H Plus Care Ltd

Larchfield House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Larchfield House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Larchfield House accommodates 75 people across four separate units (referred to by the provider as communities), each of which have separate adapted facilities. It provides care and support to people living with dementia and or a learning disability or physical disability. At the time of our visit there were 55 people living in the home.

The care service has been developed and designed in line with the values that underpin the Registering Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy.

The service has a 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 our previous inspection on 27 and 28 February 2017 we found a number of breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach in the Care Quality Commission (Registration) Regulations 2009. The provider was given an overall rating of 'inadequate' which placed them into special measures. We took enforcement action against the provider due to the concerns found.

Following our last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, is the service 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led' to at least good. The provider submitted the action plan by the required timescale and informed us improvements would be made by 31 August 2017.

During our most recent inspection we found noticeable improvements had been made but further improvements were required.

Appropriate action was not always taken to reduce the risk of cross infection. We have made a recommendation for the home to seek current guidance and best practice in relation to a documented process for cleaning practices in order to monitor; prevent; detect and control the spread of infections. People and their relatives felt they were kept safe from harm. However, information in people's care records were not always accurate and medicines received by staff were not always processed. This meant people did not always receive their medicines when required.

Legionella was still present in the home. We saw continued monitoring was carried out to ensure people's safety.

People were supported to have maximum choice and control of their lives and staff did support them in the least restrictive way possible. The policies and systems in the service supported this practice. The service was compliant with Mental Capacity Act and its codes of practice.

People and their relatives gave positive feedback about how the service met their nutritional needs. We have made a recommendation for the service to seek current guidance and best practice in regards to the deployment of staff when meals are served to people in their rooms. Staff's interaction with people was being continually monitored. Staff were appropriately trained; supervised and appraised. The service achieved good health outcomes for people.

People and their relatives felt staff treated them with kindness and compassion. Staff knew how to respond to people's diverse cultural and spiritual needs. People were supported to access external bodies, community organisations and advocacy services. People were treated with dignity and respect.

Information relating to people's disabilities were not always clearly communicated and understood by staff. We have made a recommendation for the service to seek current guidance and best practice in order to be compliant with all aspects of the Accessible Information Standard.

Complaints were not always thoroughly investigated. The service made sure people's preference and wishes in regards to end of life care were captured. Social activities were meaningful and tailored to meet the needs of people living with dementia.

The systems in place to check for accuracy of records were still ineffective. There was no managerial oversight of lessons learnt from incidents and no analysis of information gathered to drive improvements. The provider did not comply with its condition of registration; duty of candour and had failed to achieve all of the improvements it stated would be made by 31 August 2017.

People, their relatives and staff felt the improvements had been made to the service and it was well-managed.

As a result of the improvements made the service has been removed from special measures.

We found breaches of regulations as a result of this inspection. 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?

Requires Improvement

The service was not always safe.

Appropriate action was not always taken to reduce the risk of cross infection.

People and their relatives felt they were kept safe from harm. However, information in people's care records were not always accurate and medicines received by staff were not always processed. This meant people did not always receive their medicines when required.

Legionella was still present in the home. We saw continued monitoring was carried out to ensure people's safety.

Is the service effective?

Good

The service was effective.

The service was compliant with the Mental Capacity Act and its codes of practice.

People and their relatives felt the service met their nutritional needs.

Staff's interaction with people was being continually monitored.

Staff were appropriately trained; supervised and appraised.

The service achieved good health outcomes for people.

Is the service caring?

Good

The service was caring.

People and their relatives felt staff treated them with kindness and compassion.

Staff knew how to respond to people's diverse cultural and spiritual needs.

People were supported to have access to external bodies,

community organisations and advocacy services.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information relating to people's disabilities were not always clearly communicated and understood by staff.

Complaints were not always thoroughly investigated.

The service made sure people's preference and wishes in regards to end of life care were captured.

Social activities were meaningful and tailored to meet the needs of people living with dementia.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to check for accuracy of records were still ineffective.

There was no managerial oversight or lessons learnt from incidents and no analysis of information gathered to drive improvements.

The provider did not comply with its condition of registration; duty of candour and had failed to achieve all of the improvements it stated would be made by 31 August 2017.

People, their relatives and staff felt the improvements had been made to the service and it was well-managed.

Larchfield House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place on 1 and 2 November. The inspection team consisted of two inspectors, a specialist advisor whose specialism was in infection prevention and control and two experts 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.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the information we have collected about the service.

We requested and received a report of all safeguarding alerts raised about the service and Deprivation of Liberty Safeguards (DoLS) applications submitted to the local authority since our last visit.

We carried out observations of care throughout our visit.

We spoke with two people who used the service; seven relatives; seven care staff ; acting house keeper and two housekeeping staff; one laundry staff; a chef, an activities co-ordinator; maintenance manager; dementia trainer; business manager and the registered manager. We looked at 11 care records; three staff records; eight medicines administration records; and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 27 and 28 February 2017 we found breaches of Regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to staff not being adequately skilled to perform specific task required of their job roles; records not being accurate; complete and fit for purpose and building and equipment were not satisfactorily managed. After our visit the provider sent us an action plan by the required deadline which stated that required improvements would be made by 31 August 2017.

At our previous inspection, we found staff responsible for handling medicines, were not effectively skilled to perform the task.

During this visit, we found nursing staff had to complete three assessed medicine rounds as part of their induction. Once nursing staff had completed their induction, competency assessments were carried out every six months. This was confirmed by records viewed. A registered nurse told us they had undergone two competency assessments since March, "When you are new, they (management) want to see your competency." This meant people were kept safe because the service made sure staff responsible for the handling of medicines, were effectively skilled to carry out the task.

At our previous inspection, we found where people were prescribed medicines to manage behaviour; there was not information in their care records to describe when they should be used.

During this visit, we viewed medicine administration records (MAR) with a registered nurse. We saw there were PRN protocols to inform the administration of 'as required' medicines. MAR charts included information on when to use medicines, this included people who displayed behaviours that challenged.

At our previous inspection, we found people's nutritional needs were not accurately assessed and were carried out by staff that did not have the skills or knowledge.

During this visit, we found nursing staff had received relevant training and were knowledgeable about how to complete nutritional assessments. We viewed malnutrition universal screening tools (MUST) used to assess whether people were at risk of malnutrition. These were fully completed; up to date and regularly reviewed. People were regularly weighed and their fluid intake was monitored. Records indicated people had consumed reasonable intake of fluids on the days of our inspection. A registered nurse told us, "We aim for 1.5 to 2 litres per day." We saw people had drinks in their rooms and were offered drinks regularly throughout the day. This meant people were protected from harm because their nutritional needs were accurately assessed.

At previous inspection, we found information contained in 'Choking and aspirating' risk assessments was unclear, contradictory; not kept up to date and staff did not always follow instructions when preparing thickeners. Food thickeners are used to help people who have difficulty with swallowing. Food thickeners come in various consistencies (stages). If the wrong thickener is given, there is a risk of aspiration (food going

down the wrong way).

During this visit, we found care records documented the stage of thickeners people required. This information was also displayed in people's rooms and other nutrition related information such as, safe posture while eating and drinking. For example, a person's care plan stated 'stage one, one scoop to 100mls' following a speech and language therapist's assessment (SALT) on 15 June 2017. However, information documented about thickeners was not consistently written in a way staff could understand. For instance, we viewed the nutritional record for a person who was assessed as at risk of choking. The record instructed staff to use stages, two, three and four thickeners. We found this information to be potentially confusing. We looked at the person's most recent SALT assessment carried out on 27 October 2017. This stated the person required stage three thickeners. Staff we spoke with said they were aware the person required stage three thickeners. We brought this to the attention of the registered manager who assured us the records would be amended to reflect the correct information. We asked the registered manager if information about thickeners was included in prompts when staff offered people drinks. The registered manager responded, "I don't think it does." We discussed whether the relevant stages were entered in the fluid planner, located on people's electronic care records. The registered manager told us this was not the standard practice but, "By the end of the today it will be done." Following our inspection additional supporting evidence was received which showed appropriate corrective measures was taken by the provider in regards this issue.

At our previous inspection, we found a number of risks to people from the building and equipment as they were not satisfactorily managed.

We looked at whether people were protected against risks from the building and equipment. We saw all furnishings were intact as was floor surfaces. The home had refurbished people's room by replacing carpet with hard flooring. All staff had to demonstrate their competency to a supervisor before they could use equipment. Training for use of equipment was provided by either the supplier or through senior staff. We observed rooms were uncluttered and doors that needed to be kept secured were locked. People's personal emergency evacuation plans (PEEPs) were in place. These indicated the assistance required to ensure people reached a safe zone in the event of fire. This meant people were kept safe from emergencies in the home.

We found portable appliance testing (PAT) which ensured electrical items were safe had not been carried out and was currently three months out of date. We brought this immediately to the attention of the registered manager. After our visit the provider sent us a PAT certificate which confirmed in response to our feedback the relevant checks had been completed.

Staff were aware of the need to report infections to external agencies such as Public Health England and provided an example of when this had happened. Training records confirmed staff had attended the relevant training. Infection control was also an agenda item at the heads of department daily meetings. Information was also shared by use of the staff group's 'WhatsApp' service to make sure the escalation and reporting mechanism, was understood and followed by staff. However, as observed at our last visit on 27 and 28 February 2017, some staff wore clothing items with long sleeves in conjunction with their assigned uniform. This meant no appropriate action had been taken to reduce the risk for cross infection.

Cleaning audits were carried out on a daily basis and staff knew their responsibilities around infection control. Cleaning trolleys were not left unattended and chemicals used were not left exposed. However we found no documented process for cleaning and staff told us they were not aware of any. An infection control policy was in place but this was generic and not personalised to the service, apart from the name of the premises had been inserted. We observed while cleaning mops had the correct colours allocated and were

currently disposable; there was an issue of insufficient mop heads available for the number of rooms to be cleaned. We saw staff shared mops between rooms and the water was not always changed. Laundry bags were overfilled which had a potential for staff to sustain injuries. This information was fed back to the registered manager.

We looked at the various cleaning schedules for each community and saw variances with the housekeeping times allocated to each community although most were around the same size. We saw inconsistent housekeeping staff numbers and housekeeping staff told us they felt help was not always forthcoming when asked.

We have made a recommendation for the home to seek current guidance and best practice in relation to a documented process for cleaning practices in order to monitor; prevent; detect and control the spread of infections.

Staff knew how to log accidents and incidents. In a monthly report submitted to us by the provider, we saw there had been a reduction of incidents in the periods of August; September and October 2017. The provider stated this was due to improvements made in care planning and monitoring. Although the report stated 'trends in accidents and incidents were analysed and multi-disciplinary team input was sought where required', during our visit the registered manager was unable to show us a report of the analysis undertaken and the lessons learnt. For example, in the document named 'Monthly report for CQC - 13.10.17', the report stated that in quarter one, 15 people had a fall or were found on the floor, and then in quarter two, 29 and in quarter three, 27. However, the report does not provide robust analysis of the increase of falls between quarter one and quarter two and the actions the provider was taking to mitigate risks and reduce reoccurrence.

Relatives felt the service was kept clean. Comments included, "It's pretty good. I'm not sure about gloves and aprons. Her (family member) room is always clean and tidy", "It's clean", "It is always clean but I still insist on going over the bathroom with disinfect", "It's pretty clean. I am not sure (if worn by staff) about gloves and aprons" and one person commented, "Yes, they (staff) keep the place clean and me. They do wear gloves and aprons."

Legionella was still present in the home and total disconnection of all showers in the building was still in place since 3 June 2016. The provider had a 'Legionella/Water Risk Assessment action plan dated 21 August 2017. This showed the risks identified and actions taken to mitigate them. For instance, daily flushing of taps; close monitoring of cold water outlets and constant temperature checks. We noted samplings of outlets were carried out on a monthly basis. Since August 2017 around 15 outlets had been descaled or replaced and this still continued. We found the provider was following the requirements as detailed within their legionella action plan. This meant continuing monitoring was in place to ensure people's safety.

People and their relatives felt they were kept safe from harm. Comments from relatives included, "Yes very safe", "They (staff) look after her (family member) very well", "Yes, (believes family member is safe) she (family member) has to be hoisted and doesn't show any concern. Yes, we can talk to someone if there is a concern", Yes, I feel he (family member) is safe. He had a fall earlier on but it was his fault, he will try and do things without his frame." A person commented, "Yes, I do (feel safe). I don't have any concerns."

Staff we spoke with, including housekeeping staff, told us they had attended safeguarding adults training. This was confirmed by our view of staff records and the staff training matrix. Safeguarding and whistleblowing policies and procedures were in place and easily accessible for staff. Whistleblowing signage was visibly displayed in all communities. This informed staff what they should do if they wanted to report

poor and unsafe working practices.

We noted the 'Berkshire Safeguarding Adults Policy and Procedures' was available and accessible for staff. This is a set of steps implemented by the six local authorities located within Berkshire for consistently dealing with allegations of abuse or neglect.

We asked the local authority to send us a list of safeguarding referrals they had received since our last inspection. As part of the information received from the local authority, we received information about an incident that resulted in a person's safety being compromised due to unsafe care. For example the person's care record inaccurately recorded the amount of fluid the person had been given. Furthermore, their pre-admission assessment did not process and record all of the person's medicines. This meant the person did not receive all of their required medicines, when required. As a result the person was hospitalised and received treatment and care. The local authority upheld the complaint made against the provider. Subsequently, the local authority had met with the provider who provided an action plan to make sure this incident did not happen again.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We used this information to review all safeguarding incidents that had happened in the service since our last visit. We found the provider had taken appropriate action to investigate concerns and protect people from harm. However, the service could not show us what lessons had been learnt. For instance, where medicine errors had happened there was no analysis to check for trends or emerging patterns. This meant there was a potential for the same incidents to be repeated.

People had risk assessments for 'personal risk and behaviour'; skin integrity; eating and drinking and falls. Care records included interventions to mitigate these risks and they were up to date and regularly reviewed. We observed people had call bells within their rooms. Some people were not able to operate their call bell we saw regular safety checks were carried out by staff. This was supported by a relative who commented, "They (staff) keep an eye on her because she can't use the bell." Some people who were at risk of falling had a sensor mat linked to their call bell system. We observed a staff member immediately respond when a sensor mat was activated. This showed risk to people's personal safety had been assessed and plans were in place to minimise these risks.

People and their relatives felt there were enough staff to meet their care needs. Comments included, "There have been a few changes. A staff nurse is always around she (family worker) has a key worker. If she needs help they (staff) are always available", "They (staff) do change around between floors. I have come every day and think her (family member) needs are taken care of. She hasn't shown any obvious reaction to the changes", "Yes, quite regular"; "It is wonderful now. Over the last year it (staffing) has been improving" and "At the moment staffing levels are good."

The registered manager told us there was a period when staffing levels were low however; this had improved with staff being offered the opportunity to work extra hours. There was also a reduction in the use of agency staff. A review of staff rotas and staff dependency assessments confirmed staffing levels were appropriately monitored.

Safe recruitment practices were followed before new staff were employed to work with people. We saw relevant checks were made to make sure staff were of good character and suitable for their job role.

Good

Is the service effective?

Our findings

At our previous inspection on 27 and 28 February 2017 we found a breach of Regulation 9, 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to conditions in Deprivation of Liberty Safeguards (DoLS) not being met; staff not following the correct best interest decision making process; consent not being sought and ineffective support for people at mealtimes. We issued a requirement notice against the provider and requested an action plan. After our visit the provider sent us an action plan by the required deadline which stated that required improvements would be made by 31 August 2017.

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).

At our previous inspection, we found where local authorities imposed conditions on authorised deprivation of liberty safeguards (DoLS), these conditions were not always met by the service.

We looked at 28 DoLS applications and found appropriate applications had been made to ensure people were legally restricted. There was a clear process that made sure staff members were aware of which people had authorised DoLS and any conditions that were placed by the supervisory body. For instance, one DoLS condition stated the service should 'update care plans and risk assessment for harm from other service users and show how this can be safeguarded and the risk reduced." We saw the person's care record and risk assessment was regularly reviewed and updated. The registered manager showed us the service's electronic 'DoLS conditions tracker', which enabled them to monitor conditions and make sure they were met.

At our previous inspection, we found best interest decision making did not always involve people; their relatives and relevant health professionals, where required. Staff who signed relevant best interest documents could not demonstrate the decisions made for people were the best outcomes and people's consent was not always sought.

During this visit, we found the service was compliant with Mental Capacity Act and its codes of practice. Care records showed best interest decision making involved people; their family members and the service had looked at the least restrictive options. The service sought consent from people or those who legally acted on their behalf. For instance, where people required their medicines to be given covertly (disguised in food or drink), the service followed the correct protocol. Care records showed the service had sought approval from

the GP and advice from the pharmacist. Best interest meetings recorded family member's involvement in the decisions made.

At our previous inspection, we found people did not always receive appropriate support at meal times; food was not always presented in a timely manner and food temperatures were not always maintained.

During this visit, we found there were still periods where people had to wait a while before their meals were served. This specifically related to people who received their meals in their rooms. We noted staff assisted people in the dining areas first before any meals or assistance was offered to people who remained in their rooms. Although lunch started at 1pm, people in their rooms were not served until 1.30pm or later. This meant people were not always given their meals in a timely manner.

A relative felt there was enough staff but felt this was not always consistent throughout a certain time of the day. They commented, "In the lunch sessions, I feel they can do with more staff." This was confirmed by our observations of the lunch time period. We fed this back to the registered manager.

We recommend the service seek current guidance and best practice in regards to the deployment of staff when meals are served to people in their rooms.

Staff that provided people with one to one support with their meals in the dining areas were unhurried. The atmosphere was calm and pleasant. Staff worked as a team and there was constant interaction and communication with the people they supported. However, this did not occur on a consistent basis in all the communities. For instance, during the breakfast period, apart from asking people what they wanted to drink or eat, and assisting those people who required support with their meals, there was minimal interaction between staff and the people they supported.

We viewed the service's 'dignity in dining standards – meal time experience' audits. These were carried out on a monthly basis to make sure people with dementia were treated in a dignified manner and their meal time experience was a pleasant one. The service looked at areas such as, whether the dining areas were clean, organised and prepared for food service; people were offered choice; food was presented attractively on the plate and staff's interaction with people. We saw improvements had been made however; further monitoring of staff interaction with people during mealtimes was required. A view of the service 'environment person-centred dementia care audit' dated 29 August 2017, showed staff interaction with people was being continually monitored.

People and their relatives gave positive feedback about how the service met their nutritional needs. Comment from relatives included, "They (staff) constantly come around with drinks and overall make sure she (family member) drinks. As far as I'm aware the food is okay, she hasn't lost any weight"; "As far as I can see (family member) looks 10 years younger. Her skin is very good. They (staff) encourage her to eat. You wouldn't think she was 94. It is a good sign that she eats, sleeps and drinks well", "They cater for her (family member) needs, although she can't leave her room, they check on her regularly, bring her drinks and food and help her to eat", "fantastic food." One person commented, "There is usually a choice, the meals are good. I think I have put on weight and have plenty to drink." Another person told us, "The food is nice and good. They (staff) give us choice."

When discussing how people were supported at mealtimes. A staff member commented, "We always give (people) a choice of what food and drink they would like. At lunch time we visually show them the food on offer and they decide what they want." Our observations confirmed what the staff member had said. People were offered meals that were well presented, hot and nutritional. We spoke with the chef who demonstrated

an awareness of people who had normal; diabetic or pureed diets. They told us sugar was used in smoothies and desserts for non-diabetic people who were losing weight and vegetarian and halal foods were offered to people who required it. Care records showed people's food and fluid in-take was regularly monitored. This meant people's nutrition; hydration needs and preferences were met.

The service took part in a Hydration project run jointly by two clinical commissioning groups (CCG). As result of this structured drinks rounds were introduced; daily recording of people's fluid intake and staff attended relevant training. We looked at the hospital admissions for people for urinary tract infections and saw these had been reduced. This meant the service achieved good health outcomes for people.

At our previous inspection, we found staff did not receive appropriate training, supervision and appraisals. During this visit we found staff were appropriately trained; supervised and appraised.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included, "Yes, I trust them implicitly. She (family member) is happy, clean and well cared for"; "Every day care is very good. They (staff) are aware of her (family member) special needs. She is very nervous and has always had a low pain threshold", "Yes" (felt staff were skilled), she (family member) wouldn't be here if they were not", "Yes, on the odd occasion that I want to get up they (staff) show their skills with the hoist" and "Yes, my needs are met. Staff are very nice."

Staff completed mandatory training in the areas such as safeguarding adults; moving and handling; fire safety; MCA and DoLS and infection control. We noted training was delivered face to face and by e-learning. Comments from staff included, "I've done all of my training. I had nine to do" and "Plenty of training here." We saw appropriate action was taken by the registered manager when staff were non-compliant with attending the required training. This meant people received care and support from staff that were equipped with the necessary knowledge and skills to provide effective care.

Staff received regular supervisions and yearly appraisal. This was confirmed by our view of the service's supervision and appraisal matrix'.

People's care records showed relevant health and social care professionals were involved with people's care. Care plans were in place to meet people's needs in these areas and were regularly reviewed.

The service's electronic person centred care system enabled staff to generate a detailed hospital pack. This contained a summary of risks hospital staff needed to be aware of; care required; contact details of health and social care professionals involved with people; their latest BMI and prescribed medicines. This made sure people received consistent, co-ordinated and person-centred care when they moved in between services.

Good

Is the service caring?

Our findings

People and their relatives felt staff treated them with kindness and compassion in their day to day approach. Comments included, "They (staff) are very gentle with her (family member) and always speak to her when they see her", "They (staff) are patient and caring", "They (staff) are lovely and very caring", "Carers are kind and compassionate and most of the staff do treat me well" and "They (staff) treat me pretty well. They bring my meals and drinks and have a short chat if I want."

Staff told us how they made sure people and those close to them, felt like they mattered. For instance a staff member commented, "I make sure I pay attention and give them (people) eye contact. When families visit, I ask them if they want to go into the quiet lounge. Most families prefer to sit in the communal area." People and their relatives gave examples of how staff, made them feel like they mattered. Comments included, "They (staff) always refer to her (family member) by name and talk to her even though she is not responsive" and "They (staff) call me by my name and usually greet my visitors in the same way. They check on me often if I am in my room and call out a greeting when they pass my door."

Staff showed genuine concern for a relative who appeared to be unsettled on their arrival to the home. They approached the person with sensitivity and made sure the person's privacy was protected when trying to establish what had happened.

Staff knew how to respond to people's diverse cultural and spiritual needs. For instance, staff supported a person who was religious by playing music specific to their religion. Staff who knew the person spoke about them with affection. They told us the person could not speak English, so a staff member who was fluent in the person's language, developed flash cards with simple words to enable other staff to support them. We viewed the person's care record. We saw prompts on the electronic care planning system that made sure the person's preferred music and television channels were accessible. This meant people's communication and cultural needs were met.

People were supported to access external bodies, community organisations and advocacy services. A person told us, "I can more or less make my own decisions. If I need to see a doctor or any other professional they (staff) will organise it. Mostly my daughter will intervene if necessary, which is rare." This was supported by a staff member who commented, "Some people have advocates, independent mental capacity advocates (IMCAs) or receive support through their families. Care records confirmed what the person and staff had told us.

People and their relatives said staff made sure their privacy and dignity was protected when personal or intimate care was carried out. Comments included, "They (staff) close doors and put a sign up when someone is receiving personal care", "If I am with her (family member) in the room they (staff) will always knock before coming in" and "She (family member) doesn't bath she is topped and tailed every day. The door is closed when they (staff) give her personal care."

The service had dignity champions. We spoke with a dignity champion to find out how in what ways they

made sure people received care in a dignified and caring manner. The staff member told us, "Dignity is not just about making sure curtains are closed before carrying out personal care. You need to treat people in the way you would like to be treated. I remind carers to treat people with dignity for example if people are asleep, do not wake them up. I will carry out observations and if I pick up on any issues, I will bring it to the attention of team leaders." We noted care records gave staff clear instructions on how staff should respect people's choices and treat them with dignity when carrying out various aspects of care.

During our visit we found the provider was registered with the Information Commissioner's Office (ICO).The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found personal information was kept securely and password protected.

People's relatives said they felt welcomed in the home and they were able to visit without any restrictions. Comments included, "There is no restriction when we visit and I come as often as possible", "There is no restriction. I can come in anytime and always feel welcome" and "There are no restrictions on visit."

Requires Improvement

Is the service responsive?

Our findings

We have inspected this key question to follow up on concerns found during our previous inspection on 27 and 28 February 2017. End of life care was under the key question of 'Caring' in the previous assessment framework, but was moved to this key question when the framework was reviewed and refined.

At our previous visit, we found little or no information in regards to people's preferences for end of life care. During this visit we observed people had a care plan on 'Death and dying'. Plans included information on people's wishes regarding whether to go to hospital or remain at the home in the last stages of life. Spiritual beliefs and wishes were documented for example, to be attended to by a priest and preferences for burial or cremation.

Registered nurses we spoke with were aware of the importance of following the wishes of people from different faiths. An administrator told us they hoped to attend a bereavement course offered by a local funeral director and commented, it was important to "Support families." They showed us a 'thank you' card sent from a family. It read: "We just wanted to say heartfelt thanks for all you did for [name of person] to make his final hours as comfortable as possible." This showed the service made sure people's preference and wishes were captured and people received compassionate care when they approached the end stages of life.

People and their relatives told us they were able to contribute in the planning of their care. For example a relative commented, "We (the family and service) planned his (family member) care together. They (staff) asked a lot of questions when he came in, such as what he liked, his hobbies, etcetera." Another relative told us, "When she (family member) first came in they took down a raft of information about her preferences and her condition." This was supported by our view of pre-assessments which were accessible and recorded various aspects of people's care needs. These included people's mental and physical health; daily living skills; communication, hobbies and interests. This made sure care, support and treatment offered was personalised and reflected what people said they wanted.

Care plans and risk assessments were regularly reviewed and were up to date. A registered nurse told us that care plans were "Reviewed every month" but also "Reviewed as required as things changed." People and their relatives confirmed they were involved in reviews of care.

Relatives spoke about the responsiveness of staff. Comments included, "They (staff) will always respond quickly if she (family member) needs anything", "If she (family member) is distressed they (staff) react quickly", "They (staff) are quick to help him (family member) when needed."

People had a range of activities they could be involved in and, were able to choose whether to participate or not. Relatives comments included, "She (family member) does have one to one sessions with the activities people when she spends time in her room", "I take her (family member) out into the garden. That's one of her likes. She tends not to want to get involved in activities but enjoys being in the lounge with other relatives", "I come in every day. She (family member) doesn't want to get involved in any activities but does

go into the lounge."

The service was in the process of training a number staff to become dementia coaches. Part of the training focused on using meaningful activities that were specific to people's needs, in order to stimulate them. We spoke with the dementia practice development coach, who told us staff used people's life histories and preferences in their day to day living in order to stimulate them. This was supported by the activity co-ordinator told us about a person who enjoyed music. The person's room had a picture of their favourite band and staff made sure activities, both in and outside of the service was specific to the person's musical preference. The activity co-ordinator said they had seen a marked improvement in the person's mood. This showed the service ensured social activities were meaningful and tailored to meet the needs of people living with dementia.

We looked at whether the service ensured people had access to information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw a pictorial service user guide written in easy read format. Where people had a disability or sensory loss, these were recorded in people's care records. However one relative when talking about their family member's experience of being moved between different communities commented, "Problems came about because it took some time for staff to realise she was blind." This meant people could not always be confident information relating to their disabilities would be clearly communicated and understood by staff.

We recommend the provider seek current guidance and best practice in order to be compliant with all aspects of the Accessible Information Standard.

People and their relatives knew how to raise complaints. Some responded they were happy with the care provided and had no need to complain, whilst other felt their complaints had been responded to appropriately. Comments included, "No, but I wouldn't hesitate if I felt there was something to complain about", "Yes, in the beginning she (family member) had marks and a cut on her face. We were told she had fallen out of bed. They (staff) have placed a pad (sensor mat) next to her bed. There haven't been any other instances of concern" and "We did have a complaint some time ago. [Name of person] broke her hip whilst she was having one to one care. It wasn't correctly recorded and not very well organised complaints procedure, but it is much better now."

The service's complaint policy and procedure had been updated. A one page copy of the complaints policy was in an easy read format and visibly displayed in the service.

When people raise complaints and concerns the service did not always fully take their views on board, or thoroughly investigate all concerns and complaints raised. For example, a complaint that was received in August 2017, the concern raised about high use of agency staff and poor moving and handling practice. We noted that in the provider's response to this concern, they had only partially addressed this concern because only the issues in regards to the high use of agency staff had been responded to. In another complaint, which was raise in July 2017, we noted a person's relative had made a complaint which highlighted numerous concerns, however, again the service only partially responded to the concerns raised. This meant, complaints were not thoroughly investigated.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on 27 and 28 February 2017 we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 and continued breaches in Regulations 9, 12, 17. These related to person-centred care; safe care and treatment and good governance. We issued a requirement notice against the provider and requested an action plan. After our visit the provider sent us an action plan by the required deadline which stated that required improvements would be made by 31 August 2017.

At our previous inspection, we found the service had not worked in line with its medicines policy and procedure and safeguarding policy and procedure.

During this visit, we found improvements had been made in relation to staff working in line with its safeguarding policies and procedures. However, further improvements were required in relation to its medicines policy and procedures.

At our previous inspection, we found care records lacked important information to ensure people's welfare and safety.

During this visit we saw the service had installed a new person-centred electronic care system although paper care records were still also in use. Improvements had been made to ensure records were accurate and fully completed. For instance, the service used the 'resident of the day' approach. This took a holistic view of a person and set aside a day where all departments from nursing; hospitality; finance to housekeeping would spend a day focusing on the person. One part of the process was to make sure care records were updated. Staff checked for any gaps; to see if risk assessments were updated and care plan reviews had been completed.

We noted one of the functions of the electronic person-centred care system, was to alert staff if assessments were overdue. A registered nurse confirmed this and commented, "The system alerts us. I have to check that everything has been done. I check throughout the day." Whilst viewing a person's electronic care record we found 13 alerts for assessments that needed to be reviewed. A staff member we spoke with was unable to tell us why this had not as yet been addressed.

We looked at the person's paper care record. We saw personal information that belonged to another person who used the service. We brought this to the attention of staff who immediately removed the information.

Another person had been assessed at risk of choking; we saw unclear information recorded as to the type of food thickener staff should use. We reviewed and discussed with the registered manager, a safeguarding incident that had been brought to our attention by the local authority. This showed unsafe care was due to poor administration of medicines practice and inaccurate record keeping in relation to the person's fluid intake, which compromised the person's safety. This resulted in the person being hospitalised. These showed systems in place to check for accuracy of records were still ineffective.

At our previous inspection, we found quality assurance systems and processes in place to assess and monitor risks to people's health, safety and welfare, were ineffective. During this visit we found the service had taken action to make sure systems in place to monitor areas such as falls; accidents and incidents and safeguarding; were robust in order to mitigate identified risks. This was in the form of audits which were regularly carried out.

The provider had told us they had looked for any trends and analysed the information gathered. We requested to see the analysis carried out however the registered manager was unable to produce this information during our visit. For instance, we looked at the service's 'Analysis of complaints 2017'. This showed since our last visit, the service received 14 complaints. The information gathered captured dates of complaints; names of the people the complaints related to; who raised the complaint; names of staff who responded to complaints; details of complaints; when complaints were responded by; actions taken; if policy paper work was completed and any remarks. There was no documented analysis carried out to check for emerging patterns such as, types of complaints received; numbers of times staff members were involved in complaints. This was also found when looking at the service's audits of safeguarding; accidents and incidents and recent visitor and staff surveys. Therefore, Information gathered by the service was not effectively analysed and used to drive improvement to the quality and safety of the service and the experience of people who engaged with the service.

On the first day of our visit we spoke to the registered manager to understand how the service used learning from incidents to drive improvements in the service. When referring to safeguarding incidents, the registered manager stated information was shared with staff via the 'WhatsApp' web service. For instance, they showed us safeguarding incidents that had been sent to staff in order to share learning. We found this was not appropriate because staff were left to interpret what lessons they thought could be learnt from safeguarding incidents. On the second day of our visit the registered manager had developed an online questionnaire for staff to complete in order for learning to be shared. As this had only just been developed we could not see how effective it was however; this still did not deal with managerial oversight into lessons learnt.

Legionella was still present in the home which meant people were not able to use the showers since June 2016 however; the service's 'Legionella action plan' showed continued monitoring was carried out to ensure people's welfare and safety. We viewed the 'Larchfield House Home Improvement Plan' dated October 2017 and saw, in order to remove Legionella, the provider had arranged for pipework throughout the building to be replaced. We noted the time frame for the work was November 2017 to April 2018.

At our previous inspection, the service was given a rating of 'inadequate' and was placed in special measures. As a result of this we placed a condition on the service's registration on 30 June 2017. This meant the service was required to submit reports on the first working day of each month. These reports were to document audits carried out; identified actions; the persons responsible for the actions and projected timescales. For the months of August; September and October 2017, the provider's report submissions were late and did not contain the required information. Therefore, we were unable to use this information to monitor the service before our visit, to make sure appropriate action was taken by the service to keep people safe.

Due to the breaches in regulations found at our last visit, we issued requirement notices against the provider and requested an action plan. After our visit the provider sent us an action plan by the required deadline which stated that required improvements would be made by 31 August 2017. We found during this visit, the provider had failed to achieve all of the improvements they stated would be made by 31 August 2017.

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

Regulations 2014.

At our previous inspection, we found Larchfield House had failed in the duty of candour. This gives clear steps for the management to follow when certain safety incidents happen. Management and staff were not knowledgeable about the duty of candour and had not attended the relevant training. During this visit, we saw training records that confirmed management and senior staff had attended the relevant training in September 2017. We asked the registered manager to show us examples where they had carried out duty of candour in their work practice when certain incidents had happened. The registered manager was not able to provide us with this information. We reviewed the safeguarding incident the local authority had brought to our attention and found the duty of candour had not been applied. This meant people who used the service, and others, had not received information or apologies when they were involved in relevant safety incidents in line with the duty of candour.

This was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we found an action plan had not been developed and implemented in response to a community pharmacy's audit. During this visit we looked at the pharmacist's medicine audit and found the recommendations made had been acted upon.

At our previous inspection, we found the service did not notify us of certain incidents about people's care 'without delay', as required. During this visit we found the service had made sure the Care Quality Commission (CQC) had received statutory notifications in a timely manner.

At our previous inspection, we found the service did not displayed its prior inspection ratings conspicuously, both within the building itself and on any website they use. During this visit, we found the inspection ratings were visibly displayed in the service and on its website.

People and their relatives felt the service was well-led. Comments included, "I don't have much to do with them but it seems to be run smoothly", "Management is accessible. [Name of registered manager] has not been here long but he does listen and is fair", "I haven't had much contact but it seems to be run well", "Oh yes, its (management of the home) changed hands 18 months ago. The quality of care and the place itself is good" and "Now, yes. They have new management and it has become more homely."

During this visit we saw management were visible and accessible for people; visitors and staff. Most of the staff members we spoke with felt supported by management however; there were a few staff members who told us they did not feel listened to. For instance, housekeeping staff told us help was not always forthcoming when asked. A staff member when describing some of the improvements the service had made commented, "There have been a lot of improvements under [name of registered manager]. Staff are more caring and new care staff coming in, are pro-active. Agency staff are inducted and trained by team leaders and nurses."

In order to ensure people living with dementia received care, treatment and support centred on their specific needs the provider had enrolled a number of staff (this included activity workers; care workers; registered nurses and management) to train to be dementia coaches. An environmental person-centred dementia care audit was carried out by the dementia development coach. This showed areas where improvements could be made to positively enhance the experience of people living with dementia. The service was in the process of addressing areas highlighted for further improvement.

'Larchfield House Home Improvement Plan' showed plans were in place to have dementia friendly furniture in people's room and a dementia garden by August 2018.

People and those important to them had opportunities to feedback their view about the home and quality of the service provided. This was carried out by way of care reviews; 'residents and 'relatives' meetings and surveys. We saw appropriate action was taken by the service in response to feedback received. For instance, we viewed a 'residents meeting' held on 15 September 2017 which documented people requesting to watch 'old movies'. We saw correspondence sent by the registered manager to a local cinema requesting an opportunity for people at the home to have a private screening. Activity staff also arranged movie afternoons on a weekly basis based upon people's preferences. We saw the service provided people and their relatives with updates of changes that were planned for the service.

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 Information in people's care records were not always accurate and medicines received by staff were not always processed. This meant people did not always receive their medicines when required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always thoroughly investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to check for accuracy of records were still ineffective. There was no managerial oversight of lesson learnt from incidents and no analysis of information gathered to drive improvements. The provider did not comply with its condition of registration and had failed to achieve all of the improvements it stated would be made by 31 August 2017. Regulation 17 (2) (a), (c), (3) (a), (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 20 HSCA RA Regulations 2014 Duty of

personal care

Treatment of disease, disorder or injury

candour

People, who used the service, and others, had not received information or apologies when they were involved in relevant safety incidents.

Regulation 20 (1), (2), (3), (4).