HC-One Limited

Berry Hill Care Home

Inspection report

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23 May 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

We inspected Berry Hill Care Home on 22 and 23 May 2017. The inspection was unannounced. Berry Hill Care Home is a situated in Mansfield in Nottinghamshire and is operated by HC-One Limited. The service is registered to provide accommodation for a maximum of 66 older people who require personal care. There were 46 people living at the home on the days of our inspection visit. The service is split across two floors, each with communal living areas.

At our previous inspection, on 11 October 2016, the service was rated as requires improvement and multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found. During this inspection we found that although some improvements had been made there remained concerns in relation to the quality and safety of the service. This resulted in us finding new and ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The service had a registered manager in place at the time of our inspection. 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.

During this inspection we found that the systems in place to reduce risks associated with people's care and support were not always effective and this exposed people to the risk of harm. Risks in relation to people's care were not planned for appropriately to ensure people received safe care and people's care records did not always contain sufficient guidance for staff to minimise risks to people. Medicines were not always stored or managed safely.

Staff were not deployed effectively to meet people's needs and keep them safe. People could not be assured that action would be taken to protect them from harm or abuse as staff were not sufficiently skilled in identifying and acting upon concerns.

Safe recruitment practices were followed and people were supported by staff who received training, supervision and support. We found staff had limited knowledge in some areas and the registered manager took swift action to address this.

People were enabled to make decisions. Where a person lacked capacity to make a certain decision they were protected under the Mental Capacity Act 2005. We found there was a risk that some people may not be supported in the least restrictive way possible.

People's day to day health needs were met, however, there was a risk that people may not receive

appropriate support with specific health conditions. People were supported to have enough to eat and drink.

People could not be assured that they would be treated with dignity and respect at all times. People were not always offered the opportunity to be involved in the planning or reviewing of their care plans. However people felt involved in day to day decisions about their care and support.

People could not always be assured that they would receive support that was based upon their individual needs and preferences. People were not consistently provided with the opportunity to discuss and plan for the end of their life. In addition to this care plans did not all contain accurate, up to date information about the support people needed.

Staff were kind and caring and respected people's right to privacy. People were provided with some opportunity for social activity and were supported to maintain relationships with family and friends.

People were supported give feedback about the service, raise issues and concerns and there were systems in place to respond to complaints. Staff were also involved in giving their views on how the service was run.

Systems in place to monitor and improve the quality and safety of the service were not effective and timely action was not taken in response to known issues.

Records relating to the care and treatment of people who used the service were not consistently accurate or up to date. Sensitive personal information was not always stored securely.

The management team were responsive to feedback and swift action was taken to address some areas of concern raised during this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems in place to reduce the risks associated with people's care and support were not always effective. Medicines were not always stored or managed safely.

Staff were not deployed effectively to meet people's needs and keep them safe.

People could not be assured that action would be taken to protect them from harm or abuse as staff were not sufficiently skilled in identifying and acting upon concerns.

Safe recruitment practices were followed.

Is the service effective?

Requires Improvement

People were enabled to make decisions. Where a person lacked capacity to make a certain decision they were protected under the Mental Capacity Act 2005. We found there was a risk that some people may not be supported in the least restrictive way possible.

People's day to day health needs were met, however, there was a risk that people may not receive appropriate support with specific health conditions.

People were supported by staff who received training, supervision and support. We found staff had limited knowledge in some areas and the registered manager to swift action to address this.

People were supported to have enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People could not be assured that they would be treated with dignity and respect at all times.

People were not always offered the opportunity to be involved in the planning or reviewing of their care plans. However people felt involved in day to day decisions about their care and support.

People could not always be assured that they would receive support that was based upon their individual needs and preferences. People were not consistently provided with the opportunity to discuss and plan for the end of their life.

Staff were kind and caring and respected people's right to privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive the support they required as care plans did not all contain accurate, up to date information about the support people needed.

People were provided with some opportunity for social activity and were supported to maintain relationships with family and friends.

People were supported give feedback about the service, raise issues and concerns and there were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

Systems in place to monitor and improve the quality and safety of the service were not effective and timely action was not taken in response to known issues.

Records relating to the care and treatment of people who used the service were not consistently accurate or up to date.

Sensitive personal information was not always stored securely.

People and staff were involved in giving their views on how the service was run.

The management team were responsive to feedback and swift action was taken to address some areas of concern raised during this inspection.

Berry Hill 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 done to check that improvements to meet legal requirements planned by the provider after our 11 October 2016 inspection had been made, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We inspected the service on 22 and 23 May 2017. The inspection was unannounced. The inspection team consisted of 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection visit we spoke with eight people who used the service and the relatives of five people. We spoke with eight members of care staff, two members of the catering team, the activity coordinator, the registered manager and a regional manager.

To help us assess how people's care needs were being met we reviewed ten people's care records and other information, for example their risk assessments. We also looked the medicines records of six people, three staff recruitment files, training records and a range of records relating to the running of the service. We spent time in communal areas observing care and support.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found that people could not be assured that risks associated with their care and support would be managed safely. Risk assessments were not always in place as required, some were incomplete and staff did not always follow guidance to minimise risks.

The majority of care plans we reviewed included assessments aimed at identifying and reducing the risk of harm to people. Although these assessments were reviewed regularly, they did not consistently offer staff sufficiently detailed guidance on what steps to take to reduce the risk of harm. For example, one person displayed behaviours that people may find challenging at meal times. The assessment explained what these behaviours were and what their impact may be but did not instruct staff how to manage these. We observed this person during three meal times and saw that, although staff were managing the behaviour and kept the person safe, no consistent approach was used. A second person was known to wander around the service and we saw incidents recorded when they had walked into other people's bedrooms, which may cause them distress. Although the risk assessment noted this, no guidance was provided for staff on how to keep this person and others safe. This lack of guidance on how to keep people safe put people who used the service at risk of harm.

There was a risk that people may not be adequately protected from the risk of falls as control measures were not always in place to reduce this risk. We reviewed one person's care plan which stated that they were 'nursed in bed' so there was no risk of falls. The care plan did not contain any further detail related to falls risk. We reviewed incident records and found that the person had fallen in a communal area a month prior to our inspection visit. We also spoke with a member of staff who confirmed that the person continued to occasionally spend time in the lounge. Despite this the falls risk assessment and care plan had not been updated and consequently no additional control measures had been put in place to reduce the risk of further falls when the person was in communal areas. This posed a risk that the person may fall again.

People were not always protected from the risk of choking. We found that guidance in care plans was not always followed. One person had been assessed as being at risk of choking, their care plan stated they should be served food of a modified consistency. On the first day of our inspection visit we observed the person alone in their room eating food which was not of the required consistency. There were no staff present in the area which meant had the person choked, staff would not have been aware of this and consequently would not have been able to respond to provide emergency first aid. We also spoke with a member of staff who informed us that they sometimes gave the person chocolate and biscuits, this was contrary to advice provided by a speech and language therapist (SALT). This put the person at risk of choking and consequent harm. We discussed this with the registered manager following our inspection who informed us that a new referral to SALT would be made to ensure staff had access to the most up to date guidance.

There was a risk that people may not adequately protected from the development of pressure ulcers. The quality of care plans relating to pressure area care was variable which meant staff did not always have access to the required information. One person had recently moved in to the service and records showed

that they had previously sustained pressure damage to their skin. We reviewed their care plan and found that although there was a risk assessment that recorded that they were at 'high risk' of skin damage their 'skin integrity care plan' was blank. This meant that staff did not have access to detailed information to ensure that risks were minimised.

People told us that they received their medicines as prescribed. This was also reflected in the feedback of people's relatives, the relative of one person told us, "They support [relation] to take their medicines as far as I am aware." We spoke with another relative who told us that the service had an effective process in place for ensuring their relation had their medicines if they went out of the service. Despite this, during our inspection we found a number of issues relating to the management and storage of medicines.

There was a risk that people may not receive their medicines as prescribed as medicines records were not always accurate. Medicine administration records (MARs) had not always been fully or accurately completed to show that people had received their medicines as intended. We found several gaps in people's MARs which meant either the medicines had not been given or staff had not recorded when they had given them. We checked these and found on one occasion where a person had not been given their medicines as prescribed. Handwritten entries and changes to MARs were not always signed by staff as required to ensure that accurate information about people's medicines had been documented. This is important to prevent errors.

People's medicines were not always stored safely to ensure they were at their most effective. We found two occasions where medicines were still in use beyond their recommended shelf life. This meant that medicines were being used longer than the expiry date and may no longer be effective. Medicines were not always stored in accordance with the manufacturer's instructions. For example we found eye drops which should have been stored in the fridge were being stored at room temperature. This could have had an impact on the efficiency of the medicine. In addition to this medicines were not always dated when opened. This meant it was not possible to determine whether the medicine was being used within the manufacturers recommended shelf life.

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above people told us they felt safe at Berry Hill Care Home. The relative of one person told us, "They (staff) do everything they can to mitigate the risk of falls, such as sensor mats." Another relative commented, "Safe, I have absolutely no qualms at all about that whatsoever. I can tell [relation] is calm and can sense everything is okay." Staff also told us they felt people were safe at the service, stating the level of training and availability of equipment as reasons. One staff member told us, "We look after people very well. We have all of the correct equipment and only the senior (nursing assistant) and nurse give out medicine, so they (people) are safe that way."

In contrast with the above we found that for some people care plans contained clear information about how to keep people safe. Risk assessments were included in care plans and clearly detailed risks relating to people's support. On the whole we observed staff assisting people to move and transfer safely. We saw one incidence of unsafe moving and handling practice where staff did not apply the brakes on a person's wheelchair when assisting them to transfer, this placed the person at risk of slipping from their chair. We discussed this with the registered manager who informed us that they had no previous concerns about the practice of the staff member and felt this was due to the staff feeling nervous about the inspection.

During our October 2016 inspection we found that there were not always sufficient staff to meet people's

needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that although changes had been made to better monitor staff availability, further improvements were required to ensure that staff were effectively deployed.

Sufficient numbers of suitably qualified and experienced staff were not always effectively deployed to meet people's needs and keep them safe. We spoke with a member of staff who told us that there should always be a staff member in the main communal areas. However, we observed periods of up to 10 minutes when vulnerable people were left unattended. For example, we observed that, following a meal, care staff supported people to return to communal areas. A number of people required the assistance of two members of staff to help them mobilise safely which meant staff were not available to monitor the safety of people in the dining room at all times. We recorded that these absences were generally over five minutes. During one of these periods we had to intervene to keep people safe as a person had taken a large trolley used for serving food and began pushing it against the back of another person's chair. After we had stopped them from doing this, they then began trying to push a second person. No care staff were available to support the person at this time. We intervened for a second time when we found a person walking around the service in an undignified state and supported them back to their room. On a third occasion we supported a person who had accidentally sat on a second person in the large lounge and was unable to raise themselves, causing distress to both people. Care staff were not available on any of these occasions.

The registered manager told us that staffing levels were set by the provider based on the needs of people using the service and a dependency tool was used to assess this, they told us they could request additional staff if needed. The provider had determined required staffing levels to be 10 staff on day shifts and four staff on night shifts. We looked at the staffing rota for the four weeks preceding our inspection. These showed that the minimum number of staff were deployed for all night shifts but there were 10 (of 30) shifts when less than 10 staff were deployed on day shifts. This could potentially expose people to the risk of unsafe care as sufficient staff may not be available to meet people's needs.

This was an ongoing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In spite of the above, people and their relatives told us there were generally enough staff at Berry Hill Care Home. The relative of one person told us, "Are there ever enough staff?! But yes there is generally someone around and staff do their utmost best. Staffing levels have improved under the new manager." Another relative told us, "Buzzers are answered quickly most of the time, there is always someone around." This was echoed by staff we spoke with who told us they felt that, generally there were sufficient numbers of staff deployed to meet people's needs and keep them safe. A staff member said, "We can manage with the staff we've got. Obviously everyone would say they could do with more, but we seem to get all our jobs done." A second staff member said, "Sometimes on nights you can be left on your own (in a section of the service). Most days we are ok, but sometimes you are running around trying to find someone to help you." A third added, "Most of the time its ok, but we find it hard if people have appointments or staff are off the floor. (Meaning away from the main communal areas)." The registered manager informed us and records confirmed that there was a system in place to ensure that call bells were responded to in a timely manner.

There was a risk that people may not always be protected from risk of abuse as not all staff we spoke with were able to demonstrate a good level of understanding of the signs and types of abuse or their role in raising a safeguarding concern. Although training records showed that the majority of staff had received updated training on safeguarding procedures, this had not been effective for all staff. Although some senior staff demonstrated an understanding of safeguarding procedures, not all of the staff we spoke with were able to tell us how and when they should raise a concern. This posed a risk that staff may not identify or

respond to incidents of a safeguarding nature appropriately. Despite this, we noted that the registered manager had raised concerns appropriately to the local multi-agency safeguarding hub (MASH). This is where any safeguarding concerns are made in Nottinghamshire.

The provider had a designated telephone line to enable staff to confidentially raise concerns regarding poor practice at the service. Only one of the staff members we spoke with was aware of this and not all of the staff were aware of the provider's whistleblowing policy. However, the majority of staff we spoke with told us they would feel confident and comfortable to raise a concern with the registered manger. One staff member said, "I'm so passionate about my job, there is no way I would sit back and let anything happen to my clients. I'd discuss it with my manager first, and then we'd take action."

People could be assured that safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider.

Requires Improvement

Is the service effective?

Our findings

During our October 2016 inspection we found that there was a risk that people's rights under the Mental Capacity Act (2005) may not be protected as the principles of the Act had not been adhered to as required. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that improvements had been made in this area and the service was no longer in breach of regulation. Further improvements were needed to care plans to ensure that care and support was provided in the least restrictive way possible.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

On the whole people's rights under the MCA were protected. People's care plans contained clear information about whether people had the capacity to make their own decisions. Detailed assessments of people's capacity in relation to specific decisions had been carried out when their ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interests decision had been made which ensured that the principles of the MCA were followed. For example one person was identified as lacking capacity to manage their finances or safely administer their own medicines, but was assessed to have capacity to decide what food and drink they preferred.

There was a risk that care and support may not be delivered in the least restrictive way possible. Where decisions had been made in people's best interests some care plans lacked detailed guidance for staff on how best to support the person. For example records showed that one person was at times resistive to personal care. A mental capacity assessment had been conducted which stated that the person did not have capacity to make decisions in this area. We looked at the care plan which stated that should the person resist care staff may need to 'carry out care in their best interests as efficiently as possible', there was no further information to clarify what this meant. This lack of information posed a risk that the person may not be supported in the least restrictive way possible and did not respect their rights under the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate and these had been granted. There were no conditions specified on the DoLS authorisations that we reviewed.

Staff we spoke with demonstrated a mixed understanding of the MCA. One staff member was able to explain how the act should be applied and how a person's understanding and capacity may vary. They told us, "You can't just assume that they don't have capacity." However none of the other staff we spoke demonstrated a

working knowledge of the MCA or how it should be applied. This could expose people to the risk of receiving care and support that does not reflect their wishes and staff making decisions that may not be in their best interests.

On the whole where people had capacity we saw staff supporting people to make choices and decisions and staff gained their consent before providing care and support. We observed isolated incidents where people were not provided with the information they needed to make an informed choice. For example, we observed a staff member administering medicines to a person and although they were gentle and encouraging in their approach they did not explain what the medicines were or what they were for.

Most people were positive about the food at Berry Hill Care Home and told us that they were given a choice of food and drink. One person told us, "Everything is marvellous, the food is good and they will do you a diabetic pudding, if anything there is too much." The relative of another person told us, "The food is outstanding. My [relation] used to be a very good cook and I have heard no complaints from them." We spoke with two people who told us that the food served was not to their taste. The registered manager informed us that they had identified this and had recently made changes to the menu to better reflect people's preferences.

During our visit we observed three meal times and saw that people were offered a choice and appeared to enjoy their meals, some people requested additional servings which were provided. Staff supported people who required assistance with their meal in a calm and unhurried way and the atmosphere was generally relaxed and pleasant. We saw that people had access to drinks and snacks throughout the day and that staff were aware of any dietary requirements such as people who required a low sugar diet.

People's care plans detailed what support they needed with nutrition and people's weight and Body Mass Index (BMI) were assessed regularly to identify any weight loss. We saw that where changes or concerns were noted action was taken. For example one person's appetite had decreased, this had been identified by the staff team and they were monitoring the person's weight and food intake and had contacted the GP to request specialist support. The relative of one person commented, "[Relation] has put weight on since being here thanks to staff encouragement."

The service was not always responsive to people's changing health needs. We spoke with the relatives of two people who told us that the service was, at times, slow to adapt to changes in people's health and support needs. For example, due to a recent change in their health one person required more frequent drinks, however this was not implemented by the staff team. The relative we spoke with told us it took two further deteriorations in the person's health until the correct support was provided.

People could not be assured that they would receive effective support in relation to their health. Where people had specific health conditions we found that care plans did not consistently contain adequate detail in relation to their health needs. Whilst some people's care plans contained some information about health conditions, other plans contained very limited information. For example, we reviewed the care plans of two people who used the service who both had diabetes. One person did not have a care plan in place in relation this, although the other person did have a care plan it lacked information about how staff should recognise changes in the person's condition. Another person's had a condition which put them at increased risk of contracting infections, despite this, their care plan contained very limited information about the health condition or the risk of infection. This lack of information placed people at risk of not receiving the support they required.

In spite of the above, records showed that people were supported to attend appointments and access

healthcare. People we spoke with all told us that staff would notice if they were unwell and would call the doctor if needed. The relative of one person told us that staff "reacted pretty quickly" to get the doctor in and sometimes before they asked. People's care records showed regular appointments with the optician, dentist, chiropodist, district nurses and other health professionals. The outcomes of appointments were recorded in care plans. Staff made contact with relevant healthcare professionals when people's needs changed. For example one person's record showed they were referred to a physiotherapist when they experienced difficulty mobilising.

People were supported by staff who had regular training and support. Care staff we spoke with told us they had access to regular training and that this had helped them better meet people's needs. A staff member said, "There's loads of training. The dementia training was really good. We learnt about the different kinds of dementia and why people act as they do." A second staff member told us, "We've got enough training definitely. We can request more in supervision if we need it."

Training records we reviewed showed that almost all staff had completed the training identified as compulsory by the provider. This included; emergency procedures, fire drills, health and safety, moving and handling, infection prevention, the Mental Capacity Act, safeguarding and equality and diversity. Staff who had not yet completed these courses were booked to attend future dates. Despite the training we found that staff knowledge in relation to the MCA and safeguarding was variable. We discussed this with the registered manager who following our inspection visit informed us that additional training had been sought for staff in the above areas to ensure their competence.

Staff in all roles told us they felt supported by their peers and the registered manager and felt able to raise any concerns or issues with them. We saw that staff had access to regular face to face supervision meetings with the registered manager and that they found these helpful. A staff member said, "[Registered manager] is lovely. I know I could go to her with anything. When we have supervision we discuss training or the residents, it's good to know how I'm doing." A second staff member told us, "The supervisions are good. I find it helpful being able to talk to the registered manager face to face. She has helped me when I've had a concern, she sorted it out straight away." A third added, "She is a fantastic manager, the supervisions are good, everything is up to date."

The registered manager explained that, as they were not a trained nurse and there was no deputy manager, nurses employed by the service accessed clinical supervision from other registered managers employed by the provider on an 'as required' basis.

Requires Improvement

Is the service caring?

Our findings

People could not always be assured that they would be treated with dignity and respect. Whilst in the majority of cases staff respected and promoted people's dignity this was not always the case. For example one person had fallen asleep and was slumped over with their head on the dining table. The person was left for a significant period of time before staff intervened to wake the person and assist them to a more comfortable area. We observed another incident where staff were not available to prevent a person sitting on a chair which was heavily soiled. We intervened to inform staff that the person had sat on a wet chair, a member of staff assisted the person to move chairs but did not support or prompt the person to change their clothes. This did not promote people's dignity.

Language used by staff to describe people who used the service was not always respectful or empowering. We saw that terms such as 'rude', 'fussy' and 'abusive' were used to describe people's behaviour. One person's care plan was focused on negative aspects of their behaviour which were a result of their diagnosis of dementia, other important information was omitted. Their activities care plan stated that they were 'aggressive' and did not engage in the homes activities, however we spoke with the activities coordinator who told us that the person loved to sing and enjoyed music. This information was not contained in their care plan and perpetuated the person's negative reputation. In addition to this, outdated and potentially offensive terms such as 'bedbound' and 'wheelchair bound' were used in care plans to describe people. This did not promote people's dignity.

People could not be assured that they would receive person centred support that was based upon their individual interests and preferences. The quality and quantity of information in care plans about people's background, interests and preferences was inconsistent. The provider had developed a booklet specifically designed to capture this information and although we saw a blank version of this in one care plan, we did not see any completed. Whilst some people's care plans contained information about their preferences this was not always the case. For example one person's care plan contained detail of important social relationships, frequency of contact and how the person kept in touch with their family, whereas another person's plan simply stated that 'family' was important to them but did not contain any further information about this. This meant that people may not receive support that was based upon their individual preferences.

The quality of information contained in people's care plans about communication was variable. One person's care plan stated 'communication is often inappropriate' and 'can be aggressive', the care plan did not contain any guidance for staff about how best to support the person. We also observed that another person who used their behaviour to communicate was frequently overlooked by staff, again we found that this person's care plan did not contain any information about what the person's was trying to communicate with their behaviour or how staff should respond to this.

People could not always be assured that they would be provided with the opportunity to discuss and plan for the end of their life. A number of people who used the service were nearing the end of their lives and we found that the quality of end of life care planning was variable. We observed three care plans for people who

were nearing the end of their lives. Whilst one person had an end of life care plan in place advising staff of their wishes and what specific support and medication they required, the other two people's care plans were lacking important information about people's treatment choices at the end of their life and neither contained any information about their preferences for their last days of life.

Staff we spoke with were unaware of people's wishes and support needs regarding end of life care and could not identify the people at the service who may require this support. One member of staff told us, "We've got quite a few who have anticipatory meds (pain relieving drugs prescribed when a person is nearing the end of their life), but no one who you would call poorly, poorly." A staff member told us they did not require a care plan for end of life care because, "We just know what to do." This approach did not ensure that people's wishes for the end of their lives were respected.

People were not always offered the opportunity to be involved in the planning or reviewing of their care plans. Staff we spoke with said they aimed to involve people or their relatives when possible in reviews. They told us, "We try and talk to the families. If the client can't talk to us we ask them (families).If they are capable of answering the questions then we do sit with the client when they first come in." Although care plans we looked at were regularly updated, they did not show evidence that people and their relatives were routinely involved in the design, planning or review of their care. Most people and their relatives alike told us they could not recall being involved in the development of their care plan. The relative of one person commented that this had improved under the leadership of the current registered manager, they told us, "I wasn't involved in developing the initial care plan but have been involved in reviews recently." We discussed involvement in care planning with the registered manager who acknowledged that this was an area for improvement.

Despite having limited involvement in care planning people told us that they felt involved in day to day decisions about their support and this was reflected in people's comments. The relative of one person told us, "[Relation] appears to be in control (of their support), there are no problems there."
During our visit we saw that staff routinely checked with people about their preferences for care and support, people were offered choices about how they spent their time, what they ate and their involvement in activities.

There was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. The registered manager told us that no one was using an advocate at the time of our inspection but explained they would make a referral for advocacy should they need to.

The majority of people and relatives that we spoke with were positive about the approach of the staff team and told us that they thought staff were kind and caring. The relative of one person told us, "Yes, the staff are kind, the place is very calm, there is a sense of ease." Another relative commented, "[Relation] knows that this is their home and is always happy to return." A third relative told us, "[Relation] loves it here."

We observed numerous examples of positive interactions and support between staff and people using the service. For example one person declined to eat anything for lunch, the member of staff encouraged the person without pushing them until they agreed on something that they fancied. Staff were positive about the service they provided and enjoyed their jobs. A staff member told us, "We've got some good staff here, they are all caring. We do a good job, clients always say they are happy and we get good feedback. A second staff member said, "We are all caring, I don't think you could work here if you weren't caring or interested in the job." The registered manager praised the staff team for their commitment to people living at Berry Hill Care Home, they told us, "The staff are bothered about people, they care."

Staff told us they aimed to promote peoples independence. One said, "We try to encourage them to be as independent as possible. One chap goes out on his scooter and we support people to wash their own hands and face." A second staff member told us how they had supported a person to go shopping for Christmas gifts for their family.

People we spoke with told us that staff respected their right to privacy. The staff we spoke with were able to describe how they respected people's privacy and dignity. Staff told us they would protect people's privacy and dignity by always knocking before entering rooms and ensuring the person was suitably covered when carrying out personal care. We observed that this happened throughout our inspection but noted some occasions when staff entered a room without knocking or waiting for a reply. There were no restrictions on when people's friends and relatives could visit them and there were a number of small quiet communal areas in the home which gave people the option of more privacy when their friends and families visited.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. One person who used the service told us that staff say, "I'll be back in a minute and then do not come back", they went on to tell us that they had been waiting an hour for staff assistance. This was confirmed by our observations. Another person required assistance to have a cigarette. They asked a staff member for assistance but the member of staff was not available to support them. The person waited a period of 25 minutes and became increasingly frustrated in this time. They told us that since moving into Berry Hill Care Home they had to significantly reduce the amount they smoked as they were reliant upon staff availability.

People could not be assured that they would receive the support they required as care plans did not contain sufficiently detailed guidance for staff. People received a comprehensive assessment before they moved into Berry Hill Care Home which recorded their preferences for the gender of care staff, their health and support needs, treatment plans, mental capacity and dietary requirements. However information from these assessments was not always included in care plans. For example, one person's assessment contained details about their preferences for treatment, but this was not referenced at all in their care plan.

Information contained in some care plans was basic and did not provide sufficient guidance to inform safe and effective support. For example one person's 'safe environment care plan' stated that staff should 'maintain safe environment' and 'prevent hazards', no additional information was provided about what the potential hazards were or specifically how to ensure a safe environment for the person. Another person often used their behaviour to communicate their needs, there was limited information about this in their care plan. We spoke with a member of staff who told us about how they put this person at ease; however we found that this was contrary to advice provided to an external health professional. This lack of information in care plans put people at risk of receiving inconsistent support.

Some care plans contained contradictory information. For example one person's care plan suggested that they had dementia, however there was no clear information in relation to this in their care plan. We asked a member of staff if this person had dementia and they said, "I'm not sure, that is a good question." We were later informed that the person did not in fact have dementia.

Staff we spoke with demonstrated a basic understanding of peoples support needs but not always their preferences or likes and dislikes. Staff said they did not always find the care plans useful and told us they did not always find time to read them. One staff member told us they hadn't read any care plans and was unable to demonstrate an understanding of people's specific needs when questioned. They said, "We get a quick look at them (care plans) sometimes if we do the daily report." A second staff member said, "They (care plans) do give you some pointers on what you are supposed to be doing. You haven't got time to read through them. As long as they have the basics, the big picture, it's all you need." This put people at risk of receiving care that was unsafe and did not meet their needs.

In spite of the above most people we spoke with told us that they received the support that they required and that staff were responsive to their needs. The relation of one person told us, "If [relation] doesn't want to

move they (staff) will take things to them and they can have their meals in the lounge if they choose."

People were provided with some opportunity for social activity. The service had a designated well-being coordinator who was responsible for activities, both people who used the service and their relatives were positive about their enthusiasm for their role. The relative of one person told us, "There is a new (well-being) coordinator and they are really good. [Well-being coordinator] tries to engage residents." The well-being coordinator had only been in post for a short period of time and was still in the initial stages of planning activities. During our inspection we saw that they provided a range of one to one activities including flower arranging and games. However we noted these activities were not yet specific to people's likes or life histories. Additionally we noted that the activities coordinator was often the only staff member available in communal areas and although they were fully trained to provide support this meant that activities may be interrupted by the need to provide support and this was confirmed by our observations. A significant number of people who used the service spent all day in their bedrooms, the activities coordinator told us they tried to spend time with these people in their rooms when possible. However there was a risk that this may not be possible due to them being needed to support people in communal areas. We discussed this with the registered manager who informed us that the activities coordinator normally spent the morning visiting people in their rooms and the afternoon in communal areas.

Staff told us people were able to go out on visits and trips to local attractions as the service had its own minibus. People went to Newstead Abbey, garden centres and to the theatre. A staff member told us they had taken people to a dementia friendly theatre performance which people had enjoyed.

People were supported to maintain relationships with family and friends. During our visit we saw people's relatives and friends visiting. People spent time together in communal areas and appeared to feel comfortable and relaxed.

There were a number of ways for people and their families to provide feedback on the service provided at Berry Hill Care Home. We observed an electronic feedback system was available in the foyer of the service which enabled people who used the service and visitors to leave feedback at a time to suit them.

People told us that they felt able to make a complaint. A relative of someone using the service told us, "Oh yes I know how to complain, but to honest I haven't had to. If [relation] has any gripes they will say but they haven't said anything."

The provider had a clear complaints policy and procedure which was available at the service. Staff we spoke with understood the process for raising a complaint and supporting people to do so. We looked at the complaints records since our last inspection. These showed that four complaints had been received. All four showed that the service responded within the timescale identified in the policy. Investigations were thorough and honest and the complainant was kept informed throughout the process. Records showed that the majority of complainants were satisfied with the outcome and response.

Requires Improvement

Is the service well-led?

Our findings

Berry Hill Care Home has a history of non-compliance with the fundamental standards. At our September 2015 and November 2016 inspections we found concerns related to the quality and safety of the service provided at the home. Our November 2016 inspection resulted in us finding multiple breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, although we found improvements had been made in some areas, we also found breaches of the legal requirements. This did not assure us that effective governance systems were in place to ensure that Berry Hill Care Home consistently met the fundamental standards.

During our November 2016 inspection we identified that although there were systems in place to assess and monitor the quality of service that people received, these were not fully effective in identifying all issues and action plans developed as the result of audits did not always cover all identified issues. During this inspection we found that governance and management systems were still not fully effective in ensuring people received high quality, safe care and support.

Records relating to the care and treatment of people who used the service were not consistently accurate or up to date. Missing information in care plans and incomplete risk assessments put people at risk of receiving inconsistent and unsafe care. Care plan audits were not consistently effective in identifying areas for improvement or ensuring action was taken to address deficiencies. For example audits had identified missing information in one person's care plan for two consecutive months. We reviewed this person's care plan and found that despite the registered manager noting on the April audit that the actions had not been completed the plan had still not been updated. We reviewed another person's care plan and found that it did not contain sufficiently detailed information to inform care and support. A recent audit of this care plan had not identified the issues we found. This failure to take action on the lack of information in care plans placed people at risk of inconsistent support.

In addition to the above there were insufficient processes in place to ensure that adequately detailed care plans were implemented when people moved into Berry Hill Care Home. One person had moved into the home at the end of April 2017, we reviewed their care plan and found it that some areas of their care plan, such as the skin integrity care plan, were blank, and other parts contained only basic information. This meant that staff did not have enough information to inform the care and support provided to this person for a period of three weeks. We reviewed other care plans for people who had recently moved into the home and found that these were also basic and lacked meaningful detail to inform the support provided by staff. For example records showed that another person who had recently moved into the service needed support to mobilise, however there was no detail of this in their care plan. This failure to ensure that staff had access to accurate and up to date information about the people they were supporting put people living at Berry Hill Care Home at risk of receiving inconsistent and potentially unsafe support. This risk was exacerbated by the fact the that service frequently provided support to people at the end of their lives which meant that they had a high rate of new admissions to the service.

There were systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare

of people who used the service. However, these were not always effective. For example, the registered manager conducted monthly weight loss audits to try and prevent unplanned weight loss, however these audits were not robust. In the month prior to our inspection these audits documented that one person had lost a significant amount of weight. We were informed by staff that no measures were in place to reduce the risk of further weight loss and there were no actions noted on the audit to address this, it simply stated that the person was coming towards the end of their life. We discussed this with the registered manager and following our inspection visit they informed us that the person's weight had actually been recorded incorrectly and clarified that they had not lost a significant amount of weight. This error had not been identified in the audit process which appeared to show that no action had been taken.

Some aspects of the risk assessment documentation developed by the provider did not enable the provision of high quality, safe care. The provider had developed a care plan format which the service was required to use, this included a form for assessing the risk of falls. Whilst the risk assessment forms did prompt staff to identify risks they did not clearly detail, the seriousness of the risk, what controls measures had been put in place to reduce risks or the level of risk after control measures had been put in place. For example we saw that many people who had been assessed as being at risk of falling had falls reduction equipment in their rooms. It was not clear in people's care plans if this was effective in reducing the risk of falling or if it lowered the risk of someone sustaining an injury from a fall. It was also unclear what other controls measures had been considered. The provider's paperwork did not enable staff to conduct a robust assessment of the risk of falls and put people at risk of not getting the support they required.

Systems in place to monitor and improve the quality of the service were not consistently effective. Although the provider had a comprehensive audit system in place, this had not been effective in identifying or addressing the issues we found during our inspection visit. We saw records of the most recent audit undertaken by a representative of the provider. This audit looked at the quality of the service in areas such as audits, medication, care delivery, the business and staffing. The outcome of this audit was very positive with only one action to 'ensure that care plans did not contain contradictory information.' It did not identify issues found during our inspection visit such as those relating to care plans, risk assessments and medicines management and as a result action had not been taken to resolve these issues.

Swift action was not taken in response to known issues. An internal 'inspection' completed by the providers quality and compliance team in February 2017 had identified a number of 'areas for development'. During our inspection we found that a number of these areas still remained of concern such as, staff knowledge of the conditions that people lived with, the use of undignified language to describe people who used the service, the lack of care plans for people who present with behaviour which may put them and others at risk and the lack of person centred information in care plans. It was unclear what action had been taken by the provider to support the registered manager to improve in these areas.

In addition to the above we also found concerns about other areas of governance during our inspection. Sensitive personal information was not stored securely. We found that cupboards containing care plans were left unlocked throughout the duration of the first day of our inspection visit. This meant that information relating to people's health and support needs could be accessed by people who used the service and visitors. This was a breach of confidentiality and did not respect people's right to privacy or promote their dignity.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place at the time of our inspection visit and we received positive

feedback about the impact they had on the service from people, relatives and external professionals alike. Comments from the relatives of people living at Berry Hill Care Home included, "The manager has brought about improvements," "The current management are superb, there is a sense of order now," "Since the new manager has been here communication has improved, they always let me know about things, there is a good balance" and "[Registered manager] is approachable, absolutely, she has an open door and will make time for me."

Throughout our time at Berry Hill Care Home the management team were open, honest and receptive to feedback. The registered manager had an understanding of some of the challenges faced by the service and had plans to make improvements. Following our inspection the registered manager took swift action to develop an action plan based upon the most significant issues we found. This included arranging training for staff, making improvements to risk assessments and care plans, implementing additional checks on medicines practices and reviewing the deployment of staff.

We checked our records which showed that the registered manager had notified us of events in the service. A notification is information about important events which the provider is required to send us by law.

Despite the concerns identified during our inspection visit, people we spoke with told us they were, on the whole, happy living at Berry Hill Care Home and said that they felt the home had a good atmosphere. The relative of one person commented, "I am very grateful that [relation] is being looked after so well," another relative said, "I like the atmosphere here."

People who used the service and their families had the opportunity to be involved in some aspects of the running and development of the home. Regular meetings were held for people who used the service. Records of recent meetings showed that these were used to discuss topics including food and activities. Regular meetings were also held for the relatives of people who used the service, the registered manager told us that these were not well attended as most people's relatives felt comfortable to come directly to them should they need to discuss anything. The provider also conducted regular satisfaction surveys. A survey had been completed in May 2017 and the results were in the process of being collated and analysed.

Staff told us that they were happy working at the home and felt supported by the registered manager. The staff we spoke with told us that the atmosphere and culture of the service had improved under the leadership of the registered manager. They told us there was an open culture at the service and that they would feel comfortable in raising an issue with or asking for support from, the registered manager. One staff member said, "I know I could go to (registered manager) with anything". A second staff member added, "I know if I had a problem and told the manager, they would act on it straight away."

Staff were able to offer feedback on the service in a number of ways including supervision meetings, informal conversation, team meetings and in an annual staff survey. Records showed that staff meetings took place regularly and were used to address issues, discuss areas such as training needs and staffing levels and to share significant information about people who used the service. The staff we spoke with told us they had not attended any recent meetings. One member of staff told us, "We've not had one (meeting) for a while." A second staff member said, "We have team meetings but I've not been to one." In addition to staff meetings daily 'Flash meetings' were held to share information within the staff team, records also showed meetings were also held in relation to specific areas such as nutrition and falls management. Staff also had access to 'Have your say' leaflets, which were short, sharp guidance documents which had been developed by the provider as a way to share learning across the organisation.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with their care and support as risk assessments were not always in place as required, some were incomplete and staff did not always follow guidance. Medicines were not always managed or stored safely. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified and experienced staff were not always effectively deployed to meet people's needs and keep them safe. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance systems in place to monitor and improve the quality and safety of the service were not effective. Records relating to the care and treatment of people who used the service were not consistently accurate or up to date. Sensitive personal information was not always stored securely. Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

We issued a warning notice against the provider detailing areas where improvements were needed governance systems and processes.