Care UK Community Partnerships Ltd

Priors House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection took place on 23 May 2016 and was unannounced.

Priors House is a nursing home which provides care to older people, people living with dementia and young people with physical disabilities. Priors House is registered to provide nursing care for up to 80 people. At the time of our inspection vist there were 66 people living at the home. The home provides care and support across two floors, divided into four suites. The ground floor provides residential care (Jephson suite) and care to people living with dementia (Telford suite). The first floor provides residential care (Victoria suite) and nursing care (Beaufort suite).

There was a registered manager in post. The previous registered manager left the service in January 2016 and the new registered manager had been appointed in March 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service has not previously been inspected so it was it's first inspection since being registered.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at Priors House and relatives agreed their family members felt safe and protected from abuse or poor practice.

The provider assessed risks to people's health and welfare and wrote care plans that minimised the identified risks. However, some care records and risk assessments required additional information to make sure staff provided consistent support that met people's needs.

There were enough staff on duty to meet people's health needs. The provider relied on agency staff to support existing staff and people sometimes felt on occasions they did not have continuity of care from an established staff team.

People's medicines were managed, stored and administered safely in line with GP and pharmacist prescription instructions.

People were cared for by kind and compassionate staff, who knew their individual preferences for care and their likes and dislikes. Staff understood people's needs and abilities and they received updated information at shift handovers to ensure the care they provided, supported people's needs. Staff received training that was essential to support people's needs. Staff felt they had the right skills and knowledge to support people safely and effectively.

Nursing and care staff supported and promoted people's choice and understood their responsibilities to comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records

showed consideration had been made if a persons' liberty may be deprived, as the provider had made applications to the local authority. However, there were inconsistent records for some people who lacked capacity and where they needed encouragement with those decisions to ensure decisions were taken in their best interests.

People were offered meals that were suitable for their individual dietary needs and personal preferences. People were supported to eat and drink according to their needs, which minimised risks of malnutrition. Staff ensured people obtained advice and support from other health professionals to maintain their health.

Care was planned to meet people's individual needs and abilities and care plans were reviewed although some information required updating to ensure staff had the necessary information to support people as their needs changed. People were supported to pursue their interests and hobbies and live their lives how they wished, and staff supported people to remain as independent as possible.

The quality monitoring system included reviews of people's care plans and checks on medicines management, but some of those reviews did not identify the issues we found. Accidents, incidents and falls were investigated by the provider and actions taken to minimise the risks of a re-occurrence. Improvements were required in monitoring people whose health conditions posed risks to them and the management and deployment of staff, to ensure safe levels of care were maintained to a standard that supported people's welfare.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered, recorded and stored safely and were given in line with their prescription or GP instruction. There were enough staff to keep people safe and staff understood their responsibility to report any observed or suspected abuse. Staff supported people who had been identified as at risk but this was not always reflected in peoples' care records.

Is the service effective?

Good

The service was effective.

People were involved in making day to day decisions about their care and support needs. Where people did not have capacity to make decisions, support was sought from family members and other professionals in line with legal requirements and safeguards. People received support from a staff team that were trained to meet people's needs. People were offered meals and drinks that met their dietary needs and were referred to other healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate towards people who felt confident asking staff for support. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by encouraging them to make their own day to day decisions and to live they lives how they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People said staff knew and understood their personal preferences and how they wanted to spend their time. People took part in a range of activities that kept them physically and mentally involved. However staff's knowledge of how they

supported people was not always consistent and the recording of people's health needs was not always reflective of the support they received. People told us they knew how and who to make a complaint to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We received mixed responses from people and staff about leadership within the home. Some people and staff spoke positively about it, others did not feel supported by some of the senior staff, especially those responsible for shift management. Some staff felt their concerns were not always listened to. There were processes that checked the quality of the service such as regular checks, meetings, surveys and quality audits and improvement actions were monitored.

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

This inspection took place on 23 May 2016 and was unannounced. The inspection consisted of three inspectors and one specialist advisor. Our specialist advisor was a qualified nurse and a specialist in dementia, mental health and end of life care.

Before the inspection visit, the provider completed 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. During the inspection, we gave the provider, registered manager and staff opportunity to let us know what they do well, and what areas they had identified to improve and focus upon. The PIR was mostly reflective of what we found on the day, however some examples of how people with dementia were supported within the environment, were not being completed or were not yet in place.

We reviewed the information we held about the service. We looked at information received from other agencies involved in people's care. We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with the local authority before this inspection but they did not share any information with us that we were not already aware of.

We spent time observing the care people received from staff in the lounges and communal areas of the home. We spoke with 16 people who lived at Priors House, one visiting relative and a friend of a person living at the home. We spoke with one nurse, two unit managers, one team leader, a dementia care lead and eight care staff who provided care to people. (In the report we refer to these as staff). We spoke with other staff who supported people, such as an activities co-ordinator, a receptionist and a housekeeper. We also spoke with the registered manager, a regional director and an operations manager. We reviewed 10 people's care plans and daily records to see how their care and treatment was planned and delivered, as well as 15 people's medicines records. We checked whether staff were trained to deliver care and support appropriate

to each person's needs. We reviewed the provider's quality monitoring system to see what actions were taken and how these were monitored to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at Priors House and said they received the care and support they needed from staff. People said staff made them feel safe and at ease and were not worried when asking for help. One person told us, "They make me feel safe because I trust them all." Another person said, "The hostesses are great, anything I need I get."

Staff knew and understood their responsibilities to keep people safe and protect them from avoidable harm. Staff understood what abuse meant and what to do if they suspected someone was at risk. Comments from staff included, "I would bring it to the manager's attention and if the situation was being caused by the manager, I would go to the head office or report it to safeguarding and CQC", "Safeguarding is keeping people safe, protecting people." Staff had received training in safeguarding adults and staff told us their training had been refreshed to keep their skills and knowledge up to date. One staff member said they found the training useful because, "We worked through scenarios." They told us some scenarios identified specific areas, such as, "Neglect, bruising, shouting at people." The registered manager was aware of safeguarding procedures and described the actions they would take in the event of concerns being raised with them. They said if any staff member had caused a person harm, "I would raise a safeguarding incident, tell you (CQC), and call the police if necessary." Our records showed the provider had correctly notified us when safeguarding concerns had been raised.

Staff understood how to manage identified risks associated with people's care, for example how to reduce the risks of skin damage to people, how to transfer people safely and keep people safe in bed. For example, one person was identified as being at risk of falling from bed. Assessments had been carried out that demonstrated bed rails would pose a greater risk to this person's health. A 'hi low' bed (a bed that can be raised or lowered to reduce falling from height) was used to minimise the risk of injury and this was the person's preferred choice. A unit leader told us about another example where risks to people and staff's health and welfare had been identified and acted upon. We were told one person recently made accusations against staff behaviours. These accusations had been investigated fully and were found to be unsubstantiated and were due to the person's condition. To minimise the risks, it was decided two staff provided care and support to this person. We were told this action helped protect staff and ensured any further allegations would be witnessed by more staff, so prompt action could be taken if required. In both these examples, staff knew how to manage those risks, but care records were not consistently completed that explained why changes in people's care had occurred, and what staff were required to do. The registered manager gave us assurance these would be reviewed.

The majority of people told us they felt there were enough staff, as staff supported them promptly when they rang their call bells for assistance. We heard call alarm bells ringing during our inspection and with one exception, call alarms were answered and responded to in a timely manner. Comments people made were, "Staff come quickly if I press my buzzer", "If I push my call button they come within a minute" and "I get up at 6 am and press the call button for a shower. They are quite quick but if they are delayed they come and let me know." People living on the nursing suite (Beaufort) and a visiting friend said they felt there were not always enough staff to support them. One person said, "They are a bit thin on the ground sometimes,

especially at weekends." They said this sometimes delayed staff providing assistance when they needed it.

People told us the home was supported by a high number of agency staff which meant they were not always supported by the same staff. However, people said this had recently improved because the provider had completed a successful recruitment campaign that reduced the use of agency staff. Staff across both floors confirmed this and said this would improve staff continuity at the home.

Staff felt there were enough staff, but if people's needs changed, they felt it was not always possible to provide the levels of care they required, although they said people remained safe. One unit lead manager told us staffing was "Generally good." However, they told us about a particular person who had high physical and mental health needs that required the support of two care staff at all times when they received care. They said this person was, "Having a 'bad' day today, so 'borrowed' one staff member from Telford (dementia suite) for the day. Staff told us if they were redeployed to where the greatest need was at short notice, this sometimes impacted on the other staff team as they were one short. This happened during out visit when one staff member supported people in another suite. We found no examples where a temporary decrease of staff in one suite impacted on the safe care people received.

The registered manager was confident staffing levels met people's needs and this was supported by the regional director. The regional director said they used dependency tools to review and calculate staffing levels. They were confident levels met people's needs and if needs changed, staffing levels and dependencies were reviewed. The regional director said, "If we need extra staff, we can look at it, increase staff then if it's permanent, we get it signed off." The registered manager said high agency use meant people did not always receive care from consistent staff but was confident when new staff started, this would improve consistency and reduce the need for agency staff to cover at short notice, and minimise staff being reallocated at short notice.

To minimise potential for medicines errors, only nursing or trained staff administered medicines to people. The nurse and registered manager told us they had assessed staff to ensure they remained competent to support people with their medicines. Each medicine record had a photo of the person to confirm their identity which staff said helped ensure medicines were given to the right person. Medicines delivered in boxes and liquid form, were kept in a locked cupboard and liquids were marked with the date the medicine was first opened, to ensure they were administered or disposed safely. We checked topical cream applications and found completed body maps that told staff where the cream was to be applied, however we saw some gaps in the recording. The nurse was confident topical creams were being applied, however the records required improvement to demonstrate consistency with their application, in accordance with people's prescriptions.

We looked at 15 medicines administration records (MAR). These records were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Staff recorded when medicines were not administered and the reason why not. For example, if a person declined to take them. Protocols for medicines that were to be given as required were in place and recorded in what circumstances they should be given and important information such as the maximum dosage within specified timeframes. We checked the clinic room, controlled drug storage, administration of controlled drugs, medication trolleys, refrigeration temperatures and disposal of medications. Medicines were being administered, recorded and disposed of safely.

Good

Is the service effective?

Our findings

People told us they were pleased with the support they received from staff and felt staff had the skills and experience to care for them. One person said they felt confident with staff's abilities because in their opinion, "They all try their best; they are willing to help me."

Staff were satisfied with the quality of the induction process when they started work at the home. Staff said the induction process helped them because they received essential training and support from more experienced staff. The induction was linked to the Care Certificate which provides care staff with the fundamental skills they need to provide quality care. One staff member told us their induction included, "Shadowing other carers (care staff). I have completed some training and I have work books to go through. The unit manger signs this off when I am competent." They told us they had a 'buddy' and said this was, "Great because I have someone to support me if I am unsure about something."

Staff told us they received the training and support they needed to carry out their roles effectively. One staff member told us, "I have had enough training; it's both face to face and on the computer." We asked if they found it useful and they said, "Yes it's good. If it's a quiet time we can log on and complete some training. I have had mental capacity training. It was good, I understand people must make choices for themselves and I must ask before I help anyone." We saw staff put their training into practice, for example supporting people with choice, independence and mobilising people safely, using necessary equipment to transfer safely.

Staff told us they were trained to support people living with dementia or other cognitive impairments. Staff recognised some people's memories were limited and used reminiscence, old photographs, people's life histories to help stimulate people's previous experiences to get people engaged, or to purse their interests. Staff provided support at the person's pace, recognising everyone's abilities were different.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

Speaking with nursing and care staff, we found they worked within the principles of the MCA. Staff recognised the importance of seeking consent, regardless of people's capacity, before providing any care or support. People we spoke with told us staff recognised they wanted to remain independent, which included making their own day to day decisions. Staff gave us examples of how they sought consent and how they made sure people had consented before any care was provided. Staff understood the need to provide people with choice where possible and if they could not, staff encouraged people and told people what they were doing, whilst giving people choice. One staff member explained how they supported people with limited capacity. They said, "I would try and find out why they were refusing and maybe ask someone else to

help." They said if people became anxious they would, "Let them calm down, some people don't always want comfort so I try and offer reassurance." They said if people's behaviour became unpredictable, "I would report to the unit manager if it kept on happening." They said they would seek support from other healthcare professionals to see if there were underlying medical reasons why behaviours had changed." Staff told us they had received training in the Mental Capacity Act 2005 (MCA) and we saw this was evident in how they supported people through choice.

We saw mental capacity assessments or decisions that determined where people lacked capacity, were not always recorded or consistent with what staff told us. The unit manager recognised improvements were required to ensure staff had the necessary information so they provided the right levels of support and encouragement. People, their family and appropriate healthcare professionals were involved in best interest meetings to decide what actions would be taken.

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).The registered manager understood their responsibilities under the legislation. Where people needed restrictions to keep them safe and protected, records showed people's capacity to make decisions had been assessed and where needed, DoLS had been authorised where restrictions on people's freedom were needed to keep people safe from harm.

Most people were complimentary about the food. Comments made were, "There is quite a good choice. If you really don't like the choices you can have an omelette or something flavoured to your choice", "It is variable. Some very good, some indifferent." They added, "You get two choices. You can choose something else. I believe there is new systems where you can have any dish you want any time of day. I haven't tried it yet." This person showed us a laminated card telling people they could choose any food at any time of day, and advised them to ask staff for this. There was a list of food items which were always available. One relative said, "The food is nicely served. It is like being at home. You don't have to sit at the table. You can sit in your room if you want to."

We spent time overseeing the mealtime experiences for people on the dementia suite (Telford), and the residential suites (Victoria and Jephson). We found people had different experiences. For example, on Victoria people chose what they wanted and staff had time to sit with people. There were good interactions and laughter and people were encouraged to have more food if they wanted to. One person preferred sandwiches and they had their preferred choice.

However on Jephson and Telford, people received a different service. On Telford, we did not see people offered a plated option, to make their choice. This is important for people living with dementia because visual and sensory stimulation can help people make choices, rather than relying on their memory which may be impaired. Some people were told what their meal was, others were not. We saw one person put their vegetable soup into another person's apple juice. Staff noticed the first time, and replaced the juice, however the same person did it again without staff noticing, so the person continued to drink it. On Jephson, menu cards stated different choices to what was provided so staff told people what the two choices were, and people made a choice from this. We spoke with one person on Jephson and asked them what they thought about lunch. They said, "I choose to have my breakfast in my room and the other two meals here in the dining room." They added, "I asked for tuna salad and fruit salad at dinner time (they got this choice). It is very nice." The regional director was told about the varying approach to mealtimes and said they were disappointed with our findings but agreed to seek improvements to the standards the provider expected.

People, who required it, were supported to eat their meals in their room, assisted by staff. We saw one staff member assisting someone in their room. There was lovely interaction and ongoing conversation from the staff member who sat by the persons' bed. The staff member was patient and supported them to eat at a pace comfortable to them.

Throughout the day we saw staff offered people a choice of hot or cold drinks. Staff knew which people required their drinks thickened to reduce the risk of choking. People had access to kitchenette areas within each suite so they could make their own hot or cold drinks if they wished, thus retaining levels of independence. These areas also contained stocks of fruit juices and pre made chilled sugar free fruit drinks that people could help themselves to. Snacks such as fruit, crisps and biscuits were available should people want a snack throughout the day.

Staff told us people where weighed monthly but if identified at risk, people were weighed more regularly. Staff told us if their weight caused concern, support from other health care professionals would be requested. One staff member said if a person lost weight, "I would report it to the manager, and the General Practitioner would be informed of this to refer onto the local dietician services".

People's healthcare was monitored and health professionals involved where necessary, such as speech and language therapy and dieticians. People had access to a GP who visited the home every week. Staff told us the GP was available for advice and would visit the home when required, usually within a short response time. Records showed that people were supported to attend routine health appointments to maintain their wellbeing such as, chiropodist and optician.

Good

Is the service caring?

Our findings

People on both floors were complimentary about staff who supported them in a caring way. People and a relative spoke positively about the staff, their caring attitudes and the care they provided. Their comments included, "They are all caring", "They all try their best; they are willing to help me", and "They (staff) leave the door open and pop in and say hello when they walk past." People told us the support they got from staff made them feel 'as though someone cared about them'. One person told us they felt well cared for since they moved into the home short term. They said, "I came for respite and decided to stay because the staff are kind." A relative and a visitor told us that when they visited they were welcomed by staff. They said, "There is never any problem with family visiting. They are very flexible. There is no problem with visiting."

People said they liked knowing family and friends could visit without restriction and people had access to communicate with them in a variety of ways. Some people told us they had a telephone in their rooms which meant they could speak with people important to them, whenever they wanted.

People said staff were patient and supported them at a pace they preferred. People said the qualities staff had, showed them they cared about people and how they felt. Comments people made to us were, "The carers (staff) are patient beyond belief", "They (staff) are very good, very patient and very friendly. Staff behave as if they enjoy their jobs." Another person gave us one example that demonstrated staff's caring approach. They explained, "They (staff) have endless patience. I emptied my water all over myself once. I called them (staff) and they said 'never mind, we will soon clean that up.'"

Staff understood the importance of caring for people and we asked them 'what does good care look like'. Staff said good care meant, "Respecting people, being polite", "Listening to them, being patient", "Going the extra mile… taking the time to sit and talk with people to get to know them" and "Treating people how I like to be treated." Staff understood professional boundaries, yet still cared for people in a supportive and nurturing way. People we spoke with confirmed staff provided care to them in line with these comments.

Staff told us they enjoyed working at the home. We asked staff what was good for people living at Priors House. Comments made were, "It's a lovely environment", "Person centred care", "People are individuals" and "Morale and teamwork is good (Victoria Suite). We are happy bunnies".

Staff knew people's preferred names and addressed people as they preferred, whether first names or other names they were known by. Staff spoke with people in a positive and respectful way. In all suites, people were relaxed and at ease with each other and staff. Interactions between staff and people were sociable and friendly. Staff supported people to be as independent as possible and assisted people to do the things they wanted to do. For example, one person enjoyed sitting outside on the garden bench, admiring the view. We sat with them outside and they said, "it is beautiful. I love to come out most days. We are very lucky with the fields and horses to look at."
Some people chose to spend time in their room, either through choice or because they were cared for in bed due to their health. People said staff checked to ensure they were okay.

We observed a number of interactions between people and staff. These were all positive, staff took time to engage with people and they responded positively. Staff seemed to know people well and could share jokes with them, people seemed familiar with staff and were happy to chat and laugh together. One person told us when staff spoke with them and supported them, their approach made it easier for them to ask for help. They said, "They don't look down on you. It is just from one person to another." People's bedrooms were individually furnished. For example, people furnished their rooms with personal items such as furniture, pictures, photographs and other personal memorabilia. People said this made it feel 'like a home from home'. One person told us, "I think it (Priors House) is great. It is like home. Very friendly. The staff are nice." They added, "It is my home now until I die. It is very nice."

Throughout the day people were able to make choices about day to day living such as what they wore, how they lived their lives and what they wanted to do. Where people had chosen to remain in their rooms or sit in a particular area, their choice was respected. When staff talked to people they demonstrated they had a good knowledge and understanding of individual people

Most people we spoke with were able to express their views and opinions so we asked them if they were involved in their care decisions. Some of the people we spoke with had not been involved in how their care plans were designed around their needs but people were satisfied with the levels of care provided. Some people told us family members were involved in care planning decisions.

Staff respected people's privacy and dignity and they understood people's need for personal space and privacy. Staff knocked on bedroom doors and waited for permission to enter. People said staff were respectful, a typical comment was, "Staff are respectful and polite". When people required assistance with their personal care, staff managed this discreetly and made sure all doors were closed. Staff told us they supported people in line with their personal care routines and wishes. Staff said some people enjoyed a shower, although for some, this took time. One staff member said it was not a problem. They said, "To help someone in the shower it can take an hour but it takes as long as it takes; if people can do things for themselves I let them."

Requires Improvement

Is the service responsive?

Our findings

People told us they were generally happy with the support they received from staff and were complimentary about the staff who provided their care and support. One person said, "The staff are very good, caring and even though I can do somethings for myself, sometimes you are tired, they (staff) help."

People told us there were occasions when staffing were not always responsive to their needs, which had some impact to their daily routine. For example, we spoke with one person who enjoyed sitting in the garden. They told us they had been waiting for a staff member to unlock the door. They explained this frustrated them, saying, "I can't do some things, like open this door (door to garden). You have to find someone, sometimes you wait." They told us they had asked staff, but said, "Staff are too busy, they haven't got time, it's frustrating." They told us it happened throughout the week. In the end, we asked a staff member to open the door as an external latch needed to be raised before people could access the garden.

Other people told us staff in some suites were not always able to respond to their needs, and we saw examples where staff were not responsive. For example, on Jephson suite one call alarm bell sounded for six minutes. We went to the room and the person said, "I want to go outside." We spoke to the unit manager and they arranged for a staff member to take the person out into the garden. We asked why the call alarm bell was not answered. They told us someone (staff) had been in to the person but the, "Buzzer had not been switched off." The person told us no one had been into see them before us.

During our visit we saw one person was in bed asleep (door open) for most of the day. At 15.55 we spoke with the unit manager to see if this person stayed in bed because of their health condition. The unit manager said [name] had been having sleepless nights for the past month. We were told the person was now being assisted with a shower and staff had given them a drink and something to eat. We asked if this person had been referred to the GP to establish why they had become restless. The unit manager told us they were sure it had, but there was no record of a referral. They told us it would be in the 'GP book' but was unable to find an entry. We asked for a copy of the GP book entry to be sent to us. The registered manager agreed to send it to us, but we did not receive a copy.

We looked at 10 care records and found some care records did not have sufficient detailed information that provided staff with the information they needed to know. Staff had good knowledge for some people, but for those people with more complex care needs, staff gave us inconsistent feedback. For example, one person's care plan showed they had epilepsy and were prone to seizures. There was no detailed management plan to monitor and manage the seizure. One seizure record stated 'When [person] has a seizure [person] will be immobile for short periods of time as [person] needs to sleep (no time period stated).' We asked staff what they believed a long seizure was and were given conflicting information. Records showed this person had suffered two seizures this year. This person's last seizure occurred on 20 May 2016 and lasted for a few minutes. Records and staff told us they had been asleep since the last seizure occurred three days ago. Staff told us they monitored the person following this seizure. We found a previous seizure occurred on 15 March 2016. Records stated 'Suspected seizure this morning…999 called as non-responsive, was unconscious for 30 minutes but breathing.' Speaking with staff showed there was no

consistent timeframe when emergency assistance or interventions of care would be called.

There was no information for staff that told them what this person's seizures looked like or what assistance staff should provide during an episode. Staff gave us differing accounts such as, "[Person] shakes" or "[Person] goes in and out of being conscious." We asked staff what action they took if this person had a seizure, "I would tell the nurse and we monitor [person]." We were told the nurse would make a clinical decision as to whether medication needed to be administered. We checked the medicines that would be administered in the event of a seizure. The medicines record stated, 'Medicines to be administered after long seizures', but there was no information available that described a time length for a long seizure.

There was no evidence available that showed the person had been placed on fluid or food charts, since their last seizure had happened, three days previously. We asked the staff members what diet or fluids the person had consumed during the last 24 hours. One member of staff reported, "He had a bit of food yesterday", another staff member said, "I am not sure, you will need to ask the unit manager." This meant there was insufficient information and knowledge to ensure that the person remained hydrated and nourished..

Other care records sampled did include detailed information about people, their previous backgrounds, personal preferences and people's levels of communication. Where people had certain conditions such as Parkinson's, dementia or who were at risk of falling, care records provided staff with the information they needed. For example, one care record stated a person was blind and described how staff should support and approach that person, without causing them anxiety or frightening them.

Staff told us some of the inconsistencies was due to records being recorded in written form, and electronically, and sometimes this prevented them corresponding with each other. The unit manager told us daily records were entered on to the electronic system and paper daily records were only used if the system was not working or if staff did not have access to the system (agency staff). We asked if the paper records were then added to the provider's electronic system. The unit manager said they were not. This meant two systems were in place and there were no effective checks to ensure care records accurately reflected the right levels of support people needed.

Priors House was a purpose built home that specialised in providing dementia care. The provider's own website stated, 'We understand that people living with dementia have specific desires and needs so we have designed our care homes and gardens with this in mind'. The home was dementia friendly in its layout, design and access. Clear signage helped people and staff navigate around each unit. Corridors had framed pictures and other items such as textiles, scarves, handbags, locks and handles that people could touch and hold. On one of the corridors, a shop had been set up that sold items such as sweets, chocolates, shampoo and body wash. We were told a person living at the home occasionally worked at the shop to help sell items. There was a 1950's inspired lounge area but we were told people did not usually use this room. The home also had a cinema and people could watch a movie without restriction. Staff said, "People could take a ticket and watch a movie, with popcorn." During our inspection, no one used the cinema although it was used for group activities, family gatherings and during our visit, a music activity for people took place there late afternoon. The activities co-ordinator told us, "I try to have something on the screen all the time as it is more inviting. I make DVDs of film trailers. Care staff assist me by telling me someone wants to watch a film." They told us they incorporated 'movie nights' into the planned activities schedule.

People said they enjoyed the range of activities and that the activities they did, met their needs. Comments made were, "The care workers take me out into the gardens in my wheelchair" and "Activities are good, plenty of things for everyone." One relative (of person on nursing unit) said, "They try and encourage (name) to join in with things. It is so important to get out. They have a mini bus." They added, "They have been out

to the transport museum, to garden centres, things like that." One person told us they had recently had a manicure which they enjoyed. They said their son visited them weekly and they went out together which they also enjoyed. We were told the provider had a mini bus that could take people out on trips. There was a coffee shop that provided a relaxed atmosphere for people and family to sit and enjoy.

We asked one staff member what they thought about the quality of dementia care provided. They said there was room for improvement, especially with staff having time to 'engage people'. They told us, "I would like to see one extra, it would make a difference." They said with current staffing, "The girls (staff) are just doing the physical, meals, washing, dressing. We need to do more meaningful things for people like sewing, flower planting, baking cakes." We were told some of this happened, but only when staffing levels allowed. They said, "I can't get involved all days." They told us some people living with dementia could become challenging to others or at risk of falling. They said staff supported people to remain calm and safe, however on occasions, this prevented staff getting equipment to move others. They said this meant some people sat in the lounge longer than they wanted because of staff response times which sometimes caused them or others to become anxious or unsettled.

There was a strong emphasis on people remaining independent with their personal care as far as possible. Staff said this was important because it gave people control over what they wanted to do for themselves. Staff said they referred to care records and found daily 'handover' provided them with useful and relevant information to help meet people's needs. Staff said this was important, especially if they had been off or if people's needs had changed since they last supported them. However, care records did not always reflect people's current needs which meant staff did not have the information they needed.

People told us they would talk to staff if they had a concern or complaint .Everyone we spoke with said they had not made a complaint about the service. The provider's complaints policy was accessible to people which informed them how to make a complaint and how to pursue it if they were not satisfied with their response. Records showed formal complaints had been responded to in accordance with the provider's policy and to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People said the atmosphere in the home and the support they received from all employed staff was good. People said Priors House felt relaxed and 'homely'. One person supported this, saying, "This is a happy place and the cleaners are as jolly as the carers (care staff). They are part of my company, and the 'tea ladies'. It is a very friendly place." A relative we spoke with said of the home, "The ambience is lovely and it is run very smoothly and professionally."

The registered manager had been in post since March 2016. Most of the people we spoke with told us they did not know who the registered manager was. People knew the previous registered manager had left, but not everyone knew who had replaced them. Comments made that supported this were, "The old manager used to come in regularly to talk to you, but I haven't spoken to this new one", "I have met the new manager in passing by my room, but not to talk to" and "The new manager came to see us in the dining room. But I don't really know her. The last manager was very nice, a jolly person."

Staff (care staff, team leaders, unit managers) were supportive and complimentary of the registered manager and staff felt supported by them in their roles. Staff said the registered manager was approachable in relation to any ideas they had that improved the service, and any support they needed. One staff member told us the registered manager gave, "Brilliant support personally", had a, "Very open door and you can go in any time and be given guidance." Another staff member said, "The level of support is great, it's a lot better than other homes I have worked in. The manger (registered) is brilliant." Staff understood the leadership structure and lines of accountability within the service; they were clear about the arrangements for whom to contact out of hours or in an emergency situation.

Some staff gave us mixed opinions about the support they received from unit managers and staff said personalities and communication, meant some shifts did not always run smoothly. For example, one staff member told us they asked their unit manager for some advice regarding a person's care, and how it was to be delivered. They said communication between care staff and their unit manager, "Was not good, and that the attitude of the unit manager was 'poor'." They told us, "Sometimes if you ask why a person needs something done a certain way, the unit manager will say, "It doesn't matter, it doesn't concern you." Some staff said this had a negative effect on them. We asked the registered manager about this. They said the home had experienced a high number of staff vacancies and had to use a high number of agency staff, which could affect staff morale. The registered manager said they had recently completed a successful recruitment drive and believed they would have a more stable and consistent team which would benefit people living and those working at the home. They told us they were aware improvements within the staff team were required and had plans to address this, such as increased one to one supervisions and impromptu observations of staff practice. They assured us any poor practice would be addressed.

Another staff member (non care staff) told us they felt their views or opinions did not count, especially when connected with people's care. They gave us an example where they spoke with a unit manager about a person who had been sleeping, and whether they had anything to eat or drink. They told us, they knew this person had an unsettled night, but felt when they asked the unit manager, their response indicated that 'I

was not worthy' of knowing what was happening with this person as they were non care staff.

During our visit we saw the management of important information was not always effective. For example, we asked to see records of GP visits and we were told a 'GP book' was kept, however this could not be located. We asked for copies to be sent to us following our visit. We did not receive the GP entry records we asked for.

We looked at other examples of records and found inconsistencies with the quality and inputting of records. For example, daily log records for the monitoring and effective management of seizures did not match, which meant there was an unclear picture of what had happened and timescales. As the person was in bed, they were required to be repositioned every four hours during the day, and to be repositioned every two hours during the night to reduce potential for skin breakdown. We checked examples of repositioning records and found they were not completed at the correct time intervals and there were no effective checks in place to ensure they were completed and turned when required. Another person's care records showed they were resistant to personal care but there were was no information that told staff how they supported this person. Some staff told us they did not always have access to the electronic system, so written care plans were printed for staff to refer to. We found examples where written care plans had not been printed for staff to consult for guidance. Unit managers told us they were not, and could not guarantee people's important information was to hand. This meant there was no effective record management to ensure consistent levels of care and recording supported people's needs.

People told us they were able to share their concerns and feedback. The provider sought this from annual quality surveys and people and relatives meetings. We saw minutes of the last meeting held in April 2016 where people made suggestions for improvements. This was put into an action plan called, 'You said, we did'. Positive action was taken, such as setting up cookery lessons, improved signage for the cinema and napkins at mealtimes.

The regional director and operations manager explained the provider's audit system. They said the registered manager completed weekly and monthly audits and combined all the action plans in to one 'Service Improvement Plan'. The registered manager told us, "It is easy to follow one main plan, rather than a lot of action plans, I know what needs doing." We checked this action plan and found where a concern had been signed as completed, action had been taken. The regional director said incidents, accidents and serious events were monitored at location and provider level to identify any trends or emerging patterns. They told us there were no concerns at Priors House and this was something they reviewed on a regular basis.

The operations manager and regional director told us they did regular visits to the home and checked progress against the service improvement plan, as well as their own checks such as recruitment, health and safety and care plans. The regional director said, "We do what you do, we turn up unannounced, check certain areas in line with the ratings." They also told us the provider checked action plans and quality across the organisation and if key themes emerged, internal quality teams could visit and complete their own audit to establish any patterns or emerging trends. The regional director said of Priors House, "This is one of my strongest homes." Some of the provider's audits had not identified some examples in inconsistency of records. When we fedback some of the concerns we found, they assured us they would take the necessary actions to improve and ensure people received a service that was safe, effective and that responded to personal needs.

The provider met the requirements of the regulations such as, having a registered manager in post and they understood their legal responsibility for submitting statutory notifications to the CQC, such as incidents that

affected the service or people. The provider submitted their PIR before the required deadline and we found most of what was included, was reflected in what we found.

The provider planned to open their doors to the public on 17 June 2016 as part of National Care Home open day. The home planned a celebration for people and relatives who used the service and it provided members of the public a chance to see the standard of care and support people received. Priors House had a 'Top 20' award recommendation within the organisation, as an acknowledgement of the care provided.