Avens Care Homes Limited

Prestbury Court Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 8 and 9 December 2015. The first visit was unannounced and started at 7am, to allow us to meet with the night staff. The visit on the second day was by appointment. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection followed up on an inspection carried out on the home on the 25 and 27 March 2015. On that inspection we identified a number of concerns about the service. On this inspection in December 2015 we looked to see what had improved.

Prestbury Court Residential Home is a care home, registered to provide care for up to 48 people. People living at the home are older people, many, though not all of whom are living with dementia. People may also stay

Summary of findings

at the home for a short period of time on respite, or for intermediate care prior to a return home. At the time of the inspection there were 31 people living at Prestbury Court Residential Home.

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

We found that although there had been some improvements, some areas were still of concern. We also identified new concerns in relation to the management of risks.

We found there was a lack of effective leadership and governance at the home. Systems had not been put in place to fully address the concerns identified in the last inspection report, or to ensure care was delivered effectively and safely. It was not always possible to see what improvements had been made as the results of audits, because they did not always contain a robust analysis of the information gathered.

Risks to people were not always being assessed, or actions were not always taken to minimise risks where possible. Learning did not always take place following incidents because information was not always updated or analysed. Risks to people from infections were not assessed or mitigated.

Care plans were personalised to each individual but did not always contain sufficient detailed information to assist staff to provide care in a manner that met people's wishes. A new care planning system was being provided which the registered manager told us would address these concerns.

Staff had a good basic understanding of how to support people with dementia, and allowed people to be as active as they wished, although this was not always consistently practiced where people demonstrated behaviours that challenged. We saw many examples of positive and supportive dementia care being delivered, but we also saw instances where staff did not recognise that people's physical care needs were not being met.

The home had a programme of activities for people to follow which were provided one to one or in groups. However some people remained at risk of social isolation.

Medicines were not always being managed properly, or stored securely. People did not always receive their medicines as prescribed and stock levels were not possible to assess as records were not being properly maintained of the medicines held at the home.

People were protected by the home's systems for the safeguarding of people. Staff understood what they needed to do to keep people safe or report concerns, and staff were recruited following a full recruitment process. However, there were not always enough staff on duty to support people consistently and in the way they needed, and staff had not yet all received the training and support they needed to carry out their role. This included for behaviours that presented challenges or to support long term health conditions such as diabetes. Following the inspection we were told that the home manager had been authorised to use agency staff to cover if needed for staffing shortfalls, and that additional staffing cover had been provided.

The premises were subject to a programme of refurbishment, and adaptation to better meet the needs of people with dementia. We have made a recommendation with regard to seeking further advice on best practice in relation to environmental adaptation for people with dementia.

The principles and implementation of the Mental Capacity Act 2005 (MCA) were not well understood or put into practice. We did not identify that people were being unduly restricted or that staff were not acting in accordance with their best interests. But there was not a clear understanding of the principles and practice of the act and records were not completed appropriately to ensure for example people that should be involved in best interest decisions had always been consulted. This meant people's wishes might not be being acknowledged.

People enjoyed their meals and people's dietary needs were respected. Where people needed support with eating this was given with time for people to eat at their own pace.

Summary of findings

Systems were in place to manage complaints, however, stakeholders had limited opportunities to influence change and suggest improvements at the home.

Records were not all well maintained, for example records to show how much people who were at risk of dehydration or poor nutrition had eaten or drunk. Records we saw were not kept up to date.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The home was not always safe. Not enough action had been taken to ensure concerns raised at the last inspection had been addressed.

Risks to people were not always assessed, reviewed in a timely way or actions taken to minimise risks where possible. Learning did not always take place following incidents because assessments were not always updated or analysed.

There were not always enough staff on duty to support people consistently and in the way they needed. However the home was now following a full recruitment procedure for staff.

People were protected by the home's systems for the safeguarding of people. Staff understood what they needed to do to keep people safe or report concerns from abuse.

Medicines were not always being managed properly.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not all received the training and support they needed to carry out their role.

The principles and implementation of the Mental Capacity Act 2005 (MCA) were not well understood or put into practice.

The premises were subject to a programme of refurbishment, and adaptation to better meet the needs of people with dementia. We have made a recommendation the provider seek further advice on best practice in this area.

People enjoyed their meals and people's dietary needs were respected. However records in relation to fluid intake for people at risk of poor nutrition or hydration were not completed well.

Is the service caring?

Good

The home was caring.

We saw many examples of positive and supportive care being delivered. Staff had a good intuitive understanding of how to support people with dementia, and allowed people to be as active as they wished.

Summary of findings

Information was available to support people's communication, which was well understood by staff.

Staff respected people's confidentiality, and talked discreetly to them about their care needs.

Is the service responsive?

Requires improvement

The home was responsive.

Care plans were personalised to each individual but did not always contain sufficient detailed information to assist staff to provide care in a manner that respected people's wishes. New care plans were being provided.

The home had a programme of activities for people to follow which were provided one to one or in groups. However some people remained at risk of social isolation.

Systems were in place to manage complaints and ensure people with communication difficulties were able to raise concerns.

Is the service well-led?

Inadequate

The service was not always well led. Not enough action had been taken to ensure concerns or breaches raised at the last inspection had been addressed.

The provider and registered manager had not ensured that there were effective systems for governance, quality assurance and ensuring safe care for people. People did not always have access to formal ways of influencing change and improvements at the home.

The registered manager did not always demonstrate clear and effective leadership of the staff team.

Records were not well maintained and did not always reflect a thorough assessment of people's needs.

Prestbury Court Residential Home

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 was 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 also to follow up on an inspection carried out on the home on the 25 and 27 March 2015. On that inspection we identified a number of concerns about the service. Following the inspection the provider sent us an action plan telling us what they intended to do to improve. We also met with the provider to discuss our concerns. Prior to this inspection we requested an updated action plan from the registered manager.

This inspection took place on 8 and 9 December 2015, and was carried out by two adult social care inspectors. We looked at the information we held about the home before the inspection visit. We spoke with staff from the local authority who had supported people to be placed at the home and a local social services manager who had been working with the home looking at concerns raised about the service. We also spoke with the local Care Trust quality monitoring team to gather their views about the service.

Many of the people living at the home were living with an advanced dementia, which meant they were not able to communicate with us verbally about their experiences of care at the home. We used the Short Observational Framework for Inspection (SOFI) for several short periods during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support people received, including staff supporting people with their moving and transferring and being given medicines. In addition to our observations (which included fourteen people who lived at the home), we spoke to or spent individual time with six of the 31 people who lived at the home; four visitors; a visiting district nurse; the registered manager and director from the provider organisation (referred to as the provider in the report); and eight members of staff. We spoke with the staff about their role and the people they were supporting.

We looked at the care plans, records and daily notes for seven people with a range of needs. We also looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies. We looked at four staff files to check that the home was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Inadequate

Is the service safe?

Our findings

At the last inspection of Prestbury Court Residential Home in March 2015 we had identified breaches of legislation in relation to the recruitment of staff and systems for protecting people from abuse. We had also identified concerns about the staffing levels at the home and the management of medicines. The service was rated as "Requires Improvement" for this key question in March 2015.

The provider and registered manager had sent us an action plan telling us what they intended to do to put this right, and sent us an updated plan before this inspection visit. On this inspection in December 2015 we saw that although some improvements had been made, for example to the systems for the recruitment of staff, we still identified concerns in relation to the management of medicines and staffing levels. We identified new concerns in relation to the management of risks, and infection control.

People were not being protected by the homes risk assessments and risk management processes. Risks were not always being identified. Patterns, for example of falls, were not consistently being analysed to see if there were changes that could be made to prevent a re-occurrence. Accident forms were completed by staff and collated on a monthly basis by the registered manager. However a thorough analysis of these incidents had not taken place to protect people from a re-occurrence. For example we saw that one person had fallen nine times since 3 November 2015. This had included two incidents where the person had sustained head injuries. Medical advice had been sought for the person appropriately at the time of the incidents. However many of the falls had been unwitnessed, and there was no evidence of a change to or review of the person's planned care as a result. There was no care plan to guide staff on any supervision that the person needed or was to have for their safety, and no evidence that this had been considered.

Another person had a falls risk assessment and bed rail assessment in place. However they had been found to have fallen from their bed during the night. They had also apparently fallen having pushed themselves off a recliner chair. Their bed rails assessment and falls risk assessment had not been updated following the incidents, and the falls had not been recorded on the falls record in the person's care file. We discussed with staff that the person was sitting quite high in their bed, above the bedrails in place. Staff suggested this might be because of the type of mattress the person was on. This should have been a consideration in the bedrail assessment and we asked them to review the person's care as a matter of urgency. Following the inspection the registered manager confirmed that actions had been taken to protect the person.

People were assessed for poor nutritional intake and were weighed regularly. We saw evidence that staff followed up where people had lost weight and we saw in some people's files that appropriate actions had led to people recovering weight they had lost. However people's nutritional risks were not always being reviewed on admission to the home or following a return from hospital, when they might be at increased risk. Where people were found to be at risk their files recorded food and fluid intake was to be monitored, to ensure that they received appropriate nutrition. However food and fluid charts were poorly completed, so it was not always possible to see what food or fluids people had taken. Charts did not identify the target amount of daily fluids for that person, and were not being totalled each day. Some entries just recorded "8pm Juice", so it was not possible to assess the amounts of fluid taken to maintain people's health and well-being. Quantities of food were not always specified, and there was no system in place that meant someone took responsibility to review the fluids being taken in by individuals. This meant that people might have a low intake for several days without this being identified as a risk.

Where people were at an identified risk of pressure damage, risk assessments were undertaken to

identify care actions or equipment needed to prevent breakdown in the person's skin. However there was not clear evidence in every instance the actions to prevent tissue damage were being carried out. For example, one person's risk assessment and care plan indicated they were to be repositioned two hourly when they were in bed. The records in the person's room did not evidence that this had been carried out. Records indicated there were long periods of time between turns, exceeding the stated two hours. On some occasions the record was marked 'declined'. However there was no record in the care plan to indicate what actions staff should take if the person declined this support.

We saw two staff move a person, by lifting them under their arms, which is not in accordance with good or safe practice.

Inadequate

Is the service safe?

We checked with the person's care plan which stated they needed the support of two staff to transfer from a wheelchair to an armchair. This was not enough detail to ensure the person was moved safely. This was discussed with the home's management.

Environmental risk assessments had been carried out, and some actions taken, for example the removal of plastic bags from some bins that could present risks to people. However we saw items around the home and easily accessible in people's rooms that could present risks to people if accidentally ingested, such as shampoos and bath foams. Hand sanitiser gels were not stored securely in wall mounted containers.

This is a breach of Regulation 12 (1) and 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being protected by the home's systems for the management of medicines. At the last inspection in March 2015 we had identified concerns over the application and recording of prescribed creams. On this inspection we found there were still concerns.

We found that the medicines in use were stored securely, with the exception of creams and topical medicines, many of which had been left out left in people's rooms. These could present a risk if accidentally misused or ingested. Creams and other topical medicines had not always been marked with an opening date, so it was not possible to see if they were still in date. The recording systems for the administration of creams and topical medicines did not demonstrate that people received their medicines regularly or in accordance with the prescribing instructions. It was not possible to tell if the medicines had not been applied or had been applied but this had not been recorded on the medicine records (MAR). One person had been prescribed a topical steroid ointment to be applied twice a day. On two days the records indicated this had been applied on three occasions. On another person's record a cream was recorded as having been applied on around half of the occasions it should have been over a 29 day period. This told us that medicines were not always being used as prescribed.

The temperature of the medicines refrigerator was being recorded daily, but was at times operating at a higher temperature than the recommended range of 2-8 degrees centigrade. This had been routinely recorded by staff but no actions taken to ensure medicines were still safe at that temperature.

Where there was a variable prescription for medicine, that is for "one or two tablets" to be taken, the staff member had not always recorded the amount of medicine given out. This, along with the home not carrying stock forward from the previous records meant that it was not possible to carry out an accurate audit of the amount of medicine in stock. Handwritten changes to medicines records had not always been signed by two people, which would act as a double check of the accuracy of the change.

Protocols for the administration of "as required" medicines were not clearly recorded in people's care notes. For example we saw that one person had been prescribed a medicine used to control anxiety or manage their behaviours. There was no clear guidance on the person's care plan about the circumstances in which this should be used, or which interventions or support that staff should try before resorting to medicine to control the person's behaviour. This could lead to the person being given inconsistent care from staff with different interpretations of the person's needs. It is worth noting that one person's records showed that the medicine was given infrequently, and that when it had been used and had been unsuccessful staff had sought medical advice and supported the person in other positive ways. This told us that staff did not routinely rely on medicine only to help manage people's behaviour.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed two members of staff giving people their medicines, and saw that they were given their medicines with sufficient time and explanations to help them understand what they were taking. Staff told us they understood how the systems for the safe administration and recording of medicines worked and they had received appropriate training.

There were not always enough staff at the home to support people in a timely way or ensure their needs were met. The registered manager told us that they felt there were enough staff on duty. The manager did not use a tool to determine what levels of staffing were needed, based on people's

Is the service safe?

needs. There were mixed views from staff about whether there were enough staff to support people's care needs. A staff member told us staff struggled to get everything done. They said "I can't put a time on people. They have different needs every day". Staff said they said they struggled to find time to compete records about people's needs.

On the first day of the inspection there were five care staff on duty with a deputy manager. The deputy manager was the team leader, responsible for liaising with external agencies, administering medicines and supervising the care for 31 people, some of whom presented with behaviours that challenged and with significant dementia. Staff told us at times there had been fewer staff than this, as cover could not always be arranged for sickness. They said they were not able to use agency staff and the home's own staff could not always provide additional hours cover. Following the inspection we were told that the home manager had been authorised to use agency staff to cover if needed for staffing shortfalls, and that additional staffing cover had been provided.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At the inspection in March 2015 we identified the provider had not ensured systems were in place to protect people from abuse. Since the last inspection there had been a number of safeguarding concerns or complaints about Prestbury Court which had been raised with and investigated by the local authority safeguarding team. The provider and register manager had co-operated with the investigations, some of which were understood to be ongoing.

On this inspection in December 2015 we saw that the number of staff that had undertaken training in safeguarding adults had increased. We saw evidence that where concerns had been identified the provider or registered manager had reported them to the safeguarding authority, for example with one person who had unexplained bruising. Information was available for staff in the employee handbook and whistleblowing policy on how to raise concerns, but this was not on display in the home. Staff told us that they would report anything they saw that they were worried about, but were not all aware of where information was kept in the home about who to contact.

We saw people approaching staff for re-assurance and support during the inspection. Visitors told us that they felt their relatives were safe at the home. One told us "I think everything is OK here. We come in all the time, so I think we would know if (person's name) is unhappy." However another relative told us that their experience had not been so positive. This was discussed with the provider, and we suggested that they speak with the family directly to give them the opportunity to discuss their experiences. The family told us they had spoken with the home's management.

During the inspection we looked at the infection control practices at the home. We found that there were no individual risk assessments where people had known risks. During the inspection one person was admitted to hospital with a soft tissue infection. The manager told us that they had been at increased risk due to a skin condition. Many areas of the home had a significant odour problem throughout the two days of the inspection, including some people's rooms and communal areas. We discussed this with the cleaning staff who told us they had access to the cleaning materials they needed, and a carpet cleaning machine. The registered manager told us that there were cleaning checklists completed each day, and that they carried out spot checks of cleaning schedules to ensure they were completed.

Staff told us they had good access to aprons and gloves, and we saw that these were changed frequently. Most staff had completed training in infection control which covered such areas as barrier nursing and hand hygiene. We looked at the home's laundry area. This was situated in an outbuilding and was clean and clear from a build-up of dirty laundry waiting to be washed. The laundry person demonstrated they had clear workflow systems ensuring a separation of clean and contaminated laundry. However the wall and floor surfaces were not all easily cleanable and there was no infection control audit in place.

This is a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in March 2015 we had identified concerns over the systems in use for recruiting staff. On this inspection we saw that improvements had been made. People were protected because the service had followed a full recruitment procedure when appointing new staff. Staff files showed that references and employment histories had been obtained, and disclosure and barring service (police) checks had been carried out. Where there were concerns

Inadequate

Is the service safe?

over the staff member's appointment there were systems in place to ensure a risk assessment would be carried out. Policies were available for disciplinary and grievance actions.

Requires improvement

Is the service effective?

Our findings

At the last inspection of Prestbury Court Residential Home in March 2015 we had identified concerns over the level of skills, knowledge and training that staff had received in relation to their job role. People's rights were not being protected, because staff did not understand the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager completed an action plan telling us the actions they intended to take to improve this. On this inspection in December 2015 we looked to see what had changed.

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.

We checked whether the service was working within the principles of the MCA. We found that there was still a lack of understanding of the principles and implementation of the MCA in practice at the home. The home's training matrix showed that the majority of staff had undertaken the home's training package in relation to the Mental Capacity Act and DoLS, and the registered manager told us they were seeking face to face training for staff to re-enforce this. However people's files did not indicate a person centred approach had been taken to the principles of the act. Staff were acting to protect people, but would benefit from a better understanding that capacity assessments must be decision and time specific, and of the principles of the MCA. There were some instances where capacity assessments were generic and one instance of where staff had made a decision on behalf of one person but had not followed the code of practice for the MCA. It is likely, based on the information available that the decision would be the same as the action taken by staff. Staff must however consult with people's relatives or other professionals providing support and these actions had not been taken.

In other instances where best interest decisions needed to be made for people these had not always been completed. For example one person was being given medicines for a health condition. However they had significant dementia and although they were compliant with taking medicines they did not understand what they were taking. There had been no capacity assessment or best interest decision made to ensure that it was in their interests to continue to take the medicine. We did not see best interest decisions had been undertaken to support people with bed rails or pressure mats being in place where they did not have the capacity to consent to this. Several people had small stair gates at the entrance to their room. We were told this was to keep people out of their room and keep them safe. For one person this was in relation to their sexual vulnerability. However there was no assessment of risk or a best interests decision in relation to this.

We did not identify instances where people were being unduly restricted or that staff were not acting in accordance with their best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us that applications had been made for authorisations for everyone at the home and they were awaiting a response from the local authority, for all except one person where a decision had been made. However discussions with staff and the registered manager indicated that not all the applications were appropriate, or based on a clear understanding of the principles of the act and DoLS.

This is a breach of Regulation 11 (1) (3) and (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that there had been a significant focus on training at the home since March 2015, where we had identified concerns with staff skills and training. On this inspection however we again identified concerns over staff training and induction practices, staff skills and the provision of training to meet people's individual needs.

Since the last inspection the home had purchased a training system for staff to complete in house, which was externally marked. On this inspection, staff told us they were working through this, but some said they found it difficult to complete as they were working long shifts, and were expected to complete this in their own time as they were too busy in work.

Requires improvement

Is the service effective?

In March 2015 there had been concerns about the Induction practices followed at the home. We found we still had concerns that the induction programme did not fully prepare staff for their role at the home. We looked at five staff files, including people who had started working at the home recently. Staff had worked three shadow shifts and completed an induction checklist before starting to work with people. This was the same as at the last inspection, in that there was no evidence that all staff had undertaken an induction that met nationally recognised induction standards. The file for one person showed that they were completing their Care Certificate which is a nationally recognised Induction programme across the care sector. A decision had been made that other newly appointed staff were already experienced and did not need to do this. However there had been no recorded individual skills assessment to underpin this decision.

We found that training systems did not always identify specific staff training to meet people's needs, or provide an overall assessment of the training needs of the staff team. The home had a training matrix which identified training staff received. The registered manager told us that as a priority the home's staff had completed training in moving and positioning, first aid, The Mental Capacity Act 2005, safeguarding, and person centred care. They told us that they "were satisfied that staff had a level of understanding of the training they need". The registered manager told us that they monitored staff skills and competence in practice through observations of practice with individuals. We saw this in a staff member's file, however we did not see individual training needs assessments or an overall training needs analysis for the home based on the needs of the people who lived there. For example the training matrix did not cover areas such as specific long term health conditions such as diabetes, although there were people at the home living with this condition.

We found that there were still some concerns over staff skills. For example a nurse had expressed concerns highlighted by a GP visit the day before over how the home was supporting people with behaviours that challenged or presented risks to people. The manager agreed that staff had completed some training to support people with dementia but had not received training or support in managing challenging behaviour, despite several people at the home presenting with these behaviours. This was also highlighted to us by a staff member who was concerned that not all staff had the skills they needed to support and protect people. We observed an instance where staff needed additional support to manage a situation for one person. We saw staff attempting to reason with one person to eat a special diet, however the person became agitated and distressed as they wanted the same meal as other people. The deputy manager stepped in and managed the situation well, offering the person an additional portion of a low sugar dessert with cream which they ate and enjoyed. This demonstrated to us that although some staff were skilled at managing behaviours that might be challenging, not all staff understood how to de-escalate behaviours that might escalate or support people in a positive way.

This is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to the healthcare they needed, both inside and outside of the home. However we identified an instance when relatives had requested staff contact a GP as instructions from a pre-admission assessment had not been carried through. Records did not always indicate the outcome of healthcare staff being called in, which meant that staff might not be clear about any potential changes to their treatment plan. For example one person had been given a detailed bowel management plan drawn up by healthcare professionals. However the person's care plan had not been updated to reflect the new plan.

We saw evidence in people's files of both services visiting the home and of people being supported to attend medical reviews. District nurses and GPs attended the home throughout the two days of the inspection. A visiting relative told us that staff noticed if their relative had a health problem, They said that their relative didn't complain easily, but staff were "good at picking up her body language" and knew if it was different to the person's usual behaviours. We saw evidence that staff had contacted health professionals out of hours to report concerns about people's well-being.

On the second day of the inspection we observed people being supported to eat their lunch. Where people needed support to eat this was given sensitively and in ways that supported people's dignity. Meals were presented well. The cook was able to tell us about people's preferences and choices, including textures that people needed to help with swallowing difficulties.

Requires improvement

Is the service effective?

For example some people needed their meal presented in a 'fork mashable' texture following advice from speech and language therapists. One person told us the home were "very good" at remembering their special diet.

The chef told us they had the flexibility to prepare other meals if people wanted them, and that a tray of sandwiches was prepared for people at night. We saw evidence that night staff had cooked one person an omelette in the middle of the night as they had requested it.

Prestbury Court residential Home is a large period building extended with a two story extension to one side and a new wing with six additional rooms on another. The building was not managed in separate small units, so people had free access throughout the building, via a lift if needed to the first floor. There were communal facilities on the ground floor, with three lounges and dining room, so people could choose where they wanted to be.

We used the SOFI tool and principles to observe staff working with people. We saw staff understood how people's care was to be delivered and how to communicate effectively with them. We asked a staff member about one person's communication needs and how they would communicate if they did not want to do something. The staff member showed us they understood the person's communication and they respected the person's wishes in relation to their care. A visitor told us that staff understood their relative's communication and said "They do quite well, given her behaviours". Another person told us that the staff understood what help they needed. They told us "The staff are ok – some are better than others, but they know what they are doing."

Since March 2015 the registered manager told us the home had been developing an improved environment to support people with dementia to live more comfortably and find their way around the building more easily. The registered manager told us that they had recently ordered some dementia friendly signs and they were aware of good practice advice with regard to environmental design. Doorways to people's bedrooms had been brightly painted to contrast with the architrave and fitted with door knockers to re-enforce people's sense of private space. Information and a picture of the person was secured outside the room to help people identify their own space.

Lighting had been changed in many areas of the home to provide daylight lighting, which the manager was anticipating would lead to a decrease in the number of falls. Where carpets were being replaced they were being replaced with plain rather than patterned carpets which were more suitable for people with dementia. Locks had been fitted to people's doors to help ensure their privacy. These were openable from the outside in case of an emergency. People were encouraged to choose colours for their own bedrooms or to bring in items of their own furniture to help them feel more familiar with their environment. We saw that some people were active for much of the time around the communal areas and corridors. This gave people some sense of freedom and ability to be more active if they chose.

We recommend the home seek further advice and guidance from a reputable source on current best practice in relation to the specialist environmental needs of people living with dementia.

Good

Is the service caring?

Our findings

Staff demonstrated many examples throughout the inspection of supporting people in a caring and compassionate way, even though at times they were pressured. Staff greeted people cheerfully by their name regularly, even though they may have only seen them a few minutes previously. Staff knew people well, including those who had been recently admitted. We saw them chatting with people throughout the inspection, including laughing and joking with them when they passed by. Staff noticed if people looked uncomfortable or seemed to be looking for help as they passed them. We saw they took time to engage with them and waited for their replies before making them more comfortable and checking they were alright. They had an understanding of what 'well-being' looked like for that person, and could tell us what signs they would look for to determine if the person was unhappy or distressed.

Staff had patience when supporting people. One person's care plan included that they might repeat questions. We saw staff politely responding and continuing their conversation with the person when they did this, with the person changing to another subject in time and appearing less anxious.

We saw staff allowed people freedom to undertake activities without being disrupted, although it may have been inconvenient for staff. For example a person with a significant dementia came into the home's office which was occupied and closed the window. A passing staff member saw this and commented that the person liked closing windows and curtains. They didn't try to remove them from the office directly, letting the person look at things in the office before inviting them to go with them to the lounge to complete a puzzle. They engaged the person in conversation and they left the area contentedly.

People were encouraged to make decisions about their care, treatment and support. Staff had a good understanding of how people with dementia might communicate their choices through their behaviours. A staff member told us "I like to look after people like I would want to be looked after. I like to give people the choice of what to wear and time to make decisions".

One person presented significant challenges, including becoming distressed and agitated at times. We saw that staff had a good understanding of how to support this person, and had a positive approach towards supporting them. A staff member told us "For them it's all about having a choice. They just want someone to spend time with them, and that usually helps her calm and settle." We saw an experienced senior staff member putting this into practice successfully, moving the person rapidly from anxious and distressed to calm and positive in their mood.

People told us the staff were caring. They said "I am very contented, Everybody's lovely" and "Can't grumble. They look after me very well. Staff are very good". A visitor told us their relation had previously been in another home for respite care which wasn't a home for people with dementia. They told us they were happier with their care at Prestbury Court.

Care was delivered in private and staff spoke discreetly about people's personal care needs, such as if they needed to use the toilet. Records were kept securely locked away with the exception of some charts used to record food and fluid intake and re-positioning charts to relieve prolonged pressure which were kept in people's rooms. Records were written respectfully, and staff spoke about people with understanding, even when they were discussing behaviours that might be challenging.

There was open visiting at the home. The registered manager told us that relatives were encouraged to continue to support their relation if they wished, for example one relative helped with encouraging the person to walk and do physiotherapy exercises with them. A service user guide with minimal text for people with dementia was available on the home's website, although this was out of date.

Requires improvement

Is the service responsive?

Our findings

At the last inspection of Prestbury Court Residential Home in March 2015 the home had been rated as requiring improvement in this key question. People had not been consistently receiving support that was responsive to their needs; their care needs had not always been assessed and recorded, and some people were at risk of social isolation. We looked to see if action had been taken to address these issues for people.

On this inspection each person living at Prestbury Court had a plan of their care, based on an assessment of their needs. However assessments were still not always comprehensive enough to ensure people's needs could be met, or were compiled without significant input from the person concerned. Where staff had identified people's care needs these were not always being met and care plans did not always contain enough detail to ensure people received the care they needed or wanted.

Records showed that some people and /or their relatives had been present when an assessment of their needs had been carried out, but this was not always the case. Some records contained very little information about the person, their preferred lifestyle choices and wishes with regards to their care.

We saw that care needs identified in people's pre-admission assessments were not always actioned in a timely way. One person's plan stated that a GP was to be contacted as soon as possible after the person had been admitted to review a significant health condition. However this had not been carried out until four days after their admission. A GP raised concerns over appropriate seating for another person. A district nurse had also visited at the request of the GP and identified a high specification cushion was needed to support the person with their pressure area care. Following this being identified the provider went to the person's home to bring their own chair into the home and a suitable pressure relieving cushion was provided. We discussed this with the registered manager who told us that the pre-admission assessment had not highlighted that the person needed a different seat and they had not used one in the hospital. This told us the assessment may not have been thorough enough to identify the person's needs.

This is a breach of Regulation 12 (2) (a) and (b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a plan of care based on their assessment. Some care plans contained good 'person centred' information, but this was inconsistent and some information was contradictory. For example one plan contained good information about how to communicate with the person and their preferred times of waking and going to bed. But another person's assessment just said that they needed assistance to go to bed and that they slept well, with no indication of their preferred rising or bed times. The person might have had difficulties in making this decision themselves. Another plan indicated that the person was continent, and then later that they could be incontinent at times.

Some plans contained information about the person's life prior to coming into the home. This gave staff useful information about how to support the person with dementia, and understand their behaviours in the context of the life they had lived. However there was little evidence of how this impacted on the care people received.

This is a breach of Regulation 9 (3) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff contacted people's representatives, keeping them updated about changes in the person's health or any accidents. A relative we spoke with confirmed this. Another relative confirmed that they were very satisfied with the service and that staff spoke with them to update them whenever they visited.

We saw some evidence that people's preferences where identified were supported, for example one person had their meals on a tray as indicated in their care plan rather than on a bed table. People told us "Yes they look after me alright. I leave it to them, they know what to do" and "I am going to stay here. I like the room and I like the people. Staff are wonderful. I eat very well, and keep myself to myself. I have my own phone so I can keep in touch with people". There was a system of monthly care reviews in place, and we saw evidence that one person's care plan had been reviewed promptly following a hospital stay.

Care plans included some information on how staff should promote people's independence, such as by cutting up food for one person and leaving it within their reach, or

Requires improvement

Is the service responsive?

encouraging a person to wash their own face and hands. One person we met was in pain. Their relative told us the person had been given pain relief. The pain had been a problem prior to the person's admission and staff were liaising with the person's GP to try to address this. The relative told us "They're doing all they can".

At the previous inspection in March 2015 we had identified that some people were at risk of social isolation, and that activities on offer were not always personalised to meet people's individual needs and wishes. On this inspection in December 2015 we spoke with people, observed some activities taking place and looked at the records in relation to activities provided. We found that although there had been some improvements there were still areas for development.

We found that although improvements had taken place with regard to the provision of activities, some people were still at risk of social isolation, and activities were not yet always reflecting people's individual wishes and interests. The activities advisor told us that they were helping to train another person to support them with the provision of activities at the home which would mean they were able to be provided 7 days a week. The second person would work with them on three days which meant they would be able to provide more activities to people who spent much of their time in their rooms, and ensure activities were more individually targeted.

We looked at the file for one person who was physically very frail. Their file said that they enjoyed listening to music, in particular classical music. We visited them in the room and saw that their radio was tuned to a classical music station. The activities file showed that the person had received one to one interaction, but not since the 19 November 2015. Prior to this the records said that the person had been read to, discussions held with them about Christmas, and having received a hand massage and manicure. Since then the records indicated they had been on 'bed rest'. The activities organiser told us that it was sometimes difficult to provide activities that people enjoyed as people's ability levels fluctuated widely. This meant that in group activities people who were more able dominated and people who needed more support found it difficult to receive the support they needed to engage with the activity.

On the days of the inspection some people were having manicures and were discussing Christmas in the lounge. One person in their bedroom said "There's nothing to do here. There's nobody to talk to". When we asked if staff came in to their room to chat they replied "once or twice". For some people we did not see any organised activities scheduled. However another person told us they were able to go into the communal areas if they wished but "liked their own company" and did not wish to join in.

The home had a complaints policy and procedure and concerns that had been identified were investigated with records kept. A relative we spoke with told us that they had raised concerns about some things such as missing laundry, which staff had addressed promptly. They told us they would raise concerns with the home's management or seniors, who would sort things out for them. Complaints were collated, and the registered manager told us that any actions needed were included in the home's action plans and quality assessment. The provider looked at complaints and concerns during their visits.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2015 this area was rated as inadequate. We had identified concerns that the quality assurance systems were not effective in ensuring people received high quality and safe care, and there were not clear records in place to monitor and review people's care.

On this inspection we looked to see what actions had been taken. We found that although some improvements had been made we still had concerns over the management and leadership at the home.

We found there was not a cohesive staff team. Staff confirmed that they had regular meetings, but one told us the staff did not speak up at team meetings any longer as they felt there was no point as they felt 'nothing was going to change'. The registered manager told us that staff were told she was always accessible for them if they needed or wanted to discuss a concern, and we saw evidence they were reminded of this at staff meetings and supervisions.

We found the registered manager was positive and passionate about good dementia care. At the start of the inspection the registered manager told us they had made "massive improvements" at the home since the last inspection. However we identified that many of the same issues were still of concern on this inspection and had not been resolved by actions taken. Some areas such as the assessment and management of risk had deteriorated. This told us that the provider and registered manager had not taken sufficient action to respond to the concerns, or the actions they had taken had been ineffective. The provider told us he was "disappointed" with what we had found.

Following the last inspection the registered manager and provider told us they had made improvements to the quality assurance systems at the home. The registered manager told us there had been a "really robust audit" of the service; however this was not available in a written format.

We found the quality management systems that had been implemented were not always robust or had not led to appropriate actions being taken. For example, a medicines audit had last been carried out on the 13 November 2015. This had identified the temperature of the medicine storage area was not being monitored but no apparent action had been taken by the time of our inspection over a month later. A quality audit carried out in December 2015 had looked at the medicines of a small number of people, and had not identified some of the other concerns with medicines administration we found.

The provider and registered manager had sent us an action plan following the inspection in March 2015, and an updated version in November 2015. In this they told us a report on governance had been carried out by a director of the provider company. There was also a monthly registered manager's audit due which was to be carried out by the manager of another home within the company. A recent audit had been carried out by a group manager from the company on the 3rd December 2015. The audit sampled areas of practice, and had identified some but not all of the issues we identified on this inspection. Areas of concern were highlighted to be looked at as a part of the home's governance visits by the director and with the registered manager, but this had not yet been carried out.

Questionnaires had been sent to stakeholders such as relatives to gather their views about the home during February 2015. The returned questionnaires had not been collated or analysed according to the registered manager, who told us that any areas needing attention had been incorporated into their action plan, although we did not see this. We asked if people had been given feedback about their comments and the manager told us "no-one has asked for feedback". There were no relatives or resident's meetings. The registered manager told us that they went around the home each day asking people for their views; however this was not recorded anywhere. This told us that there were limited formal opportunities for people to have a say in the way the home was being run.

The home had not carried out a full assessment of the home in relation to best practice in dementia care, despite the fact that most of the people at the home had dementia. There were no robust systems for assessing the levels of staffing needed or training that staff needed either individually or for the whole staff team. The home's management had not gained a clear understanding of the Mental Capacity Act 2005 or put this into practice.

Records at the home were not well maintained. At the last inspection we identified people were at risk because accurate records about each person were not consistently maintained. There were gaps in food and fluid balance

Inadequate

Is the service well-led?

charts as well as for prescribed creams. This remained the case at this inspection. Care plans did not contain sufficient detail to ensure staff understood how to support people in the way they wanted.

This is a breach of Regulation 17(1), (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they were putting into place a new computerised system for the recording of people's care plans. This they told us would address many of the issues in relation to care records such as turning charts and fluid balances being kept up to date. The provider had been planning this after the last inspection, but it was not yet in place.

The registered manager was on holiday for the week of the inspection but came in for the first day to assist us with the inspection. We discussed the accountability of staff in the absence of the registered manager. A director from the provider company was at the home for both days of the inspection. Staff told us that they had been given delegated duties while the manager was away and the provider confirmed that the deputy managers were responsible in the absence of the manager for the operation of the home. For example we saw that they organised and led the shifts and delegated duties. But they were also working directly on the floor and counted on the rota. This meant that any management duties were constantly taking them away from delivering care.

The registered manager told us that they were involved with local groups promoting good practice in dementia care and were hoping to work with another local home to develop their practice jointly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) and 12 (2) (a), (b) (g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider and registered manager had failed to provide safe care and treatment for people, assessing the risks to the health and safety of people and doing all that is reasonable practicable to mitigate risks. Medicines were not being managed properly. Infection control risks were not being assessed, managed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed to meet people's needs. The provider and registered manager had failed to ensure staff received training, learning and development to help them fulfil the requirements of their role

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

Regulation 9 (3) (a) and (b) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

How the regulation was not being met:

The provider and registered manager had failed to properly assess people's care needs and develop a care and treatment plan to meet all their needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1) (3) and (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the Regulation was not being met: The provider and registered manager had failed to ensure the service acted in accordance with the requirements of the Mental Capacity Act 2005

The enforcement action we took:
We issued the provider and manager with a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1), (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider and registered manager had failed to operate an effective system for good governance, including the assessing and monitoring of quality and safety at the service. The provider and registered manager had not ensured accurate records were maintained in relation to people at the home

The enforcement action we took:
We issued the provider and manager with a warning notice in relation to this breach.