

Chasewood Care Limited

# Chasewood Care Limited

## Inspection report

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Tel: 02476644320

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09 November 2017

10 November 2017

24 November 2017

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

The inspection site visit took place on 7, 9, 10 and 24 November 2017. The first day of the inspection was unannounced; we told the provider we would return on the second, third and fourth day of the inspection visit. The reason for the fourth day of our inspection visit was to check the provider had taken immediate action to improve the safety of the premises.

The care home provides accommodation and personal care for up to 107 older people, some of whom live with dementia. At the home at the time of our inspection visit. At the time of our inspection, one unit was out of use, awaiting refurbishment. Fifty-one people lived in five units on two floors.

The previous registered manager had retired from the service in December 2016. The current manager had worked at the service since June 2017. They had not yet registered with us, but they had applied to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection in December 2016, we judged that improvements were required in delivering a safe, effective, responsive and well-led service. At our focused inspection in August 2017, when we looked only at the KLOE of well-led, we found some improvements had been made, but some further improvements needed to be made in the governance of the service.

At this inspection we found the required improvements had not all been made since August 2017. Some of the improvements we had identified as required at our previous inspections in 2015 and December 2016, were ongoing. At this inspection, we found the required improvements had still not been completed in managing and mitigating risks to people's safety and wellbeing or in the leadership and management of the service. The service continues to be rated requires improvement in safe, effective and well-led and has been re-rated from good to requires improvement in caring. We will re-inspect the service within 12 months, to check whether all the required improvements have been made.

The provider's quality assurance system was not sufficiently robust to identify and mitigate risks related to the premises. The provider took action to mitigate some obvious risks identified during our inspection, but their premises risk assessment had not been robust enough to identify them prior to our inspection visit.

Risks to people's safety and wellbeing had not all been identified and were not minimised in their paper care plans. The provider's plan to implement electronic care plans was still in progress and people's paper care plans had not been updated when people's needs changed.

The provider had not made all the improvements they said they would make since our previous inspection. Improvements were required in the provider's understanding of the legal responsibilities of being a

registered person and in preparing and supporting their manager to become a registered person.

The provider had not maintained effective oversight of staff's practice to ensure they understood how to manage risks to people's health and wellbeing. Staff did not consistently use the equipment described in people's care plans to ensure they were supported safely. Staff did not demonstrate they understood their responsibilities to provide safe care in relation to good infection prevention and control practice.

People were offered a choice of meals that supported them to maintain a balanced diet that met their preferences. However, improvements were required in staff's practice and record keeping, to ensure risks to people's mealtime experience and dietary intake were minimised.

Staff were trained in the fundamental standards of care and in subjects that were appropriate to people's needs and people were supported to obtain advice from healthcare professionals when their health needs changed.

The manager understood their responsibility to apply for the authority to restrict people's liberty in their best interests. Staff demonstrated they understood the principles of the Mental Capacity Act 2005, by supporting people to make day-to-day decisions about their care and support.

People told us they felt well cared for because staff were kind to them. However, Staff did not always consider the wellbeing of those people with complex needs who could not express themselves verbally. There was not enough information in people's care plans for staff to understand their histories and interests to enable staff to provide person centred care that focused on them as individuals.

People were supported to maintain their cultural and religious traditions and were able to engage in activities around the home and local community. People told us they had no complaints about the service. Complaints and concerns were responded to and resolved promptly while maintaining effective relationships between the complainant and the provider.

The provider and manager planned to continue to improve and develop the service. A newly implemented system for medicines management and administration gave assurance that medicines were managed and administered safely. The planned service developments included bringing the local community into the home, networking opportunities and working in partnership with other health and social care agencies.

There were breaches of the Regulations. The provider had not ensured that the premises used by the service were safe to use for their intended purpose and were used in a safe way. The provider had not adequately assessed and minimised risks to service users' health and safety and had not done all that was reasonably practicable to mitigate any such risks. The provider's systems for governance and quality assurance were not sufficiently robust to ensure risks to the quality of the service were identified and mitigated.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe. There were risks to people's safety in relation to the premises that the provider had not identified before our inspection. People's individual risks were not consistently identified in their care plans and were not consistently minimised by staff's actions. Medicines were managed and administered safely. The provider's systems for infection prevention and control were not consistently understood and demonstrated by staff.

**Requires Improvement** ●

### Is the service effective?

The service was not consistently effective. Staff did not consistently encourage people to eat enough to meet their dietary needs. People were supported to access healthcare services when needed. The provider had begun a programme of refurbishment throughout the home, to provide people with a suitable environment, that met their needs. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

**Requires Improvement** ●

### Is the service caring?

The service was not consistently caring. Some people said they were supported by kind and caring staff, but some staff did not demonstrate a caring attitude. Some people were able to express their views and to be involved in planning their care, but some people's views and experience were not understood by staff. Some people said they were treated with dignity and respect, but staff's actions were not always respectful and staff did not always promote people's dignity.

**Requires Improvement** ●

### Is the service responsive?

The service was not consistently responsive. Information about people's previous lives, pastimes and interests were not always made known to staff, to enable them to provide person centred support. People were supported to maintain their cultural and religious traditions and were supported to engage in activities around the home and local community. Complaints and concerns were responded to promptly and without prejudice to the complainant.

**Requires Improvement** ●

**Is the service well-led?**

The service was not consistently well-led. The provider's systems and procedures for monitoring the quality of the service were not sufficiently robust to identify risks related to the quality of the service. The manager was not consistently mentored or guided by the provider to understand the requirements of being a registered person. Staff recognised and appreciated the manager's leadership skills and experience of delivering care and support. The provider and manager planned to continue to improve and develop the service. Planned service developments included working with external partners and inviting them to contribute their skills and experience to improve the quality of the service.

**Requires Improvement** 

# Chasewood Care Limited

## 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.

Chasewood Care Limited is a residential 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 accommodates up to 107 older people, some of whom live with dementia, in six units, on two floors. The inspection site visit was conducted by two inspectors 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 first day of the inspection site visit was conducted by two inspectors and an expert by experience on 7 November 2017. We told the provider we would return on the subsequent inspection visit days. Inspection visit activity started on 7 November and ended on 24 November 2017.

We had already asked the provider to complete a Provider Information Return (PIR) earlier in 2017, so we did not ask them to complete this again. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account when we made the judgements in this reports. We reviewed the information we held about the service and information that was shared with us by the local commissioners of care.

Many of the people who lived at the home were not able to tell us about their care and support, but we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider, the manager, two deputy managers, six care staff, a domestic staff, a catering

assistant, two visitors and five people who lived at the home. We reviewed six care plans, staff duty rosters and six recruitment files. We reviewed records of the checks the provider and management team made to assure themselves people received a quality service. The manager had sent us the results and analysis of their quality assurance audits for September and October 2017, as requested, by email after the first day of our inspection visit.

# Is the service safe?

## Our findings

During our previous comprehensive inspection in December 2016, we had identified improvements were required in managing risks related to the premises, in particular improvements in preventing and managing the risks related to fire safety. At this inspection we found the provider had taken action to improve how risks related to fire safety were identified and managed. The local fire prevention officer had revisited the home and was satisfied that the measures in place and action plans would mitigate risks to people's safety in the event of a fire.

However, the provider's premises risk assessment and action plans were not sufficiently robust to minimise risks to people's safety in relation to the premises. They had not proactively continued to identify and mitigate risks related to the layout of the premises or the fixtures and fittings. They had not taken appropriate action to minimise risks related to the premises.

During the first day of our inspection, we identified physical risks related to the premises that compromised people's safety. The provider had not identified or taken action to minimise the risks we identified and was unable to show us a written risk assessments of the premises.

In a ground floor lounge, the double doors leading out onto an enclosed terrace did not shut securely and could not be locked. A block of wood had been used in an attempt to jam the retaining door shut at the lowest edge. This was not effective as neither door shut tight. People who needed support to go outside were at risk of going outside independently and unobserved by staff. Staff told us the door had been like this 'for some time', but could not say how long. The provider's premises risk assessment had not identified this as a risk to people's safety or wellbeing prior to our inspection. By the fourth day of our inspection, the provider had secured the doors and arranged for the doors to be replaced.

We saw that people were able to walk through the dining room into the kitchen where a hot oven was left unattended, which presented a risk of burning. The barrier between the dining room and kitchen was a lift up flap with no lock, which meant anyone could touch the hot oven. After we asked the provider whether this was a risk to people's safety, they fitted a discreet lock under the flap on the third day of our inspection.

The provider had not conducted a risk assessment, with control measures and actions to minimise risks related to their refurbishment programme. The refurbishment programme included redecoration of the entire home and replacing worn or outdated fixtures and equipment. The refurbishment programme had started with updating and decorating the communal areas and empty bedrooms. The provider was unable to show us a written risk assessment, with planned control measures and actions, to minimise risks to people's safety during the refurbishment programme.

One entire unit on the ground floor was out of use, but was being used to store discarded furniture and equipment and workmen's tools. On the first day of our inspection, the individual doors along the unit were not locked. There were no signs to inform people not to enter and no barriers to stop people from entering this unit. One person had walked into this unit and used the toilet, which also did not have a working light.



After we shared our concerns with the provider about the risks related to people's safety in regard to this area, the provider installed a child-safe stair gate at the entrance to this unit on the same day. By the fourth day of our inspection, they had cleared the furniture, equipment and tools from the kitchen and locked the other doors.

The system for reporting maintenance issues was not sufficiently robust to ensure repairs were undertaken promptly and effectively. The provider told us there were maintenance books on each floor for staff to record any maintenance issues. Staff told us they reported maintenance issues on an 'incident report'.

On the second day of our inspection, we found one person's en-suite toilet was missing the flush press-button, which caused the water to flow continuously. The manager and staff could not tell us how long the button had been missing. Another person's room did not have a curtain rail, which meant there were no curtains at the window to keep out the dark and cold air at night. The manager told us the maintenance person had signed this particular piece of work off as 'completed', but it had not been completed. By the fourth day of our inspection, these maintenance issues had been addressed.

On the third day of our inspection, the provider's CCTV system showed one person had sustained an unwitnessed injury in the laundry room. They had been able to enter the laundry room because the key coded lock was faulty and the door did not close securely. After the accident had occurred, the provider called a workman out to replace the lock the same day.

This was a breach of Regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment in relation to the premises.

The provider continued to engage specialist suppliers to make sure that essential supplies, such as water, gas and electricity, were regularly checked, serviced and safe to use.

During our previous comprehensive inspection in December 2016, we found improvements had been made in supporting people to manage their individual risks. We had found staff knew people well and understood how to support people safely, using the equipment that was prescribed for them. At this inspection we found improvements were required in staff's practice to ensure people were supported safely at all times.

On the first day of this inspection visit, we saw some staff did not use their knowledge of people and information in their care plans to minimise risks to people's personal safety. Some staff did not always use the equipment described in people's care plans to support them to mobilise and did not always use it safely, in accordance with their training. For example, one person was supported to mobilise without using the stand hoist, as instructed in their care plan, and staff used a wheelchair without footplates attached.

By the fourth day of our inspection visit, the manager told us they had held meetings with all of the staff to share feedback about our observations and to establish why they had not followed the written guidance in people's care plans. Staff had been reminded that 'shortcuts' were not acceptable. They were reminded of their responsibilities to speak up if they needed support or equipment to ensure people were always supported safely. The manager had ordered some additional and replacement equipment, to ensure there was enough equipment, in good repair, to support people safely whenever they needed support to mobilise.

People's risk assessments and care plans were not clearly updated when their needs changed, which put them at risk of unsafe support from staff. At our previous inspection in December 2016, we had reminded the provider we expected to see a continuous improvement in records of risk assessments and personalised care plans. This was to ensure all staff had access to the detailed information they needed to support people

safely. The provider had not made the progress they had agreed they would make. They told us it had taken longer than they had anticipated to recruit a manager with the appropriate skills to implement the required improvements in care planning.

The provider used recognised risk assessment tools to identify risks to people's health, but these were not always used consistently by staff. In the paper care plan we reviewed for one person, staff had not recorded their assessment of risks to the person's skin as part of their monthly care plan review. The risks to the person's skin were not clearly explained between December 2016, when they were identified as 'at risk' of skin damage and September 2017, when they were identified as at 'high risk' of skin damage. Their skin care plan was marked, as 'reviewed' and 'no changes', despite the fact that their risks were currently identified as 'greater' than they had been nine months previously.

The manager showed us one person's care plan that had been created electronically. We saw the electronic care plans automatically generate risk assessments related to people's needs and abilities. At our focused inspection August 2017, the manager had told us they planned to implement electronic care plans. However, at the time of this inspection, the electronic care plans were still a 'work in progress'. Only the paper records were available to staff and these were not reviewed and updated consistently or effectively.

This was a repeated breach of Regulation 12(2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

The manager had already identified that improvements were required in infection prevention and control (IPC). The provider had delegated the responsibility for preventing and controlling the risks of infection to a senior member of staff, but had not given them effective guidance in line with the Department of Health's Code of Practice. There was no named infection prevention and control lead at the service.

There were no written cleaning schedules available to domestic staff. Domestic staff had cleaned the home according to verbal instructions only, as they did not have a checklist to refer to. We found the underside of a shower chair was dirty and rusty, after the domestic staff had finished cleaning the bathroom according to their verbal instructions.

Care staff attended training in infection prevention and control, but had not recognised the risks of infection related to equipment they used. Staff had continued to use a crash pad at the side of one person's bed, although it was ripped and therefore, prone to collecting dirt, dust and germs inside the cover. Staff continued to use a dirty wheelchair, 24 hours after we had identified that it needed cleaning. The provider's internal IPC audit had not identified there were still unmitigated risks related to infection prevention. By the fourth day of our inspection, the manager had held meetings with staff to remind them of their responsibilities for effective infection prevention and control.

The manager told us the provider's infection prevention and control (IPC) policy, procedures and audits did not offer the reassurance they needed to be confident that people were safe from the risks of infection. They had arranged for an IPC expert to spend a week at the home in November 2017, to re-educate staff and implement effective procedures and guidance.

Improvements had been made by the provider in recruiting staff safely. Records showed the provider had been more consistent in following the guidance for safe recruitment than we had found at our previous inspection. The recruitment process included making all the pre-employment checks required by the regulations, to ensure staff were suitable to deliver personal care.

None of the people we spoke with were concerned about the amount of staff on duty. They all told us they received care and support when they needed it. The manager had made changes to the shift working pattern to allow an hour and a half overlap between the incoming and outgoing shift. Staff told us there were usually enough staff on the rota to support people safely. Staff identified that staff sickness absence sometimes had an impact as they could not always get additional staff at short notice. On the first day of our inspection, the activities coordinator was asked to step-in to support people at lunch time. Each staff shift included a named first aider and named fire marshal, which minimised risks to people's safety in an emergency.

The deputy manager told us staffing levels were more reflective of people's needs now because they were based on people's dependency scores. They described staffing levels as, "Quite good and it is a safe amount." The deputy manager was working on the electronic care plans, which included an automated dependency analysis to determine an appropriate number of staff. Once the electronic care plans are implemented in full, staffing levels might change according to the calculated dependency score.

People told us they felt safe at the service, because they had their own room and could choose when they socialised. People told us having staff around made them feel safe, because they trusted the staff. One person told us, "I feel safe here. I would rather stay here than go anywhere else."

Improvements were required in staff's knowledge and use of the provider's safeguarding policy and procedure. Staff had training in safeguarding, but did not all demonstrate awareness of their responsibilities or the local safeguarding authority's protocols. Staff told us they raised concerns with a deputy manager. They told us, for example, if they saw any unexplained bruising on a person, they would record it on a 'body map' and report it to a deputy manager. One member of staff said they, "Never really reported it further."

Staff had recently been told by the manager they must report every accident, incident or unusual or unexplained event to the manager, to enable the manager to categorise and investigate or refer to the local safeguarding team appropriately. The manager told us they had referred people to the local safeguarding team when they were identified as 'at risk of abuse' from other people. The manager had notified us when they made a referral to the local safeguarding authority which had been substantiated and action taken. They had not realised they needed to notify us as soon as they made a referral, without waiting for the outcome of the safeguarding team's investigation. They told us they would notify us at the same time as they made referrals in future.

Medicines were managed and administered safely. People told us they had their medicines when they needed them. We saw staff wore a red 'do not disturb' tabard when they administered medicines. The staff member sat down next to the person, explained what they were offering the person and made sure they had swallowed the tablets before they moved away and signed the electronic Medicines Administration Record(MAR). Since our previous inspection in December 2016, the provider had changed how medicines were obtained and dispensed. They had moved from paper based records to electronic records. Medicines were now being supplied in their original packaging instead of blister packs.

Staff told us the new system was easy to use. They said they signed electronically when they administered people's medicines and the system automatically calculated how many medicines were left in stock. Staff had to 'log in' to the recording system, which told them who needed which medicine at which time of day. The system automatically raised an alert if a medicine was missed or given in error, and the member of staff was not able to 'log out' until a senior member of staff had investigated the error. Staff told us the system increased their confidence in administering medicines, because it minimised the risks of errors in medicines administration and recording.

Records showed the manager analysed accidents and took action to minimise the risks of a reoccurrence for each individual. There were no identifiable patterns as to the causes of the accidents recorded for September 2017. In October 2017, the manager had identified that a decorative picture had contributed to the severity of the injuries one person sustained. The manager removed all pictures with glass frames and planned to replace them with less hazardous frames once the redecoration of the corridors was complete.

Staff told us they completed accident and incident reports, which were sent to the office. Staff we spoke with said they were not sure of the process after that. One member of staff told us they never discussed learning from accidents and incidents. Another member of staff said, "Nobody ever says anything." By the fourth day of our inspection, the manager had held meetings with staff to remind them of the processes and procedures for reporting, investigating, learning and feedback when incidents occurred and when concerns were raised.

## Is the service effective?

### Our findings

People who were able to tell us, said staff had the skills and experience to meet their needs effectively. People said, "I think they are well trained", "They know how to look after me" and "The staff know me well. They know what I like and don't like."

Most of the people who lived at the home had been lived there for several years. Their paper care plans were in the process of being recreated in an electronic system. We looked at the paper care plans for two people who had moved into the home since our previous inspection, to check how their needs were assessed and how their care was planned.

Care plan records showed people's health, personal, emotional, cultural and spiritual needs had been assessed in accordance with the regulatory guidance. People's individual and personal risks had been assessed in discussion with the person. Their care plans explained how the identified risks should be minimised by staff's actions and use of appropriate equipment. Care plans were centred on the person's individual needs, preferences and abilities with guidance for staff about the person's abilities and needs for effective communication.

Staff had training in the fundamental standards of care, as set out in the Care Certificate, and in subjects that were appropriate to people's needs, such as food hygiene, dementia awareness and falls prevention. The deputy manager told us, "Staff cannot work if they are not trained up." Staff told us they were supported to study for nationally recognised qualifications in health and social care. Staff told us they were invited to one-to-one supervision meetings with their line manager. A member of staff said the meetings were held every couple of months and, "They are okay. You can voice your opinion."

People told us there was a choice of meals and they could get a drink anytime they liked. One person told us there was plenty of choice of meals. We saw people were offered hot and cold drinks and snacks throughout our inspection visit. There was a list of people's allergies, food likes, dislikes and cultural preferences in the kitchen. A catering assistant told us care staff updated the list when new people moved in, so they could be confident people were offered meals that met their needs.

During our focused inspection in August 2017, we had noted the manager had created a new dining room on the first floor. This encouraged people to look forward to mealtimes as a highlight to the day, to regularly move from their armchairs at meal times and enabled them to socialise. The manager told us this had a beneficial effect on people's appetites and their nutrition. The dining room was still being used during this inspection visit, and most people were encouraged to sit in friendship groups. We saw people were offered a choice of meals. For people with complex needs, who may not be able to communicate verbally, staff showed them both plates of food to assist their decision making.

The manager had made improvements to the food choices. The majority of main meals were still obtained as frozen, ready prepared meat and fish dishes, but the manager had re-introduced some fresh cooked vegetables, home baked potatoes and home baked cakes. The kitchen facilities were available during the

evenings, so care staff could prepare home cooked snacks of people's choice.

During our previous inspection in December 2016, we had found improvements were required in supporting people to maintain a balanced diet that met their needs. We noted that staff did not consistently apply the provider's policy of offering people choices or second helpings to improve their appetites and mitigate the risks of weight loss. At this inspection, we found improvements were still required in staff's understanding of how to mitigate the risks of people spending time together in a small space at lunch time and the need to mitigate the risks related to poor appetites and weight loss.

Staff did not all demonstrate the same level of awareness of people's needs at mealtimes, and the risks they posed to each other. For example, on the first day of our inspection, before the meal was served in the dining room, people were waiting for more than ten minutes without any staff in the room. One person with complex needs walked round the room, invading other people's personal space, which annoyed the other people. People started to get angry and quarrel with each other, but there were no staff available to intervene and distract the person and calm the atmosphere. When the catering assistant came into the dining room, they had to serve the meal and support everyone's emotional needs single handed. No-one was offered a second helping at lunch time on that day.

The manager told us that there were usually more staff on duty at lunch time, because they had recently implemented a shift pattern to include one and half hours overlap between the morning and afternoon shifts. On this particular day staff were almost all working a 'long shift' with no midday handover, so did not have the benefit of additional staff during this period. The manager told us they planned to consult with Age UK about the possibility of identifying people with experience of supporting people with dementia, who might like to work for a few hours each day, to improve the mealtime experience for everyone. On the fourth day of our inspection visit, the manager had arranged for lunch to be served in two sittings, which enabled staff to deliver a more enjoyable lunchtime experience for everyone.

Staff still did not consistently apply the provider's policies and were not proactive in supporting people to maintain a nutritious and balanced diet. One person's weight record showed they had lost weight in the previous six months and had been referred to a dietician, who had recommended a soft diet. By the end of lunchtime the person had not eaten their meal, but staff did not offer them an alternative meal when they cleared the plates away. The person's daily records included a chart to show what they had eaten each day. Some of the daily records had either not been completed or had been misplaced. The remaining records frequently said, 'soft meal' or 'pureed meal', so it was impossible to know whether they were usually offered a choice or encouraged to eat a balanced diet to maintain their weight.

The manager prepared 'transfer' packs when people needed to be transferred to other services. A member of the local ambulance service had been called to the home on the third day of our inspection. They told us staff had given them all the information they needed to support the person safely when they were transferred to another service. The information included a profile of the person's needs and preferences, their medical history and an up-to-date medicines administration record.

People told us they were supported to access healthcare services when they needed them. People said, "If I need a doctor I get one straight away" and "They always get the nurse or the doctor to help me." Records showed people were referred to their GP and community nurses when needed and staff recorded and acted on the healthcare professionals' advice. The manager had created a room for the community nurses to keep their own supplies and records, which made it easier for the nurses to support people promptly when needed.

The provider was working on a refurbishment programme throughout the home to provide a more suitable environment for people who lived with dementia. The manager had consulted Age UK about colour schemes that were supportive of people living with dementia. They had decorated some bedrooms in calming and warm colours and rearranged the furniture to promote people's independence. For people who needed to be able to access their en-suite wash basin in their wheelchair, the cupboards had been removed under the washbasin to enable them to do so independently. Some people had memory boxes outside their bedroom doors, which were intended to enable them to identify their own bedroom door.

At the time of our inspection visit, all the directional signs and information for people and visitors had been removed from the walls in the main corridors while they were being redecorated. The manager told us these would be replaced, but was not able to identify a 'planned date' for re-installing the signs and information, because the provider had not created a formal risk assessment and action plan for the refurbishment work. The manager told us improvements in supporting people to orientate and find their way around the home were in progress. They showed us some of the artwork that people had made, which they planned to display in reception and along the corridors. By the fourth day of our inspection, we saw work had begun with 'remembrance poppies' created from people's handprints, on display in the reception area.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager understood their responsibilities under the Act. Where restrictions on people's liberty had been identified, the appropriate applications had been submitted to the authorising authority. Where a DoLS had been granted with a condition, we saw the condition was being met.

Staff attended training in the Mental Capacity Act 2005, and we saw they invited people to make their own decisions about how they were cared for and supported. People told us, "I never have to do things that I don't want to do" and "If I want some peace I can go to my room." A member of staff said, "People may have dementia but they can still make their own choices."



## Is the service caring?

### Our findings

People told us the staff were kind and helpful and treated them with respect. People said, "The staff explain things to me, like the choices that we have for lunch" and "I feel like they know me well. They look after me." Another person said, "They don't rush in and out of my room in five minutes. They ask me how I am and offer to do things for me." People told us the provider was, "A nice man" and said, "The owner comes to speak to us." We saw the provider knew people well and greeted them like old friends.

However, staff did not consistently demonstrate the same level of understanding or behaviours in caring for people. We found that people with more complex needs did not experience the same level of caring that other people told us they experienced. Improvements had been made by the end of our inspection, but the provider had not proactively maintained effective oversight of staff's practice to ensure all staff supported people with kindness and respect prior to our inspection.

Some staff did not show concern for people's wellbeing. We saw some staff did not use the equipment that was prescribed in the person's care plan to support them to mobilise. Staff supported the person to transfer from one chair to another in a wheelchair without footplates attached. This meant the person had to make a greater physical effort to stand up, and then to hold their feet up off the floor, than was necessary.

People were not consistently supported to maintain their privacy and dignity. Two people told us, "I am treated with respect" and "The staff are good. I feel listened to." However, we saw people with more complex needs were not consistently supported to maintain their dignity and respect. Some staff had not recognised that using unhygienic equipment, such as a ripped crash mat and a dirty wheelchair, was disrespectful to the person.

People who were able to speak for themselves, or had relatives to speak on their behalf, had brought items of furniture and personal possessions into their bedrooms, to make them feel like home. Staff were responsible for supporting people to make their bedrooms feel personal and homely, if they had no family members to support them.

On the second day of our inspection, we saw two people's bedrooms did not provide them with a homely environment that protected their privacy or promoted their dignity. One person's bedroom did not have a curtain rail, which meant there were no curtains at the window to keep out the dark and cold air at night and ensure the person's privacy. The second person's en-suite bathroom had a faulty toilet, which meant the water ran continuously. Their bathroom contained only empty bottles of toiletries. No individual staff member had taken responsibility for ensuring the two people's bedrooms were homely and their personal toiletries' needs were met.

The manager told us that the local commissioners of care had asked them to nominate a member of care staff as a keyworker, or 'best friend' for each person that they commissioned care for. The manager had been considering whether this was the best way to ensure people's individual needs were met, or whether they should identify a team of keyworkers for each person.



By the fourth day of our inspection, everyone had been allocated a keyworker. We found the second person's toilet had been repaired and their bedroom had been rearranged and was more homely, with their personal photos placed where they could see them. The person's bed was neatly made and looked inviting. Their newly bought toiletries were arranged neatly in the bathroom and their bedside light had been repaired.

We saw some staff understood people and knew them well. We heard staff encouraging people to make choices in their day-to-day decisions. The manager told us they continuously assessed people's emotional needs and were able to suggest which unit in the home they would be most settled in. They told us, "We look at characters and personalities and think 'where will they fit in better with the other residents'." We saw some staff reassured people physically and verbally when they displayed signs of becoming anxious. One person's care plan stated they responded well to male carers and we saw a male member of care staff sat with this person when they were eating their meal.

We saw people who were not able to communicate verbally, looked to staff for recognition and guidance. However, on the first day of our inspection, when people had gathered together in the dining room, in anticipation of their lunch, there were no staff present for ten minutes. People with complex needs had no one to support them in the confined space of the dining room. Some people with complex needs became restless and agitated, which caused everyone in the dining room to become agitated and the atmosphere was not conducive to a good lunchtime experience.

One person with complex needs was under the care of a dietician, who had advised staff to offer the person soft foods to ensure they were able to eat a balanced diet. The person's daily records included a chart to show what they had eaten each day, because the person was not able to remember for themselves. Some of the daily records had either not been completed or had been misplaced. The remaining records frequently said, 'soft meal' or 'pureed meal'. Staff had not recognised the importance of knowing what the person ate each day, to ensure they were offered a varied as well as balanced diet.

## Is the service responsive?

### Our findings

During our previous inspection in December 2016, we had identified that further improvements were required in obtaining and using information about people's previous lives and interests. This information is used to ensure staff are able to respond to people appropriately and that people are supported to maintain their preferred routines.

People told us staff engaged and interacted with them more than they used to. People told us, "The carers have asked me what I like and want" and "They know what I enjoy." One person said, "In the past the staff were always too busy and didn't speak to me much. The staff mix more with me now. They want to know things. They ask me whether I'm fed up. They're always glad when I answer their questions."

However, we found the required improvements were still in progress in relation to written records of people's previous lives and interests. The amount of information in people's care plans about their past experiences, lives and interests was inconsistent. There was little written guidance in people's care plans to enable staff to proactively encourage people to maintain their interests in relation to their previous lives or careers. The manager told us staff's acquired knowledge of people had not been added to the paper care plans, because the electronic care plans were due to be implemented from December 2017. This was where staff's knowledge will be recorded and will be available to all staff as soon as the system is implemented.

The electronic system will allow staff to create daily records electronically of how people are supported and cared for, including information about their appetites, moods and behaviours. The technology that supports electronic records will enable people's relatives to access the records, with the person's consent, to obtain reassurance that their relative is responded to appropriately and effectively, according to their needs. The electronic care plans include people's social, religious and spiritual needs with an option to record the type of activities the person enjoyed.

We saw people were supported to maintain their cultural traditions with relevant meal options and by staff who spoke in people's first language. People told us they were supported to maintain their spiritual traditions and attended religious services at the home.

We saw people who were able to mobilise independently were able to 'drop-in' to any of the lounges and join in with whatever activity was going on at the time. Some people had watched an 'old movie' one morning and then gone off to another room. Several people appeared to enjoy walking around the house, checking where other people were and talking to staff in passing. Several men had gravitated to the same lounge, which gave the appearance of an informal 'gentlemen's club'. They all appeared to be happy with each other's company.

One person's care plan said their only interest was in watching the television. We saw staff supported them with this by enabling them to sit in their preferred chair, directly in line with the television. An activities coordinator supported people to engage in creative pastimes and we saw the result of their most recent work in the reception area. The manager showed us some other artwork that people were in the process of

creating, which they planned to display around the home.

People told us they were supported to engage in activities they enjoyed. They told us they had newspapers, magazines and books, attended musical evenings and helped with the washing. One person said, "I like to knit or sit here and have a talk and a laugh and watch people playing dominoes." Another person told us they had helped to clean the pond in the garden.

All the people we spoke with said they had 'no complaints' about the service. They told us they would be comfortable to make a complaint directly to the manager or provider if they wanted to complain about anything. A relative told us when they had raised concerns about their relation's care and support, the manager had met with them to discuss how their concerns could best be resolved. They told us they had agreed a resolution and they knew the manager would reconsider the agreed action with them, if they felt the need to raise similar concerns in the future. They were happy that raising concerns had not impacted their right to continue to visit their relation as often as they wanted.

There was little recorded information in people's care plans about people's wishes and expectations for being supported at the end of their life. Staff had training to make sure they understood the importance of knowing the person and recognising their spiritual needs and beliefs. The deputy manager told us they would, "Make the person feel as comfortable in themselves, warm and as pain free as possible and to have things around them that make them feel comfortable, things that mean something to them. Ensure they are not on their own. If they like music playing, we have it playing."

## Is the service well-led?

### Our findings

During our focused inspection in August 2017, we found significant improvements had been made since our inspection in December 2016, which had a beneficial impact on people's health and well-being. Further improvements in how the service was managed and led were planned and in progress. At this inspection we found that some of the planned improvements were still in progress and were not complete. We found the manager that had been appointed in June 2017, had not been given sufficient time and support to make all the planned improvements. They had been occupied in providing support and guidance to staff and reviewing and revising the policies, procedures and practices that underpinned the values of the service.

Improvements were still required in governance and leadership. The provider's procedures for maintaining a safe environment were not sufficiently robust. The provider had not identified or minimised several obvious risks to people's safety. After we asked the provider about the obvious risks of people accessing unsuitable or unsafe areas of the building, the provider mitigated the risks. They installed a child-safe gate to the unused unit on the ground floor, they secured the patio doors and arranged for them to be replaced, they had replaced the lock on the laundry door and installed a bolt to deter people from walking into a kitchen on the first floor. The provider's own risks assessment had not identified these risks prior to our inspection visit.

The provider's stated procedure for reporting maintenance issues was not understood or used effectively by staff. Staff told us they used incident forms to report maintenance issues, whereas the provider told us they should record maintenance issues in a dedicated 'maintenance book'. Staff told us, when they reported concerns about the premises and equipment, they were not advised of any follow up actions the provider planned to take. This resulted in maintenance requirements not being identified and categorised to determine an agreed timescale with the maintenance person. The provider could not be confident that maintenance issues were identified and resolved in a safe and timely manner.

The provider showed some understanding of their responsibilities as a provider of a regulated service. For example, they had added the rating and a link to the latest inspection report to their website and continued to display the latest CQC rating in the entrance hall. However, improvements were still needed in the provider's understanding of the obligations of being a registered person.

The manager had not yet registered with us. Their application to become a registered manager had been delayed by an error in the application form. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager had not yet learned about or understood all the legal obligations of being a registered person. They did not know a registered person needed to send CQC statutory notifications when they made a referral to the local safeguarding authority. They thought they only needed to notify CQC of the outcome of any safeguarding referrals. Until the manager is a registered person the obligation to notify CQC of

significant events remains with the provider.

Following our inspection in February 2016, we had imposed an additional condition on the provider's registration effective from April 2017. The condition requires the provider to send us copies of their governance audits and action plans by the 28th day of each month. The provider had not maintained compliance with the additional condition of their registration. The additional condition was intended to ensure the provider conducted regular audits of the quality of the service and sent us their analysis, with action plans that described the actions they planned to take to improve the quality of the service.

The provider had not ensured the manager understood that the additional condition was an additional legal obligation that could constitute a breach of the regulations. We had been sent copies of completed monthly audits and action plans by the 28th of May, June, July and August 2017, in accordance with the additional condition. We had not been sent copies of the monthly audits and action plans in September or October 2017, because the manager had been occupied with implementing improvements in practice and the day-to-day management of the home. The manager sent us their analysis and action plans for the previous two months during this inspection.

This was a repeated breach of Regulation 17(1) HSCA (RA) Regulations 2014 Good governance.

The manager was already aware the provider's infection prevention and control (IPC) policy, procedures and audits did not offer the reassurance they needed to be confident that people were safe from the risks of infection. In August 2017, the manager had invited an external specialist to conduct a comprehensive IPC audit of the home. They had already received the external specialist's report and planned to implement the recommendations that were appropriate for a care home. The manager had also arranged for an IPC expert to spend a week at the home in November 2017, to re-educate staff and implement effective procedures and guidance.

Staff told us they continued to notice improvements in people's outcomes of care, because the manager worked with them to deliver person centred care. We saw the manager knew people well, understood their needs and abilities and provided leadership to staff in the way they interacted with people. Staff told us the manager had driven beneficial changes to the service and had improved how staff felt about their role. Staff told us, "[Name of manager] is very thorough, they are very knowledgeable" and "We had kind of lost the energy, but we are getting that back. [Name] gives you support when we weren't getting it before. They are always here, walking about."

Staff told us, "The movement is slow but we are getting there. I feel more positive with [Name] being here and all the changes they have made" and "A year ago people were saying we are going to lose our jobs, but since [Name] came we are moving forward. Firstly the staff were very wary, but they had been through a lot. They didn't know if [Name] was going to stay." The manager told us they had successfully recruited a full staff team and did not need to use agency staff. They told us some staff who had left during the various changes of management, had now returned to work at the home.

The manager had implemented many improvements since our previous inspection. For example, they had changed from paper records for medicines administration to an electronic recording system. The electronic system meant errors and issues were identified and flagged before the staff administering medicines could sign out of the system. The system provided an accurate count of every medicine, which supported a continuous audit regime.

The manager had implemented changes to people's mealtime experience and to the choice of food and

snacks available. They had engaged an activities coordinator to encourage people to 'get creative' and to produce artwork to display around the home. They planned to link up with a local art college and invite the students to share their skills with people.

They had encouraged the provider to refurbish the home to provide a more welcoming environment with a calm and homely atmosphere. The service development plans included a new reception area, with a receptionist, who would also be able to deliver administrative support. The manager told us making people and visitors feel welcome was important. They said, "It is about getting that meet and greet right, that first point of call so when you arrive and ring the bell, there is someone to let you in."

The manager was working to raise the profile of the home and demonstrate to stakeholders the improvements that had been made in the last six months. They had held an open day for social workers and invited representatives from the local healthcare commissioners to visit the home. They planned to hold regular clinical governance meetings at the home, and had invited the local health and social care commissioners to attend the meetings and bring their expertise to influence future developments at the service.

The manager was considering how to develop supportive relationships with other organisations. For example, they had offered Age UK the use of their training rooms and in return Age UK would provide staff training. They were also considering the possibility of developing a day care service and had started signposting families to support agencies, such as, the independent advocacy service for financial advice.

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 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured that the premises used by the service were safe to use for their intended purpose and were used in a safe way. The provider had not adequately assessed and minimised risks to service users' health and safety and had not done all that was reasonably practicable to mitigate any such risks.</p> |
| Regulated activity   | Regulation   |
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Governance systems and processes were not sufficiently robust, established or operated effectively to ensure risks to the quality of the service were identified and minimised to provide a good quality service to people.</p>   |