Healthcare Homes Group Limited

Overbury House Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 January 2017, it was unannounced.

Overbury House Nursing and Residential Home provides residential and nursing care to a maximum of 61 older people some of whom may have dementia. At the time of our inspection there were 43 people living in the home, 15 of whom were receiving nursing care.

At the time of our inspection visit a registered manager was not in post. 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.

We last inspected this service on 02 and 05 December 2014 and found the provider was in breach of regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not protected against the risks associated with unsafe administration and recording of medicines. At this inspection we found improvements in the administration of medicines had been made. The provider had introduced a new system to help ensure people received their medicines and to improve the recording in relation to this, this had been effective in making the improvements required. People received their medicines within the required specified time frames and we saw medicines being administered safely.

We concluded the provider was no longer in breach of regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe administration of medicines. However, at this inspection we found the provider remained in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because we found additional concerns in respect to the assessment and management of risk. This is because we found risk assessments were not always in place for identified risks, sufficient actions were not taken to protect people at risk of malnutrition, dehydration, and skin breakdown, and actions were not always taken in response to accidents and incidents.

We found the provider was in breach of three further regulations. They were in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not everybody living in the home received the support they required at mealtimes and action was not always taken to ensure people were adequately hydrated. We found that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's quality assurance systems had failed to identify in a timely manner that improvements were needed and had failed to sustain areas where there had previously been no concerns. We found the quality of records in the home was poor. Care records did not always contain sufficient information, there were gaps in the records, and at times records were illegible. This meant the provider was in breach of regulation

17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Improvements were required in this area. We have made a recommendation that the provider review this legislation and associated guidance to ensure they are acting in accordance with the MCA.

There was a lack of documented personal preferences to ensure that staff delivered support the way people living in the home wanted. Activities and some of the design in the home did not always take in to account people's individual needs or preferences.

People felt safe living in the home; however we were not confident that all staff in the home understood the importance of identifying and responding to safeguarding concerns. People and relatives told us they felt able to raise concerns and confident that the provider would take action to address these.

The provider and management team took concerns and complaints, including the issues identified at our inspection, seriously and responded thoroughly. They and the management team were open, honest, and transparent in regards to the issues in the home and the improvements required. There was a clear plan of action to drive improvements and the provider was taking action to make the improvements required in the home; this included clear oversight at provider level.

The provider had recently reviewed people's needs in the home and increased staffing levels. As a result of there was sufficient staff to meet people's needs.

The provider had made recent changes to ensure staff felt supported and had the necessary skills and knowledge to carry out their roles. Staff and relatives were positive about these changes and the benefit they had brought to people living in the home. New staff received the support they needed to carry out their role.

People told us they felt involved in decisions regarding the care they received. Staff supported people to maintain important relationships and encouraged relatives to visit the home.

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.

Risks to people's wellbeing and safety were not always identified and actions to minimise risks were not always taken.

There was sufficient staff to meet people's needs.

Medicines were administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had taken action to ensure staff had the skills and support to carry out their role.

Staff sought people's consent; however the provider did not always act in accordance with the requirements of the MCA.

Some people did not receive the support they needed to eat and drink. Staff did not always ensure people received adequate hydration. Meal times were not a pleasurable experience for some people living in the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always provide support in a caring manner. People's dignity and independence was not always promoted.

People felt listened to regarding their care and support. The involvement of relatives was welcomed and encouraged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and activities in the home were not always provided in a way that met people's individual needs and preferences.

The provider took action to deal with concerns and complaints. People and relatives felt listened to and able to raise concerns if needed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality of records in the home was poor. The systems in place had not always been effective at identifying and maintaining areas that required improvement.

The provider and management team were open, honest, and transparent in regards to the issues in the home and the improvements required. They were taking action to drive improvements in the home.

Overbury House Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meetig 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 inspection took place on 11 and 12 January 2017 and was unannounced. The inspection was carried out by two inspectors.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also spoke with the local authority adult safeguarding team and the local clinical commissioning group for their views on the service.

During our inspection we spoke with seven people using the service and six relatives of people using the service. We spoke with five care staff, two nurses, one agency staff member, the chef, deputy manager, two interim managers, and two representatives from the provider. We also spoke with a visiting healthcare professional.

Not everyone living at the home was able to speak with us and tell us about their experiences of living in the home. We observed how care and support was provided to people and how people were supported to eat their lunch time meal.

We looked at six people's care records, three staff recruitment files and staff training records. We checked the medicines records for six people. We looked at quality monitoring documents, accident and incident records, and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Whilst some risk assessments were in place, we found these were not always detailed and not all risks to people had been fully identified. For example, we found one person was at risk of behaviour that may challenge themselves and others. There were no risk assessments or guidance in place for staff to help them manage this risk appropriately. For another person we saw they were at risk from a specific medical condition, which caused them significant pain and had previously resulted in surgery. We found there were no risk assessments or guidance in place for staff on how to manage this risk.

We found actions were not taken to manage the risk to people from malnutrition. We looked at the records of two people who were at risk of malnutrition. One person's care records showed the person's weight should be monitored on a weekly basis. The records showed that this was not always happening. This meant there was a risk the person could be losing weight and it was not being identified in a timely manner. For the second person we saw their risk assessment had been incorrectly completed and did not take in to account that the person had experienced recent weight loss.

Actions were not always taken to ensure people at risk of skin breakdown were safe. We looked at the records of two people who had experienced areas of skin breakdown which required dressings and nursing care. We saw one person needed to be repositioned every two to four hours, to protect against further skin breakdown. The repositioning records showed this was not always happening within the required specified times. Whilst risk assessments had been completed, for one person this showed they were at high risk and their risk assessment should be reviewed monthly. We found this had not happened and their risk assessment had only been reviewed twice in six months.

A nurse we spoke with told us a wound assessment should be recorded at every dressing change. We found for the second person with an area of skin breakdown, a wound assessment was not always taking place when their dressing was changed. We saw whilst both people had individual assessments of each area of skin breakdown, they stated a picture should be taken with each time the wound was reassessed. This would help nursing staff identify if the wound was healing and assist with further risk assessments. We found pictures had not always been taken. When pictures were taken they were not kept with the individual wound assessment and were not titled, so it was not always clear what the picture was of. This meant it would have been difficult for nursing staff to have reviewed the wounds and assess the overall level of risk.

There was a system in place for the reporting of accidents and incidents that occurred in the service. However, we found this was not always effective in managing risks to people living in the home. We saw one person had fallen and sustained an injury to their head. There was no evidence of any action taken to mitigate against the risk of further falls or evidence of any medical follow up in either the incident form or the person's care records. Given the potential seriousness of the injury we were concerned there was no record of monitoring and observations for signs of concussion or other head injury complications. We found another person was at high risk of falls. We saw this person had fallen at the beginning of November 2016. An incident form had been completed which stated that the use of bedrails should be considered and a risk assessment for their use was required. It also showed that a referral to a healthcare professional for advice

in managing this risk should be made. At the time of our inspection visit there was no record to show this referral had been made or that this had been followed up. A risk assessment for the use of bedrails had been completed on 20 November 2016; however this said they were not required. There was no detail recorded as to why this was and what other actions would be taken to manage the risk of falls. We saw the person had fallen from their bed a third time on the day of our inspection visit. We discussed the management of these falls with a nurse; they told us the regular hourly checks detailed in the person's falls risk assessment had not been taking place as they were reviewing the use of bedrails for the person. However, at the time of our inspection bedrails were not in place and this meant no additional measures to manage the increased risk of these incidents had been taken.

At our inspection visit we found a number of call bells in people's rooms were not secure in the walls and, in some cases the wiring was exposed. This posed a risk to people living in the home.

The above information meant that not all risks were regularly reviewed, managed or reduced. It also meant that new or agency staff did not have up to date guidance in the event that permanent staff were not available. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe living in the home. One person said, "Oh yes I feel very safe here and nothing is too much trouble for [staff]." Another person told us, "I feel safe just knowing there are people around and staff usually come quite quickly if ever I need them." The staff we spoke with had the knowledge to recognise, prevent, and report harm to ensure that people were protected from the risk of abuse. However, following our inspection visit the provider shared with us an incident that demonstrated not all staff working in the home understood safeguarding procedures. This had resulted in a delay in reporting an incident, which had meant local safeguarding bodies been unable to take prompt action and provide the person involved with support. The provider told us in response to this they would be providing additional training and support to all staff in order to ensure safeguarding responsibilities were understood.

We received varied feedback from people and relatives regarding staffing levels. Three of the relatives we spoke with told us they had noticed staff numbers had increased and this had made a positive difference. One relative said, "[Staff] have more time with [name] now they're not so rushed." However, two other relatives told us they had concerns regarding sufficient staffing at the weekends. One said, "Weekends is the time you notice there is less [staff] around." The second relative expressed concern that staffing levels in the home had meant their relative had to wait for long periods for assistance with their meals and medicines.

The interim managers told us a staffing dependency tool was in place, however they had reviewed this and identified issues with how the tool had been completed. They acknowledged that this had meant staffing levels had not been sufficient. They confirmed that the use of the tool had been reviewed and as a result staffing levels had been increased. The staff we spoke with confirmed this. They told us this had made a difference to the running of the home and meeting people's needs. One staff member told us they no longer felt like they were "Going round in circles, because you felt you couldn't give the quality of care you wanted to because there wasn't time to do it."

Staff files showed safe recruitment practices were being followed. This included the required health and character checks, such as references and Disclosure and Barring Service (DBS) checks, to ensure the risk of employing unsuitable staff was minimised as far as possible. Where staff were employed from abroad, we saw that thorough checks had been made to ensure the validity of the person's references, qualifications, employment history and experience. We also saw that checks had been made to ensure the person was legally entitled to work in the UK.

Our previous inspection in December 2014 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect to the management of medicines. This was because people did not always receive their medicines on time, records were not always completed properly, and there was no guidance in place for 'as required' medicines. At this inspection we concluded the provider was no longer in breach of this regulation in relation to the management of medicines.

The provider told us they introduced a daily audit in December to help ensure that medicines were administered as prescribed and the records were accurate. Whilst we found some record errors in one person's medicine administration record and for the stock of one homely remedy we saw that the other five MARs we checked were accurate and concluded that this had been effective in driving some improvement. We saw guidance for 'as required' medicines had now been put in place; although these did not always contain specific individual detail relating to each person.

The people we spoke with told us they received their medicines on time. One person said, "[Staff] are pretty regular with everything." They went on to tell us staff always made sure they asked if they were in pain and required any pain control. Another person told us they received support with external medicines. They told us staff were careful about applying the medicine required and they felt their condition had improved. On one of the days of our visit we saw medicines were given later than planned. However, we spoke with two nurses and one of the interim managers who provided us with reasonable reasons regarding why this had been delayed. They told us this was not a normal occurrence and that whilst the medicine round had been later than planned; people had still received their medicines within the required timeframe.

The provider told us they were in the process of undertaking competency checks for all staff administering medicines to ensure staff understood and were following safe practice. We observed medicines being administered to people in the home. We saw this followed current guidance and was completed safely.

Requires Improvement

Is the service effective?

Our findings

We observed the support provided to people over lunchtime. We saw diet sheets had been devised to show at a glance who required a specialist diet, such as fortified or pureed meals and whether the person required prompting or assistance. We saw staff used this to ensure people received the correct meals. We saw that this was not always effective in ensuring people required the right level of support to eat. For example, we saw one person was recorded as needing assistance with their meals. We saw for the duration of the main meal, this person did not receive the assistance required. We saw this impacted on their ability to eat their meal.

We found actions were not always taken to ensure people received adequate hydration. We saw two people required their fluid intake to be monitored and there was guidance in place for staff on how much fluid the person should receive daily. We saw these records were not adequately completed. For example, for one person over a period of twenty seven days the total amount the person had drunk had only been added up and totalled on seven days. This meant staff were not sufficiently monitoring if both people were receiving adequate fluids.

On one of the days of our inspection visits we heard a person calling out for help, they told us they were thirsty and had been unable to drink as their mug had been placed outside of their reach. A relative we spoke with told us their relative had experienced a similar situation on a number of occasions. This meant that staff were not always ensuring people had access to fluid to ensure people remained sufficiently hydrated.

The above information meant the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that there was a delay for some people in receiving their meals. This meant that some people sitting at dining tables had been waiting for 30 minutes before their meal was served. A relative we spoke with told us they had found on occasions that their relative had waited one or two hours for meals. This meant for those people their meal time experiences were not always positive.

People we spoke with talked positively about the food provided. One person we spoke with told us the food was, "Tip-top" and the menu included their favourite meals. Another person told us, "I can never remember what's for dinner but it's always very nice and we can choose what we like; we don't have to have anything we don't like.", A relative we spoke with told us they had sampled the food on offer, they said it was, "Brilliant, very palatable."

Although menus were available, some people and staff we asked didn't know beforehand what was on offer for lunch. However, we saw that people were given visual choices from two main options at the mealtime and people told us they could have something different if they didn't want either of these. For example, some people chose sausages, while others opted for the fishcakes and we noted that one person chose to have soup, with bread and butter. The chef confirmed to us that they were always flexible and happy to

cater for any individual requests that people may have.

The chef demonstrated a good knowledge and understanding of people's individual dietary needs, including what foods people shouldn't have, and why. We saw that the chef followed NHS guidance on soft and dysphagia diets. A dysphagia diet is one that features different textures of foods and liquids. It is used with people who have problems with chewing and swallowing.

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 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.

We saw some people had mental capacity assessments in place regarding whether they could make decisions relating to taking medication, personal care, taking part in social activities, and having their photo taken. However, where we saw people had been assessed as not having capacity to make these decisions there was no record of what decision had been taken in the person's best interests or how this decision had been reached. We saw for one person a relative had given consent on the person's behalf for their picture to be taken. The relative did not have a lasting power of attorney and this meant they did not have the legal authority to provide consent on the person's behalf.

We saw some people had safety gates to the doors of their bedrooms. We asked the management team why this was, however they were unable to tell us. There was no information in people's records relating to whether people could consent to the use of such safety gates or why they were being used. We were concerned that the provider had not considered if this practice restricted people's movement and if this was the case that it was in the person's best interests. The provider told us applications for DoLS had been made. We looked at one of the applications which did not show why the decision to make an application had been made.

The above information meant the provider was not consistently following requirements set out under the MCA. We recommend the provider reviews this legislation and associated guidance to ensure they are acting in accordance with the MCA.

Whilst we found some issues regarding the implementation of the MCA, people we spoke with told us their consent was consistently sought before staff did anything. One person told us, "They [staff] always ask me first if it's alright to do something for me before they do it." Staff we spoke with demonstrated a good understanding MCA and the importance of seeking people's consent. For example, one member of staff explained how they always made sure that people knew what was going on and gave their consent before any care was provided. Another member of staff said they were clear about enabling people to make their own decisions, such as what time people got up in the morning or went to bed at night, what people wanted to wear and what time they went to the communal lounge if they wanted to. One member of staff said, "We assume people have capacity and can make their own decisions. Even if people can't speak to us, they can usually still express themselves with their body language."

People we spoke with told us that their needs were met appropriately by well trained staff. One person told us, "I've no doubt that the staff know what they're doing and they certainly seem very well trained. Obviously some are better than others but even the youngsters are very good."

Prior to the inspection we had received concerns regarding the skills and competency of some staff working in the home. We saw the provider had responded robustly to these concerns. They had carried out competency checks on staff, identified areas where additional training and support was required, and taken action to address this. One staff member spoke positively and enthusiastically about how this had provided more opportunities for learning and development.

We saw the provider had reviewed the training it provided and staff training records to ensure staff had the training required. They told us they had decided to provide certain training, such as dementia care and mental capacity, more frequently. Staff told us they felt the training they received was effective and that they felt confident in their work.

The staff we spoke with told us that previously new staff had been expected to carry out their role with little formal induction or support. They told us this had recently changed and all new staff now shadowed experienced staff before they started working on their own. The provider confirmed they had reviewed how new staff were supported in the home. They told us new staff now shadowed four shifts, a probationary review and supervision took place, following this it would be agreed if the new staff member was ready to work independently in the home or if further support was required.

Staff we spoke with said they hadn't received any supervision in the last year. Supervision is a meeting between staff and their manager to discuss their roles, training needs and personal development. This meant there was limited support for staff in this area. However, we saw the provider had started to address this with staff. Staff told us they were aware the new management team were in the process of arranging supervisions for staff, records we saw confirmed this.

People told us they had good access to various healthcare services. One person said, "Oh most definitely, if the carers notice anything wrong with me they tell the senior staff who will contact the doctor or nurse for me." We observed a staff handover meeting and saw staff discussed people's health care needs including if they needed to discuss these with a medical professional. Records showed that where necessary people were referred for input from a range of healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Whilst we saw some kind and caring interactions between staff and people, we found occasions where people were not always treated with respect and their dignity was sometimes compromised. We saw that this appeared to happen when staff were task focused, for example when supporting people with their meals. We saw one person had fallen asleep at a dining room table whilst waiting for their meal. We saw that this person was left asleep at the dining table throughout the lunch period and staff took no action to protect their dignity. We saw staff had assisted another person to sit at a table on their own at lunchtime in a chair facing a blank wall. Whilst staff acknowledged that the person appeared disorientated and distressed by this, they did not take action to resolve this. A relative provided us with several other examples of care their relative had received which had compromised their relative's dignity. These related to a lack of attention to their relative's personal appearance. On one occasion we heard a staff member referring to a person who needed assistance at lunchtime as, "An assist." We found this language to be dehumanising and did not promote the person's dignity

We found people's independence was not always promoted. For example, we saw and a relative told us, that drinks were not always placed within people's reach so they could help themselves. One person told us about an example where staff had forgotten to share important information they had requested with them and this had meant they were unable to participate in an important event. They told us how upset this had made them feel.

The above information meant people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the relatives we spoke with raised concerns regarding the high use of agency staff and the impact this had on the amount of staff who knew people well. One relative said, "When [staff] get to know [people] it's got to be better for everybody, stability, that's what's needed." One relative told us on one occasion they had rung up the home to discuss their relative's care. They told us it was clear from talking to the member of staff that they did not know who their relative was. They told us that this had made them feel worried and anxious. Staff we spoke with told us that whilst they had shared similar concerns, they felt less agency staff were being used and a more stable staff group was being developed. The provider told us they recognised the use of agency staff in the home was high and had put in place plans to minimise the impact of this. This included, ensuring they use the same agency staff members to aid consistency for people in the home.

People we spoke with told us they found staff to be caring and kind. One person told us, "They [staff] are a lovely bunch, they're all so kind and caring and they're always so cheerful; nothing ever seems to be too much trouble for them." Another person said, "Yes, I think the staff are all very caring; I feel very well cared for here thank you." A third person explained, "They [staff] always speak nicely to me and we often have a bit of a laugh, which makes all the difference." Four of the relatives we spoke with confirmed this. One relative told us, "They don't do it just for show; they are genuinely caring all the time." Another relative said, "Some lovely staff, really nice people."

Whilst we saw some areas of poor practice we saw some staff behaving in a caring and thoughtful manner. For example, we saw one person was walking around the home without shoes on. A number of staff noticed this and throughout the day we heard staff checking that the person was happy and comfortable like this. We noticed that these staff gently encouraged the person to consider other footwear but respected the person's wishes and right to say no. On another occasion we noted that one person was sitting quietly but seemed a bit withdrawn. A member of care staff approached the person gently, knelt down, rubbed their hand and spoke to them. They asked if the person was alright and whether they would like a drink. The person responded positively to the member of staff, with a smile and happily accepted a drink, which the staff member assisted them with. We saw that, following this interaction, the person was more attentive to their surroundings and no longer withdrawn.

People and relatives we spoke with told us they felt listened to and involved in decisions regarding their care. One person told us, "I have been able to plan my support and I'm hoping to be able to move somewhere else soon. They [staff] are helping me look for other places where I could be a bit more independent." One of the relatives we spoke with told us communication and involvement about their relative's care had improved. The management team provided us with an example which demonstrated they were committed to trying to involve and consult people and their relatives, where appropriate, in the care they were providing.

Relatives we spoke with told us they were able to visit when they wanted and staff supported their relationships with their relative. One relative told us, "You always get a welcome." Another relative told us how staff had encouraged and supported them to visit and spend time with their relative.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt involved and listened to regarding the support provided. However, not everyone we spoke with could tell us that they had participated in formal care planning or reviewing their care plans. Some of the care plans we looked at showed the involvement of the person, or their relative where appropriate, however this was not consistent with all the care plans we looked at.

The care plans we looked at did not always contain sufficient guidance and information for staff. For example, we saw one person was receiving end of life care, however there was no care plan or detail regarding how this care should be provided or the person's preferences in relation to this. This meant staff did not have sufficient written guidance to meet people's needs. It also meant that new or agency staff did not have sufficient guidance to meet people's needs in the event that permanent staff were not available.

A number of relatives we spoke with told us they did not always feel that staff, particularly agency staff, knew their relatives. This meant they were not always confident that care was delivered in line with their relative's preferences. One relative provided us with an example where they had found an agency staff member did not know their relative's preferences. They said they had found the staff member providing a nutritional supplement not in line with their relative's preferences. They told us as a result their relative had refused to take the supplement.

We asked how staff knew what people wanted and how they liked to be supported. One member of staff told us, "Well, there is information in people's care plans either in the deputy's office or the nursing office but we don't get to look at them very often; the team leaders or seniors mostly do that." This member of staff added that they got told how people need to be supported and that the red folders in people's rooms showed people's specific needs. Examples of this were whether people needed to be repositioned and how they had their food and drinks. However, there was a lack of detail in these regarding people's preferences and wishes to ensure staff provided support the way the person wanted. Some of the staff we spoke with said it would be helpful if people's room files contained an overview of people's care and support needs, as well as their likes and dislikes. One member of staff told us, "It would be good to have a fact sheet in people's room files, including whether a person likes to go downstairs and come back to their rooms regularly for personal care."

The home had a number of themed areas, such as a 1950's American style diner and a nature themed walkway. These had been designed to stimulate and provide entertainment to people living in the home. However, some of the design elements in these rooms had not taken in to account the specific needs of people living with dementia. One of the interim managers told us they had recognised this and had plans in place to review the use and design of these rooms, to ensure they were better utilised and met the needs of everybody living in the home.

We saw the provider recognised the need to provide care in line with people's preferences and individual needs. They had taken action to address some of the issues above. For example, the provider had commissioned an independent report and training by a specialist in dementia care to ensure that the care

provided was responsive to people's needs. One relative we spoke with told us they had seen recent improvements in the way care was provided to their relative. They told us as a result of this they had found their relative was happier and more relaxed.

We received mixed responses regarding the activities in the home. People and relatives told us external musical entertainers visited the home on a regular basis. They spoke positively about this entertainment. One person we spoke with told us, "[Musical entertainer] really is very good and that [staff member singing] is excellent." Another person said, "They have some good music; it's nice to hear some of the stuff from the 50s and 60s that I used to dance to, rather than all ancient stuff." A relative told us that one of the entertainers would visit people in their rooms and provide one to one entertainment. During the first afternoon of this inspection we observed musical entertainment in the main lounge with a professional singer and musician. Everyone we saw was engaged in the music and animated, with many people smiling, tapping their feet, clapping and singing along. We also saw one person get up from their armchair and start dancing with staff and others, when the music began. This person had previously shown little interest in mobilising or interacting with others. A member of staff also joined the musician and sang a couple of songs, which people living in the home were delighted with.

Whilst the musical entertainment in the home was well received, people and relatives we spoke with told us there was a lack of other enjoyable activities in the home and not all the activities took in to account people's individual needs and interests. One person said, "I keep myself fairly well occupied, I like to read or watch the television. I enjoy the music but, there isn't really a great deal to do here. I would like to be able to go out more; it would be nice if we could have a few outings now and then." One relative told us they felt activities were geared towards the more able in the home. They said their relative, and others in the home, sometimes struggled to join in. We reviewed the activity records for three people who spent large periods of time in their room. We saw there was a lack of activities for these people, with it often being recorded that people had received assistance with their breakfast as an activity or that people had been able to hear the musical entertainment from their room. Two staff we spoke with told us that they were very conscious of not wanting people to feel lonely or isolated and therefore tried to spend some one-to-one time with people whenever possible.

Some of the staff, and a relative, we spoke with also said that they felt people living in the home needed more personalised activities. They said they felt that, apart from the music events, the main themes for activities were 'colouring in' (arts and crafts) or people having their nails done (pamper sessions). Two care staff said they would like to see people having more support and encouragement to follow more personalised interests and hobbies. Staff said they would like certain times to be allocated when people could be taken out, even for just a walk in or around the surrounding village.

People said they could complain or raise any issues if they had any and said that they felt they would be listened to properly. One person said, "Most of the time any problems get sorted out and put right quickly." Another person said, "I don't have any complaints whatsoever. But I would just talk to the carers if I had a problem." Relatives told us they felt listened to and encouraged to provide feedback. We saw the provider and management team took concerns and complaints seriously. They had responded robustly to concerns presented to them and in a transparent manner.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection we received concerns from the local authority and local health body regarding the management of the home. We saw there were systems in place to audit and monitor the quality of the care provided. For example, we saw audits were undertaken on medicine management, care plans, and health and safety. The provider also carried out regular quality monitoring visits. These covered areas such as training, staffing, nutrition, and activities. We found the audits in place were not always effective and did not identify all the issues found at this inspection. For example, not all the issues relating to the safety of the premises and equipment in the home, meeting people's hydration needs, and the management of risks to people's safety had been identified.

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. We found at this inspection whilst the required notifications had been submitted, we found that over the past year they had been sent to the wrong address. This had not been identified by the provider and this meant we had not received the notifications required.

Our findings during this inspection showed that the provider had failed to meet the regulations in respect to safe care and treatment, nutritional and hydration needs, dignity and care, and good governance. In addition, the provider had consistently failed to sustain and make improvements where non-compliance and breaches of regulations had been identified during previous inspections. This meant the provider had failed to take sufficient action to maintain standards in the home and ensure the service was compliant with these regulations. Whilst the provider had an action plan in place to address and monitor these areas, we were concerned that this had been because the local authority and health body had identified and reported these concerns to the provider. This meant we were not confident that the systems in place were effective in identifying these issues independently.

We found the provider had failed to ensure care records contained sufficient guidance for staff. This was of particular concern as some of the staff working in the home were agency staff. Additionally we saw that some of care records were generic and others used a tick box form. For example, whilst people had care plans for how 'as required medicines' should be administered these were the same for everyone. This meant there was insufficient information and guidance for staff regarding the person's individual circumstances and how the medicines should be administered. In another case we found a risk assessment for the use of bedrails had been completed by just ticking yes or no boxes with no recorded explanation for why the boxes had been ticked. We found gaps in the records for people in relation to their wound care, fluid and food intake, and weights. One of the medicine administration records showed staff were not following consistent recording. This meant whilst staff were verbally able to provide us with explanations there was no recorded reason why as required medicines had been given or why other medicines had not. We found that people's care records were disorganised and in some places writing was illegible. This meant at times it was difficult to gain a clear picture of people's care needs and the support provided.

The above information meant that the provider was in breach of Regulation 17 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

The provider acknowledged that improvements were needed. They told us additional training had been booked for staff and they were considering the introduction of more appropriate care records to aid better recording. They had also implemented regular daily spot checks on records to help identify where improvements needed to be made. The provider told us they were reviewing their quality monitoring systems to ensure issues were identified in a timely manner so that the quality of the service would be maintained and improved.

At the time of our inspection visit a registered manager was not in place in the home. There were two interim managers who had recently started to work in the home. Prior to this inspection in January 2017 the provider contacted us regarding concerns they, the local authority, and the local health body had identified in the home. The provider told us, "There is a strong commitment at corporate and board level to put things right." We saw that the provider's safeguarding lead was basing themselves at the home and providing support. The operations director and the director of clinical governance were carrying out regular visits to the home in order to provide support and monitor the progress of improvements.

We saw a full action plan in response to the issues identified had been drawn up. We saw the action plan covered issues we identified at this inspection. The action plan showed how the provider would make the improvements required and by what date. The provider was reviewing and updating the action plan for the home on a weekly basis, to help ensure improvements were being made in a timely manner. We also saw the provider was working closely and proactively with other professionals to help ensure they were providing good quality care in line with best practice guidance. At the time of our inspection visit the action plan had only been in place for six weeks. This meant we could not judge how effective some of the actions taken were and if improvements could be sustained.

Relatives we spoke with told us they felt confident in the current management team and in the actions the provider had already taken to make improvements in the home. One relative told us there had been, "A marked improvement." Another relative said, "It's turned the corner now." A third relative told us, "I've got great faith in [the management team]."

Staff spoke positively about the management team and its leadership. All the staff we spoke with told us that things had improved a lot in the home during the last couple of months. One member of staff said, "Staff and residents are all a lot happier now. It used to feel as though the focus was all about money, rather than people getting good care. Everyone was stressing out all the time." Another staff member told us that prior to December 2016 they had felt that the home, "Wasn't being managed or overseen properly." They told us that whilst, "It's going to take a while" they had seen a difference already. They said this had resulted in happier, better supported staff, and morale had improved.

We asked how staff knew what was expected of them with regard to their care duties during their shift. One member of care staff said, "We just know what to do. We get told our allocation of the people we're looking after at the beginning of our shift [for example, the Cotman corridor], then we just get on with the routine." Staff told us that the deputies usually decided which staff would be responsible for what on each shift. However they told us that this wasn't always effective or appropriate. One member of staff told us, "The allocations of staff should be based more around staff's competency. For example, one member of staff isn't very confident or competent and they've been allocated to work with agency staff." Another member of staff said, "Our care would be vastly improved if the deputies worked more side-by-side with us on the floor. Seniors do work more closely with us, so it would be better if they did the allocations rather than the deputies."

We found the provider and management team in the home to be open, honest, and transparent. We saw that they had called a residents and relatives meeting to discuss the issues they had found at the home. Relatives we spoke with told us they appreciated this. One relative said they, "Couldn't believe how honest" the provider had been. They went on to say people were, "Encouraged to speak" and share concerns.

However, not all the staff we spoke with felt the provider and management team were transparent and honest about events in the home. One member of staff told us, "I don't know why they [management team] can't just be open and honest with us, we wouldn't act any differently. It makes us feel undervalued and not respected; it leaves us feeling like we are 'just' the carers and don't need to be included in what's going on." The management team told us they were concerned some staff felt like this and would take immediate action to address and improve this.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: people were not always treated with dignity and respect. Regulation 10 (1) (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: risks to people were not always assessed and action was not always taken to mitigate against risks. The provider had failed to ensure the premises and equipment used were safe for use. Regulation 12 (1) (2)(a)(b)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: actions were not always taken to ensure people were sufficiently hydrated. People were not always supported to eat. Regulation 14 (1) (4)(a)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. The provider

had failed to implement effective systems to assess, monitor and mitigate the risks to people using the service. The provider had failed to ensure there was an accurate, complete, and contemporaneous record in respect to people's care. Regulation 17 (1) (2)(a)(b)(c)