Bupa Care Homes (CFHCare) Limited

Greenfield Residential and Nursing Home

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 & 16 March 2016 and was unannounced. This meant the provider did not know we would be visiting to inspect.

At our last inspection, we found the provider was in breach or legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, in respect of staffing, safe care and treatment, meeting nutritional and hydration needs, person centred care, need for consent and good governance. At this inspection, we found improvements had been made in each area.

However, we found the service was in breach of legal requirements relating to the need for consent. This was because the provider could not demonstrate that care and treatment was only provided with the consent of the relevant person. In addition, where a person was unable to give such consent because they lacked capacity to do so, the provider had not acted in accordance with the Mental Capacity Act 2005. You can see what action we have told the provider to take at the back of the full report.

Greenfield Residential and Nursing Home is a purpose built care home, registered to accommodate up to 112 people, with varying needs, who require 24 hour nursing and/or personal care. There were 96 people living there at the time of our inspection. The home is split into four 'houses' for people with different levels of need, including people who are living with dementia. The home is located in Ingol, close to the city of Preston and is accessible by road and public transport. Ample car parking is available at the home.

The home did not have a registered manager in post. Management cover was being provided by a relief home manager whilst a suitable candidate was being recruited. The previous registered manager had left but had not yet applied to de-register. 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.

There were an adequate number of staff deployed in each of the four houses to meet the needs of people who lived there safely. We observed staff responded to people's needs in a timely fashion and there were always staff available for people to call on if they required assistance. Robust recruitment processes were followed to ensure only suitable candidates worked with people who lived at the home. The home assessed people's needs appropriately to ensure they could be met fully and safely.

Checks were carried out to make sure the environment was clean and tidy. However, we found some areas of the home required more attention to detail. The relief home manager had already identified this as an area for improvement and took swift action to remedy this.

People's medicines were managed safely with the exception of stock such as creams and eye preparations, which had a limited shelf life. We have made a recommendation about this.

We found improvements had been made with regard to staff skills, experience, training, supervision and support. People we spoke with told us that staff knew what they were doing and had the necessary knowledge and skills to meet their needs effectively. Staff told us and records we looked at confirmed that improvements had been made with regard to staff supervision and support. Staff explained that the team was now more stable and that they received regular, worthwhile supervision.

The service ensured people received sufficient nutrition and hydration which met their needs. People were supported to eat and drink as required. People's health was monitored routinely and they were supported to access external healthcare services if they needed them. The home was operated from purpose built premises, which assisted in the environment being suitable for it's purpose.

People's involvement, or the involvement of other relevant persons in reviews of care was not always recorded in detail. We have made a recommendation about this.

The service did not routinely involve advocates in cases where people lacked capacity to make decisions and did not have someone else to speak for them with regard to their care and treatment. We have made a recommendation about this.

People were cared for by a consistent staff team who had developed positive and caring relationships with them. We found improvements with staffing levels and staff deployment had resulted in a positive impact on the experience of people who used the service. Throughout our inspection we witnessed kind and compassionate interactions between people who lived at the home and staff. There were no restrictions on visiting times.

During this inspection, we found the care delivered to people was more centred around the person; staff were driven less by tasks and more by providing care to people. Prior to anyone being admitted to the home, a thorough pre-admission assessment was carried out to assess people's level of need, to ensure the service could meet their needs fully. The assessments were wide ranging and covered all aspects of care.

We found assessments of people's needs and written plans of care were, in the main, reviewed regularly, in line with timescales prescribed by the provider. However, we did find some cases where reviews had not taken place as planned, which meant people's plans of care may not have been sufficient to address their current level of need.

The service employed three activity coordinators. Activities included trips out into the community, visits from entertainers and singers, board games, crafts, baking and one on one time for people who preferred not to involve themselves in group activities. The provider had implemented a suitable complaints policy and procedure. Feedback about people's experiences of care and treatment were sought in a variety of ways.

Systems designed to assess, monitor and improve the service were being operated effectively. The service had a written plan of improvements to improve the experience of people who lived at the home. However, we found audit tools that were used in each 'house' were not used consistently, as directed by the home's policies and procedures.

Improvements had been made with regard to the leadership and management at the home, which had resulted in an improved caring culture. Staff we spoke with knew what was expected of them and told us they were generally supported to fulfil their role. The service had implemented a wide range of policies and procedures which provided staff with clear information about current legislation and good practice

guidelines.

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.

The service worked to ensure staffing levels were based upon the needs of people who used the service, so that people received the care they needed in a safe manner.

The service generally managed people's medicines safely. However, we found that medicines with a limited shelf life were not always managed in line with best practice guidance.

The home was kept clean and tidy. Processes and procedures were in place to prevent and control the risk of the spread of infection.

The service operated robust recruitment practices to ensure only suitable people were employed to work at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the service did not always formally record people's consent to care and treatment. In addition, assessments of people's capacity to consent were not always undertaken in line with the Mental Capacity Act 2005.

The home had appointed a member of staff to review people for applications under the Deprivation of Liberty Safeguards. However, this staff member had left the service and at the time of our inspection no-one had yet been appointed to continue this work.

Improvements had been made with regard to staff skills and experience. However, some staff felt that additional training would help them to provide a better service for people.

People were able to access external healthcare services as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People's involvement, or the involvement of other relevant persons in reviews of care was not always recorded in detail.

The service did not routinely involve advocates in cases where people lacked capacity to make decisions and did not have someone else to speak for them with regard to their care and treatment.

People were cared for by a consistent staff team who had developed positive and caring relationships with them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service had implemented new documentation for the assessment of people's care needs and written plans of care. This helped the service to capture more information about people in order to provide care that was centred on them.

We found some people's written plans of care contained conflicting information, which could lead to confusion among staff about how care was to be delivered.

The service employed three activity coordinators. Activities included trips out into the community, visits from entertainers and singers, board games, crafts, baking and one on one time for people who preferred not to involve themselves in group activities.

The provider had implemented a suitable complaints policy and procedure. Feedback about people's experiences of care and treatment were sought in a variety of ways.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People we spoke with, visiting relatives and staff told us that improvements had been made with regard to management and leadership at the home.

Systems designed to assess, monitor and improve the service were being operated effectively. The service had a written plan of improvements to improve the experience of people who used lived at the home.

Tools used to monitor the performance of the service were not used consistently in each 'house'. This meant issues or concerns may not be raised in a timely manner.	

Greenfield Residential and Nursing 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 & 16 March 2016 and was unannounced. This meant the provider did not know we would be visiting to inspect.

The inspection was undertaken by five adult social care inspectors, including the lead inspector for the service and one bank inspector. We also had on the inspection team an expert by experience, who had experience of caring for someone who used similar services and a specialist professional advisor who had expertise in the care of older people and those who are living with dementia.

Before we undertook the inspection, we reviewed all the information we had available about the service. This included notifications from the provider about significant events at the home, reviews on the internet and social media, information from the local fire safety officer, commissioners from the local clinical commissioning group and the local authority. We also reviewed information that had been shared with us from other professionals.

We used a variety of methods during our inspection to gather people's views on their experience of the care and support provided by the service. We spoke directly with 14 people who lived at the home and six visiting relatives. We also spoke with 24 staff and three visiting professionals. We spent time observing interactions between people who lived in the home and staff as well as using the Short Observational Framework for Inspection (SOFI). This tool helps us to better understand the experience of people who are not able to communicate with us directly. We also looked at care documentation of 20 people, 14 of which we pathway tracked. Pathway tracking is where we look in detail at how people's needs are assessed and care planned

whilst they are living at the home. We also looked at a variety of other records relating to the management of the service, which included audits, policies and procedures, service certificates, minutes of meetings and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

We spoke with people who lived in the home, visiting relatives, staff and visiting professionals about whether they thought the service was safe. Everyone we spoke with told us they thought the service was safe. When we asked what made them feel that way, we received responses from people and their relatives which included; "The windows are shut at night and they pull the curtains across"; "It's such a nice place"; "Help is at hand, they have an entry buzzer and someone is around if [Relative] falls"; "The way staff are"; "[Relative] is well looked after, we know he's in good hands"; "[Relative] is happy, you don't get a smell and the staff are very friendly" And; "I can`t say I want to be here but I do feel safe here".

When we last inspected the service, in March 2015, we found concerns in relation to staffing and the deployment of staff, medicines management and infection control. Following that inspection, the provider sent us an action plan which showed how they planned to make improvements. During this inspection, we checked what improvements had been made in these areas.

At the time of our last inspection, the home relied heavily upon agency staff to cover a high number of shifts during both the day and night. Additionally, the service had a higher than expected rate of sickness absence among staff and staff morale was very low. These factors had impacted negatively on the consistency and the quality of care people received. During this inspection, we found that significant improvements had been made with regard to staffing.

We spent time observing staffing in each area of the home. We found an adequate number of staff deployed in each area to meet the needs of people who lived there safely. We observed staff responded to people's needs in a timely fashion and there were always staff available for people to call on if they required assistance. When people who were in their bedrooms used call bells, to summon assistance from staff, they were answered promptly. We reviewed duty rosters for the period leading up to and following our inspection and found that staffing levels were consistent. We could see there had been a reduction in sickness absence and that regular bank staff were used to fill any gaps in staffing due to annual leave or unforeseen absences.

The provider had undertaken a recruitment drive to fill vacancies at the home and had filled all staff vacancies, with the exception of three night nurse posts. These were covered by regular agency nurses. This helped to ensure people received consistent care from a regular staff team with which they were familiar. We asked those we spoke with whether they thought there were enough staff on duty and received positive responses from all but one area of the home, including; "Yes I do, they answer the bell quite quickly" And; "Yes, they're always walking up and down". We did, however, receive some mixed responses from Oak House, where we were told; "On Monday they were swamped out. There's a regular two on at night"; "No. they could do with more on, there's a lot of pressure on them" And; "To me it's a bit mixed, you sometimes have to wait a long time".

We discussed staffing with the relief home manager, who was in charge at the time of our inspection, and the clinical services manager. They explained that each area of the home was staffed according to the dependency levels of people who lived there, which were reviewed regularly. We saw that dependency levels

had recently been reviewed and that staffing levels had been adjusted accordingly in each area of the home. This gave us assurances that staffing levels were decided upon in line with the assessed needs of people who used the service, to ensure they were met safely. We did, however, alert the relief home manager to the concerns raised in Oak House and were assured they would look into this immediately.

When we last inspected the service, we found significant concerns with regard to the safe management of peoples' medicines. Concerns were centred around a lack of regular checks to ensure people received their medicines safely and a lack of guidance for staff with regard to medicines that were for use 'as and when required'. During this inspection, we found the provider had made significant improvements.

We found guidance for staff regarding the use of 'as and when required' medicines had been reviewed and updated in each area of the home. This helped to ensure safe and timely administration of these medicines when people needed them. The guidance contained a good level of detail and helped staff recognise when people needed these medicines if, for example, they were not able to tell staff directly.

We found regular checks of medicines administration were undertaken in each area of the home on a weekly basis, in addition to a monthly service-wide audit of medicines. This helped to ensure that the home's policies and procedures around medicines administration were followed correctly and any mistakes identified. The number of medicines errors reported since our last inspection had reduced significantly and the service had undertaken work with the local pharmacy to try to ensure systems that were in place for ordering, receipt and disposal of medicines were appropriate.

We observed medicines administration in each area of the home and found staff followed good practice guidance in order to administer medicines to people safely. Staff who administered medicines told us that they had received appropriate training and underwent regular checks to ensure they were competent to administer medicines. Training records and records of competency checks we saw confirmed what staff had told us.

Coupled with appropriate policies and procedures which were regularly reviewed and updated, the above matters helped to demonstrate the home managed people's medicines safely.

However, we found that some medicines which had a limited shelf life, such as ointment and eye drops, had not been dated upon opening. This meant the provider could not be certain that these medicines were used whilst still 'in date'.

We would recommend the provider reviews their systems for medicines that have a limited shelf life to ensure that practice is in line with national guidance.

When we last inspected the service, we found staff were not following infection control procedures, in line with best practice. The measures the provider had put in place to identify, prevent and control risks of infection were not being operated effectively. During this inspection we found significant improvements had been made in this regard.

We found each area of the home to be clean and tidy, with the exception of the satellite kitchens in each unit. These areas were found to be in need of more attention to detail when it came to cleaning. We alerted the relief home manager to this during our inspection, who assured us that immediate action would be taken to resolve the issue. During the second day of our inspection, we found this work had been completed and staff who were responsible for cleaning these areas had been reminded of the importance of attention to detail.

We observed staff in each area of the home followed good practice guidelines with regard to infection prevention and control. Staff used appropriate Personal Protective Equipment (PPE), such as disposable gloves and aprons when required and we saw staff using good hand washing techniques at appropriate points between tasks. Staff confirmed there was always enough PPE available around the home. However, people we spoke with told us that staff sometimes did not wear all the PPE that they should. One person told us; "One of them came without gloves so I told her" Whilst another commented; "No aprons, just gloves".

We would recommend the provider explores how best to ensure staff use correct PPE at the appropriate times.

One area of the home had recently experienced an outbreak of infection. We spoke with people who lived there, staff and visitors, and reviewed information that was available to us about this event. Those we spoke with confirmed that the outbreak had been managed appropriately, in line with good practice guidelines. This helped to show that the service took appropriate steps to manage any outbreak, to minimise the risk to people who used the service, staff and visitors.

The home had implemented appropriate policies and procedures to guide staff practice and had trained staff in order to safeguard people who lived at the home. Staff we spoke with told us and training records confirmed that staff undertook training to recognise and prevent abuse during their induction as well as periodic refresher training. Staff we spoke with were able to confidently describe what forms abuse might take and what action they would take if they had concerns. This helped to ensure that people were protected against the risks of improper treatment, discrimination and abuse.

The service undertook a thorough assessment of people's needs prior to agreeing to admit them to the home. This helped to ensure that any risks to a person's health or well-being were identified in advance, so the service could confidently say they could or could not meet their needs prior to any decision being made. This reduced the risks of unsafe care and treatment because only people whose needs could be met safely were admitted to the home. Regular reviews of people's needs were carried out to ensure care was planned in such a way that risks to people were minimised in line with any changes in their needs.

Where people were at risk, for example, of falling due to reduced mobility or pressure sores, the service responded appropriately. Risks to individuals were assessed and regularly reviewed to ensure the appropriate strategies were in place to enable people to be as independent as possible, without compromising their safety. For example, we saw people with reduced mobility were encouraged by staff to ensure they used their walking aids to reduce the risk of them suffering a fall. We saw with regard to pressure area care that assessments of people's skin integrity were carried out regularly and plans of care drawn up to ensure people received support from staff to reposition and hence reduce the risk of pressure sores developing. This helped to show the service assessed risks to individual people's safety and put measures in place to help reduce such risks.

The service operated safe recruitment practices, which included obtaining references from previous employers, checks on qualifications and checks with the Disclosure and Barring Service. This helped to ensure that only suitably qualified people of good character were employed to work with people who used the service.

Environmental risk assessments were carried out and staff were aware of the requirement to report any hazards. People's bedrooms and communal areas appeared safe. The home was secured by keypad locks. No one we spoke with raised any concerns about the safety or security of the premises. Plans had been put

in place to deal with foreseeable emergencies such as fire, flood or power loss. Each person who lived in the home had a personal evacuation plan, which was individual to them, in case they needed to be evacuated from the building during an emergency.

Requires Improvement

Is the service effective?

Our findings

We spoke with people who lived at the home, staff, visiting professionals and relatives about how effective the service was. The responses we received were mainly positive and included; "They [staff] all know what I need and know what they're doing" And; "The staff are all lovely and know how to look after me". Comments from visiting relatives included; "As far as I'm aware they know how to look after [Relative]" And; "I think the staff are very good indeed". We did, however, receive some negative comments from staff in two areas of the home, which are covered below.

When we last inspected the service, in March 2015, we found concerns relating to the skills, experience, training and supervision of staff; nutrition and hydration, and how the service gained valid consent to care and treatment. Following our inspection, we received an action plan from the provider which showed how they planned to make improvements for people who lived at the home. During this inspection, we checked to see what improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

With regard to consent, we found the service had suitable policies and procedures in place to guide staff practice. Throughout our inspection we observed staff gained consent from people before they provided any support, for example before undertaking personal care interventions or assisting someone to eat. Staff showed a good understanding of gaining consent from people. However, we found that people's consent had not been formally recorded in the care records we looked at. Out of 14 records we looked at only one had been signed, by a relative who had a lasting power of attorney. A Lasting Power of Attorney (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself.

We found other cases where people's relatives had made decisions for them without having a LPA. People's relatives normally would and should be involved in the assessment and care planning process, as this helps to build a fuller picture of the person and their preferences. However, they should not take decisions for the person without a LPA.

We looked at people's care records which contained assessments of their capacity to make decisions. The assessment document that was used was in line with the Mental Capacity Act 2005 (MCA) Code of Practice. However, the reverse of the document required the staff member who completed the assessment to state

whether the person concerned had the capacity to make a number of decisions about their care, lifestyle and future decisions. Assessments of people's capacity should be time and decision specific. In the cases we looked at, the capacity assessment was being used as an 'umbrella' assessment to cover many areas. This showed the service was not acting in accordance with the MCA when carrying out such assessments.

In addition, we found cases where people's written plans of care contained conflicting information regarding their capacity to consent. For example, one part of one person's plan of care stated they did not have the capacity to make any decisions for themselves, whilst another stated they were able to make choices about daily living. Elsewhere in the person's plan of care, we found a generic mental capacity assessment which stated the person's capacity could fluctuate. These conflicting pieces of information in someone's written plan of care may lead to confusion among staff with regard to offering the person as much choice and control as possible over their care and daily life.

Where a person lacks capacity to make decisions for themselves, a process should be followed to ensure any decisions made on their behalf are in the person's best interests. The process would normally involve the person themselves, to a greater or lesser extent, those who are close to them and professionals who are involved in the care of the person. When a person does not have relatives or friends to act in their best interests, advocacy services can provide an independent person to assist in making sure the outcome of the process is in the person's best interests.

When we looked at people's care records, we saw that some decisions, such as the use of bed rails, had been recorded as being in the person's best interests. However, the service was unable to evidence the involvement of people other than the care worker who had completed the documentation. This gave rise to concerns that the provider was not ensuring best interests decisions were being arrived at according to the correct process, in line with legislation.

The above matters constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider could not demonstrate that care and treatment was only provided with the consent of the relevant person. In addition, where a person was unable to give such consent because they lacked capacity to do so, the provider had not acted in accordance with the Mental Capacity Act 2005.

We saw from records that applications had been made to deprive people of their liberty in each area of the home. A senior member of staff had been tasked to review each individual person who may have lacked capacity to make decisions about their care and treatment, including whether to live and receive care at the home. We saw a number of applications had been made during this review and, where authorised by the local authority, conditions were incorporated into people's plans of care. However, the member of staff who had been completing the reviews had recently left their post to take up employment elsewhere and, at the time of our inspection, nobody had continued the reviews for DoLS applications. We discussed this with the relief home manager who assured us they were going to appoint a member of staff to complete the reviews as soon as possible.

Staff we spoke with were aware of the MCA and DoLS and how this may affect the care and treatment they provided for people, including possible restrictions. We looked at people's care records which indicated they had a DoLS authorisation in place. However, in some cases, we were unable to locate documentation relating to the authorisation. In addition, staff in each area of the home were unable to tell us exactly who was the subject of a DoLS authorisation. The provider should ensure that where authorisation for DoLS has been granted, clear details are recorded in each person's written plan of care, to ensure there is no confusion among staff as to whether there are any restrictions in place for the person.

We found improvements had been made with regard to staff skills, experience, training, supervision and support. People we spoke with told us that staff knew what they were doing and had the necessary knowledge and skills to meet their needs effectively. Staff we spoke with told us they received a comprehensive induction when they began work at the home and confirmed they received satisfactory training to enable them to fulfil their responsibilities. We saw from training records and staff confirmed they had received training in many topics including safeguarding vulnerable people, MCA and DoLS, Moving and Handling, Fire Safety and infection control. The provider employed a dedicated training officer who provided the majority of training face to face and in house.

However, we received some negative feedback from staff in two areas of the home. In one area, a member of staff told us their induction had not adequately prepared them for their role, working with people who had complex needs and were very vulnerable. They told us they now felt confident in fulfilling their duties but described being "Thrown in at the deep end". In another area of the home, a member of staff told us they had not received specialist training to care for people who were living with diabetes. They told us they felt they had received sufficient training in other areas, but felt they would be able to provide a better service for people with this additional training. We discussed this with the relief home manager who told us that training needs were continually analysed to ensure the service could meet people's needs effectively. They explained that further training such as that mentioned was already included in the home's training plan.

Staff told us and records we looked at confirmed that improvements had been made with regard to staff supervision and support. Staff explained that the team was now more stable and that they received regular, worthwhile supervision. Staff also commented that management support had improved greatly since the departure of the previous registered manager. They told us they now felt more able to approach managers with concerns or suggestions and were confident in managers to resolve any issues.

We observed the lunchtime experience during the first day of our inspection. We saw people could choose where they ate their meals, in the dining room, lounge or in their own rooms. Many people made good use of the dining facilities during the lunchtime service. We observed staff supported people if they required it, in a relaxed, patient and unhurried manner. People appeared to be comfortable with staff and everyone we spoke with told us they enjoyed their meal.

People's preferences with regard to food, along with any allergies or professional guidance were recorded and shared with the person responsible for preparing meals. This helped to ensure people received nutrition that met their needs and reflected their likes and dislikes. We spoke in detail with one of the hostesses, who had a very good level of knowledge with regard to the nutritional needs of active people who were living with dementia.

We saw from records that staff monitored people's nutrition and hydration. Where people were at greater risk of poor nutritional intake or dehydration, staff monitored their intake more closely. We looked at records for people whose food and fluid intake was being monitored and saw people had gained weight and people's whose weight had stabilised, which showed their nutrition and hydration needs were being met. the hostess we spoke with explained that as part of their role, they ensured people received extra snacks and extra fluids if they had been identified as being at risk of poor nutrition or hydration. We observed this taking place during our inspection. However, we found in some cases that supplementary charts relating to food and fluids were not always completed consistently.

People we spoke with and staff told us that they were able to access external healthcare services as required. We looked at records which confirmed a variety of professionals were involved in people's care, to help to ensure their health and wellbeing was maintained. Staff explained they could make referrals to

healthcare professionals for specialist assessments, guidance and advice. This was clearly recorded in people's care records to ensure staff delivered care in accordance with professional guidance. For example, we saw that where one person had begun to refuse their medication and blood monitoring on a more frequent basis. Staff explained the person's GP was going to be contacted the same day for guidance and advice, which wold then be incorporated into the person's written plan of care.

The home was operated from purpose built premises. As such, the layout of the home and it's facilities were suitable for purpose. Each area of the home provided pleasant surroundings for people who lived there. Clear signage helped people to navigate the home and contrasting colours were used, for example between hand rails and walls, to help them stand out. People were able to personalise their rooms as they wished. Memory boxes were used to help people recognise their bedrooms.

Requires Improvement

Is the service caring?

Our findings

We received positive feedback from people about how caring the service was. Comments included; "Everyone is very kind and polite"; "Everybody's OK, they treat me with respect"; "They're alright, they're pleasant"; "I don`t go out of my room a lot but the carers are in and out to see me" And; "The carers find time to talk to me when they come in". Comments we received from visiting relatives were equally as positive; "I have been in other homes and I think this is probably as good as it gets"; "The staff are great!"; "Yes, the staff are alright, they really do care for [Relative]"; "From what I've seen they're all lovely, I've no complaints" And; "It's pretty good, very friendly".

When we last inspected the service, in March 2015, we found the provider had not ensured people were fully involved in reviewing their written plans of care to ensure their preferences and wishes were taken into account. Following our inspection, we received an action plan from the provider which explained how they planned to make improvements for people who used the service.

During this inspection we found improvements had been made with regard to involving people in planning the care that was delivered to them. The provider had re-designed their care planning documentation which had resulted in an approach to care that was more centred around the person. More detail had been recorded about people's social histories and preferences. Along with thorough assessments of people's needs, these helped to formulate a plan of care that reflected the person's individuality and helped to ensure their needs could be met consistently.

We spoke with people and those important to them who confirmed they were involved in the assessment and care planning process. This helped the service to gather important information about people and their experiences of care they had received at the home. However, we found recording of review meetings did not consistently capture the views of people and their relatives in detail.

We would recommend the provider explores how best to capture and record discussion which took place during reviews of people's care.

We saw that in one case where a person was living with dementia and lacked capacity to make decisions for themselves, the service had sought support from an advocate with regard to assessment and best interest decisions. However, we found no further evidence of advocacy services having been used to support other people, for example if they did not have family or friends to support them.

We would recommend the provider explores how best to signpost people to, or involve advocacy services when appropriate in order to support people with decisions relating to their care.

We found improvements with staffing levels and staff deployment had resulted in a positive impact on the experience of people who used the service. People we spoke with told us they were cared for by a much more consistent staff team, who they had begun to develop positive relationships with. Staff confirmed they now had more time to spend with people and worked in the same area of the home, which enabled them to

get to know people better, in terms of their needs, preferences and social histories. Staff we spoke with knew people well and were able to describe confidently, and in detail, the needs and preferences of people they cared for. Staff spoke with people in a respectful manner.

Throughout our inspection we witnessed kind and compassionate interactions between people who lived at the home and staff. The interactions we witnessed appeared natural and pleasant. People were clearly comfortable and relaxed in the presence of staff. Staff addressed people in a respectful manner, promoted their dignity and respected their privacy. Staff ensured personal care interventions were carried out behind closed doors in the person's bedroom and where people required support, for example, to eat, staff provided support in a patient and dignified manner.

Relatives we spoke with confirmed there were no restrictions on visiting times.

Requires Improvement

Is the service responsive?

Our findings

We discussed with people who lived at the home, their relatives and staff, how responsive the service was to people's individual needs. We received positive comments from those we spoke with, including; "I get everything I need, it's really quite good"; "I`ve never complained but if I had to I would tell one of the carers about it"; "We complained about [Relative] not having an injection, but it was resolved"; "If I press my buzzer, they come right away" And; "They are very attentive".

During our last inspection, we found the service was not delivering care to people that was centred on them. We found concerns with regard to; personal care not being delivered in line with people's preferences; monitoring of people's physical condition not being undertaken appropriately; a lack of information about people's preferences and social histories and a very task-led culture across the whole service. Following our inspection, we received an action plan from the provider which explained how they planned to make improvements for people who used the service. During this inspection we checked to see what improvements had been made.

At the time of our last inspection, the provider had begun work to implement a new format of assessment and care planning documentation. During this inspection, we found the new documentation had improved the amount of information that had been captured about people's social histories, preferences and how they wanted care to be delivered to them. This was a significant improvement in terms of capturing information about people's individual circumstances in order to inform the care planning process.

We looked at how staff monitored people's physical condition, for example, their weight, bowel movements, blood sugar levels and skin integrity. We found that improvements had been made with regard to the recording of checks in these areas. Where concerns were raised about a person's condition, we could see the service took appropriate steps to involve external professionals and make changes to the person's plan of care in line with changes in their circumstances and according to professional advice.

During this inspection, we found the care delivered to people was more centred around the person; staff were driven less by tasks and more by providing care to people. We established from speaking with people and staff that this was due to an increase in staffing levels and better staff deployment, which had resulted in a less task driven culture throughout the service.

Prior to anyone being admitted to the home, a thorough pre-admission assessment was carried out to assess people's level of need, to ensure the service could meet their needs fully. The assessments were wide ranging and covered all aspects of care. We found comprehensive plans of care were in place for people who lived at the home, which generally included a good level of detail about people's preferences, and we saw some good examples of short term care plans, for example, around a course of antibiotics and wound care. The majority of care plans we looked at contained a good level of detail to guide staff to deliver care that met people's assessed needs, in line with their preferences. However, we found inconsistencies in the level of personal detail that was recorded. Some assessments we looked at contained a good level of detail about the person and their individual preferences, whilst others did not. This information would assist staff greatly

in planning care that met the person's individual preferences. We raised this with the relief home manager who explained work was underway to try to capture as much information about people as possible to enable the service to incorporate this into written plans of care.

Some of the records we looked at contained conflicting information. For example, one person's plan of care stated they ate independently, whilst another part of their plan stated they required assistance from staff. Similarly, another person's plan of care stated they should receive pressure area care every two hours, whilst another part of their plan stated every four hours. During our inspection, we saw that each of these people were provided with care and support that met their needs. However, conflicting information in people's plans of care could lead to confusion amongst staff and ultimately, the person may not receive appropriate care and treatment as a result.

Additionally, we found one person's plan of care lacked detail around their current behaviour. The person had started to become increasingly confused, and had started to refuse personal care interventions. This had not been addressed in their written plan of care, which meant there were no clear strategies recorded to guide staff in delivering care to this person. We discussed this with the person in charge of that area of the home during our inspection. They informed us that all staff were aware of the person's current circumstances and that a plan of care and strategies to guide staff would be implemented immediately.

The assessments of people's needs and written plans of care we looked at were, in the main, reviewed regularly, in line with timescales prescribed by the provider. However, we did find some cases where reviews had not taken place as planned, which meant people's plans of care may not have been sufficient to address their current level of need.

We discussed the issues above regarding care planning with the relief home manager during our inspection. They explained to us that they had identified some shortfalls in care planning as part of their routine quality assurance processes and had begun an audit of all care plans which would be completed within the next two weeks. This gave us assurances that the service was in the process of addressing the issues we identified regarding care planning.

The service employed three activity coordinators to provide a wide range of activities for people who lived at the home. These included trips out into the community, visits from entertainers and singers, board games, crafts, baking and one on one time for people who preferred not to involve themselves in group activities. People we spoke with told us, and relatives confirmed, that activities took place as planned and that there was a wide range of entertainment for them. We observed activities took place in each area of the home during our inspection. A visiting relative commented "They do have regular activities here all the time – it`s not just on today because you are here."

The provider had implemented a suitable policy and procedure to deal with complaints and concerns. We saw from records that complaints were dealt with appropriately by the management of the home. Where required, thorough investigations took place to establish facts and to establish root causes to make improvements to the service. Three of the people we spoke with during our inspection told us they had made complaints informally and had been satisfied with the to resolution their problem. Everyone we spoke with during our inspection told us they felt happy to raise concerns, or make a complaint, if they needed to and were confident their concerns would be taken seriously and dealt with.

Feedback about experiences of care and treatment was sought from people who used the service and their relatives, by way of satisfaction surveys, regular meetings and reviews of people's care. We saw records which confirmed this. However, we found reviews of people's care were not always recorded in detail, which

may lead to important feedback about their experiences not being taken on board or responded to. The relief home manager assured us they would review how important feedback was captured and acted upon by the service, following our inspection.

Requires Improvement

Is the service well-led?

Our findings

We spoke with people who lived at the home, visiting relatives, staff and external professionals to find out what their opinions were with regards to the management of the home and whether they felt the service was well-led. We received positive feedback from everyone we spoke with apart from three staff who worked in various areas of the home.

We were told that significant improvements had been made with regard to the leadership and management at the home, which had resulted in an improved caring culture. Since our last inspection in March 2015, the registered manager had left their post and two relief home managers had taken charge of the service in the interim. Staff told us that things had improved greatly in the last six months and spoke highly of both the relief home managers, describing them as supportive and approachable.

Prior to our last inspection, and since, the service had experienced a significant degree of instability with regard to management. The home has had a high turnover of 'house' managers, who were responsible for each area of the home, as well as two clinical services managers and three home managers since our last inspection. People we spoke with, relatives and staff all commented that this had impacted the quality and consistency of the service, but that they could see improvements over the last six months or so, which was positive. The negative comments we received from staff members, as mentioned above, related to the instability of management.

When we last inspected the service in March 2015, we found concerns with the efficacy of systems which were designed to assess, monitor and improve the quality of the service provided. At that time, the systems that were being operated had not identified the concerns we reported on at the last inspection, which included infection control, people's involvement in care planning, staff knowledge and skills, and staff supervision. We received an action plan from the provider which told us how they planned to make improvements for people who used the service. During this inspection we checked to see what improvements had been made.

We found the relief home managers had implemented a wide range of short term audits and checks to assess the position the service was in and to take action to resolve any issues raised. In addition to this, the provider had implemented a wide ranging suite of audits and checks to assist the management of the home to monitor and improve the quality of the service. We discussed our inspection findings with the relief home manager who shared with us their central service improvement plan. This was a document designed to capture any issues or concerns raised through various audits and checks on quality. The document had been used to address areas of concern since our last inspection and to track progress against improvement objectives. We could see that improvements had been made in all areas and that work was still on-going to improve the quality of the service further. This helped to show that improvements had ben made which had a positive impact on people's experience of using the service.

The service improvement plan highlighted the issues we raised during our inspection, which showed the management team at the home were already aware of and taking steps to resolve them. This included

appointing a member of staff to lead on Deprivation of Liberty Safeguards applications, records not always being completed fully by staff and reviews of care not always being recorded in detail. This showed the systems that were in place to assess, monitor and improve the service were being used effectively to improve people's experience.

However, we found audit tools that were used in each 'house' were not used consistently, as directed by the home's policies and procedures. For example, we found audits in different areas of the home were not completed each month, as they should have been and some audits, such as care plan audits were not completed fully. We raised this with the relief home manager during our inspection who showed us that these issues had been identified. Senior staff in each area were being given additional training and support to ensure audits and check were completed in accordance with policies and procedures. They explained that now the home had more stability with senior staff and house managers, they hoped to see rapid improvements in this area.

We discussed the culture of the service with people we spoke with and received mainly positive comments about how improvements had been made. Nearly everyone we spoke with told us the management were supportive and approachable and had made a lot of changes for the better. Staff told us this had led to better consistency in staffing, which in turn had led to them being able to provide a more person centred service as they were less task-focussed. We received negative comments from three staff with regard to the culture at the home. They explained this was due to not currently having a manager in charge of the 'house' in which they worked and no one taking ownership or responsibility with regard to concerns that had been raised. Following our inspection, we were able to confirm with the relief manager that a 'house manager' had been appointed for that area of the home.

Staff we spoke with knew what was expected of them and told us they were generally supported to fulfil their role. Some staff did, however, comment that sometimes leadership from senior staff could have been better. Staff confirmed this was again in areas of the home which had lacked stability in staffing and management.

The service had implemented a wide range of policies and procedures which provided staff with clear information about current legislation and good practice guidelines. This meant staff had clear information to guide them on good practice in relation to people's care. We found daily records to show that various people at the home had been involved in incidents that required notification to the Commission and/or the local Safeguarding team. We received statutory notifications about significant events at the home, as required, and found the relief home managers responded to requests for information in a timely manner.

Since our last inspection, the service had implemented regular group meetings for people who lived at the home and their relatives. These meetings gave opportunity for people to discuss the service in an open forum with staff and management, in order to raise concerns and make suggestions. We looked at the minutes of the most recent meetings and found attendance had increased. The relief home manager told us they intended to sustain these meetings as a way of involving people in how the service was run day to day and to gain feedback about how the service was performing.

The home did not have a Registered Manager in post. The previous Registered Manager had left but had not applied to cancel their registration. We had been notified that the provider had employed a new home manager who would register with the commission in due course.