Advinia Health Care Limited

Cloisters Care 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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 13 and 19 October 2015 and was unannounced.

The last inspection took place on 22 and 26 June 2015 when we found four breaches of the Health and Social Care Act 2008 and associated Regulations. We issued two warning notices telling the provider they needed to make the necessary improvements by 10 August 2015.

At this inspection we found that improvements had been made. The previous breaches and the warning notices had been met. However, we identified risks to people's safety and wellbeing at this inspection.

Cloisters Care Home is a nursing home for up to 58 older people with nursing needs. The ground floor was also for people who were living with the experience of dementia. At the time of our inspection 48 people were living at the home. The home is managed by Advinia Healthcare Limited, a private company who manage 16 residential and nursing homes and home care services in England and Scotland.

There was a manager in post. She was in the process of applying to be registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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 and associated Regulations about how the service is run.

There were not always enough staff deployed to keep people safe and to meet their needs.

People's capacity to consent and make decisions had been assessed and recorded. However, in a small number of cases the records relating to specific decisions did not always indicate whether there were discussions with a person who had been assessed as having capacity.

Although there was a range of organised activities, people's individual interests, social and emotional needs were not always met.

The provider had not always identified and mitigated risks to people's safety and wellbeing.

The provider had taken action to meet the concerns identified at the inspection of 22 June 2015 and had put in place measures to help keep people safe from harm.

We found that some people were at risk of choking and this had not always been managed appropriately, however, during the inspection the provider took action to remedy this and produced clear information and guidance for staff to ensure that people always received the individual support they needed.

Improvements had been made to the way in which people's medicines were managed so they received their medicines as prescribed.

Improvements had been made to risk assessments and the way in which staff supported people to stay safe.

Improvements had been made to the maintenance and cleanliness of the environment.

The provider had appropriate safeguarding procedures and the staff were aware of these.

There were checks on staff suitability before they started working at the home.

The staff were appropriately trained and supported to carry out their roles and responsibilities.

People's healthcare needs were appropriately assessed, monitored and met.

People's nutritional needs were met.

Most of the staff were kind, considerate and polite towards people. They had good relationships with the people who they supported and their visitors. The provider had introduced staff training which helped them to experience what it felt like to be cared for and the staff told us this had given them a different perspective on their work.

Some staff worked in a task centred way, and although they were not unkind, they tended to focus on the task they were doing rather than the person they were caring for. The manager was aware of this and was providing more training and support for the staff to help them improve the way in which they cared for people.

The staff had assessed and planned care to meet people's needs. They regularly reviewed these plans.

People knew how to make a complaint and felt confident their complaints would be investigated and acted upon.

There had been improvements in the care and treatment people at the home received and the improvements were continuous and ongoing.

The manager and the provider regularly audited the service and had plans to make further changes to the service. People living at the home, their visitors and the staff reported the culture and the atmosphere at the home had improved and was open and inclusive.

Following our last inspection, we placed the service in special measures. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. As the provider has demonstrated improvements and the service is no longer rated as inadequate for any of the five questions, it is no longer in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

There were not always enough staff deployed to keep people safe and to meet their needs.

Some of the call bells at the home were not accessible to people.

The provider had taken action to meet the concerns identified at the inspection of 22 June 2015 and had put in place measures to help keep people safe from harm.

We found that some people were at risk of choking and this had not always been managed appropriately, however, during the inspection the provider took action to remedy this and produced clear information and guidance for staff to ensure that people always received the individual support they needed.

Improvements had been made to the way in which people's medicines were managed so they received their medicines as prescribed.

Improvements had been made to risk assessments and the way in which staff supported people to stay safe.

Improvements had been made to the maintenance and cleanliness of the environment.

The provider had appropriate safeguarding procedures and the staff were aware of these.

There were checks on staff suitability before they started working at the home.

Is the service effective?

Requires improvement

The service was not always effective.

People's capacity to consent and make decisions had been assessed and recorded. However, in a small number of cases the records relating to specific decisions did not always indicate whether there were discussions with a person who had been assessed as having capacity. There were no formal mental capacity assessments in place where medicines were administered covertly (without the person's knowledge).

The staff were appropriately trained and supported to carry out their roles and responsibilities.

People's healthcare needs were appropriately assessed, monitored and met.

People's nutritional needs were met.

Summary of findings

Is the service caring?

Good

The service was caring.

Most of the staff were kind, considerate and polite towards people. They had good relationships with the people who they supported and their visitors. The provider had introduced staff training which helped them to experience what it felt like to be cared for and the staff told us this had given them a different perspective on their work.

Some staff worked in a task centred way, and although they were not unkind, they tended to focus on the task they were doing rather than the person they were caring for. The manager was aware of this and was providing more training and support for the staff to help them improve the way in which they cared for people.

Is the service responsive?

Requires improvement

The service was not always responsive.

Although there was a range of organised activities, people's individual interests, social and emotional needs were not always met.

The staff had assessed and planned care to meet people's needs. They regularly reviewed these plans.

People knew how to make a complaint and felt confident their complaints would be investigated and acted upon.

Is the service well-led?

Requires improvement

The service was not always well-led.

The provider had not always identified and mitigated risks to people's safety and wellbeing.

However, there had been improvements in the care and treatment people at the home received and the improvements were continuous and ongoing.

The manager and the provider regularly audited the service and had plans to make further changes to the service People living at the home, their visitors and the staff reported the culture and the atmosphere at the home had improved and was open and inclusive.

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

The inspection took place on 13 and 19 October 2015 and was unannounced.

The inspection team consisted on 13 October 2015 of two inspectors, a pharmacy inspector, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal experience of caring for someone with dementia. On the 19 October 2015 the inspection team consisted of one inspector.

Before the inspection we looked at all the information we held on the provider, including notifications of accidents, incidents and safeguarding alerts. We looked at the provider's action plan which showed the improvements they had planned and made since our last inspection. We asked the provider to complete a Provider Information Record (PIR). This is a document which the provider completes to state where they feel they are meeting the required Regulations and where improvements are needed.

During the inspection we spoke with 12 people who lived at the home and 14 of their visitors. We also spoke with staff on duty, including the manager, two nurses, care assistants, catering and domestic staff. The provider's operations manager and quality assurance manager were visiting the home during the inspection and we spoke with them. We spoke to one visiting healthcare professional.

We observed how people were cared for and supported. We looked at the care records for 14 people, staff recruitment and training records. The provider's audits and records of accidents, incidents and complaints. We also looked at how medicines were managed, including the records relating to this.

Requires improvement

Is the service safe?

Our findings

At our inspection of 22 June 2015 we identified that people were put at risk because the staff did not always follow safe practices, people's medicines were not managed in a safe way and the environment was not clean. We issued a warning notice telling the provider they must make the necessary improvements by 10 August 2015. The provider created an action plan which told us the actions they had taken to meet the warning notice. The provider updated us with ongoing improvements and changes to their action plan.

At the inspection visit of 13 and 19 October 2015 we found that the provider had made the necessary improvements in the required areas.

The provider did not always have enough staff deployed to meet people's needs and keep them safe. People living at the home and their visitors told us they did not believe there were enough permanent staff. Some people said there was a reliance on temporary and agency staff. They said that the standard of care and support from these staff was not good.

Some people told us that they had to wait a long time for call bells to be answered. One person said, ''the bells are answered erratically.'' However another person told us, ''call bells are answered quickly.'' People told us that it depended on the time of day and the staff on duty. People also told us that they did not always receive support to get washed and dressed or have their meals at the same time each day because of staff shortages. Relatives told us the staffing levels varied and on some days there were not enough staff to support people in communal areas and this had led to incidents where some people were physically aggressive to others and this had not been stopped in time. The relatives told us staff shortages were particularly a problem at weekends. One relative told us that meals were ''sometimes very late – depending on staff.''

We observed that staffing levels on the 13 October 2015 did not always ensure people's needs were safely met. During the morning the nurse responsible for administering medicines was disturbed by other staff and people who lived at the home on a number of occasions. She was required to assist people with eating their breakfast and had to stop giving medicines to attend to people so they did not fall. Therefore the medicine's round was interrupted. This meant there was a risk that people may not receive their medicines as prescribed.

At one point during i13 October 2015 we observed an incident where a person defecated in a communal lounge. No staff were present and one of the inspection team had to find a member of staff and alert them to the incident so they could support the person and manage the situation. Other people seated in the lounge had dementia and may have been at risk if the situation had not been addressed immediately. We also saw that people had to wait a long time for their lunch. Some people were served lunch at 1pm however, others had to wait until 2pm before they were served their lunch. Some people were supported to have their lunch in their rooms or the lounge. One person who required prompting and support with meals did not have an assigned member of staff to help them. A member of staff supporting a person in the bedroom next door told us they had to keep checking on the other person. This person was not eating their meal which had been left on a table in front of them. There was only one member of staff supporting people for the majority of lunch time in the dining room on the ground floor. This member of staff was supporting some people with their meals so at times could not see what other people were doing from where they were seated. Some of these people required supervision to make sure they were safe. At one point on the 13 October 2015 a person who required support to use the toilet waited half an hour for the staff to be free to support them. They required the assistance of two members of staff. Whilst they were using the toilet one of the members of staff was called away to support another person so they had to wait for a third member of staff to be available to support them when they had finished.

Many of the people living at the home had a high level of physical care need, including a need for two people to move them safely. Some people required support and supervision because of their needs associated with their dementia because they were a risk to themselves and others. The staff told us there was not always enough staff on duty to meet everyone's needs and keep them safe. For example on 13 October 2015 there were 22 people living on the ground floor and four care assistants on duty to support them. It was the second day working in the home

for one of these care assistants. The provider had assessed this as sufficient staffing, however the staff on duty did not agree and explained that they could not meet everyone's needs in a timely way.

We looked at the staff off duty rotas for September and October 2015. We saw that on some occasions the staffing levels did not meet the provider's own assessed staffing levels. This was due to short notice absences which had not been covered. The manager told us they were in the process of recruiting staff and there were shortages of permanent staff. They told us that some work was covered by temporary staff employed by an agency. We noted that during one night in October 2015 both nurses working at the home were temporary staff who did not know the needs of people living there. This could mean people were at risk of receiving inappropriate care and treatment. The staff rotas indicated that some staff worked long hours without sufficient breaks. For example, between 5 and 18 October 2015 one member of staff worked 13 days in a row, 11 of these days were ''long days'' (shifts of 12 hours). The previous two weeks the same member of staff had worked for ten long days and three additional afternoons and evenings. The preceding two weeks the person had worked 12 long days. Another member of staff had worked for ten long days between 7 and 20 September, nine long days and one other shift between the 21 September and 4 October and 11 long days with one other shift the following two weeks. Many of the staff regularly worked five 12 hour shifts in a row without a day off in between. The majority of days off were single days and the staff then worked another period of long days in a row. There was a risk that staff working these long hours without sufficient breaks and time off were not fit to safely care for people and meet their needs.

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

The manager told us they had identified the risks associated with low staffing levels and were recruiting more permanent staff. She also told us that, where possible, they requested the same member of staff from the agency so they were familiar with people's needs.

On 19 October 2015 we found that the provider had increased staffing levels. The staff on duty told us that they felt there were enough staff on duty on that day to meet people's needs. The nurses told us they had time to attend to their responsibilities because there were enough care staff on duty.

On 13 October 2015 we found that some of the call bells in bathrooms and toilets on the first floor were missing or had been tied up making them inaccessible to people. On 19 October 2015 we found that calls bells on the first floor were all accessible, however two call bells on the ground floor had been tied up in a way which meant people may not have been able to reach them. A number of other call bells had been knotted so that the cords did not reach down to the floor meaning people who had fallen may not have been able to reach these. We informed the provider about this and they immediately rectified the problem, making sure the calls bells were accessible.

On 13 October 2015 we found that the provider had not always responded appropriately when people had been identified at risk of choking. For example, one person had been seen by a Speech and Language Therapist in June 2015. They had been assessed as requiring a soft diet and thickened fluids. However, the guidelines and care plan for this person did not give specific details about the consistency of the person's food and fluid and did not specify the individual support this person needed. We saw that the care plans for other people at risk of choking also did not give clear information and details. For example one care plan stated, the person required a ''pureed diet and thickened fluids'', but did not specify the consistency of these. We observed a member of staff who had started work at the home the day before our visit supporting a person who was at high risk of choking to eat their meal. The member of staff did not thicken the person's fluid and did not know about the care this person needed to receive with support to eat and drink. We told the manager about this.

On 19 October 2015 we saw that the staff had reviewed and updated all care plans where people were at risk of choking or needed additional support with texture modified food and drinks. They had created individual guidelines for each person which recorded the support they needed, the consistency of their food and drink and any additional information, for example the position they needed to be in when eating and drinking. Laminated copies of the guidelines were placed in each person's room, in a central file on the tea trolley, in the dining room and in people's

Requires improvement

Is the service safe?

care records. The nurses had talked to all staff about these guidelines and they knew to check each person's individual plan before they supported them. The information was also shared with others who may support people, for example the activities coordinator, hairdresser and relatives. Thickeners for fluids were stored in people's bedrooms, the tea trolley and dining room so that these could be easily accessed as needed.

The manager told us that they had requested additional training for staff around texture modified diets and the nurses were monitoring the way staff supported people until this training was provided.

The nurses had identified and assessed risks to people. There were recorded plans to reduce these risks. For example, supporting people to move safely, risk of developing pressure sores and nutritional risks. The staff had used recognised assessment tools and had recorded changes in people's needs and the level of risk. Where there was an identified risk, plans were in place to support people.

We observed staff supporting people to move from wheelchairs to arm chairs using hoists and by supporting them to stand. We also observed the staff supporting people to walk around the home using walking frames. The staff supported people in a safe way, ensuring the equipment was being used correctly and safely. They also addressed potential hazards, for example making sure people's shoe laces were tied in a safe way, adjusting the length of people's trousers when they were too long and removing obstacles when people were walking around the home independently.

People's medicines were stored, administered and recorded appropriately. The provider had made the required improvements since the last inspection. However, there were some areas where improvements to practice and procedures would further reduce risks to people's safety and well-being. For example, people who were prescribed medicines to be taken 'when required' had care plans to support their use, however these were not sufficiently detailed to guide staff where people were unable to communicate their need for these medicines. For example, how someone expressed pain. These plans were also kept with the care plans and not easily available to nurses who were administering medicines.

Some people were given their medicines covertly (disguised in food or drink). There were guidelines in place regarding this and decisions about this had been made by the person's representatives, GP and staff at the home. The decision to administer medicines in this way was considered in the person's best interest. However, the home had also not consulted with their pharmacist as to whether the medicines prescribed were suitable to be administered in this way.

Medicines that needed cold storage were stored appropriately and the temperature monitored. However only the actual temperature of the fridge was recorded daily not the minimum and maximum. This had been highlighted in a recent audit by the pharmacist and the home had plans to rectify this.

Records showed that people had received their prescribed medicines as planned. There were no errors or gaps on medicine administration records. The amount of each medicine received and stored at the home was correctly recorded. There were accurate records of medicines which had been disposed of.

The staff responsible for administering medicines had been trained and there was a record of this, including assessments of their competency at administering medicines.

The nurses had monitored changes in people's health and needs associated with medicines, for example monitoring fluctuations in blood sugar levels. They had liaised with the person, their GP and family to make sure changes to their medicines were made as needed.

The staff recorded administration of creams and topical lotions. They also recorded the use of prescribed fluid thickeners and food supplements.

The staff had undertaken their own regular audits of medicines management. The provider had also arranged for additional audits from senior managers and the supplying pharmacist had also audited medicines management shortly before our inspection.

People told us they felt safe and secure living at the home. Relatives and visitors also told us they thought people were safe.

The provider had a procedure for dealing with safeguarding alerts. They had taken appropriate action in response to allegations of abuse which had happened at the home.

Requires improvement

Is the service safe?

They had worked with the local safeguarding authority to investigate these concerns and to ensure people were protected from further abuse. There were clear records of investigations and action taken to support people.

The staff understood about safeguarding procedures and knew what to do if they were concerned someone was being abused or at risk of abuse. For example, one member of staff said, ''I would report anything that concerned me to the unit or homes manager, and I know I could report it to the local authority too.''

The environment was clean throughout and there were no unpleasant odours. Equipment looked clean and well maintained. The staff attended to spillages and accidents promptly and efficiently. People told us they found the home was clean and well maintained. The staff told us the environment and equipment had been deep cleaned and there was a schedule of regular cleaning. The provider had undertaken audits of infection control and cleanliness. Where they identified problems these had been addressed. There were schedules to ensure all areas of the home were thoroughly cleaned. Cleaning products were stored safely and securely and were labelled correctly.

The provider undertook their own audits and assessments of health and safety. These identified areas of concern. The provider employed a full time maintenance worker to attend to these. There was evidence of external checks on electrical, water, fire and gas safety. Equipment had been regularly serviced and checked. The provider had procedures for fire safety including individual evacuation plans. There were regular fire drills and the staff had training in fire safety.

The provider's systems for recruiting and selecting staff were appropriate. They carried out checks on potential staff suitability, including references from previous employers, criminal record checks, full employment history, checks on identity, nurse's registration and work permits. These checks were evidenced in staff recruitment files. The manager told us that all staff took part in an interview with her which included how they would respond to certain scenarios. The staff confirmed this.

Requires improvement

Is the service effective?

Our findings

Some people were given their medicines administered covertly (disguised in food or drink). They had been assessed by the doctor, nurse and family member as requiring these medicines in their best interests; however a formal mental capacity assessment for this decision had not been made.

Some people's care plans contained documents which stated that staff should not attempt to resuscitate them if their heart stopped. These documents were completed with varying detail. The majority were completed appropriately, however, one form stated that the person had capacity to made decisions but there was no record this had been form had been discussed with the person. Some care plans had been signed by relatives as agreement that the plan was in the person's best interest. However, in some cases people had been assessed as having capacity to make decisions about their own care but they had not signed agreement to their own plans.

We spoke with the manager about these examples. They agreed to make sure consultations with people were appropriately recorded. They said that where people had capacity to make decisions but did not wish to sign documents, this would also be recorded.

People's capacity to make other decisions had been assessed by the staff. There was information about their capacity to make specific decisions. Where people lacked capacity there was information about how decisions should be made in their best interest and who should be involved in these decisions.

The staff told us they had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. They demonstrated a good awareness of these and were able to explain that a person was able to make their own decisions and choices unless assessed as lacking capacity, in which case a relative or representative could make decisions on their behalf as long as it was in the best interests of the person.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager was aware of her responsibilities under this legislation. The staff had carried out assessments of people's capacity and these were recorded. Where people were unable to consent and their liberty had been restricted the provider had ensured this decision had been made by a group of their representatives in their best interest. For example, the access to the front door in order to leave the home was controlled by a digital number lock. Where people had been assessed as at risk if they left the home without support, an application under DoLS had been made to the local authority. We saw copies of the requests for authorisation and the manager had kept the person's next of kin and CQC informed of these applications. The provider monitored when DoLS authorisations needed to be reviewed or updated.

The provider had introduced some features to the environment to help orientate people, for example, feature walls and coloured doorways. There were some signs on doors to help orientate people and ''memory boxes'' containing personal items were situated outside bedroom doors to help people identify their room. The staff had access of information about people's life stories and things which were important when communicating with them in each bedroom. However, not all the colour schemes, lighting and additional features were designed specifically for people who had dementia and some features led to confusion. For example, a clock on the wall of the ground floor corridor was not working on either day of the inspection. We spoke with one person at lunch time who found it hard to accept that it was lunchtime because the clock indicated it was quarter to six. There were notice boards with information for people, but some of this information was not easy to read or for some people to understand. There was a notice board displaying the date on each floor, but no other information about the day. There were large activity notice boards with pictorial information and some visitors told us these were a good guide to what was happening at the home. There was some equipment, such as games and toys, but these were not readily accessible to people, they were stored in a lounge behind furniture. The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, '' Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety.'' The guidance also refers to the use of ''tactile way finding cues.'' The

Is the service effective?

government guidance on creating ''Dementia friendly health and social care environments'' recommends providers ''enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.''

The staff had access to comprehensive training. This included an induction about the home and the staff member's roles and responsibilities. Training records showed that the staff had received training in areas the provider considered mandatory. The provider monitored staff attendance and when training updates were due. The staff told us they were well trained and they had the information they needed. They said the training was informative and helped them with their roles. The provider had recently introduced training which helped the staff to experience what it was like to be someone who lived at the home. This training included spending time in a wheelchair, being supported to eat a meal by staff and having sensory deprivation. Some of the staff at the home had been trained to train others in this. All the staff we spoke with told us that this training was very helpful and had supported them to understand some of the experiences people living at the home had. The manager told us they had noticed the impact of this training in the way that the staff supported people. One of the staff told us, ''the training gave me such a valuable insight into what it must feel like to lack capacity and not be able to do things for myself.''

The training records showed that the staff had undertaken a range of training and this was up to date. The training included, the Mental Capacity Act 2005, health and safety, fire safety, safeguarding, food hygiene, infection control and dementia. The manager told us they were arranging for additional training for the nursing staff regarding risk assessment and care planning.

The staff told us that they were well supported. They said that the manager gave them good formal and informal support. They had regular meetings with the manager as a team and as an individual to discuss their work and any concerns they had. The manager told us that she spent time working on the units with the staff, and the staff confirmed this. They said that she was always available if they needed to discuss something. The staff told us they had opportunities to develop their skills and career. For example, some staff told us they had been invited to lead on specific pieces of work.

The staff told us they worked well as a team and supported one another. They said there were good systems of communication and they were well informed about the needs of people living at the home and any changes when they attended work each day.

People told us that their healthcare needs were met. They said that they were able to see the doctor or other healthcare professionals as needed. We spoke with one visiting healthcare professional who told us that the staff made referrals appropriately and followed their guidance and instructions. They said they felt the staff were ''efficient and caring.'' The home employed nursing staff who assessed, monitored and treated people's nursing needs.

There was evidence of regular appointments with healthcare professionals. These included information and feedback from the professional. The GPs visited the home regularly and the staff communicated changes in people's health needs clearly.

The staff had maintained clear records of people's wounds and injuries. They had created care plans to show the care and treatment people needed with regards to wounds. These included information on the progress of the wound. People were provided with pressure relieving equipment to reduce the risk of developing pressure sores. The staff checked these were in working order and recorded their checks. People who were considered at risk were repositioned regularly and this was recorded.

The staff regularly weighed people and monitored changes in their weight. Where people had identified weight loss, there was evidence the staff had acted on this by making referrals to a dietitian. However, some of the records did not indicate whether these referrals had been followed up and what further action the staff had taken to reduce the risks of malnutrition.

People told us they generally liked the food and that variety and choice had improved since our last inspection. One person told us they did not like most of the food on the menu, but that the chef bought and made them individual meals of their choice. The chef told us that they tried to get to know people's individual needs and provide for this. There were two main choices for the lunch 13 October

Requires improvement

Is the service effective?

2015.. People were offered a choice at the point of service, by the staff showing them the different meals plated up. People were also able to choose an alternative, for example an Asian meal, salads, jacket potatoes and cheese on toast. Food portions were generous and reflected individual appetites. The food looked and smelt appetising and was freshly prepared.

There were written menus on the dining tables and available for people to view before the meal, however there were no pictorial menus which some people may find easier to understand.

Although people were offered a choice of meal, not everyone was offered a choice of drink at mealtimes and throughout the day. For example, people were given glasses of orange and blackcurrant squash but were not always offered a choice between these and were not offered other cold drinks. One person told us, ''I would just love a cola'' and a visitor said that their relative was always given blackcurrant squash but that they did not actually like this. Salt, pepper and vinegar were available on dining tables, but people were not offered these or any other condiments if they were dining in the lounge or their rooms.

We Recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

Good

Is the service caring?

Our findings

At the inspection of 22 June 2015 we found that the staff did not always treat people with dignity and respect. Sometimes people's privacy was not respected. The provider told us they would take the necessary action to make improvements.

At this inspection we found that improvements had been made. The provider had arranged for ''experience'' training for all staff. This involved the staff spending time in wheelchairs, being supported to eat and having sensory deprivation. This training had helped the staff to understand about the experiences of people living at the home. The manager and staff told us they thought this had improved staff practice.

We observed that some staff practice was task based rather than focussed on the person. For example, we saw the staff supporting people to eat with very limited interaction with them. The staff referred to ''feeding'' people rather than supporting them. We heard someone requesting staff assistance and the staff attended to this but did not speak with the person. We saw some staff supporting people to walk down the corridor but they did not interact with people as they were walking along. The manager acknowledged that some of the staff were still focussed on the task they were performing, she told us ''it takes time to change this kind of culture in the staff team.'' However, we saw that examples of good staff practice were recognised by the provider and shared with all the staff team so they could learn from this. The manager addressed poor practice through supervisions and meetings and the senior staff led by examples.

People told us that some of the night time staff and temporary agency staff did not always support people in a personalised way. For example one visitor told us, ''they do not talk to (my relative); they just come in the room, do what needs doing and go again without even saying hello.'' The manager told us that if poor practice from an agency staff was brought to her attention then she requested that the staff did not return to the home and told the agency about this.

People told us that the care varied according to which staff were on duty. For example one person told us some staff asked them what they wanted to do, if they wanted to use a wheelchair and if they wanted to leave their room. They said that other staff did not offer them choices. One person told us, ''some carers are not gentle, some are good.'' Another person told us, ''they are mostly good but sometimes they get cross with me.'' However, most people told us the permanent staff were kind and caring. They said they were polite. Some of the things people told us were, ''It is not a 5* hotel but it gives good care'', ''they try to do their best'' and ''over the last couple of years the staff have been more courteous and improving all the time.'' Some people living at the home and their visitors spoke about specific staff by name telling us they were very attentive, caring and understood the needs of people.

We observed some positive interactions. The staff offered people choices and explained what they were doing. They also made positive comments, for example complimenting people on their appearance, laughing along with people and talking to people about the person's family or interests. We saw that some of the other employees of the home, (in addition to the care staff) were also very kind, caring and attentive. For example, we heard a person calling out from their room and the maintenance worker went to check on them, found they needed assistance and supported them with this. We also saw this member of staff asking someone if they were cold and needed a blanket or additional clothing. The manager told us they had worked with all the staff to help them understand the importance of treating people in a kind and caring way.

Family members and visitors were made welcome at the home and they told us this. They were able to visit whenever they wanted and were involved in caring for people if this is what they wanted. The staff were kind and considerate towards visitors and had good relationships with them. There was a friendly atmosphere where people living at the home, staff and visitors appeared at ease with each other.

The staff treated people with privacy and respect. They attended to personal care tasks in private and made sure people's bedroom and bathroom doors were closed. They knocked on doors before entering and explained what they were doing when supporting people. For example, the staff ensured one person's dignity was maintained when they supported them to change clothes following a spillage. People moving from bathrooms to bedrooms were appropriately dressed and covered.

Visitors told us their relative's cultural needs were met. Some people told us there was a regular church service at

Good

Is the service caring?

the home and others told us they received regular communion. Visitors told us they felt their relative's cultural needs were met. For example, one person had access to Asian TV stations in their room and Asian meals were provided for those who required these. The manager told us that she was trained to understand about providing nursing care, including end of life care, to people of different cultures. She recognised the importance of staff understanding individual cultural needs and making sure the care reflected these. She told us that she was starting to introduce training for the staff to help them provide better care in this area. The staff had started to liaise with people's families to get a better understanding of individual cultural needs. The manager said that there was a multicultural staff team and certain staff were able to provide support for people whose first language was not English and to educate other staff in aspects of their culture that were important.

We saw that information about people's lives were displayed in some bedrooms and in care folders. Some of the staff knew about the people they were supporting and their lives before they moved to the home. However, other staff did not know this and were not able to tell us about people's personal interests, hobbies or things that were important to them.

People appeared clean and appropriately dressed. They told us they were able to have regular baths and showers if they wanted. A hairdresser visited regularly and people told us they were happy with this service. People's hair and nails were clean. Men were cleanly shaven if this was their choice. The staff were attentive when people spilled food or drink on themselves and when they needed their clothes changed. The staff did this discreetly and explained what they were doing.

Requires improvement

Is the service responsive?

Our findings

At the inspection of 22 June 2015 we found that people's emotional and social needs were not always being met. The provider wrote to us telling us they would make the necessary improvements.

At this inspection we found that improvements had been made, however people's individual social and leisure needs were not always being met.

People gave us a variety of feedback about activities at the home. Most people who participated in the organised activities enjoyed these. However, people told us that they would like more variety in activities. One person said, ''it is the same each week and I am not really interested.'' Another person said, ''the activities don't change much.'' One person said, ''the home is not organised, residents are not informed of what is happening at the home, the activities are boring, same sheet every week, the outside space is dreary.''

The home employed two activities coordinators, although one of these had been away from work for several weeks before our inspection. The activity coordinator had arranged some special events and had a plan of activities for each day. However, many of the people living at the home did not engage in the organised activity. There was limited social interaction and support to meet individual social needs. In particular, 21 people chose to remain in bed on the first floor. They did not receive any individual support to meet their social or leisure needs. The activities coordinator told us that they did provide some individual support for people who remained in bed, however, this did not take place every day. The staff who supported people in bed were focussed on the task they were performing and did not spend time sitting talking to people. The majority of people living on the ground floor spent the day in one lounge. Although there were some organised activities during the day, these were short and did not engage everyone. There were a number of visitors and small groups of people were engaged in conversation, particularly with the visitors. However, some people did not participate in any activity. They were not given things to do. There were some resources such as games and craft materials but these were not offered to people or accessible for people to help themselves.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us they were trying to produce more information for people and to improve activity provision. They had created a newsletter, which they hoped would give people regular information about the home and activities. There were some special events organised, such as a Halloween event. The activities coordinators had also introduced a weekly session to introduce people to the use of computerised tablets. There was a café area situated on the ground floor where people were able to entertain visitors and help themselves to drinks.

The manager told us they had identified a need for better resources for people who had dementia, such as tactile and sensory items. They told us they were in the process of purchasing these.

People's individual needs had been assessed and recorded in care plans. The care plans were regularly reviewed and updated. The way in which people required support had been recorded and was personalised. Care plans included physical, personal care, health and emotional needs. There was also information about how the person communicated and expressed their choices.

People living at the home and their visitors told us they knew how to make a complaint. The majority of people who had made a complaint told us this had been dealt with appropriately. One person was not happy with the provider's response to their concerns, but we saw that this was being discussed further and the provider and local authority were working with the complainant to resolve the concerns. Some people told us they felt the provider was more responsive in the last few months and that the new manager was open to suggestions and complaints.

We looked at the record of complaints and saw that the provider had responded appropriately to these. They had acknowledged the complaint and apologised to the complainant. They had also investigated the concerns, given feedback to the complainant and taken appropriate action.

At the time of the inspection the manager had not introduced a system to analyse complaints and incorporate them into the home's improvement plans. She told us that she would be doing this to help identify trends and to look at preventing further complaints about the same things.

Requires improvement

Is the service well-led?

Our findings

At the inspection of 22 June 2015 we found that the provider's audits did not always identify or mitigate the risks of unsafe care and treatment. We issued a warning notice telling the provider they needed to make the necessary improvements by 10 August 2015. We also found the culture at the home was not open or inclusive. The provider wrote to us with an action plan telling us about the improvements they were making at the service.

At the inspection of 13 October 2015 we found that improvements had been made.

The provider created an improvement plan which they regularly reviewed and updated. They used this as a tool to decide what areas of improvement needed to be prioritised. The plan included information about when improvements had taken place. The provider had used the last inspection report, feedback from their own quality audits and the audits of commissioners and other external parties to record all areas which needed improvement. There were clear and realistic timescales for these.

The provider had identified risks associated with insufficient staffing levels. The need to recruit and maintain more permanent staff was a part of their action plan. The manager told us this was the main area of concern at the home and there was a need to address this. She also acknowledged that to achieve this would take time because of the need to recruit suitable staff. However, the staffing levels at the service were having an impact on the care and treatment of people who lived there. People were at risk of receiving care which was not suitable or safe. People were also at risk because the provider had not always identified that call bells were inaccessible. People's social and leisure needs were not always being met in a personalised way.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The records relating to the management of the service were appropriately maintained. However, some of the care records for people living at the home were not well organised. Information was not always clearly recorded and some hand written notes were hard to read. The manager told us that nursing staff were receiving training around record keeping and that this was an area she had identified for improvement. However, she had prioritised other improvements and was planning to address this shortly after the inspection.

There had been improvements at the service since the inspection of June 2015, in particular the way in which medicines were managed, risks were identified and managed and the caring support of people who lived at the home. The manager also demonstrated a responsive attitude following concerns identified on the first day of this inspection visit. For example, where we identified risks associated with insufficient information about texture modified drinks and food, the staff had reviewed and updated all care plans relating to this immediately and had put in place additional guidance to make sure people were kept safe.

The provider employed a quality manager who was external to the home. She visited the home on a regular basis and carried out audits of the service. The operations manager also visited the home regularly and carried out audits and checks. The manager told us the provider and these senior staff had been supportive and helped to improve the service. The provider's audits included detailed checklists connected to the Care Quality Commission's key questions – safe, effective, caring, responsive and well-led. The provider had looked at these different areas of care provision in detail and had identified areas they considered needed improving.

The manager and staff carried out their own audits on the environment, medicines management, records and care. They recorded these and there were detailed plans where problems were identified. The manager audited all accidents and incidents and there was a record to show how the likelihood of these reoccurring could be reduced.

People living at the home and their visitors told us the manager was available and listened to their views and opinions. The said that they felt positive about the changes at the home and felt it had improved. We saw records of contact the manager had received from visitors confirming improvements had been made at the home. One visitor told us that ''there has been an improvement recently as staff chat less together and give more attention to (my relative).''

The staff also spoke positively about the changes at the home. They said they felt everyone had worked hard to

Requires improvement

Is the service well-led?

improve the service. They felt the culture and atmosphere at the home had improved. One member of staff said, ''I feel things are a lot more positive.'' Another member of staff told us, ''things are on the up!'' The staff told us they felt supported by the manager. There was a system of ''employee of the month'' to recognise good practice. Some of the other things the staff told us were, '' the training has improved'' and ''dramatic changes for the better have occurred very recently.''

The manager started working at the home in July 2015. She was a registered nurse and had past experience of managing nursing homes. She was in the process of applying for her registration at the time of the inspection. The manager told us she worked evening, weekend and night shifts at the home to support the staff and to make sure care was consistent. The staff confirmed this.

The manager was in the process of recruiting a deputy manager for the service. There were two unit managers, also qualified nurses, in post to manage the day to day running of each unit.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured that sufficient numbers of suitably qualified, competent and skilled staff were deployed at the service.** Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users did not meet their needs or reflect their preferences.** Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not always identified and mitigated risks relating to the health, safety and welfare of service users.** Regulation 17(2)b