Hartwood Care (2) Limited

Sunnybank 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

About the service
Sunnybank House is a care home providing personal and nursing care to up to 60 people. There were 52 people using the service when we inspected. The accommodation is arranged over three floors. The Rose unit is on the ground floor and provides residential care for people with less complex needs. Dahlia Unit is on the first floor and cares for people living with dementia. Nemesia Unit is on the upper floor and is a registered nurse led unit providing care to people with complex needs.

People's experience of using this service and what we found
We continued to find that some of the risks to people's safety had not been fully mitigated. Improvements were still needed to ensure that suitable numbers of staff were deployed to meet people's needs. Records did not provide assurances that people had always received their medicines as prescribed. The service was visibly clean throughout and no malodours were noted. Staff received training in safeguarding adults from harm and had a positive attitude to reporting concerns.

The deployment and availability of staff did not always allow staff the time to provide person centred care. Improvements were needed to ensure that people were able to take part in activities which were meaningful to them and which provided enjoyment and occupation. People's communication needs were identified and planned for. People expressed confidence that they could raise any issues or concerns with any member of staff or the management team and that these would be addressed. People's wishes in relation to their end of life care had been recorded and staff had received training to enable them to ensure people had a dignified and pain free death.

The governance and leadership systems in place were not yet being fully effective at helping the service increase its rating to at least 'Good'. Our conversations with the provider did offer reassurances that they understood what good care looked like and they maintained a commitment to drive improvements and to support organisational learning. People and their relatives were consulted and involved on an ongoing basis about their care and wider issues within the home.

People consistently told us that staff were kind and caring. People had developed caring and meaningful relationships with staff. Where people could make decisions about their care, they were encouraged to do so, and this helped them to feel that they had control over their lives. Relatives and friends could visit without restrictions and were encouraged to be fully involved in their family members care. Staff understood the importance of supporting people to maintain their independence.

People needs were assessed and planned for. Staff were suitably trained, well supported and overall had the necessary skills and knowledge to perform their roles and meet their responsibilities. Overall people's nutritional needs were met. The design and layout of the building met people's needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was 'Requires improvement' (August 2018). There was one breach of the legal requirements relating to safe care and treatment. The provider completed an action plan to show what they would do and by when to improve. At this inspection we found some improvements had been made and the provider was no longer in breach of this regulation, but some of the improvements needed were yet to be fully embedded.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Sunnybank House

Detailed findings

Background to this inspection

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

Inspection team
The inspection team included a lead inspector, an inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who has used this type of care service.

Service and service type
Sunnybank 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection we spoke with 23 people who used the service and either spoke with or received written feedback from 14 relatives. We spoke with the registered manager, deputy manager, regional manager, three registered nurses and six care workers. We also spoke with two kitchen staff and a staff member responsible for planning activities. We reviewed the care records of 16 people. We also looked at the records for three staff that had been recruited since our last inspection and other records relating to the management of the service such as medicines administration records, audits and staff rotas.

Following the inspection, we obtained feedback from six health and social care professionals who worked closely with the home.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as 'Requires improvement'. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Our last report had identified that there had been a failure to assess and mitigate all of the risks to people's care. At this inspection we found improvements had been made and the provider was no longer in breach of this regulation, but some of the improvements were yet to be fully embedded.

● A nutritional risk assessment tool had been put in place to inform and guide staff about people's dietary needs and the associated risks. These were readily available on each of the units. However, despite this, we observed that one person who was prescribed a soft and bite sized diet was offered a food that was not in keeping with this. When asked, staff, said they were not aware whether the person had any specific dietary needs.

● We observed during lunch on day one that there were insufficient staff to ensure that one person received the close supervision their care plan stated they required to help reduce the risk of choking. The person's care plan also stated that the person should be prompted every three mouthfuls to take sips of water. This did not happen.

● We saw two examples where the handover form contained unclear information about a person's dietary needs. Checks showed that kitchen staff had been updated with the most recent guidance but the handover form had not been updated. This increased the risk of people being offered the wrong type of diet. In the case of one person, the handover form did not record their prescribed dietary needs.

● We were not yet therefore fully assured that the risk reduction measures in place were being fully effective.

● Some people required thickener to be added to their drinks to reduce the risk of choking. The thickening powder can be harmful to people if it is accidentally ingested. We found that the thickener for one person was kept on their bedside table. However, incident reports showed that there was one person living with cognitive impairment on the same floor who was at times entering other people's rooms. We were concerned that the risks presented by the thickener being readily available had not been identified and mitigated. We have asked that this be reviewed.

● There was some evidence that post falls protocols and observations were completed to monitor whether the person was experiencing any symptoms that might require a review by a healthcare professional. Those seen had, however, not been completed for the recommended 24 hours following the fall.

● People's weight was being monitored in line with recommended frequency. Where bed rails had been recommended as a safety measure, these were observed to be in place.

● The maintenance of the environment and equipment within it were well managed. Regular checks of the safety of the premises and equipment used for people's care took place.

● Suction machines were available and checked regularly.

● Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. We did note that some of these had not been reviewed in a number of years and have asked that this be completed to ensure they remain reflective of people's needs.
● The service had a detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home.

Staffing and recruitment
● Our last inspection had identified concerns with regards to the numbers of staff deployed and with the continuity of care people received.
● This inspection found that overall, the deployment of staff generally ensured that people were cared for safely.
● Staffing levels were calculated using a recognised dependency tool. The provider and leadership used this to guide and inform decisions about staffing levels. The staffing levels provided were more than those recommended by the tool.
● However, whilst people generally received the care and support they needed, feedback from people, relatives and staff indicated that there continued to be occasions when the numbers of staff deployed was not sufficient to support the provision of person-centred care. We have described the impact of this further under the responsive section of this report.
● The service remained hampered by the frequent turnover of staff. Rotas continued to show that agency staff were required each day and each night. At night, a third of all staff were agency staff on a regular basis.
● The provider told us they had been working hard to recruit and reduce the number of agency staff required. Records showed the use of agency staff had peaked at 25% of the workforce in November and had been gradually falling. However, in July and August 2019, a high number of staff had taken leave and agency use had risen again to 25%.
● The provider expressed confidence that moving forward the use of agency staff would continue to reduce and three new staff had just been appointed. Arrangements continued to be in place to financially reward permanent staff for picking up additional shifts to help reduce the need for agency staff.
● However, the high use of agency staff has now been a concern at our last three inspections of this service. These findings indicate that more robust action is now needed to more permanently address the issues with staff recruitment and retention at this service and we will monitor this, moving forward, on a regular basis with the provider.
● Staff were recruited safely, and appropriate checks were completed.

Using medicines safely
● People were happy with the way in which their medicines were managed. For example, one person told us their medicines were "Regular as clockwork" and another said, "I have a patch which relieves the pain in my back and I can also have paracetomol".
● A healthcare professional told us, "[Staff] identified the needs of a resident with Parkinson's and ensured the correct medication was given at the correct time".
● Medicines, including those requiring additional security, were stored securely in treatment rooms on each floor which were climate controlled.
● We observed people receiving their medicines. This was managed in a person-centred manner.
● Medicines were only administered by staff who had received training and had been assessed as competent.
● Whilst people were satisfied with the management of their medicines, our checks noted some concerns.
● We reviewed the medicine administration records (MARs) and found 18 gaps where no entry had been recorded. We could not be assured that people were therefore receiving their medicines as they should. We have asked that each of these gaps be investigated. Moving forward the provider told us they would be

implementing a 'Gap analysis' form and reiterating to all medicines trained staff the protocols for escalating medicines errors. The provider also has plans to introduce electronic MARs. This system will raise an alert should medicines not be signed for in a timely way so that action can be taken to address this.
● Staff had not always managed medicines in line with best practice frameworks. For example, staff did not consistently record the application site for pain patches.
● Topical medicines administration records (TMARs) lacked information regarding the frequency with which the topical medicines needed to be applied. The majority of TMARS viewed contained gaps, but as the prescriber's instructions were not clear, we could not be certain whether this was an administration concern or not.
● Staff did not have protected time to book in and manage the changeover of the medicines cycle. We recommend that this practice is reviewed in line with NICE guidance.

Learning lessons when things go wrong
● There were systems in place to learn from safety events, but these were not always fully effective.
● The reasons why people fell were explored as part of post falls huddles to help prevent this from happening again. Some of these were comprehensive, others lacked detail and so it was difficult to be assured that every opportunity for learning had been maximised.
● As described above, we found that people's medicines administration records showed a number of gaps or omissions. Staff had not acted to escalate the omissions to senior staff and so no further investigation had been undertaken to ascertain whether these were recording or administration errors for example. Therefore, the opportunities to learn from when things go wrong were not being maximised.
● Weekly incident analyses took place and we were able to see examples where a remedial action had been taken in response to accidents or incidents.
● The provider's Care and Quality team shared updates on any critical incidents that may have occurred elsewhere within the organisation to share knowledge and practice. For example, following a scalding incident in another home, an alert was shared with all staff regarding the need to check the temperature of hot food and drinks before it was served.

Preventing and controlling infection
● The service was visibly clean throughout and no malodours were noted.
● Staff were observed to follow infection control procedures to ensure that people were protected against the risk of infection.
● People told us their rooms were kept clean and tidy and this was confirmed by relatives who spoke positively about the dedication of the housekeeping staff.
● The kitchen was noted to be clean and had been awarded the top food hygiene rating of five stars by the local council's environmental health inspectors in February 2019.

Systems and processes to safeguard people from the risk of abuse
● Most people told us they felt safe living at Sunnybank House. One person said, "The whole of the garden is completely shut off and everything about the home is really nice and safe". A second person said, "I've never felt unsafe here". This person told us about their fear of slipping in the shower. They said, "I do have a bath… There is always someone with me and I do enjoy it, it makes me feel really good". A third person said, "They [Staff] are very careful with looking after us here".
● Each of the people we visited in their room had their call bells in reach and access to a drink.
● The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.
● Staff received training in safeguarding adults from harm and had a positive attitude to reporting concerns.
● Staff were mostly confident that any concerns raised would be acted upon by the registered manager to

ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as 'Good'. At this inspection this key question has remained the same. People's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- Staff completed an induction which included completion of the Care Certificate for those care workers without prior experience of working in a care setting. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. The provider had identified that there continued to be a delay in some staff completing the Care Certificate in a timely manner and are undertaking a range of actions to address this.
- People and their relatives generally felt that staff were well trained. For example, one person said, "I think so, they go away on courses, they are very good".
- Staff completed a range of training. Some of this was deemed mandatory by the provider. This included health and safety, infection control, fire awareness, basic food hygiene, safeguarding, emergency first aid and moving and handling.
- Completion rates of this refresher training was variable and in July 2019 sat at 80%. The provider had identified that this was an area which needed to improve. To address this a number of staff had been booked on mandatory training days in September and October 2019.
- The service was also changing their training company to better meet the needs of the staff team and service.
- The provider offered additional training to staff in areas relevant to the needs of people using the service. For example, staff had completed training on diabetes and falls management.
- Some of the relatives we spoke with felt that staff would benefit from additional training in dementia. For example, one relative said, "My [Relative] suffers from sundowning and it would help if staff were more proactive to distract her to prevent issues". Records showed that some staff had recently undertaken training on managing distressed behaviours in people living with dementia. The feedback about this training was positive and the provider had plans to roll this out to the wider staff team.
- The registered manager is a registered nurse and is being supported by a newly appointed deputy manager who is also a registered nurse. There was no clinical lead in post, but a senior nurse provided oversight of the clinical care within the service and was provided with some supernumerary hours to support this.
- We did note that there was limited evidence that the registered nurses had undertaken training to support them to keep their clinical skills up to date. For example, only one of five registered nurses had training in wound care and tissue viability and the use of equipment which manages people's pain at the end of their life. Two nurses had training in male catheterisation.
- Following concerns raised with CQC during the inspection, the provider's own checks found inconsistencies with wound management and the records relating to this. The provider is proactively addressing this with the nursing team.

● The provider assured us that a range of training in clinical skills had been booked for October and told us that the new training programme included online modules on skills such as skin Integrity, venepuncture, catheterisation; use of syringe drivers, end of life care and continence management.
● Records showed that most staff had received some formal supervision sessions although this was not always in keeping with the frequency determined by the provider. This was an improving picture and supervision training had recently been provided for team leaders and senior care assistants allowing the provision of supervision to be delegated.
● Staff generally felt well supported and able to seek additional advice from the senior team at any time.

Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● There was evidence that staff understood the importance of seeking people's consent, supporting them in the least restrictive way possible and to upholding their right to be involved in decisions.
● Where there was doubt about people's ability to make significant decisions about their care, mental capacity assessments had been completed to check whether people could consent to the care and support being provided. For example, the use of covert medicines (Giving medicines to people without their knowledge) was taking place in the context of existing legal and good practice frameworks including the MCA.
● Consultations with relevant people had and continued to be undertaken to assist in reaching a shared decision about what was in the person's best interests.
● A tracking record was now being used to more clearly document which people had a legally appointed representative to act on their behalf.
● Applications for DoLS had been submitted where appropriate and there was a clear tracking system in place to monitor the dates these were authorised or needed to be reapplied for.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People and their relatives consistently told us the service provided effective care and that they would recommend the home to others. One person said, "The care you get here is very good" and another said, "It's a good home here, the staff are excellent". A third person said, I'm really happy here, it will never be like home of course but they do their best". A fourth person said, "If I can't be at home, this is the best place for me".
● The provider had recently introduced electronic care plans. This system was being rolled out in stages and was only currently being used on the Nemesia unit. Staff on this unit were using hand held devices to write, update and read peoples care plans. Paper care plans remained in use on the other two units. Both the electronic and paper care plans covered a range of needs, including, communication, mobility, nutrition,

personal care, continence, and sleeping care plans.
● The electronic care planning system assisted staff to identify whether people had needs in relation to any of the equality protected characteristics so that these might be planned for.
● In most cases care plans contained an appropriate level of detail to support staff to deliver effective care. For example, care plans for people with diabetes clearly identified the symptoms of low or high blood glucose levels and escalation plans were available.
● In line with guidance from the National Institute for Health and Care Excellence (NICE), people had oral health assessments. However, it was not always possible to see that the findings of these had been translated into an oral health and mouth care plan.
● Staff had just started to use a national initiative designed to support homes to recognise, using clinical observations, that a resident may be deteriorating and to support staff escalating any concerns quickly to health care professionals.

Supporting people to eat and drink enough to maintain a balanced diet
● People and their relatives mostly commented positively on the food provided. One person said, "It's very good and tastes homemade". A second person said, "The food is pretty good, you have a choice up to a point, but you can always ask for an omelette which I do sometimes". A third person said, "I love the fresh fruit we have in the afternoon it's always lovely".
● Relatives told us how staff had worked hard to find out which foods which might tempt their family member to eat well. One relative told us, "[Family member] has scrambled egg for lunch, the staff found out this is one of the few things she will eat and they encourage her to eat the things she likes". Another relative said, "[Family member] has an eating disorder, she wouldn't eat much for a long time, but they have discovered what she will eat. All the senior staff here are very good, in fact they are excellent. They encourage mum to eat and she is putting on weight now which is a relief to us".
● A staff member told us how they had tried different ways of supporting one person to eat well. They explained that what seemed to work the best was to give the person her food individually. The staff member said she tried it this way as otherwise the person just spent their time moving the different food items around on the plate rather than eating.
● Each day lunch and supper was a three course, hot meal, starting with soup, following by a choice of main course and a dessert. An extensive alternative menu was also available and included a range of salads, jacket potatoes and omelettes.
● Snacks, drinks and fresh fruit were readily available throughout the day and we observed people being offered supplements where weight loss was a concern.
● Nutrition meetings were held between the care and kitchen staff during which those at risk of poor nutrition were discussed. However, as noted in the safe domain, we did find some concerns regarding the monitoring of people's nutritional and hydration needs.
● We observed the lunch time meal during our inspection. Adapted cutlery and plates had been made available for those that needed this. The food looked and smelled appetising. Where people needed modified diets, these were presented in an attractive manner with each item individually pureed so that the person might still experience the taste of each food.
● Assistance with eating and drinking was provided discreetly and with empathy, but not always in a timely manner which we have reported on further in the responsive domain.
● Some people chose to eat in their rooms. Where this was the case, attention had been taken to ensure that their meals were well presented. Staff were observed to support people eating in their rooms in a safe manner, following the guidance in their nutrition plans.

Adapting service, design, decoration to meet people's needs
● Sunnybank House is a purpose-built care home and there was an ongoing programme of maintenance

and decoration to help ensure that the home provided a pleasant and homely environment.
● All rooms were spacious and had ensuite facilities and were individually furnished in people's preferred style. The corridors were light and provided plenty of room for people to walk freely or to be assisted by staff.

● There were a range of lounges where people could spend time or entertain their visitors.
● Some signage was available to support people living with dementia to recognise and access toilets and other key areas. For example, toilet doors were all painted yellow. There was scope to develop this further in line with recognised best practice.
● Seated areas were grouped together to aid social interaction.

Staff working with other agencies to provide consistent, effective, timely care, supporting people to live healthier lives, access healthcare services and support
● Each week, a GP attended the service to review people about whom staff might have concerns. People confirmed they were supported to see their doctor when required. One person said, "One time I had vertigo and felt ill, they got a doctor in here to see me".
● People were also visited by community nurses and where appropriate the Older Person's Mental Health team also visited to provide guidance and support.
● Chiropodists and opticians visited, and options were being explored to provide people with access to a visiting dental service.
● People told us that the permanent staff knew them well and recognised if they were not feeling well. For example, one person said, "One evening, I felt a bit poorly and this [Care worker] was passing and saw me. He came in and looked after me, he was so good".
● We saw evidence that changes in people's health had been escalated to the clinical or management team and external professionals. This included GP's, speech and language therapists and specialist teams such as the falls prevention team. We did note that some of the tools used for monitoring people's health and wellbeing could be used more effectively. For example, staff were using a log to record the frequency with which one person experienced urine infections, but we found that not all of the urine infections had been documented on this form.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as 'Good'. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People consistently told us that staff were kind, caring and compassionate. Their comments included, "Everybody who works in here is very well liked" and "The regular ones are like family". ● One person told us how staff had helped to make their birthday a special day. They said, "All the family came in, we sat in the garden room and the staff brought us sandwiches and had made me a birthday cake, everyone here was so kind".

● A professional told us, "I found all staff to be caring and nurturing and only saw positive interactions with my patient… I think that the care provided by staff is very good and they appear to be attentive to their patients in general". A second professional said, "The staff are extremely empathetic and supportive".

● The service had received a number of compliments thanking and praising staff for their caring and person-centred approach.

● People had developed caring and meaningful relationships with staff. We observed staff being kind, caring and warm with the people they were supporting. One staff member told us, "I try to be jolly all the time and not show our problems to the residents".

● Staff whatever their role, demonstrated empathy for people, smiled at them, said hello when passing or stopped for a chat which people readily responded to. We heard one staff member tell a person how nice their hair looked and engage the person in a discussion about the weather. Another care worker was concerned about one person having a sore throat and explained that they would get the nurse to come and see them. At lunch, we saw a care worker, gently rub one person's arm to sensitively wake them for them meal. One staff member told us, "We do everything we can for the residents, the nice thing is that you get to know them, they are special, they are not just a patient, it matters what happens to them".

● A relative told us, "[Staff members names] are thoughtful, respectful seniors. Dahlia floor usually feels calm and organised when they are working. They both speak to the residents in a kind and cheerful way. [Staff member] can encourage mum to take her medication even when mum is questioning why she should take it. [Staff members] really seem to care about the residents, [they are] always calm and compassionate even when obviously very busy. The food and catering staff are excellent. I have eaten with mum and have seen the lovely way [staff member] interacts with the residents [There are] lots of jokes smiles and compassion".

● People and their relatives also spoke extremely positively about the housekeeping and laundry staff. It was evident that their care and attention to people's belongings and to their environment made people feel cared for.

Supporting people to express their views and be involved in making decisions about their care

● Where people could make decisions about their care, they were encouraged to do so, and this helped

them to feel that they had control over their lives. For example, one person told us, "I don't use my bed, but sleep in this reclining chair, I have a good night's sleep which is important to me".

● It was evident that people were encouraged to direct where and how they spent their time.

● At lunchtime, staff spoke with people to offer a choice of drink and meals, sauces and desserts. Where people were less able to communicate their food choices, we did note that staff did not consistently use visual cues, such as 'show plates' to assist people to make a choice, despite this being in their care plan.

● There was limited evidence of people being involved in developing or reviewing their care plans and this is an area which needed to be developed. Most relatives were aware of the care plans and of the recent introduction of the electronic care planning system.

● Staff ensured that people were able to access advice, support and advocacy.

● Relatives and friends could visit without restrictions and were encouraged to be fully involved in their family members care. We saw that this happened in practice. Visitors and relatives told us they felt welcomed at the service. One relative said, "I can come in when I like and have been told I can help myself to a hot drink".

Respecting and promoting people's privacy, dignity and independence

● People and their relatives told us staff always treated people with respect and dignity.

● It was evident that staff took care to ensure that people felt good about themselves. Each person was nicely dressed with their hair well-groomed and their nails clean for example. We heard a care worker say to one person, "I'll get the hair drier and dry your hair, I don't want you getting cold, have you any perfume left to spray on".

● Staff showed respect for people by addressing them using their preferred name and maintaining eye contact.

● Staff were observed to knock on people's doors and identify themselves before entering. Staff understood the importance of ensuring doors were closed and people covered when delivering personal care.

● Care plans included information about people's religious beliefs and people were supported to follow these in practice. For example, one person with complex needs was taken in their bed to join the religious services in line with their wishes.

● There was no evidence of any discrimination in the service.

● Staff understood the importance of supporting people to maintain their independence. For example, one staff member told us, "At mealtimes, if people are able to help themselves then I let them, if not, I will offer help, I will help with the soup for example, but let the person do their main course I don't want to take their independence away, I don't want them to feel useless, I put myself in their shoes". One person told us, "They [Staff] help me, I've been off my feet for a long time but they do encourage me to do as much as I can for myself".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as 'Good'. At this inspection this key question had deteriorated to 'Requires improvement'. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans contained some person-centred information about people's preferred routines and life histories before coming to live at the home, but this was not consistent and was an area which would be developed further.
- We found mixed evidence regarding the degree to which people received care and support that was responsive to their individual needs.
- It was evident that staff understood how their role and interactions contributed to people's wellbeing throughout the inspection. One staff member told us, "I try hard to understand the person, I don't look at their disability but at the person and their abilities". They told us how one person liked to draw but was finding this hard, so they went to an art shop and bought a special pen and sketch book. Whilst the person was still only to enjoy this for short periods of time, it demonstrated a commitment to going above and beyond to meet the person's individual needs.
- Many of the people and relatives we spoke with were able to share examples of how staff recognised their individual needs and worked hard to be responsive to these. For example, one person told us, "They're very nice, some of the regulars work very hard. When you see them come on duty, you think, it will be a good day today, one of the carers grows orchids in their flat and they look after mine for me. They have just re-potted that one it means so much to me that they care and helps me with them". A relative said, "Staff throughout the building take time to say hello if I pass by with my mum and I never feel awkward if I need to ask for help with her". A staff member told us how they brought their son in to talk with one person. They said, "They talk for hours on end".
- However, the majority of people and their relatives also told us that the number of staff deployed did at times impact upon staffs ability to consistently provide this person centred care.
- People also raised concerns about the high use of agency staff which they said affected the continuity and quality of care provided. This was not because people felt the agency staff provided poor care, but because they did not know them, and their individual needs as well as the permanent staff did.
- We observed an example of this. An agency worker gave one person spaghetti bolognaise for lunch. The person was not eating the meal and told us, it was "The last thing they would eat". We discussed this with a permanent staff member on the floor. They told us, "[Person] won't eat pasta and hates carrots".
- One person told us they did not know from one day to the next who would be supporting them. Another person said, "At night, there is often just agency carers, I don't like that". A third person said, "The nurses are very conscientious, but you can get too many agency people, it makes you feel a bit insecure, you get a lot of different ones".
- Many of the relatives we spoke with shared these views. For example, one relative said, "Staff are amazing, really caring and thoughtful but there is not enough". A second relative said, "I personally feel there is a lack

of staff at times and those residents who have trouble eating and drinking don't particularly get the time spent from the carer trying to feed them, as again it's a matter of time". A fourth relative said, "I feel they would benefit from more staff being here for the little things, like mum missed the children coming in because no one came to take her".

● The majority of care workers told us more staff were required to enable them to provide person centred care and at times to meet people's needs. A representative comment was, "It's not just a numbers thing, we try to give fluids, but there is not always enough time".

● Our observations indicated that there were periods throughout the day when the deployment of staff was not sufficient to ensure that people experienced care that was fully person centred or responsive to their individual needs. For example, we observed that an agency worker was supporting one person to eat their meal in their room. Half way through this meal, they left the person as they were required to serve meals to other people, leaving the person's meal on the side. They later returned to assist the person to finish their meal.

● At lunch time on both the Dahlia and Nemesia Units, people were sat at table for long periods of time, watching others being assisted to eat and drink whilst waiting for their own meal. One person was fed their soup by one staff member and their main course by another. This is not a person-centred way to support people to eat.

● We observed periods during the morning on Dahlia Unit when people sitting in the 'Country' lounge had very little staff engagement. When staff entered the room, they always acknowledged people but their main focus during that period was assisting people with their personal care needs.

● We discussed our findings with the registered manager and provider. They understood the importance of ensuring that the numbers of staff deployed supported the delivery of person-centred care. For example, the activities staff used to take their break at lunchtime, but through taking this later were now available to support people with eating and drinking.

● The provider was confident that once the electronic care planning system was embedded throughout the service this would mean that staff spent less time on paperwork freeing them up to spend more time with people. There also continued to be a focus on recruitment so that there was less of a need for agency staff providing better continuity of care for people.

● Daily records were kept of the support people had received. However, where additional monitoring arrangements were in place such as food and fluid charts or repositioning charts, these had not always been fully completed which limited their effectiveness as a monitoring tool. It also meant that we could not be assured that people were, for example, always being offered sufficient fluids to avoid the risk of dehydration.

● We discussed our concerns with the provider who felt some of the records were due to agency staff not recording dietary intake correctly. They were confident that the transfer to electronic records would help to prevent this in future as the system provided an alert as part of the daily handover ensuring that staff were aware that fluid intake over the last 24 hours was a concern.

● There was some evidence that people had been involved in planning and reviewing their care. The provider had identified that there was scope to embed this further. To support this, there were plans in place to reintroduce a key worker system and further embed the 'Resident of the day' system.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's relatives and visitors were encouraged to continue to take an active role in caring for their family member if this was their wish. This helped to ensure that people maintained relationships that were important to them.

● People had access to a programme of activities. Records showed that in the two weeks prior to our inspection, several external entertainers had visited the service. We observed one such visit during the

inspection which really seemed to be engaging people.
● A local children's nursery also visited and other activities provided included knit and knatter groups, bingo and soft football.
● During the inspection, we received mixed feedback from people about the activities provided. One person said, "We have quite a lot of entertainment, we do all sorts of activities here. We've got nice gardens here so if its sunny we sit outside. Another person said, "I have always loved cooking, once a fortnight, I'm invited down to do some cooking, I really enjoy that". Other people told us the activities were not sufficiently varied or always in keeping with their interests.
● On Dahlia and Nemesia units, people were less able to talk with us, but a number of relatives told us that the activities programme needed to improve. Some also expressed concerns that their family members were not always included in the planned activities taking place on other floors.
● A number of relatives spoke of the need for the activities programme to have more of a focus on the provision of one to one time and be more tailored to the needs of people living with dementia. One relative said, "Residents need more time talking with carers on a one to one basis where they can interact more with the resident and have more quality one to one time". A second relative said, "Money is spent on expensive brought in activities when most of the residents on Dahlia floor would benefit from a chat, reminiscing using photo albums or a walk / sit in the garden. Staff tell me they do not get time for this". They explained that they were disappointed that their family member did not get taken down to the garden very often or supported to spend time in the other lounges.
● The activities team had been depleted for some time and whilst all staff understood their responsibility to contribute toward the activities provided, they told us that this was not always possible.
● The registered manager and provider were aware that the provision of activities was an which needed to be developed further and they were in the process of recruiting two additional staff to support improvements in this area.
● Technology was used to support the provision of responsive and timely care. For example, sensor mats and sensor beams were used to alert staff that people at high risk of falling were mobilising. Pendants were available that were linked to the call bell system.
● The introduction of electronic care records was underway and provided staff with a range of alerts should essential aspects of people's care not be undertaken as planned.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were identified and planned for. People had a communication plan. This described how the person communicated and how information might best be presented to them to help them understand this.
● Staff used a white board to communicate with one person who was hard of hearing. Activities programmes were available in large print and pictorial format.

Improving care quality in response to complaints or concerns
● Information about how to complain was readily available within the service.
● People expressed confidence that they could raise any issues or concerns with any member of staff or the management team and that these would be addressed. One person told us, "My daughter asked the manager to come and see me, she knelt down by my chair and I told her my feelings about the night staff not be able to understand me, its been better since then".

● The registered manager maintained a record of the complaints raised and the actions taken in response.

End of life care and support

● To ensure that staff were prepared to support people at the end of life in line with their known wishes and preferences, end of life care plans were in place for most people which described their individual wishes.

● Staff told us they worked closely with the local hospice and other health professionals to help ensure that people received a pain free and dignified death.

● One healthcare professional told us one of their patients "Received timely and appropriate care with regards to starting up a [Pain relief]. The staff appeared caring and I believe that the patient received good end of life care with her symptoms well managed".

● The service had received compliments from relatives thanking staff for caring about and supporting them through the loss of their family member which they had appreciated.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as 'Requires Improvement'. At this inspection this key question remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Following this inspection, the service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. This means that the provider has not taken sufficient action to make changes to ensure they improve their rating to at least good.
- Our conversations with the provider did offer reassurances that they understood what good care looked like and the challenges faced by the service. They maintained a commitment to drive improvements.
- The feedback about the registered manager and leadership team was mostly positive and demonstrated that people, their relatives and health care professionals had confidence in their ability to lead the service and drive improvements where these were needed. For example, a relative said, "[Registered manager] has introduced new ideas with positive effects…. there is a calmer atmosphere and there's more investment in the place. Staff seem happier and this rubs off on the residents". This was echoed by a second relative who said, "[Registered manager] can be seen around the home and interacting with the residents. [They] have implemented new ideas for the good of residents".
- A healthcare professional told us, "The new managers appear to have a good understanding of what is needed within the home" and another said, "[Registered manager] is very approachable, her door is always open, she seeks my advice".
- A number of staff told us the registered manager was "Striving to get things right" and "Seemed to prioritise what was best for the residents".
- The leadership team were supported by the provider who had a range of systems in place to ensure the smooth operation of the home and to support good communication.
- Daily meetings took place with all departments to discuss a range of issues relating to people's care and the running of the home. One staff member told us, "It is better here now, people didn't know their roles and responsibilities, communication was poor, now it is getting better".
- The provider had a Care and Quality team who visited the service on a regular basis to help identify and manage risks to the quality of care provided. They, along with senior staff undertook a range of audits to capture information about the quality of care. These were probing and, in some cases, had already identified the concerns this inspection found. The findings of these audits fed into a detailed service improvement which had clear timescales for actions to be implemented to drive ongoing improvements within the service.

Planning and promoting person-centred, high-quality care and support with openness; and how the

provider understands and acts on their duty of candour responsibility
● People and their relatives told us that one of the strengths of the service was the warm and friendly culture. This was in keeping with our observations. Staff were often seen to be smiling, positive and friendly in their approach to people.
● Throughout the inspection, the leadership team were transparent and collaborative and demonstrated a commitment to improve the service and to support organisational learning.
● When things went wrong, the registered manager informed necessary health and social care professionals as well as speaking with the person and their relatives as necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives were consulted and involved on an ongoing basis about their care and wider issues within the home. For example, one person told us, "I was asked to sit in on a staff interview last week, it was interesting, I enjoyed it".
● Regular residents and relatives' meetings were held and showed that people and their family members were given the opportunity to comment on matters such as the food, activities and environment. The meetings were also used to communicate key information such as staffing changes.
● Annual surveys were used to seek feedback from people and their relatives about the quality of service provided. The last survey had been undertaken in July 2019. The results of these were largely positive. An action plan had been produced to address the areas where improvements had been identified.
● Staff meetings were held periodically during which staff could discuss matters affecting people using the service or recruitment and staffing matters.
● Most of the staff we spoke with generally felt supported in their roles and told us morale and teamwork was good. However, some felt the registered manager was not always approachable or listened to their ideas. Feedback in a recent staff survey reflected this. To address this, the registered manager had introduced a staff suggestion box and was introducing 'ideas meetings' during which staff would vote for which new ideas should be acted upon.
● The provider continued to demonstrate their appreciation of staff for going above and beyond by awarding a 'Making a difference' award. Other incentive and benefits schemes were also in place. For example, one staff member received a bicycle at a discounted rate under the ride to work scheme.
● The registered manager and deputy manager were also supported to continue to develop their management and leadership skills
● The service had some systems in place to support people to feel part of their local community. For example, a children's nursery regularly visited the home allowing people to enjoy crafts and games alongside the children. A local Christian Church visited monthly to offer spiritual support to those people who valued this.
● The service had a licenced automated external defibrillator on site that was registered with South Central Ambulance Service NHS Foundation Trust and included on the 'Save a Life App'. This allowed members of the public to access this life saving equipment if required

Continuous learning and improving care
● The provider and registered manager were committed to the ongoing improvement of the service.
● Following significant events, detailed root cause analyses had been undertaken to establish any contributing factors and identify learning.
● The provider's Care and Quality team shared updates on any critical incidents that may have occurred elsewhere within the organisation to share knowledge and practice. For example, when a resident on anticoagulant medication fell and sustained a head injury, we were advised that information about safe procedures was shared including the correct medical attention to seek, assessment and care planning that

must be in place and training for team members.

Working in partnership with others

● The new management team understood the need to establish good links with local health and social care professionals to support improvements.

● Whilst the management team understood the importance of communicating with GP's and other healthcare professionals to ensure that people's changing health and wellbeing needs were responded to, some of the health care professionals we spoke with felt that their advice was not always, or only sometimes, followed by staff. For example, one healthcare professional said, "After each visit documentation has been completed by ourselves but does not appear to be acted upon…. Equally the communication has been variable and when trying to organise [specific] training this information has not always been passed on".

● The service was embedding the use of Hospital Packs. These provided a way of sharing key information about a person's needs effectively with hospital staff should the person be admitted.