meeting with senior staff including housekeeping, kitchen and nursing to discuss any information relating to people using the service, staffing levels and any other issues which could impact on the service that day. A handover record was completed for the end of every shift which provided information about each person, any health concerns and if any specific support that was required.

At the time of the inspection there was an experienced and qualified registered manager in post and the provider had appointed a deputy manager since the last inspection to provide additional support for staff.

The area director visited the home regularly to support the registered manager and to check on the quality of the service provision, which were reported back to the registered manager. During the inspection we saw the registered manager worked closely with managers from other local services owned by the provider to support each other, share information and to identify areas for improvement.

People told us they felt the service was well-led and their comments included, "The staff and manager are very good. They really try their best, I don't want to say negative things because they have some good staff" and "They have changed the manager from when I arrived. The present one I don't know. They seem to change the manager all the time but the staff and the office are good, they do look after me well." Relatives we spoke told us they also felt the service was well-led with one relative telling us, "The staff and manager are very nice. If there are worries I will speak to them and they will respond. I am very grateful for the help to my family member"

The staff and everyone we spoke with told us they felt the registered manager was supportive and approachable. Their comments included, "Yes, the registered manager offers lots of information and guidance. A good communicator, a good manner when asks to do things she is direct but respectful. Approachable and we can talk to her about personal issues. She is understanding and recognises people have a life outside of work", "The registered manager is very supportive, and hands on. The deputy manager is also supportive" and "Approachable treats everyone equally. There is an open house policy, nothing to hide. Visitors are welcome anytime."

The registered manager worked closely with the local authority and during the inspection we saw a training session was held at the home to discuss the implementation of a falls reduction programme being organised by the local authority. Information on training courses being provided by the local authority was also displayed and staff were encouraged to attend. The registered manager also attended the provider forum meetings organised by the local authority.

Each person had a named key worker and a resident of the day system was in place at the home. The registered manager explained the person who was the resident of the day was identified on the handover notes and at the daily meeting with senior staff. Being the resident of the day meant the person had additional time with their key worker.

Staff could be nominated for a 'Kindness in care' award if they had been exceptional and had demonstrated kind care for people using the service. We saw certificates displayed in the registered manager office indicating staff who had received this award.

We saw information on the organisation's philosophy, aims and objectives were displayed in the reception area of the home.

There were a number of ways people, relatives, visitors and staff could provide feedback regarding the quality of the service provided. We saw a touch screen system in the reception area which could be used by relatives and visitors to provide their feedback anonymously. The results from this system were sent to the registered manager and the responses we saw were positive.

A questionnaire was given to people using the service and their relatives annually to get their views on the service and the results were displayed in the reception area. We saw these results were also positive regarding the care provided. There were regular meetings with relatives where detailed minutes were taken and circulated. A monthly newsletter was available for people and relatives identifying forthcoming events and activities, in communal areas around the home so people and relatives had information about the service.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system in place to assess, monitor and improve the quality and safety of the services provided to service users in the carrying on of the regulated activity. Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure there were sufficient qualified, competent, skilled and experienced persons deployed to meet the support needs of the people using the service. Regulation 18 (1)