

Amore (Watton) Limited

Buckingham Lodge Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?	Good ●
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

We last inspected this service on 21 and 22 November 2017. At this inspection we rated the service requires improvement in every key question we inspect against and found five regulatory breaches. We found care and treatment was not always provided around people's assessed needs. The service did not always fully assess a person's capacity and support people lawfully with decisions in relation to their care and treatment. People were not fully supported with the hydration and nutritional needs. There were not always enough staff to meet people's assessed needs and the service was not effectively managed or run in the interest of people using it. Following the inspection, we requested and received an action plan and have stayed in contact with the service regarding the improvements they planned to make. We have regularly engaged with the Local Authority quality improvement team who were supporting the service to improve and their view was this was happening.

At our latest inspection on 8 & 10 January 2019 we found improvements had been made but these were not firmly embedded. We found two repeated breach. Regulation 9 of The Health and Social Care Act 2014, person centred care, and regulation 11, consent. We also had concerns about the competencies and skill mix across the service but were confident that this was being effectively addressed so have not made a breach. We have made recommendations for several key areas of practice which if adopted will help to strengthen and improve the service further. We found improvements were still required in four of the five questions and judged the service was not yet good.

Buckingham Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can accommodate up to 73 people in one adapted building which has three separate units across three floors, one specialising in dementia care. The others are for broadly speaking nursing and residential. At the time of our inspection there were 61 people using the service and two people in hospital.

At the time of our inspection there was a manager at the service but their post was an interim post and they were not registered with the Care Quality Commission. A registered manager is a person who has registered with the CQC 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.'

In summary we found the service was improving and there were systems and processes in place to help identify the risks to people, the resources needed and an emphasis on lessons learnt following incidents. We found however that not all care plans and daily records clearly showed how people's needs were being met. Care plans were not all up to date and did not clearly reflect peoples' preferences and preferred routines. Risk assessments and care plans were not cross referenced and information was in different places, making it difficult to track through and gave a poor oversight of the person's needs. We noted when people's needs had changed this was not always picked up in reviews which tended to comment, 'no change'. Daily notes

were brief, mainly task oriented, functional and did not appear to reflect any specific objective. We also had concerns about the timeliness of information with care plans, assessments and risk assessments not being put in place quickly enough for new admissions.

The service had reviewed all the care plans on the residential unit and these were more comprehensive and reflected people's needs. We have recommended that this care plan format should be adopted across the service to ensure they addressed people's needs in a holistic way. We also recommend staff sign care notes to help ensure there is a clear audit trail and staff accountability.

Activities of daily living for people could be improved as some people had insufficient opportunity to engage in activities meaningful to them and care observed was functional rather than holistic. This was being addressed by the current manager who told us it took time to change an 'established culture.'

The service was not always working in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. We found that staff understanding of MCA and DoLS was adequate and appropriate DoLS referrals had been made for people. Care records around care and capacity needed review to ensure they were not contradictory.

People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. We found records around capacity and how staff were to support and promote people's choice and best interest were not always in place or accurately reflecting the support people needed, why and who had been consulted.

Staffing levels were better and in line with people's assessed needs. Although staffing was sufficient we found team work was poor and staff were not sufficiently deployed across the shift. We found staff had in the past received poor induction and poor training which had not enabled them to feel confident in their role or lead effectively. This was being addressed by the current manager who told us many staff were being performance managed with clear objectives which were reviewed as part of their supervision and appraisal of their performance. Mandatory training was being brought up to date and it was recognised that e-learning was not always the most appropriate way to train staff. The manager had identified a list of essential training and had planned it in over the next year to help support staff development.

Several things had been implemented to try and identify more accurately people's experience of care and how the service was responding to their feedback. 'You said, we did' had recently been introduced and showed how the home was listening to people. Audits carried out across the home included daily walk rounds and more focused audits on specific elements of the care such as night audits and dining audits. These were happening but not firmly embedded. We have made a recommendation about community engagement and reviewing why people are spending so much time in their rooms.

People received the care they needed and the care was safe. There had been a number of medication errors and medicines had not always been available as people needed. The service had reported the errors and had put robust systems in place around this to ensure all incidents were managed robustly and lessons learnt. Some health care professionals expressed concerns that improvements were not firmly embedded

across the service. We found there had been a lot of rapid change which had included new staff, the departure of two registered managers in the space of a year and a temporary manager in post. There had also been two clinical leads leave and a new one start. This meant that although the service had made changes these had not always been clearly communicated or embedded as each manager had different priorities. We had concerns that support for the service had been provided but this had not been provided in a timely way or for long enough to help changes to become firmly embedded. We however recognised the providers commitment to getting it right and making the right resources available.

The service was working to an agreed and established action plan which was rated according to risk. This ensured the immediate priorities to stabilise the service would be addressed with longer term goals to improve outcomes for people. We found that some of these changes such as increased staffing were starting to have a positive effect but there were still areas of concern particularly the skill mix of the team. Health care could be improved upon by upskilling the nurses and by continuing to develop more positive relationships with other health care professionals and family who had lacked confidence in the service.

People were supported with their physical care needs and staff were kind and engaging but people would benefit from more support and engagement to pursue their own interests, fill their day and be less socially isolated.

The cook knew people well and was pivotal in ensuring people ate what they wanted and had access to home -made, wholesome food. Meal times would be enhanced if there was more interaction and staff being available to sit with people to encourage them to eat and drink in line with their assessed needs. We have made a recommendation about this.

The environment was clean and an outbreak of infection on the ground floor quickly contained. Some areas of the home had odours in isolated areas. The environment was fit for purpose but lacked personalisation and signage. This had been identified by the service and they were in the process of changing the use of some rooms to make them more appropriate to use and more accessible.

Staff recruitment processes were adequate and staff induction was improving to help ensure staff had the necessary competencies for their role.

Staff had a sufficient understanding of safeguarding people from abuse. There were systems in place to help address concerns about staff practice and to report any concerns to the Local Authority, police and CQC and co-operate in investigations when necessary.

There was an established complaints procedure and records showed how formal complaints were being addressed, some were not addressed within the agreed timescales. We were less clear how the service responded to individual concerns, where a formal complaint had not been made. We were told concerns from relatives and people using the service which were not documented in the complaints book and felt this should be addressed in the same way and recorded as a concern and have made a recommendation about this.

People reported feeling safe but some people's experiences of the service had been affected by a number of recent thefts. These had been reported to the safeguarding team and led to a police investigation which was inconclusive. We noted people did not all have a record of possessions completed on admission and these were not kept up to date which could invalid any insurance claim. This was raised at inspection as part of a wider issue of records not always being up to date.

Staff were caring and responded well to people's needs but we found the care centred on people's physical care needs rather than a more holistic approach which enabled and empowered people. We raised this at the time and the manager told us what they were doing to build teams and change the culture of the service. This had resulted in some staff leaving who were not prepared to accept the changes.

You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

There were enough staff to meet people's assessed needs and this was reviewed daily.

Risks to people's health and safety were known and discussed with staff to ensure a robust response in dealing with risk.

Staff understood their responsibilities and any safeguarding concerns were properly reported and investigated and lessons were learnt.

There were effective systems in place to manage the cleanliness of the service and prevent the spread of infection.

Staff recruitment processes were sufficient and helped ensure only suitable staff were employed.

Medicines were appropriately managed and errors were reported in a timely way so this could be addressed to minimise the risk.

Is the service effective?

Requires Improvement 

This service was not always effective.

Not all staff had the necessary skills and competencies to meet people's needs. Care plans were difficult to access so we were not assured staff always had the information or knowledge to meet people's needs.

Deployment of staff across the day was poor which meant not everyone got timely support to eat and drink and were concerned that people's emotional health was not sufficiently recognised

Most staff understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and appropriate DoLS applications had been made. The service mostly acted lawfully when supporting people with their care and treatment but this was not always supported by the relevant guidance and

paperwork.
People's health care was monitored to ensure they stayed healthy and risks identified.

The environment was clean and fit for purpose but some of the communal areas were under- utilised, and there was poor signage.

The service worked in partnership with other healthcare professionals to help maintain people's health but this relationship required improvement.

Is the service caring?

The service was mostly caring.

People were not encouraged sufficiently to retain their independence, retain existing skills or learn new ones.

There was insufficient opportunity for people to comment and shape the future direction of the service and communication about service development had not been communicated well.

Care staff were kind and worked hard to help meet people's needs.

Requires Improvement ●

Is the service responsive?

The service was not fully responsive.

Care plans did not always reflect people's current needs and were not person centred.

There was little in the way of meaningful occupation or activity for people.

There was a complaints procedure in place and people were given opportunities to raise concerns formally and informally but not everyone yet had confidence that their concerns would be addressed.

Requires Improvement ●

Is the service well-led?

The service was not yet well led.

The service was being managed well and was moving in the right direction although changes were not fully implemented or

Requires Improvement ●

embedded and we identified two repeated breaches of regulation.

Community engagement was poor and there was no identified person currently to take this forward.

There were robust systems to ensure the service was planned well and risks were clearly communicated and acted upon in line with people's needs.

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

The inspection took place on 8 & 10 January 2019 and was unannounced. The inspection team was made up of two inspectors, a pharmacy inspector a specialist advisor and two experts by experience on the first day and an inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of this inspection we reviewed information already held about this service. This included previous inspection reports and subsequent action plans. We reviewed the provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed feedback about the service including talking to the Local Authority and a number of health care professionals. We also reviewed share your experiences and notifications which are important events the service is required to tell us about. We carried out observations across the day.

We spoke with five health care professionals and received additional information via email. On the day of inspection, we spoke with twelve people, and four relatives. We spoke with three relatives following the inspection. We also spoke with two health care professionals on the day of inspection and a wide range of staff including five care staff, the nurse on the top and middle floor, the manager, clinical lead, maintenance staff, domestic staff, the cook, the nurse specialist, and dementia lead. We reviewed the care on two of the three floors, looked at records including six staff records, maintenance records, seven care plans, 16 medicine records and other records relating to the management of the service.

Is the service safe?

Our findings

At our last inspection on 21 and 22 November 2017 we rated this key question as requires improvement and at this inspection on the 8 & 10 January 2019 we found it was good.

We previously identified a breach of Regulation 18 of The Health and Social Care Act Regulated Activities Regulations 2014: Staffing. We found there were not always enough staff to meet people's assessed needs. We also had concerns about staff support and training to ensure staff were sufficiently competent in their job role. At our most recent inspection staffing levels were adequate to meet people's needs but activity hours were not being utilised due to vacancies and this had an impact on the care provided.

The service had sufficient staff employed for the regulated activities it provided. The service had a number of staffing vacancies but had been quick to advertise and recruit to these posts which minimised the impact and helped ensure continuity of care. The service used regular agency and bank staff where necessary. The manager told us they were fully recruited to nights and only had one full time equivalent nurse vacancy on days. Activity hours were also being recruited to. This meant the service was in a healthy position in regard to its staffing and staffing rotas showed staffing was maintained across the week. We observed staff working hard throughout the day and the shift was sufficiently organised with a detailed handover which clarified staff's roles and responsibilities. People generally looked well cared for in their personal appearance and were mostly observed throughout the day to ensure their safety. This gave us confidence that the service had the right level of staffing.

The manager told us staffing levels had been reviewed and increased across the service in line with people's assessed needs. We noted as part of this inspection that the activity hours were underutilised as a result of staff leaving and changing post. This resulted in the care we observed being functional rather than responsive to people's individual needs. Typical comments from people using the service were that there was insufficient activity to occupy them through the day and staff did not have time to chat. Staff told us they did not always have time to sit with people and reported that sickness and staffing vacancies had an impact on the service. They felt things were getting better under new management. The manager was aware of these concerns and was in the process of recruiting staff. People told us there had been recent changes in staffing but said most staff were familiar with their needs. This was echoed by relatives who said there were enough core staff who knew their family member well.

The service had systems in place to review their staffing levels and ensure they were provided according to people's assessed need and dependency level. Heads of department and shift leaders met daily (except weekends) to discuss what was happening in the service and to review any new or emerging risk, illness-hospital admission or discharge and to review staff levels and deployment. The service had a dependency tool which they used to determine levels of staffing they needed.

Some people felt calls bells could take a while to be answered. The service did call bell audits but there was no real analysis of how long on average people had to wait and if there were any reasons why people might wait longer, such as during staff handover. This information would be a good indicator if there were enough

staff across the day. One person told us "If I'm in bed and I press the bell they can take quite a long time. I don't know how long but if you press the bell because you want to go to the toilet and they don't come straight away it gets uncomfortable." Another person said something similar and particularly said call bell response time was an issue at night when staff were slower.

We recommend that a named member of staff is designated to answering call bells to help reduce delay and to demonstrate how staff were deployed sufficiently to respond to people's individual needs.

Individual risks to people care, welfare and safety were documented in their care plan. There was sufficient management overview of risk which meant any omissions of care could be quickly addressed. We found however that not all records were up to date or reflected people's current needs. For example, personal evacuation records were kept in the fire folder but were out of date. They were also kept in people's care records but several were out of date. This posed a risk particularly where there had been a decline in a person's overall health and mobility. This had been identified by the service and they updated records immediately on our feedback. Care records were being reviewed in an ongoing way and care audits identified gaps in record keeping so these could be addressed.

Most people felt risks were well managed and we were given examples of how people's health and well-being had improved since being at the service. One relative was concerned about communal areas being left unattended but we found staff were allocated to communal areas to make sure people were supervised. We also saw some people were regularly checked to ensure their safety and to give regular care such as changing their position to help promote their skin integrity. Records were kept showing the care delivered across the day and there was sufficient oversight of this to ensure records were completed and if they identified any immediate change in need which needed addressing.

Care plans and risk assessments varied in quality. Some clearly showed how staff had assessed, and reduced risk, others lacked clarity. For example, we case tracked a person identified at high risk of falls. Their risk assessment confirmed this but there was no evidence that their risk assessment was reviewed after each fall to see if anything had changed. There was no correlation with other possible risk factors such as hydration, infection or current medication. In contrast another person's record gave a comprehensive review and actions taken following a fall including review of records and increased observations in line with the homes falls pathway. This meant records were not currently completed to a consistently high standard but risk was identified and actioned as part of the flash meeting so we were confident that risks across the service were being managed.

The service was fit for purpose and designed in line with people's assessed needs. Refurbishment and replacement of equipment was part of the overall plan for the service and audits ensured issues were quickly identified and addressed. We looked at a sample of maintenance records and these were well organised with clearly explained systems and processes to ensure the safety of the service. Equipment was regularly serviced and there were clear processes to ensure people were kept safe during any given emergency. Regular testing of fire systems and drills ensured staff were confident when acting in an emergency.

There were systems in place to ensure people were safe at the service and staff were sufficiently trained to recognise any possible abuse. Staff had access to key policies and procedures and management staff were responsive to concerns. Concerns were reported to the appropriate authorities and investigated when requested. The manager notified CQC of any incident affecting the safety and well-being of people using the service and reviewed all incidents. Staff performance was monitored and any concern of poor practice addressed.

Relatives felt the service was safe as far as they could tell. Concerns were raised about a spate of recent thefts in the service. The thefts had been reported and investigated by the police but family said they were not initially informed of the thefts.

Relatives spoken with said staff were good at keeping them informed of any changes in their family members health.

Steps were taken to minimise the spread of infection and ensure the cleanliness of the service. Domestic and laundry staff were employed seven days a week across the service one on each floor. Numbers were adequate but domestic staff said sometimes numbers could drop due to planned holiday or sickness which they said affected their ability to keep the service clean. We noted through the morning domestic staff working hard but no sooner had they cleaned an area such as the toilet these needed cleaning again soon after which they were unable to do immediately.

We identified isolated areas of the service which had unpleasant odours and some of the communal chairs were unpleasant but overall the service was clean and any shortfalls in the standard of cleanliness identified as part of the management walk-round. On the first day of our inspection we were made aware of a potential infection outbreak with six people affected. The home had taken immediate actions to close the ground floor to visitors and took samples to send to public health to ascertain the cause of the infection. We were immediately advised of this and domestic staff could tell us about actions they took to prevent the spread of infection. The service stopped the infection spreading by its prompt actions. During lunch, staff were observed wearing aprons and had their hair tied back when necessary to help reduce the spread of this infection.

There were adequate staff recruitment processes in place to help ensure staff employed had been vetted and were suitable for employment. We looked at six staff recruitment files for staff employed within the last twelve months. The files included an application form, interview notes, two references; evidence of identification and a current Disclosure and barring certificate DBS certificate obtained prior to commencement of employment.

Prior to this inspection we were made aware of a number of medicine errors. We followed this up as part of the inspection when a member of the CQC medicines team looked at how the home managed people's medicines.

They concluded that the service had systems in place to help identify any medicine errors and took robust actions to minimise the risk to the person and ensure lessons were learnt. This included supporting staff to improve their practice through additional training and competencies and being accountable for their professional practice.

Medicines were stored securely for the protection of people who used the service and at correct temperatures. Everyone relied on staff to administer medicines and could tell us that they took medicines but they were not aware of what they took.

Staff authorised to handle and give people their medicines had received training and had their competence assessed to ensure they managed people's medicines safely. We observed part of a medicine round and noted staff followed safe procedures when giving people their medicines.

We found that systems were in place to enable staff to monitor medicine administration and their records for most but not all medicines.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities and written information about how people preferred their medicines given to them. When people were prescribed medicines on a when-required basis, there was written information to assist staff to give people these medicines appropriately and consistently. We noted however that staff did not use pain assessment tools when giving when-required pain-relief medicines to people who were unable to tell them about their pain levels. Pain assessments tools were available but were in the care plans and not the medicines records. Staff agreed to add this information to the care plan. When people were prescribed medicated skin patches there were additional records showing where on the body the patches had been applied but we noted that the positioning of the patches was not always in line with the guidance the service had received. This increased the risk that people applied the patches could have adverse effects from them. This was fed back at the time of our inspection so it could be rectified.

Is the service effective?

Our findings

At our last inspection on 21 and 22 November 2017 we rated this key question as requires improvement and at this inspection on the 8 & 10 January 2019 we found it was still requires improvement.

At our last inspection we identified two breaches of regulation including regulation 11 of The Health and Social Care Act Regulated Activities Regulations 2014: consent and regulation 14 meeting nutritional and hydration needs. We found the service had not always recorded decisions taken in the person's best interest or how decisions had been reached based on an assessment of capacity. We found people were not always adequately supported to eat and drink sufficient to their needs and there was poor monitoring of this. At our inspection on the 8 & 10 January 2019 we found some improvement had been made and the service was no longer in breach of regulation 14. but found the service was still in breach of regulation 11, consent. We also identified continued concerns about staff competencies and team work but felt these were being adequately addressed.

At our last inspection we identified a breach of regulation 11 of The Health and Social Care Act 2014: Consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

At our last inspection we found that records were not always accurate in relation to people's mental capacity or best interest decisions. Documentation was not always dated, signed or clearly demonstrating who had been consulted in making the decision.

At our recent inspection we found some improvement with clearer paperwork about mental capacity. The service was holding best interest meetings as required where people lacked capacity to make specific decisions about their care and welfare. We did however note that records concerning giving medicines covertly when necessary did not show who had consulted in making decisions about this. When changes were made to medicines given covertly or crushed and new medicines were prescribed, further guidance had not been sought from the pharmacist or GP and records updated specifically for these medicines to ensure they could be prepared safely. There was a lack of written person-centred guidance for staff about how they should prepare people's medicines covertly to ensure they received it safely and as prescribed.

The service had made DoLS applications to the Local Authority as appropriate and had a tracker to show the

stage of the application when it was made, approved or chased. Although records were improved we still found some anomalies and could not always see clear evidence if the person had been consulted or if a lack of capacity had been clearly established. For example, one person was described as having capacity but another document stated they were in a confused state and this had not been reviewed in terms of the impact their confusion might have. In another instance a family member had signed a document but we could not see if they held lasting power of attorney for their relative. We were also unable to see if the person could consent. They were living with dementia but able to clearly converse.

This supports a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, consent.

The meal time experience for people had been enhanced since the last inspection and people were offered appropriate choices in a meaningful way. People said they enjoyed the food and the environment was nicely set up. We found however the amount of support each person received to eat and drink was not always adequate. We observed those unable to eat independently were supported by care staff but we had concerns about the general level of support and supervision given to people during our observation. Our concerns were echoed by relatives who were not assured staff always prompted people to eat and drink sufficiently. We noted when walking around a collection of beakers with tea or coffee, partially drunk, and some untouched. Drinks in some instances were out of reach. Several people we spoke with when asked, said they wanted a drink. We raised this with staff but were not be sure what happened on a day to day basis. A relative told us their family member sometimes drank a cup and a half when they arrived but only because they supported them to drink. The service monitored people's fluid intake but some people did not have a daily fluid target and the processes if a person did not reach their target were not clearly established.

Several people were not offered lunch during our observations and a staff member told us, "They are very unlikely to eat much, if anything." Hot trolleys were on the unit from about 12.40 pm but some people did not get served until 1.45 pm. People in their rooms were given less attention and support to eat. There was a risk that people in their rooms could be overlooked particularly as staff went for their breaks after lunch. Some people ate well others were not motivated to. People were not offered alternatives to the main meal where they refused and staff did not sit with people who might benefit from some support and encouragement.

We recommend the service review its arrangements for mealtimes and consider it more than one sitting might be appropriate. The deployment of additional staff at busier times of the day would ensure people were adequately supported to eat and drink sufficient to their needs.

People made positive comments about the food which matched what the cook told us. One person said, "I have a fried breakfast. I get enough to drink. The food is reasonable, we get two choices for lunch and I get given a menu every-day." The cook demonstrated a good knowledge of people's needs, preferences and dietary requirements. One person told us, "I get too much food, they say try and eat a little bit more as you are losing weight." The cook told us they did not really have an issue with people losing weight but more with people gaining weight. We saw from records that the trend of unintentional weight loss was quickly identified and actions taken to help increase and maintain a person's weight.

The service accommodated people's specific dietary needs. One person told us, "I've had two strokes and they give me soft food so I won't choke, mash potatoes, I had shepherd's pie today, it was lovely. Pudding is nice, semolina, angel delight." Staff had a good awareness of people's dietary needs and any specialist diets or allergies. We noted that a dietary form was held in the kitchen for each person but we were unable to establish how often these were updated. The cook stated as 'people's needs change' but we felt this was not

sufficient given the regular change of staff and nurses. We felt this increased the risk of information not being passed on.

We were not assured that all staff had the necessary skills and competence for their role or that their practices were up to date. We received mixed feedback about the staff and how each shift ran on each floor. Relatives commented on some staff being inexperienced and how it worked better when there were two nurses on shift. A relative told us, "They could train and supervise staff better. They need to be supervised and directed, that was happening when they had a nursing manager. They need someone with the knowledge, skills and authority to lead." One person told us, "The staff are not trained as to what they should do properly. This could be understood in the context of recent changes in the service including the recent departure of a clinical lead seconded to the service. A new clinical lead had been appointed and oversaw the care provided by nurses on the middle and top floor. The manager had worked hard to ensure the organisation of staff was sufficient and there were clear lines of accountability. They were reviewing staff training to ensure it was more in depth and in line with people's assessed needs. Supervisions were planned and ran alongside staff development plans and clearly identified objectives to improve staff practices.

Staff employed within the last year told us their induction had not been adequate. The manager was fully aware that not all staff had the training and competencies necessary. This was being addressed through performance reviews, supervision and training. Since coming into post the new manager had strengthened the induction process and support given to both new and existing staff. Staff spoken with were positive about the recent changes and told us they were getting the training and support they needed.

Despite recent changes and reorganisation of shifts we found teams were not yet working effectively together which had an impact on the care provided. Staff said additional support was not always forthcoming although nurses were seen helping and the manager told us they and the clinical lead could help as necessary. Domestic and catering staff did not support care staff at meal times or with the drinks trolley and there was not sufficient deployment of staff at busy times of the day. The vacancies for activity staff/coordinators had an impact on the care and support people received. Staff stated morale was high and perceived the strength of the service was the commitment of its staff. Some staff said staff sickness impacted on the service but overall felt they had the right level of staffing. The manager had a clear strategy to monitor and manage staff sickness. Staff told us they could only assist one person at a time which resulted in people waiting for care. We felt improved team work would enhance the care provided.

Staff training and development was work in progress but not all staff were yet working effectively. Training considered mandatory was almost up to date but gaps were identified and some training had not been completed. Most training was completed through an e-learning training academy and some staff felt this was not a good way to learn. Staff were not all able to tell us how the training had informed their practice. Time taken to complete the on-line training ranged from 5 to 33 minutes. One staff member said, "I just can't take it in." They told us how much they have learnt from working with others. Regular, practical training was not yet fully established. The manager had been proactive in identifying gaps in staff knowledge and planning training around the specific needs of people using the service.

Staff files reviewed did not all include induction records. Some were waiting to be filed. Some staff probationary periods had been extended on the basis that not all the required training had been completed and some staff were on performance improvement plans. Induction folders formed part of the staff file and had been reviewed. Individual competencies had been signed by the employee and a supervisor, but did not include dates when the staff competencies had been assessed. We had concerns based on feedback about the thoroughness of staff induction which pre-dated the new managers employment. For example, one carer told us they had completed 3 'shadow' shifts, and were given moving and handling training by a

workplace assessor and was then 'on shift'. They confirmed that had completed an induction booklet but was not given ongoing support with this and described their experience of their induction as, 'being thrown in the deep end.' They told us their initial induction and support was poor but was improving. A second member of staff told us they were shadowed for two days, and then on a full shift. There was a significant delay in signing off their induction record. Staff were completing the 'Care Certificate,' which is a nationally recognised induction for care staff.

The manager was aware that a few staff were 'behind' with their training and the induction systems were not as required. They stated that many of the existing staff have been re-inducted using a revised, shorter format document. The manager was unaware that some staff were holding the induction document themselves. The manager was advised regarding the signing off competencies on one day and stated they agreed this was not appropriate and would make further enquiries.

Guidance and policy around best practice was in place and staff were able to access information as needed. The organisation had a number of key staff who supported staff in their role such as a nurse specialist who supported the nurses. As training was being developed we saw more opportunity for staff to share ideas and support each other and we saw some health care professional involvement in supporting and training staff to ensure their knowledge was up to date.

People's health care needs were largely met but we noted some poor record keeping and limited choice of GP which could result in delays. Family members were mostly happy with the care received. One family expressed concern about 'weight loss' of their family member but we saw from the person's record that this had been identified and was being addressed. The person had been under the review of the dietician, weighted weekly and weight loss reversed which showed interventions were appropriate. Another family member told us how their relative had acquired a pressure ulcer at the service which could be indicative of poor care. They told us however how the service had acted, ensured the right equipment was in place and the sore was getting better. We had a number of notifications about pressure ulcers and how they had been acquired. Further information requested from the previous manager had not always been forthcoming but we noted systems had improved around pressure care. A person told us how staff had helped them improve their physical health and cleared up their ulcerated legs.

Not all the care plans were up to date which could increase the risk of people not getting the care they needed. We saw however that as part of the staff handover and the daily flash meetings any changes in people's needs were highlighted and actioned. Nurses were proactive in reporting concerns and asking the GP to follow up concerns. There was a hospital admission checklist and a checklist nurses completed when requesting a GP. One practice was used and nurses said their response was not always timely but we also felt information collated by the care home was not always robust or showed how urgently support was needed. We noted the manager had collated information about people's health care needs and any gaps in service provision. This highlighted dental care as a gap but people had oral assessments in place and guidance about mouth care. It also meant the service was identifying for itself where the gaps in provision were and how this should be addressed.

The service was well maintained and clean throughout. Any deficits were clearly noted as part of their action plan. The service was purpose-built building over three floors. The ground floor was residential but we were not able to talk to anyone on that floor due to an unconfirmed contagious infection. People living on the first and second floor had varying needs some requiring nursing care and others requiring residential care. Some people were living with dementia. There were two lifts and three stairwells connecting floors, access was secure, requiring a 4-digit number. On arrival to the service we were given different numbers to access the service and not all staff were aware of the right numbers which could hinder a full evacuation if ever

necessary. This was brought up at the time of our inspection.

People spoken with were happy with their rooms and relatives all said the service was well maintained and clean. One relative said they would like to move there and said it was like a posh hotel. The dining room was nicely laid out. The lounges were clean, spacious but a little bare lacking personalisation. A sensory room was being developed. A list of activities was displayed but the board was out of date.

The corridors were wide enough for two wheelchairs to pass with hand rails along each wall. Décor was marked and scruffy, door frames and hand-rails chipped. There were a few chairs placed at points along the corridors. These had been put there for people to rest who were known to walk the corridors. There were a few photographs along the corridors. There was poor signage but this had already been identified by the service and a refurbishment plan was in place.

Is the service caring?

Our findings

At our last inspection on 21 and 22 November 2017 we rated this key question as requires improvement and at this inspection on the 8 & 10 January 2019 we found it was still requires improvement. At our most recent inspection people and relatives spoken with were generally satisfied with the level of care they received and were more confident with the service provided. We however had some concerns about the service which appeared to be delivered in a task focused way with limited opportunities for people to engage in meaningful activity.

From our observations of the carers and people using the service we saw genuine interactions which were respectful and appropriate; although discussions with care staff highlighted their frustration about the amount of time they could spend with people to support their well-being. Staff highlighted the lack of activity for some people as a concern. This was supported by our observations and from the feedback from people and their relatives.

People were not encouraged to retain their independence or to be active and were not well supported across the day. We observed people who were frail and frustrated about a reduction in their independence. We did observe some spontaneous interaction between staff and residents that was not task related but this was not consistent across the service. Not everyone felt involved in their care or consulted regularly enough about what was important to them. For example, one person had been unable to send their letters out as were reliant on staff to help them. They said they did not have access to a mobile phone as there was a poor signal and it was difficult for them to use a public phone. We felt that this person's experience reflected the lack of person centred planning as highlighted throughout the report.

The lack of activity or plan for the day affected people's experiences of the service and key opportunities for staff engagement were missed. For example, there was a lack of staff presence across the day and people in their rooms had little interaction or stimulation. One person told us, "The staff are wonderful, I've only got to ask and they help me." They also said to us, "I've enjoyed talking with you because there's no one here I can talk to and the staff don't have time." A relative told us staff were caring but busy and not always available and they were concerned about how much time staff spend with their family member when they were not there.

There was limited observed interaction at meal time and more than half of people using the service were in their rooms so missed out on opportunities to socialise with others. We could not clearly establish if people chose to stay in their rooms or were regularly asked if they would like to go to the lounge. This observation was also the observation of some relatives spoken with who said they had concerns about the level of attention and stimulation throughout the day. Staff did not routinely sit with people and encourage them to eat and drink unless they were unable to feed themselves. We observed very little conversation between people throughout lunch or at other times of the day. Relatives commented that the communal areas were not well used.

The environment was accessible and free of unnecessary restrictions but did not fully take into account people's sensory and cognitive needs. The décor other than in people's rooms was unimaginative with no interactive wall hangings, or fiddle boards. Chairs in the lounge were arranged in an institutionalised way in

a circle around the room which did not encourage engagement and we noted some people were sat in the wrong position to watch the television and we did not see clear sensory plans for people showing what they enjoyed and how staff should facilitate this such as talking books. A film was put on in one lounge and was played three times across the day. The staff told us they were currently reviewing the space available to people and how to better utilise then by creating areas offering sensory stimulation.

Staff were respectful in their conversations with people but this was not observed or experienced across the whole service. One person told us their experiences varied according to whom was providing the care. One person told us some staff were very good and laughed and joked whilst other staff sometimes spoke exclusively to each other rather than the person they were supporting. They also raised concern about staff not always knocking before entering their room and this was something our expert observed whilst talking to people in their rooms. In contrast a relative told us how their family members dignity was upheld. They said "I am reasonably happy with the care. The carers really care. They are kind and respectful. The door is always shut when they are dealing with her and if you knock they come to the door." We noted that concerns about staff performance were being addressed by the manager and in the main most staff performed well. Relatives said there were always staff they knew and the more established staff were confident in what they did and did it well.

A number of people told us the reason for gates across their door was to prevent or restrict people entering their room uninvited. Several people told us of their experiences of others entering their room and in one instance throwing things. This could potentially be a frightening experience for people and had an implication on staffing levels to ensure people could properly be supervised.

We noted most people were well dressed and presented but a number of people were not, one person had long finger nails and told us they needed staff to assist with this. Their appearance was dishevelled. Relatives commented on personal care and thought it was mostly of a good standard but raised concern about staff not always having the time.

Care records did not always demonstrate how people had regularly been consulted about their care needs. We saw some evidence of involvement with relatives when updating people's care plans and people were asked about their care needs and care experience as part of resident of the day. A named person was reviewed each day across the month. This review looked at all key aspects of the care they received from housekeeping, laundry, maintenance, catering and care. Resident of the day had been evolved to show 'you said we did,' but some records had very little detail. Relative meetings were held but poorly attended and some relatives said they got minutes others said they did not. Some relatives had completed surveys and were given their say but results from this were not collated and we saw limited feedback from residents or other stake holders. Staff were being asked for their views but these had not been collated since the last inspection so we could not see how opinions had changed from the last inspection when feedback was poor until now. There was no newsletter for the service which might help communicate some of the recent changes in the service. Resident meetings had been replaced by one to one discussions but the opportunity to take part in group discussion such as resident focus groups were not available.

Is the service responsive?

Our findings

At our last inspection on 21 and 22 November 2017 we rated this key question as requires improvement and at this inspection on the 8 & 10 January 2019 we found it was still requires improvement.

At our last inspection on 21 and 22 November 2017 we identified a breach of Regulation 9 of The Health and Social Care Act Regulated Activities Regulations 2014: person centred care. We found people were not always supported according to the assessed needs and there were poor records showing what care people received. We also had concerns about the range of social activity and the lack of stimulation for some people. At our inspection on the 8 & 10 January 2019 we continued to have concerns about the care people received and the range of activities provided. There was sufficient evidence to support a repeated breach of Regulation 9.

The service was not sufficiently organised and planned around people's individually assessed needs and the care observed was not holistic but task focussed. People's basic care needs were met but staff spent little time between care tasks with people talking to them or engaging them in activities which were meaningful to them. The activity board was not up to date and care staff on the first day of our inspection were not able to tell us if any activities were planned. Some activities took place but most people did not participate in them.

We noted limited activity on the top floor with care staff engaging a small group of people in a ball game but observed nothing on the middle floor. On the second day of inspection there was a pet for therapy dog. We observed some people spending disproportionate amounts of time in their room and some people stayed in bed with little stimulation. We did not see staff actively encouraging people to get up or join others. Most people sitting in the communal areas were asleep throughout the day and there was little conversation between people. As part of our inspection we had experts by experience covering two floors. They reported observation was difficult as there was nothing to observe, by this they meant there was very little happening. People sat some asleep until lunch time and there were no immediate plans for the afternoon. Staff did not regularly encourage people to converse or help them to reminisce. We observed staff speaking exclusively between themselves and not taking opportunities when they could to engage with people. Staff appeared pleasant and efficient and when they did engage with people this was appropriate.

People spoken with told us about some activities they did but it was clear these were infrequent. For example, one person said, "I do a bit of knitting. Otherwise all I do is rest." Another said, "I am a religious person, a lady comes here every couple of weeks and gives me communion. I watch a lot of television. They just leave me, I can be here for 2 to 3 hours and not see a soul." Another said, "I don't do nothing at all, all day. Staff pop in occasionally, not much, usually when they are doing something." One person told us they would like to go out and buy clothes and then said, "The trouble is they'd have to have a member of staff take me and I don't think they ever have anyone spare." One person who told us their day was spent watching television told us they liked sports but it was difficult as there was no Sky or BT Sport here. We asked them would you recommend the home and they said, "There's a lot of people here with dementia, if you don't have it, you'd probably want to go somewhere else, it can be quite upsetting." Relatives also told

us that although sometimes there were things planned many people did not leave their room and one relative said many residents were not able to join in things.

The lack of apparent activity concerned people but it was clear that some things were planned weekly such as bingo, and entertainers and some people had regular family visits which enhanced their day.

We discussed this with the manager who told us that the activity staff had left or moved to a different role. They said they were reviewing the level of activity within the service and keeping records of how people spent their time so this could be analysed and planned for according to people's individual needs and preferences. They said there would be greater emphasis on care staff enabling people to engage in activities of their choice in line with their needs and preferences. We questioned this as staff told us they did not have time. The service had begun to collate social histories and look at the social needs of people they were supporting. They said there was limited engagement with the wider community but the home had a minibus so people could get out if they wished, there were visits from primary schoolchildren and visits from the local church but no volunteers or others who could support regular activity and engagement.

Care, support and treatment plans were in place but were not all the same standard. They did not all reflect people's current needs and preferences of care. The care plans on the ground floor had been reformatted and updated and were more accessible. We found information in some care plans difficult to access and staff recording in different places. For example, care evaluation sheets and daily notes had to be viewed to establish the care given to a person, daily. Care plans and risk assessments were not cross referenced and gave some contradictory information. For example, one person was described as having 'full capacity' but in another document, were described as 'confused' which could impact on the persons capacity to understand and retain information sufficiently to make decisions about their care and welfare. We noted records were being archived and some essential information was not being carried across from week to week which made it hard for us to see some information. For example, when someone last had their bowels open. The length of time it took to retrieve information could slow up other health care professionals and delay them in making an evaluation.

People's daily notes did not demonstrate clearly how the care plan had been followed and there was a reliance on a tick box approach to show a task had been completed rather than a descriptive account of the persons day.

We found the admission process was not sufficiently robust or the various assessments put in to place swiftly to help ensure their care needs were clearly planned for and known by staff. Some documentation was out of date, reviews of care plans were not always robust and some information we might expect to be in place was missing. For example, where people had a specific health care need, guidance was not always in place. People's preferences and preferred routines were not clearly documented. For example, where they liked to sit, if they chose to stay in their room or if they had any preferences in terms of gender specific care. This meant staff might not be aware of the person care preferences or potential risks and meant the care was not holistically provided. We saw life stories were not completed for everyone This would help care staff know more about the person and provide care more effectively. Care notes stated, 'Slept well', 'Ate and drank well' without sufficient detail or reference to the person's plan of care. For people newly admitted to the service there was no mention of how the person was settling in or what had been done to help them familiarise themselves with the service.

This constitutes a repeated breach of regulation 9 of The Health and Social Care Act 2008, (Regulated Activities 2014.) Person centred care.

We found care plans on the ground floor had been updated and were more personalised. There was a front sheet which gave an overview at a glance of the person's needs and care preferences. Care plans and risk assessments were cross referenced to help support care staff to deliver safe, effective care. The care plans were informative with guidance relevant to the persons specific health care needs- including pictures to help staff understand how to support the person. The quality assurance officer was on site and told us it had taken a month to update the care plans on the ground floor and they were going through the other care plans to bring them up to date.

We recommend that this care plan format is used across the service and is put into place as quickly as possible. This would help to ensure care plans clearly reflect people's current needs and preferences and pull together all other documentation so it is clear to staff when delivering care what people's needs are.

We recommend daily progress notes include the full name of the staff member writing them or a signature identification record be put in place to help identify which member of staff was recording in the person's care needs and therefore could be held to account if necessary. Daily notes need to be reviewed to ensure they reflect people's needs and the care being provided.

Staff knew people and able to tell us about their needs. Shifts were organised with staff allocated to support a number of people so there was an even spread of work load. The care we observed on the day of our inspection was satisfactory with staff carrying out regular observations when required to ensure people's safety. One family member told us at times staff were not accessible or visible around the service which they explained how this increased the risk to their relative. Call bells were across the service and in every room and some people were checked regularly due to known risks to their safety. Call bells were regularly tested to ensure they worked but no one had call bell pendants which might be appropriate for people constantly on the move and at increased risk of falls. Call bells went off infrequently. We were concerned about a call bell which went off and staff did not respond to it and our expert found staff in the office talking when one of them could have responded.

End of life care was documented where people were approaching the end of their life. Additional checks were in place to ensure people's symptoms were well managed and people remained pain free and comfortable. Documentation in care files required some updating and we could not see advance care planning for some people. Staff training in end of life care was planned which would help enhance the service.

The service had an established complaints procedure which was accessible and made available so people and their relatives were aware of how to raise a concern. A note was in reception to health care professionals to bring any concerns to the attention of the manager before leaving site. The main entrance led to a manned reception area and the main office so staff were visible on arrival to the service. There were lots of complimentary cards at reception.

We spoke with relatives and people using the service their feedback was mixed. Some had concerns essentially about the number of thefts in the service and how that had been poorly communicated to help safeguard people's property. Concerns raised with us had not been recorded by the service to show how these had been addressed although relatives said they had been raised with management. We recommend the service deal with concerns and feedback in the same way they would deal with formal complaints to demonstrates how they are responsive to feedback.

We viewed the complaints policy and recent complaints. These were logged but only dated back to August 2017 when the new manager had taken over. Complaints included an investigation to establish the facts but

we found not all had been resolved within the time scale of twenty days but the complaint had been acknowledged. The manager was aware of this and said it was taking a while to investigate concerns.

Is the service well-led?

Our findings

At our last inspection on 21 and 22 November 2017 we rated this key question as requires improvement and at this inspection on the 8 & 10 January 2019 we found it was still requires improvement.

At our last inspection we identified a breach of regulation 17 of The Health and Social Care Act Regulated Activities Regulations 2014: good governance. We found the service was not consistently well managed or took sufficient account of people's experiences. We rated this key question as requires improvement. This was the second time we had rated well led as requires improvement in the last three years. At our inspection on 8 and 10 January 2019, we found that the service was improving and robust systems and processes had been put in place to improve the quality and safety of the service that people received. We found however there were still two repeated breaches of regulation so we consider this is sufficient evidence to support a continued breach of regulation 17 of The Health and Social Care Act 2008, (Regulated Activities 2014.) Good governance

We have rated this key question as requires improvement for the third time. Although progress was being made this was slow and the service priorities established had not brought positive changes across the whole service. We have identified several breaches of regulation as part of our inspection which means the service is not yet good.

Following our last inspection, the registered manager left several weeks later. The new manager was appointed but had since left. The clinical lead appointed several weeks before the last inspection also left and a temporary secondment of a clinical lead had since come to an end. The deputy manager had recently left as well as a few other key staff including the receptionist, the administrator, one of the maintenance staff and activity staff. This has slowed the progress we would have expected the service to have made.

The service has rapidly recruited to vacant posts and had several regular agency staff and a bank team who could back fill posts. In addition, the service had appointed a clinical lead and seconded a staff member to the position of unit leader for the residential unit on the ground floor. The clinical lead had oversight of the first and second floor, with a nurse and senior on each of these two floors. This new arrangement was starting to impact positively on the organisation, planning and improvement on shift. There has been a new manager in post since August 2018. They were appointed on a short-term contract until a permanent manager could be appointed. A new experienced manager is scheduled to start in March. The provider told us they had held three rounds of interviews to ensure they got the right candidate to help sustain and continue to improve the service. The temporary manager had worked hard to improve communication across the service. We found systems and processes were robust and identified any risks across the day and showed how these were being managed. The focus was on improving people's experiences and reducing any risk factors by improving people's physical health care needs.

The manager had placed emphasis on having the right team structure in place and upskilling the staff so they could deliver effective care. There were plans to continue to develop staff and strengthen the induction processes so new staff felt sufficiently confident when delivering care. The manager was developing the

nurses and team leaders through enhanced training and support by going back to basics to ensure they could lead the floor.

The main concerns we had about this service was the obvious lack of stimulation and activity for people. We accept that there had been some recent changes in the service including the activities coordinator stepping into a different role and the other activities coordinator leaving. The manager was clear that activities should be everyone's business and care staff should be enabling people to spend their time doing things they still enjoyed and were able to do. They had started to evaluate the range and level of activity for each individual so they could develop meaningful plans based on how people liked to spend their time. Life histories were on file, some complete, some not. These would help care staff have a deeper understanding of the persons back ground and how they liked to be cared for. Care plans were shifting from task focused to a more persons centred model and outcome focused. Some activities were organised and the service had a minibus and local shops people could access. Greater use of community facilities and community groups would enhance this service. There was already some work underway with the local primary school and regular engagement with the church and pets for therapy as well as outside entertainers.

We recommend the service communicates with voluntary groups and community groups as well as colleges to see what resources were available which could enhance people's daily experiences and keep them connected with their pasts. In addition, we recommend that the service closely reviews people who spend disproportionate amounts of time in bed or in their rooms to see what the reasons are and if it's always choice or if there are other factors affecting this.

Recent changes of management meant a lot of people and relatives were not clear who was managing the service and told us there had been a lot of changes which had not always been well communicated. Within the individual units we could not see a staff board telling us who was on duty and who was in charge should there be a problem or should relatives want information. There did not appear to be a focal point although there was a nurse's station. We did not see a list of forthcoming events or information from previous or planned meetings coming up where people could have their say. There was some information in the main reception and it was nice to be greeted by a receptionist who could answer any questions and sign post visitors.

The current manager was a good communicator and had built up relationships with other health care providers to try and ensure a more seamless service. Before our inspection we spoke with health care professionals who expressed a lacked confidence in the service in the past and spoke of things not being embedded. They all however recognised that the manager had worked hard to ensure the safety and welfare of people and was open and transparent when things had gone wrong and was keen to learn and develop systems and processes to prevent further incidents.

We found during our inspection that care plans were not all a consistently high standard and did not always reflect people's needs. We were however confident that there was an improving picture with a resident of the day system which was evolving and more outcome focused. Care plans on the ground floor had been redesigned and were more user friendly and helped support care staff in meeting people's needs. During both days of our inspection visit we met the quality assurance officer. They told us they were there weekly to support staff and were going through all the care plans to ensure information was accessible, up to date and cross referenced. They were knowledgeable in terms of what was needed and how far they had come in such a short time. They told us they would continue to support the service.

Although some care plans were poor we were confident that there were sufficient processes in place to capture and identify any immediate risks to people's health or safety. Concerns about staffing or the

environment were identified quickly and actions put in place to address these and minimise any risk. Daily head of department flash meetings were held and the new handover books recorded initial unit walk around and checks throughout the day to ensure things were being done. Safety huddles were held following an incident or adverse event to ascertain what had taken place and any lessons learnt. This was a supportive mechanism to help staff reflect on the incident and consider what they might do differently in the future or what went well. Staff moved quickly when a person became acutely unwell and this ensured they got swift medical treatment and avoided a prolonged hospital admission. Other events at the service were met with a swift response and care plans, risks assessments updated to ensure the persons future safety. These incidents were effectively communicated to the management team in the service. There was a wider oversight and analysis of accidents, incidents and near misses to help reduce these by establishing if everything had been done as well as looking for themes and trends. The service had an accelerated action plan and prioritised how and what they should focus their attention on first due to levels of risk. This appeared to be working effectively with tangible results. Although care plans were not all up to date immediate risks were identified through the flash meetings.

Audits schedules were in place to help ensure that the service was safe and fit for purpose. We looked at a sample of records particularly maintenance and health and safety records and found these were well organised and actions arising from audits addressed. All the issues we picked up and identified as a concern had already been identified and being addressed by the service.

During our inspection visit we met the dementia lead for the organisation who had a role to support all the homes, (older people) belonging to this provider group. We had raised concerns in our earlier feedback after day one of our inspection about the meal time experience. The dementia lead carried out their own observations on the second day of inspection. They told us The Priory Group had a dementia strategy which they were rolling out. As part of this they said they would be identifying a dementia lead in all its homes and providing them detailed training and coaching so they could cascade this to the staff teams. Staff already received basic training in dementia but this could be developed further. They told us part of their role was to support activity staff and to support services with developing good dementia care practice which might be focussed on an individual person who the service was finding difficult to support. They told us they had carried out suggestions for this service in terms of the environment, training and developing good dementia care plans. We were however unable to see their report as this was not produced at the time of inspection. The service was not sufficiently demonstrating that they were providing care, support or treatment according to people's individual needs or in a dementia friendly environment but a lot of work was taking place to improve this.

Staff retention and skills and knowledge was crucial to the continued development of the service and there were plans to develop staff and identify lead roles for nurses and care champions who would take the lead and advise and support staff in an area. The service already had identified fire marshals and first aiders on each shift and had identified shift leaders who had a more defined role. There were manual handling trainers in the building and an infection control lead.

Resident of the day meant peoples needs could be discussed as comprehensively as possible and there were surveys circulated to gather feedback and resident/relative meetings, although these meetings were not always well attended. The service did not always ensure that audits focussed on the persons lived experience.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The plan of care for people was not always explicit, up to date or sufficiently focused on the persons preferences and routines. The evaluation of care was poor and did not tell the reader what care had been delivered in line with the persons assessed needs.</p> <p>The level of activity and opportunity to participate in a range of meaningful and stimulating activities was poor as was engagement with the wider community.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Records did not always reflect how decisions had been reached, who was involved and how the service was acting in people's best interest where they lacked mental capacity.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The service was not yet compliant with all relevant regulations which meant there was insufficient oversight.</p>