

Sanctuary Care Limited

Shaftesbury House Residential Care Home

Inspection report

5 Cowper Street
Ipswich
Suffolk
IP4 5JD

Tel: 01473271987

Website: www.sanctuary-care.co.uk/care-homes-east-and-south-east/shaftesbury-house-residential-care-home

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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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Shaftesbury House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service does not provide nursing care. Shaftesbury House accommodates up to 28 older people in one adapted building.

There were 26 people living in the service when we undertook this comprehensive unannounced inspection on 27 November 2017.

There was not a registered manager in place. 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. There was a new manager working in the service and their registered manager application was being processed at the time of our inspection.

This service was rated as Good at our last inspection of 9 November 2015. During this inspection of 27 November 2017 we found that the service had not sustained the previous Good rating. The overall rating was now Requires Improvement. The key questions Safe, Effective, Responsive and Well-led were rated as Requires Improvement. We found a breach of Regulation 12; Safe Care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Caring was rated as Good.

Improvements were needed in people's care plans to identify how people were provided with person centred care which was tailored to meet their specific needs. There were some inconsistencies in care records which needed attention to ensure that staff were provided with the most up to date guidance on how people's needs were met. The new manager and the regional manager had identified improvements needed in the care plans and had an action plan in place to address this. However, this was not yet fully implemented.

There were systems in place to provide people with their medicines, which were prescribed to be administered orally safely. However, improvements were needed in how staff recorded when people had been provided the medicines that were prescribed for administration externally, such as creams. This includes the application of barrier creams, used to reduce the risks of pressure ulcers. The records for when people repositioned did not identify that guidance in the care plans had been followed.

The ways that the service assessed risks to people and actions taken to reduce the risks required improvement to provide people with safe care at all times.

People's nutritional needs were assessed. However, the systems in place for monitoring what people had to eat and drink were not robust.

There were systems in place designed to keep people safe, this included appropriate actions of reporting abuse. Staff were trained in safeguarding and understood their responsibilities in keeping people safe from abuse. However, there had been an incident which had not been reported appropriately until we had advised the service to do so.

The environment was clean and hygienic and there were infection control systems in place. However, there was a toilet in the lounge area, which was open plan with the dining room. The door to the toilet opened into the lounge. This was a potential risks to infection control and was not respectful of people's privacy. There was a programme of refurbishment and redecoration in the service planned.

There were some staff vacancies which were being covered by existing staff and agency staff. The service was actively recruiting to these vacant posts. Recruitment of staff was done safely and checks were undertaken on staff to ensure they were fit to care for the people using the service.

Staff spoke about people in a caring and compassionate way. People had positive relationships with the staff who supported them. People's views were listened to, valued and used to plan and deliver their care.

People were supported to see, when needed, health and social care professionals. The service worked with other professionals involved in people's care to improve people's lives.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with the opportunity to participate in activities that interested them.

People's views were listened to and acted upon relating to their end of life care. There were systems in place to support people to have a pain free and dignified death. However, a fault in a pressure relief mattress for one person was not supportive of this practice.

There was a system in place to manage complaints and these were used to improve the service.

Where incidents had occurred the service had systems in place to learn from these and use the learning to drive improvement in the service.

There were quality assurance systems in place which assisted the provider and the manager to identify shortfalls and address them. Where shortfalls were identified there were plans in place to address them to improve the service people received. However, these were not yet fully implemented to ensure that people were provided with good quality care at all times.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Improvements were needed in how people were provided with their medicines prescribed for external use, such as creams.

Improvements in staffing numbers were ongoing to ensure that there were enough staff to meet people's needs safely. The systems for the safe recruitment of staff were robust.

The systems in place designed to minimise risks to people and to keep them safe from abuse and harm required improvement.

There were systems in place to reduce the risks of cross contamination. However, the location of a toilet was a potential risk to infection control.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

Staff were trained and supported to meet the needs of the people who used the service.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. However, the systems in place to monitor if people had enough to drink were not robust.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

The service worked with other professionals to provide people with a consistent service.

The Deprivation of Liberty Safeguards (DoLS) were understood and referrals were made appropriately.

Requires Improvement ●

Is the service caring?

The service was caring.

Good ●

People were treated with respect and their independence was promoted and respected.

People's choices were respected and listened to.

Is the service responsive?

The service was not consistently responsive.

Improvements were needed in how people's wellbeing and needs were planned for to ensure their individual needs were being met. There were plans in place to make these improvements but they had not yet been implemented.

People were provided with the opportunity to participate in meaningful activities.

There was a system in place to manage people's complaints.

There were systems in place to support people to have a pain free and dignified death. However, a fault in a pressure relief mattress was not supportive of this practice.

Requires Improvement 

Is the service well-led?

The service was not consistently well-led.

There were quality assurance systems in place which helped the provider and manager to independently identify shortfalls. The manager was fully aware of improvements needed and these were in progress but not yet fully implemented.

Requires Improvement 

Shaftesbury House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was 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 unannounced comprehensive inspection took place on 27 November 2017 and undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service including the previous inspection report and notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. We asked for feedback about the service from the local authority and the clinical commissioning group.

We spoke with eight people who used the service and four relatives. We observed the interaction between people who used the service and the staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service with us.

We looked at records in relation to five people's care. We spoke with the manager, the care development manager, a regional director and five members of staff including care, activities, domestic and catering staff. We looked at records relating to the management of the service, three staff recruitment files, training, and systems for monitoring the quality of the service.

Is the service safe?

Our findings

Safe was rated as Good at our last inspection of 9 November 2015. At this inspection of 27 November 2017 we found that Safe was now rated as Requires Improvement.

The ways that the service assessed risks to people and actions taken to reduce the risks required improvement to provide people with safe care at all times.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risk associated with mobility, pressure ulcers, nutrition and falls. Where people had falls there was a system in place to refer them to the falls team to gain guidance on any actions the service could take to minimise these. Discussions with the manager confirmed feedback they had received about a recent referral. One person's records showed that where they had falls these had been assessed and checked to see if there were any patterns which would assist the assessment to identify how to minimise the risks. Another person's records included information on two falls which they had experienced on consecutive days and had identified a possible pattern. Their care plan or risk assessment had not been reviewed and updated to reassess the risk to this person in order to mitigate potential reoccurrence.

Where people were at risk of developing pressure ulcers systems were in place to reduce these and this included seeking support from health professionals. Care records identified how the risks of pressure ulcers developing or deteriorating were reduced. One person's records stated that staff should monitor their skin integrity and seek medical advice if there were issues. Another person's records advised staff to monitor their skin condition. However, there was no further guidance in place to show what staff were monitoring, what the warning signs were and how they would be aware of changes in these people's skin. Another person's records stated that they should be assisted to reposition two hourly in the day and four hourly at night and their air mattress should always be inflated. There was no guidance in place to assist staff in the event the person should be sleeping and their repositioning records for the day of our inspection showed a gap of six hours during the night. The person was supported to turn at 4am and the next entry was 10:05am. We could therefore not be sure that the person had received the support they needed in order to reduce the identified risk.

Two people's records included, 'Mattress and pump daily check list,' to show that pressure relieving equipment was checked and working. None of these had been completed on a daily basis. One person's records from 30 October 2017 to the day of our inspection showed that checks had only been recorded for seven days over this 27 day period. This put people at potential risk of developing pressure ulcers.

Another person's pressure mattress was sounding an alarm to check the pressure. The care development manager told us that a part had been replaced on 24 November 2017 but this had not remedied the situation and that they were awaiting a visit from an engineer on the day of our inspection. The last day of the check for the pressure mattress had been recorded on 20 November 2017. This had not identified the problem with the pressure mattress and the subsequent actions taken. The manager wrote to us the day after our inspection to advise that the engineer had not arrived and this had been chased up and was being

addressed.

Each person had a personal emergency evacuation plan (PEEP) in place which identified people's specific needs in case they needed to be evacuated from the service. However, one person's PEEP stated that they had no visual or hearing issues. However, their care plan stated that they wore spectacles and hearing aids in both ears. This was a potential risk that the person may not hear instructions or could see when evacuating the building.

Records of medicines for external application, including creams were not completed in line with their prescription. In addition they were not consistently completed. Some included codes for non-administration, but there was no key on the records to indicate why they had not been administered. There were significant gaps in the records. One person's cream charts just had the name for the cream and no instructions for administration. Cream charts had not been completed in a consistent manner which caused confusion and the potential risk of non-administration. The manager told us that the staff did provide people with their creams and was looking at ways of improving the completion of the records. However, the current systems in place for demonstrating how people were provided with their prescribed creams was not robust.

There was a toilet situated in the lounge area. This did not respect people's privacy or good infection control processes. For example a person was sitting in an arm chair eating their meal and people were going in and out of the toilet which the person was sitting near to. There was no assessment in place to show how this risk to infection control had been assessed.

All of the above is a breach of Regulation 12; Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. Where a safeguarding concern or incident had happened, the service had taken action to report this to the appropriate organisations who had responsibility for investigating any safeguarding issues. The service had taken action to reduce the risks of future incidents, this included undertaking internal investigations and disciplinary action. Staff understood whistleblowing and told us that they would have no hesitation in reporting any bad practice in the service.

However, we had received a concern in June 2017 from a relative of a person who used the service relating to medicines not being available for the person. We contacted the previous registered manager about this and they told us that they had made every effort to obtain these medicines, including contacting the pharmacy provider and the GP. A safeguarding referral had not been made in relation to this. The previous registered manager raised this with safeguarding once we had recommended that they did this. We were concerned because the incident had happened in March 2017 and the appropriate actions had not been taken. During this inspection we found that the service had learned from this incident to reduce future risks. This included the development of a process that staff should immediately take if people's medicines were not delivered to the service. This mitigated the risk of medicines not being available to people. Where things had gone wrong the service's management team had learnt from these to reduce future risks.

Despite the shortfalls we had found in relation to risks to people, they told us that they felt safe in the service. One person said, "I am quite comfortable, they are good staff, I know I am safe." Another person told us, "I have settled as they [staff] are so friendly, I get such good attention here, certainly feel safe, always carers about and no one can come up stairs except in the lift." Another person commented, "I feel safe, it is

the care and attention of the staff, it is good."

One person's relative said relating to the person's safety, "They [staff] said because [person] slips sideways in [their] chair they would prefer to have [person] down in the lounge to keep a better check on [person]. We were happy with that." They added that when the person was supported using a hoist, "Was frightened at first but they [staff] have reassured [person] and I saw them do it earlier today, they were very good." Another relative commented, "I feel confident [person] has 24 hour care and I can rest easy and know that they [staff] will phone me with any problems." Another relative told us, "We can relax for the first time in three years, we leave and know [person] is safe, well fed and well looked after."

There were environmental risk assessments in place which identified the potential risks to people using the service. Risks to people injuring themselves or others were limited because equipment, including hoists, portable electrical appliances and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. There were also records in place to show that there were systems to check the risks of legionella bacteria in the water in the service.

There was a business continuity plan in place which identified the actions that staff should take if the service needed to be evacuated or in an emergency.

We found that the maintenance cupboard was open. The care development manager told us that they were using this room when we had arrived for the inspection and they had not locked it. This was addressed immediately.

During our inspection we saw that staff were available to meet people's needs and requests for assistance were attended to, including call bells. However, one person's care records said to ensure that the person had their call bell available to them at all times when in their bedroom. When we visited them they felt around for their call bell and said, "Usually I have a buzzer, they put it on my chair, but it is not here today." We found it underneath their bed clothes. Another person told us that they did not use a call bell, "I shout for staff, got no bell, they come quickly enough, I don't call at lunchtimes as I know they are busy." At 10:30am this person called for help and no staff heard and they eventually stopped calling. Other people we visited in their bedrooms had access to their call bell.

We received mixed comments from the people who used the service and relatives about if they felt that there were enough staff to meet people's needs. One person said, "Some days the staff are busy, you have to accept it, I have a bell, they are pretty good, but do have days when they are short staffed...The waiting is worst in the mornings. Night times they are very good, weekends are alright. Staff we get lots of changes with new faces but they are quite good." Another person told us about their call bell, "Sometimes they [staff] are quick, sometimes not, they are short of staff." Another person said, "It rings on the [staff's] pagers, worst scenario is first thing in the morning when they are helping people up and washing them, also wait after tea when they are putting people to bed, longest wait is five to 10 minutes. Short staffed they have three on shift instead of four, probably once a week, they use agency and if they have been before they are good and if they are new it is a problem as they don't know where anything is." Another person told us, "Got a bell, you press it and they come but not extra quick, sometimes wait longer, worst time is in the evening when helping people to bed." Another person said, "They are there almost straight away or if seeing to someone else they come immediately they have finished there."

The manager told us that as part of their plans to improve the service and develop their managerial role they had planned to look at the dependency tool used to understand the formula for how the staffing levels were

organised. In addition they were planning to look at the layout of the building and how the staffing allocations could be improved. Staff meeting minutes in September 2017 showed that there had been some issues with staffing. However, this was in the process of being addressed, new staff had started working in the service. The manager told us that there were some vacancies in the service which they were actively recruiting to this included one team leader and maintenance who had recently left, cover for a team leader who was due to go on long term leave and an administrator. In the interim existing and agency staff were being used. The manager told us that the aim was to reduce agency staff and have the service fully staffed. There had been some issues with the recruitment including the employment of a staff member who did not turn up to work in the service.

The manager told us that the service was staffed with a team leader on each shift and four care staff in the day and evening shifts and two at night. This was confirmed in records. However we noted that there was a shortfall of one care staff on the rota for the night of our inspection. A staff member told us that they were aware of this and action was being taken to address this. We heard staff on the telephone attempting to cover the shift. There were also catering and domestic staff daily and activities staff weekdays.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

People told us that they were satisfied regarding the arrangements for their medicines. One person said, "I have lots of medicines, 14 in the morning and 13 at night, not missed any of them to my knowledge."

We observed staff administering their medicines which were to be administered by mouth, and found that this was done safely. Medicines administration records (MAR) for these medicines were appropriately completed. Records of missing signatures checks were undertaken and appropriate action taken to ensure that the records reflected when people had received their medicines.

Where people were prescribed medicines to be taken as required (PRN), for example to reduce their pain, protocols were in place. These guided staff at what point these medicines should be considered for administration. This reduced the risk of inappropriate administration of PRN medicines.

People's medicines were kept safely but available to people when they were needed. Checks were undertaken to ensure that medicines were kept at a safe temperature. Staff were provided with training in the safe management of medicines and competency tests on the safety of their practice.

People told us that the service was clean and hygienic. One person said, "It is always nice and clean." Another person commented, "It is always as clean as a pin." Another person commented, "It is beautifully clean, my room is cleaned every day." One person's relative said, "Normal public spaces you would expect smells but there are none, the common area are clean with no smells of urine, no crumbs on the floor."

After each meal the tables and place mats were cleaned and the table clothes changed where soiled.

All of the bathrooms provided paper towels and hand wash liquid and in addition aprons and gloves for the use of staff to reduce the risks of cross infection. Staff had been provided with training in infection control and food hygiene and understood their responsibilities relating to this. The service had achieved the highest rating in a local authority food hygiene inspection.

Cleaning schedules were in place which showed that the service was cleaned to reduce the risks of cross

infection.

Is the service effective?

Our findings

Effective was rated as Good at our last inspection of 9 November 2015. At this inspection of 27 November 2017 we found that Effective was rated as Requires Improvement.

People's care needs were assessed, planned for and delivered holistically. This included their physical, mental and social needs. However, improvements were needed in how the service monitored if people were eating and drinking enough.

People's records showed that people's dietary needs were assessed. Where issues had been identified, such as weight loss, guidance and support was sought from health professionals, including a dietician. For example, providing people with food and drinks to supplement their calorie intake. There was guidance in each person's plan which guided staff when they should make referrals to health professionals relating to their nutrition.

However, where people's care plans directed staff to ensure that people were drinking enough fluids to reduce risks there was no indication of how much drink these people were recommended to have. For example one person's records stated, "Balanced diet with plenty of fluids." There was no information about what plenty of fluids were for this person and the actions that should be taken if the person was not drinking enough. Their records of what they had eaten were also not consistently completed, for example, how much they had eaten at each meal. The guidance received from health professionals was to maintain, "Strict food and fluid intake." Without clear guidance and record keeping the service could not be assured that the person was eating and drinking enough and the systems in place were not effective enough. We spoke with the manager and they assured us this would be addressed.

People told us that they were provided with choices of food. One person said, "Food is good and the quality is good... I have to have everything cut up, I like the casseroles." Another person commented, "Food is good, get choice, lots of tea, lots of homemade food and I think that the food is varied, hot drinks around 8pm and they [staff] say if you want anything in the night ring the bell." Another person commented, "They do poached eggs on toast for me, I can have seconds at meals if I want, the food is first class with plenty of choice, they know I like extra custard and gravy so they give me extra." One person's relative said, "Cook asked me what [person's] favourite foods are, how does [person] like it to be served, they don't always want to eat but they [staff] give encouragement and offer other things to tempt them, there are always alternatives."

We saw that people were offered alternatives when they did not want what was on the menu and staff encouraged people to eat. Lunch time was a good social experience, once people had been served staff sat at tables and ate with people. People were provided with choices of hot and cold drinks throughout the day of our inspection. This meant that there were drinks available for people to reduce the risks of dehydration. There was a list in the kitchen of people's specific dietary needs, likes and dislikes. There was also a list of people's usual drinks for example tea or coffee and if they took milk and sugar. These also guided staff to ask for people's choices.

Staff had a good understanding of people's dietary needs. Catering staff we spoke with were knowledgeable about people's individual needs, including consistencies of softer diets that may be required for people who were at risk of choking. They explained how people were provided with fortified diets, including high calorie drinks to maintain a healthy weight.

The staff in the service worked with other professionals involved in people's care to ensure that their needs were met in a consistent and effective way. For example, referrals were made to health professionals if the service were concerned about people's wellbeing.

People told us that they felt that their health needs were met and they were supported to see health professionals if needed. One person said, "Only have to ask to see the doctor, chiropodist and optician comes here." Another person said, "Nurse comes to do my legs, and they will get me a doctor if I need one." Another person commented, "Seen chiropodist, doctor and dentist and eyes tested here." One person's relative said, "They [staff] phone me if [person] sees the doctor and ask did [person] need to see the dentist."

People's health needs were assessed and where they required the support of healthcare professionals, this was provided. Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. We saw that the service had made referrals to health professionals when they had been concerned about people's wellbeing, this included relating to their mental health, continence and falls. Staff told us that they could call health professionals when needed and they worked with them to improve people's health.

We saw records which were provided to other professionals if people, for example, required hospital admittance. These included important information about the person that other professionals needed to know about when providing care and treatment to people. For example, any allergies, their medicines, next of kin details and if they wished to be resuscitated. The care development manager told us that they previously used back packs which included people's medicines and information when people attended for example, hospital. However, over time these had not been returned to the service. There was information in people's records which guided actions to take if a person was missing from the service. This included important information that may need to be passed to the police to identify the person.

There were systems in place to provide staff with training to assist them in meeting people's needs. Records showed that the staff had attended the training they were required to do by the service and when they were to be updated. This included training in moving and handling, equality and diversity, fire safety, safeguarding, medicines, and dementia.

New staff were provided with an induction course and with the opportunity to undertake the Care Certificate, if they had not achieved a National Vocational Qualification (NVQ) or Qualifications and Credit Framework (QCF) diploma. This is a recognised set of standards that staff should be working to. This showed that the service had kept up to date with the staff induction process and took action to implement them. In addition new staff undertook shadow shifts where they shadowed more experienced staff in their induction. There were records which showed that staff were provided with one to one supervision during their probation period. These provided staff with a forum to discuss the ways that they worked, receive feedback on their work practice, were used to identify ways to improve the service provided to people and to check on any further training needs.

The records of two long standing staff which we reviewed showed that one had one supervision in March 2017 and one in March 2016. The other had supervision meetings in November 2017 and one in March 2017, there were none provided in 2016. The manager told us that the provider's policy was to have six

supervisions each year and these had been planned in and systems in place to support this. For example, head of departments and team leaders to provide supervisions to ensure that they were done.

People told us that they could use the communal areas and if they chose could have the privacy of their bedrooms. We observed that people's bedrooms had natural light and were personalised which reflected people's choices and individuality. People's bedrooms had their room number and a memory box including, for example, photographs which assisted people to find their bedrooms independently.

The manager and care development manager told us that the service was going through a refurbishment programme. In January 2018 there were plans to do the entrance hall, conservatory and dining room. This was to maximise the space in the service. In addition the lighting in the communal landings would be done. A planned visit by the provider's representatives responsible for assessing the premises to check what needed to be done was arranged for December 2017.

There was a secure garden which people could choose to go into in the warmer weather. The care development manager told us that volunteers from the community had worked in the garden, including painting it to make it more attractive for people to use.

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.

The manager understood when applications should be made and the requirements relating to MCA and DoLS. Applications had been made as appropriate to ensure that any restrictions on people were lawful. We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals, if they wanted to wear aprons during their meals, if they wanted to participate in activities and where they wanted to spend their time in the service.

Care records identified people's capacity to make decisions and where they required support to do so there was evidence to show that decisions had been made in people's best interests, for example relatives and other professionals involved in their care. For example, one person's records stated that they had capacity to make decisions but preferred to have their relative present when making some decisions. People, or where appropriate, relatives had signed care records to show they consented to the care planned for and delivered.

However, one person's records showed that items had been removed from the person's bedroom, for safety. The records identified that a member of the person's family had agreed these items should be removed. This was not identified as a best interest meeting and the records identified that the person had capacity to make their own decisions. The care development manager advised that the person had agreed to this action, but this needed to be made clearer in records to ensure that the person was not being deprived of their liberty, even though the items had been removed for safety. The manager told us that this would be

addressed and the records would be made clearer. Another person's records included information about the best interest decisions made to reduce the risks of the person not receiving the care they needed.

Is the service caring?

Our findings

Caring was rated as Good at our last inspection of 9 November 2015. At this inspection of 27 November 2017 we found that Caring was rated as Good.

People told us that they felt that their privacy was respected when the staff wanted to enter their bedrooms. One person said, "They [staff] always knock [on their bedroom door]." Another person commented, "Staff ask if I need anything or any help, just buzz and they are in and out checking on me, they always knock and then come in."

A person was in their bedroom with their door open. The manager asked if they would prefer their door shut and the person replied, "No I'm alright." We saw a staff member walking to the toilet with a person who had a continence accident. They said, "Everybody needs a little help sometimes, please do not worry, here lets shut the door." This interaction was caring and compassionate and respectful of the person's privacy and dignity.

People spoken with said that the staff were caring and treated them with respect. One person said, "It is very nice and the care and attention is good, food is good and staff are very nice, there is not a bad one amongst them, we are well cared for and I am a happy and contented person." Another person commented, "[Staff] are wonderful, helpful, cheerful." Another person said, "Staff all very nice, they must be caring to do what they do, soon looked after if we are ill." Another person commented, "I have got to know my carers well and we have a good relationship, they are a lot of fun and can take a joke."

One person's relative said, "It is brilliant, everybody is happy and helpful and kind, never seen anything to complain about, no smells and everyone says hello and is very pleasant and seems to be a comfortable place." Another relative commented, "It is fantastic, the staff are just receptive to any needs of the residents and the visitors, they are very welcoming."

We saw cards and letters received by the service from relatives and people. These thanked the staff for their caring approach.

Staff were all friendly, respectful, smiling and demonstrated meaningful relationships with people. We saw lots of interactions with laughter from staff and people. We saw one person who was having their face stroked by a member of staff, both of them were laughing and the person was beaming widely.

Staff talked about people in a caring and respectful way. They knew people well and one person's relative told us how a person liked a specific sweet, "They [staff] asked me to bring some more in for [person], they know what [person] likes."

People told us how the staff respected their independence. One person said, "I like to be as independent as I can and quite often I get up, I usually put my clothes out the night before, I can manage my buttons but if I cannot they [staff] help me, nothing is too much trouble for them, they check at night to see if I am awake

and say do I want for anything?" Another person commented, "I am independent, get myself up to shave, like to have a shower... have them twice a week... so put dressing gown on and carer comes with me to the shower room." Another person told us, "I am as independent as I want to be but on the other hand if I want help I can ask for it." Another person said, "They [staff] are there if you need them, fortunately I have not needed them, they do offer help but I don't accept much except for little things like washing my back."

We saw that staff encouraged people with their independence, such as when assisting them to mobilise and eat. People's care records guided staff on the importance of respecting people's privacy, dignity and independence. The records identified the areas of care that people could attend to independently and where they needed the support of staff.

People told us that the staff listened to and acted on what they said. We saw that people's choices were reflected in the times and location that people chose to have their breakfast and meals. One person told us, "I please myself as to where I have lunch, if I am off colour then I have it in my room." Another person said, "Go downstairs for my meals, my choice."

People's views, and those of their representatives where appropriate, were listened to and their views were taken into account when their care was planned and reviewed. This included their choices and usual routines, such as the times of getting up in the morning and going to bed at night. One person's relative told us about a meeting to assess their relative's needs, "They [staff] did not talk over [relative] in the initial meetings, they included [relative] and [relative] answered most of the questions [independently]. We filled in the blanks...they [staff] could not have done anything better."

People told us that relatives could visit them when they wanted to which was supportive of people maintaining relationship with people who were important to them. One person said, "My [relative] came and had lunch with me, [they] enjoyed it." Another person commented, "My family all come with my grandkids and their dog. They make everyone welcome here." One person's relative said, "Soon as we step inside the door they [staff] offer us a hot drink."

Is the service responsive?

Our findings

Responsive was rated as Good at our last inspection of 9 November 2015. At this inspection of 27 November 2017 we found that Responsive was rated as Requires Improvement.

There were needs assessments in place which were done prior to people moving into the service. These fed into people's care plans which identified how their care was planned for and provided. This included people's diverse needs and preferences. However, we found that some improvements were required to ensure that people received responsive care at all times. We found some inconsistencies in care plans. For example, one person's care plan had different dates of admission.

One person's records included information about behaviours that may be challenging to others. This included information about what caused them distress and triggers to this. However, there was no information to show how this person demonstrated their distress to allow staff to recognise the changes in their behaviours. Their records stated that the person, "Can exhibit paranoia if unwell," again there was no further information about this. There was guidance for staff to, "If paranoid speak when episode is over." There was no information what an episode looked like for this person and how to support this person other than offer them reassurance.

The person's care records identified that they were hard of hearing and wore hearing aids. In the documents to show where the person's care had been reviewed in May 2017 it was noted to communicate with the person staff should write things down. However, there was no further mention of this in their care plans or subsequent reviews. The manager and care development manager told us that they were not aware of where the person was communicated with them in writing.

There was no detail in the care records about how people's specific conditions affected their daily lives and if this varied from day to day. For example, one person's records stated that the person had, "Mixed dementia," there was no detail about what this meant for the person. Their records stated that the person may have delusional episodes which could impact on their behaviours. But there was no information about how these delusional behaviours presented itself apart from, "Agitation," and, "Abusive to staff," and how staff should support them. On a mental capacity form completed in November 2015, there was reference to the person seeing, "Small insects," the care development manager told us that they were not aware that this was a current issue with the person and the MCA record preceded their time as registered manager. Therefore we could not be assured that the care records provided the most up to date information about the person.

There were also some improvements required in the use of language in people's care records. For example, one person was described as, "Bed bound." This was not a positive and up to date use of language.

People told us that they were happy with the service they were provided with. One person said, "Glad I came here, food is good, laundry good, brought my TV and own walker. I came for respite but decided to stay, there are lots of people to talk to, I am a bit cheeky with the [staff] and have made friends with two of the

[other people using the service]." Another person said, "Staff help me to wash and dress and the district nurse have said for me to try and have a shower on a Monday and they can do the dressings for me after, they are helping to build my confidence." Another person said, "Have a bed bath as a daily occurrence, all of them are very gentle and you can take your time." One person told us about how they visited the service before they decided if they wanted to move in, "The manager is nice...saw [manager] first when I came and [manager] gave me enough information, came again two days later and told them I would come here and they made me so welcome."

One person's relative said, "[Person] laughs and smiles and staff tell me [person] has settled, I am very happy with the home." Another relative told us about the support provided when their relative moved into the service, "[Relative] was local to the home and knew it and was happy to come and we like the room. We had a tour of the building, got to know the layout with the manager who was so helpful... Staff have reassured [relative] and they come and have a joke with [relative].

People's daily records identified the care and support provided to people. Improvements could be made to include consistent and detailed information about the quality of the person's day. This information would enable the service to identify any changes in people's condition and wellbeing. There was a team leader communication book which included information about concerns about people and actions that needed completing. For example, to observe a person who had not been well and health appointments made.

People told us that there were social events that they could participate in. One person said, "School choirs come in sometimes, have concerts, and play card games." Another said, "The activities [staff member] is great, we talked about some word games and [activities staff] has taken some of my ideas, [activities staff] is nice and kind." Another said, "Overall it is very good, plenty to do, bingo, various entertainments, always something to do." Another person commented, "Had summer fair, got a Christmas one and we all get together, [activities staff member] is very good and does a lot for us, have an organ and singer today, I think that there is enough to do, I like looking after my plants." We saw that people had plants in their bedrooms and in the communal areas. One person's relative told us, "I come on a Friday and help [relative] play bingo, [activities staff member] phoned to tell me it had changed to a Thursday, I thought that was really thoughtful and kind."

We saw that the activities staff had a good rapport with the people giving reassurance and comfort and confidence. During the morning of our inspection we saw people passing a ball around to each other and using a parachute to pass the ball around. There was lots of fun and laughter and the activities staff encouraged people to throw the ball as hard as they could and made jokes about how they had nearly been knocked off their feet. This made people laugh. There were two students on work placement from a local college. During our inspection we saw that they assisted people with activities. The manager told us that they would be working in the service once a week until January 2018. During the afternoon people sang along with a visiting entertainer who sang and played a keyboard.

The activities staff told us about how activities were planned to meet with people's interests. They showed us photographs which included one person who they said had sold poppies for remembrance day for many years. The activities person had supported them to sell poppies to the people using the service and staff. They added that the person did not like to use the lift but had done this because they wanted to undertake their activity.

There was a programme of events which included visits from community groups, including pre-school visit, carol singing, and a pat dog. There were also entertainers planned such as hand bell ringers. There was a quarterly newsletter, the one for Autumn 2017 had a picture that people could colour, guidance to speak

with the activities coordinator if they wanted to do anything in activities and if they wanted to contribute to the newsletter, photographs of activities including kooky critters where people were handling them. Information for bonfire night and a poem was also included.

The manager in the provider information return (PIR) told us that they were planning to improve the one to one activities provided and had met with the activities staff to plan this. The activities staff said that they visited people, who preferred to stay in their bedrooms. We saw, during our inspection that people were visited in their bedrooms and offered hand massage and manicures. The activities staff also told us that weekly they took a person out into the community, for example shopping. They told us they used various forms of transport, public transport or the person booked a taxi. The person confirmed what we had been told, "[Activities staff member] has taken me into town several times in the wheelchair, I like that."

There was a small quiet lounge on the first floor which could be used for family to entertain their visitors in private. The manager told us that a person had instigated people playing card games and now these were held in this room. The manager told us that this was proving to be popular with people.

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. The procedure was displayed in the service. In addition there were suggestion boxes where people could add their comments, anonymously if they chose.

People's complaints were investigated and responded to in line with the provider's complaints procedure. However, we received a concern from a family member in June 2017. They told us that they had made a complaint to the service but they had not received a response. We contacted the service and were told that the complaint had been investigated and a response letter had been completed and sent. This had not been received by the complainant. The previous registered manager assured us that a copy of the response was sent to the complainant immediately with an explanation of actions taken to improve the service and an apology. Complaints had been used to improve the service and experiences of people, for example introducing procedures and guidance for staff.

Where people were at the end of their life there were systems in place to support people to have a comfortable, dignified and pain free death. Staff were able to tell us about people's end of life care and how they supported their wishes. In addition people's records, where people had chosen to discuss it, detailed their end of life wishes. This included if they wanted to be resuscitated and advance care planning where people had chosen to do these.

The manager told us that there was one person receiving end of life care. We noted that an alarm was sounding, "Low pressure, check mattress." We saw that staff were passing by and no one was addressing it. We asked staff about this and they said, "It has been going on and off." Another staff member said, "We have reported it to the technicians." We were told by the management team about the actions being taken to get this repaired. However, it was not acceptable because the sound of the continuing buzz and alert was not supportive of a calm and restful environment.

Is the service well-led?

Our findings

Well-led was rated as Good at our last inspection of 9 November 2015. At this inspection of 27 November 2017 we found that the service had not maintained their Good rating. Well-led was now rated as Requires Improvement.

The provider information return (PIR) stated that the registered manager had left their role in May 2017. Their application to de-register was processed in September 2017 and they were now employed by the provider as care development manager. They told us that they were rolling out workshops and road shows to the provider's services including the changes in inspection, the new key line of enquiry standards and duty of candour. The care development manager told us that they had incorporated the duty of candour into these road shows partially as a response to feedback received from staff about how they demonstrate the duty of candour. The new manager was booked to attend a road show on 6 December 2017.

The new manager started working in the service on 15 August 2017. They had made a registered manager application with us and this was being processed, including a fit person's interview planned for the day after our inspection. We saw records which showed that the manager was being supported in their new role by the regional manager. This included the development of an action plan which had identified that improvements were needed in areas such as care records. The support visit records by the regional manager identified that the action plan was revisited to check that timescales for improvements were being implemented. The action plan included improvements planned in medicines audits, mental capacity documentation, how resident of the day had not been effective in updating care plans, and training. Previous audits had not been effective in identifying and addressing shortfalls in the service. The manager and regional director told us that this was now being addressed.

The provider information return (PIR) had been submitted to us in October 2017 by the current manager. They identified improvements they had planned for the next twelve months, which included spot checks on evenings and weekends, the commencement of staff, head of department, resident and relative meetings, the setting up of a robust supervision schedule, staff training and governance of the service. This demonstrated that the new manager had identified shortfalls in the service and had a plan in place to address them. These were not yet fully implemented. However, we were assured from the records seen and discussions with the manager and regional director that there were plans in place to implement the improvements required.

People and relatives were complimentary about the manager. One person said, "Manager I see [them] most days and [manager] comes in and chats and make sure I am alright. Staff have made me very welcome." Another person told us, "The manager I have met a couple of times and is very pleasant. I would recommend it [the service to others]." One relative said that the service, "Seems to be run very professionally, I see how professional the staff are and they are constantly checking [person] is alright." Another relative commented, "[Manager] is superb and very good at guiding us along the way. [Manager] has been ace, always got time for us and every visit we go and see [them on their] office."

People were asked about their views of the service in questionnaires. There were notices in the service advising that they welcomed feedback and used comments to improve the service. There was a notice in the service which identified that questionnaires had been received in 2017. However, these showed the positive percentages of comments, (98% happy with living arrangements, 94% happy with care and support, overall satisfaction with the service 93%), but there was no information about any comments of improvement which had been received and what actions had been taken as a result of these. The regional director and manager told us that this had been identified and managers of service had said that they needed further information to allow them to make improvements. This was in the process of being addressed.

The minutes of a staff meeting in September 2017 identified that morale had been low in the service and discussions around staffing and the lack of a manager had been held. The manager appreciated that there had been issues and reassured staff that improvements were being made including employing staff and improving the allocations of staff. The manager told us to improve morale they were listening to staff and trialling new ways of scheduling and listening to staff's views if this was improving.

However, records showed that there were irregular staff meetings. There was another staff meeting in February 2017 and one in August 2016. There had been two team leader meetings in September and October 2017 where improvements to the service were identified and discussed, such as leading shifts and improvements in medicines administration. There had been only one meeting in August 2016. With the lack of supervisions this system had not been adequate to provide staff with support and the opportunity to discuss their issues. This was being in the process of being improved. There had also been activities, and catering staff meetings held.

In addition the meetings for the people who used the service and relatives had not been held to allow people to discuss their views. The manager had started to address this. A recent meeting of September 2017 had been held where people discussed ideas for activities, one being card games which was now being done, positive comments were received about the food. The records for previous meeting were September 2015. The care development manager told us that meetings had been held and they planned to send us the minutes to these which they said may be kept electronically. However, following our inspection they told us that the files were no longer available. Improvements were planned to engage people and relatives in meetings, a cheese and wine evening had been planned in October 2017 but no relatives had attended. The manager told us that they continued to try to make these improvements.

The service's staff worked in partnership with other professionals. This included seeking advice and guidance from professionals involved in people's care.

The service operated a staff 'kindness' awarded where people, visitors and colleagues could nominate them. This showed that there were systems in place to recognise good practice.

There was information in the service, including posters and leaflets about health conditions, Alzheimer's Society information, public transport and how people could complain about health services.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The systems in place for assessing and mitigating risks to people were not robust to provide safe care at all times.</p> <p>Regulation 12 (1) (2) (a) (b) (g) (h)</p>