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Hollin Knowle Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 and 14 February 2017. It was carried out by one inspector and specialist advisor in nutrition.

Hollin Knowle Residential Care Home provides nursing and personal care for up to 19 older people, including some people living with dementia. At the time of our inspection, there were 19 people receiving care at the service. There was a registered manager for the service at the time of this inspection. This is a person who has registered with the Care Quality Commission. They are responsible for the day to day management of the regulated activity of personal care at the service. Like providers, as a registered person they have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in September 2015 we found that people were not fully protected from known risks to their safety associated with the unsafe management of medicines. This was because the provider did not ensure people's medicines were being consistently given as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following our inspection the registered provider told us about their action to address this and ensure people's safety. At this inspection we found the required improvements were made. This meant people's medicines were safely managed and consistently given to them as prescribed. Related staff training and management procedures helped to ensure this.

Staffing levels and skill mix were not sufficient to consistently ensure environmental cleanliness or people's timely care, individualised care. This also had an impact on people's care as their known daily living choices, independence and lifestyle preferences were not being consistently upheld or met.

Staff were often visible, knew people well and prioritise their care to help ensure their individual safety. Staff understood and followed people's care plans to help mitigate known risks to their safety associated with their health conditions, environment and equipment used for their care.

Recognised staff recruitment, incident reporting and safeguarding procedures were understood and followed by staff when required, which helped to protect people from the risk of harm or abuse.

Equipment used for people's care was often checked and maintained to ensure safe use. Emergency planning arrangements helped to ensure people's safety. Planned environmental and repairs and for outstanding equipment servicing required helped to further ensure this.

People's health and nutritional care requirements were understood and followed by staff who supported people to maintain and improve their health. People accessed external health professionals when they needed to and staff followed their instructions for people's care when required.

People were usually provided with care in line with the Mental Capacity Act 2004 (MCA); to obtain people's consent or appropriate authorisation for their care. The provider did not regularly check whether staff understood or followed the MCA, resulting in significant delay for requesting relevant authorisation for one person's care when required. Additional staff training subsequently provided helped to reduce the risk of this reoccurring.

People received safe but not always timely support to eat and drink People were supported to receive sufficient amounts of food and drink and to maintain a balanced diet. People mostly enjoyed their meals but were not well informed about meal choice, which some people felt were limited. Food temperatures were not always effectively maintained from serving meals to when people received them.

Staff mostly received the training and supervision they needed to provide people's care. Overdue training updates were organised for staff where required, which helped to fully ensure this.

Staff were kind, caring and compassionate. They treated people with respect and ensured their dignity when they provided care. Staff knew people well and understood what was important to them for their care. People and their relatives were consulted and involved in relation to their care and daily living arrangements.

People's environment, daily living arrangements and related care requirements were not always fully considered or acted on to optimise their independence, orientation, choice or control.

People were informed about how to complain. The provider regularly sought to obtain people's views about their care but did not always act to make improvements from this. This meant people's care was not always individualised or responsive to their assessed needs and expressed wishes.

The provider's arrangements to regularly monitor the quality and safety of people's care were not wholly effective. They were not always sufficient to identify improvements needed. Improvements identified were not always acted on to improve the quality of people's care when required.

The provider was able to demonstrate how they regularly monitored many aspects of people's care and how improvements from this were often made to help ensure people's safety, health and wellbeing.

People, relatives and staff felt the registered manager was visible, accessible and mostly helpful and supportive, but did not always listen or act on what they said about care improvements needed.

Staff understood their roles and responsibilities for people's care and were informed and supported to raise any concerns about people's care and often to make improvements required.

Records for people's care and the management and running of the service were accurately maintained and safely stored. The provider met with their legal obligations to tell us about important events that happened at the service when required.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staffing levels and skill mix did not consistently ensure the quality and safety of people's care. Staff understood and prioritised people's care to help ensure their individual safety. People's medicines were safely managed. Care equipment maintenance, emergency planning, staff recruitment and training arrangements helped to protect people from the risk of harm and abuse.

Is the service effective?

Requires Improvement

The service was not always effective.People were usually provided care in line with the Mental Capacity Act 2005 (MCA). Recent provider action and additional staff training helped to further ensure this. People were supported to maintain their health and nutrition but meal choice and hot food temperatures were not consistently promoted. Arrangements for staff training and supervision helped to ensure people received the required care.

Is the service caring?

Good

The service was caring. People received care from staff who knew them well and who were kind, caring and respectful. Staff understood and promoted people's rights, dignity and comfort in care. People and relatives were often informed, involved and consulted to help agree people's care.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive individualised care to account for their known wishes, daily living and lifestyle preferences. People's care and daily living arrangements concerned with their independence, choice and environmental orientation was not fully optimised. People and relatives were confident and informed how to make a complaint or raise any concerns about people's care. Regular care feedback sought from people and relatives by the provider was not always used to make service improvements when required.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider's arrangements to monitor and ensure the quality and safety of people's care were not wholly effective; as they did not always identify or act on improvements required. Management arrangements helped to ensure staff understood their roles and responsibilities for people's care. Record keeping arrangements helped to provide accountability for people's care.

Hollin Knowle 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 inspection was unannounced on 6 February and announced on 14 February 2017 It was carried out by one inspector and a specialist advisor in nutrition.

Before this inspection, 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. We also spoke with local community professionals and care commissioners who contracted with the provider for people's accommodation and personal care at the service. We also and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

We spoke seven people, three relatives, five care staff including one senior in charge and a cook. The registered manager was not present. We also spoke with an external manager for the provider. We looked at seven people's care plans and other records relating to their care and how the service was managed. For example, medicines records, staff training and recruitment records, meeting minutes and the provider's checks of quality and safety.

As people were living with dementia at the service, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2015 we found that people were not fully protected from known risks to their safety associated with the unsafe management of medicines. This was because the provider was not always able to show people received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following our inspection the registered provider told us about their action to address this. At this inspection we found the required improvements were made.

Staffing levels were not always sufficient to meet people's care in a timely manner. People, relatives and staff felt that people received safe but not always timely care. All felt this was particular so at busier times, such as mealtimes when there were only three care staff. One person said, "I feel safe; I am cared for; but staff don't have much time to spend talking with me." A relative told us; "The staff work really hard to make sure people are safe; but there's not enough so they are rushing about." Another relative said, "There's not much in the way of activities; staff don't have time; some areas of the home are not always kept as clean as they should be." A staff member said, "Staffing levels can make it difficult at times." Another care staff told explained, "We work well as a team to make sure people are safe; but we are busy with people's routine personal care, doing laundry and making tea time meals; there's not much time for anything else." Staff confirmed it was sometimes difficult to ensure people's timely support at mealtimes, which we observed.

At lunchtime we saw people were left sitting in the dining room for over half an hour waiting for their meal, whilst staff served some people's meals to them in their own rooms. A few people who ate in the main dining/lounge area required observation and verbal prompting from staff to ensure they ate sufficient amounts. This was mostly well managed, although one person's meal was left untouched by them for almost an hour before staff noticed and supported to person to eat an alternative, hot meal.

Staffing rotas confirmed three care staff were provided throughout each day, including one senior for the personal care of 19 people, who were accommodated over three floors at the service. The registered manager was additional to the number of care staff during provided each weekday. At the time of our inspection, the registered manager was on leave. Additional support staff regularly provided each day included a cook from 8 am until 2 pm and a cleaner from 8 am until midday. There was no dedicated laundry staff provision. This meant care staff were expected to undertake cooking, cleaning and laundry tasks each day along with people's personal care associated with their safety, health, social, occupation and leisure needs.

Staff told us about two people whose health needs had more recently changed. This included two people who needed two staff using relevant equipment to help them to move; one of whom was cared for in bed. A formal measure, such as a staffing tool was not used to consider people's care and dependency needs; to help inform staff deployment requirements. We discussed staff deployment arrangements with the senior care in charge and also the provider who agreed to introduce a relevant measure to help inform their staffing arrangements.

We found that sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed to ensure people's timely care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day one of our inspection we observed that some areas of the home were not always kept clean, well-lit or free from dust and debris. This included communal toilets and a sluice area, bathing facilities and some people's bedrooms. We also saw that clean commode pots were left on the floor near the sluice sink, which increased the risk to people from germs and infection through cross contamination. On day two of this inspection we found immediate action had been taken to address this.

People's care plan records identified risks to their safety from their health conditions, environment and any equipment used for their care. For example, risks from skin pressure damage or from falls due to poor mobility. Peoples' care plans also showed the care actions required to mitigate those risks, which staff understood and followed. For example, we observed staff helping one person to move safely with their walking frame. This was done in a way that helped to ensure the person's safety and comfort.

Throughout our inspection we observed staff prioritised and provided people's care in way that helped to ensure their safety. For example, by making sure people received their medicines when they needed them and helping people to move safely. We saw that some people's care plans showed they needed to be in well-lit rooms to support their vision or orientation needs associated with their health conditions. However, low wattage light bulbs provided in some communal toilets and people's own rooms did not always fully ensure this. We discussed our findings with a senior manager for the provider who took the required action to address this.

People and their relatives felt people were safe when they received care from staff. Information was displayed to inform people of their rights and how to keep safe. This included information about what to do if they witnessed or suspected abuse of any person receiving care at the home. Staff we spoke with knew how to recognise and report abuse and they were provided with related training and procedures to follow in any event. This helped to protect people from the risk of harm and abuse.

Recognised recruitment procedures were followed to check staff, were fit to work in the home before they commenced their employment. For example, previous employment checks and relevant character references were obtained. Checks were also made with the government national vetting and barring scheme (DBS). The DBS helps employers to make safe recruitment decisions and prevent unsuitable people from working with adults or children in care.
Before this inspection local health care commissioners shared their report findings with us following their checks of people's medicines arrangements at Hollin Knowle in January 2017. The report showed the provider arrangements for people's medicines were found to be satisfactory; with a small number of good practice recommendations made.

People's medicines were safely managed. People said they received their medicines when they needed them. We observed senior care staff gave people their medicines safely and in a way that met with nationally recognised practice. Records kept of medicines received into the home and given to people by staff, showed people received their medicines in a safe and consistent way.

Care staff responsible for people's medicines told us they received relevant training for this, which included an assessment of their individual competency and regular training updates. The provider's staff training records also showed this. The provider's medicines policy was subject to a periodic review and provided comprehensive guidance for staff to follow for the management and administration of people's medicines.

The provider's revised ongoing management checks of people's medicines arrangements helped to ensure they were safely managed.

Records showed the environment and equipment used for people's care was regularly checked and maintained for people's safe use and support. Identified repairs to a number of older type windows and electrical installation checks due were planned to ensure their safe use. Staff knew the provider's emergency contingency procedures to follow. For example, in the event of a fire alarm or other domestic emergency situation, such as a mains electricity power failure. This helped to ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

People, relatives and visiting health professionals felt staff understood and ensured people's personal care needs associated with their health conditions. One person said, "They [staff'] get the doctor if needed; they make sure my feet and eyes sight are regularly checked." Another person told us, "Staff are very good – I'm happy with my care; staff help me to stay well; the district nurse comes in; they've got me a specialist bed, which helps." A visiting health professional told us, "The senior [care staff member] is on the ball and very well organised; she knows people's care needs and works well with us." A relative told us, "They [staff] are brilliant; they understand their [person receiving care] condition and how to help."

People were supported to access external health professionals when they needed to and staff followed any related instructions for people's care when required. For example, in relation to people's skin care, nutrition or in relation to routine health screening, such as foot or eye care.
People's care plans showed their health conditions, how they affected them and their related personal care requirements. Staff we spoke with understood and followed this to help optimise people's health and nutrition, which their ongoing care records showed.

People were provided with care in line with legislation and guidance in relation to consent. 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.

We checked whether the service was working within the principles of the MCA. Staff had received training and they understood the basic principles of the MCA. During our inspection we observed where possible, staff sought people's consent to their care; they offered choices and explained what they were going to do before they provided people's care. People were not always able to consent to their care or make important decisions about their care and treatment because of their health conditions. People's care plans showed an assessment of their mental capacity and any specific decisions about their care and treatment to be provided in their best interests. Related care records also showed appropriate consultation with their relatives and relevant health professionals when required; to help inform and ensure care in people's best interests. Some people had others who were legally appointed to act or make important decisions on their behalf; in relation to their health and welfare and/or finances. This helped to ensure people's rights and best interests in their care.

Staff told us about one person whose care needed to be provided at the home to keep them safe. The person was unable to understand or formally consent to this because of their health condition. Records showed the provider had submitted a formal application for this, known and a Deprivation of Liberty Safeguard (DoLS), to the relevant local authority for their formal authorisation. However, information we received before our inspection showed the provider had not acted when required to submit the DoLS

application until a visiting care professional told them to do so. We discussed our findings with a senior manager for the provider who told us about the action they had taken to prevent any reoccurrence. This included additional training for all staff in relation to DoLS; which related records showed. This helped to ensure people received care with their consent or appropriate authorisation when unable to do so. However, the provider's ongoing arrangements to check the quality, safety and effectiveness of people's care did not include regular checks as to whether staff were following the MCA. We discussed this with a senior manager for the provider who agreed to take the required action to address this.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. People were mostly happy with their meals, which they said were cooked properly and provided in sufficient amounts but some felt choice was limited. One person said, "The only choice you get unless you ask; is whether you want mashed or boiled potatoes!" Food menus provided were rotated over a four week period but lacked variety and choice. Daily menus were not visible or provided in accessible formats to help inform people's choices. The cook said they regularly spoke with people and knew their food likes and dislikes. A few people said if they didn't like or want the food on offer, they could ask for something different. We saw that requests made by two people for alternative food at lunchtime were accommodated. One of them said, "I'm happy with my meals; I was a bit worried at first but they follow what I say if I tell them I want something different; there's always plenty." Results from the provider's recent food surveys with people found they always or mostly enjoyed their meals and felt they had sufficient to eat and drink.

At lunchtime, we saw that portion sizes were tailored to meet people's requirements and there was little food wastage. Most people ate in the main dining room or lounge area at lunchtime. Staff served meals to a few people in their own rooms as they chose. Tables were set with cloths and drinking cups. Condiments were not routinely offered and one person commented they should have 'proper glassware' instead of the coloured plastic drinking cups, which they felt were more suitable for children. Staff offered people protective aprons, which some chose to accept. Napkins were not routinely provided and people were not offered a choice of their drink provided at lunchtime. Lunch was plated from the kitchen and brought to the dining room and people's own rooms located on different floors of the home. There was no way of keeping the food hot as meals were transported on an open, unheated trolley. One person told us their meals were often nearly cold when they received them in their own room.

We observed staff provided people with assistance and support to eat and drink sufficient amounts when required. Staff knew people's dietary needs and preferences and followed instructions from relevant health professionals concerned with people's nutrition. For example, the type and consistency of food and drinks to be provided, where risks were identified to people's safety from choking due to swallowing difficulties. However, we saw some people experienced delays or were kept waiting for an unacceptable time, either for their meal to be served or for the individual support they needed to eat this. When staff supported people to eat and drink, they helped them to do this at their own pace and provided gentle encouragement when required. This meant people received sufficient amounts of food and drink; but not always at the correct temperature or in the manner they preferred.

Staff said they mostly received the training and supervision they needed to undertake their role and responsibilities for people's care. One staff member said, "The training is good, we get all mandatory subjects and some additional." Another said; "We are supported to do NVQ's (national vocational qualifications) – up to level 4 in health and social care – role related." The provider maintained a staff training matrix, which showed staff received training relevant to their role, people's care needs and general health conditions. Staff received regular individual supervision to help monitor their understanding of people's care and identify any further training requirements. Records of the provider's recent checks of staff training showed action was planned for staff to receive training updates identified as due. For example, fire,

moving and handling and first aid. This helped to ensure staff received the training they needed to provide people's care.

The provider had recently introduced the care certificate for new staff to undertake. The care certificate identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring; treated people with respect and ensured their dignity in care. One person said, "Staff are lovely – kind and helpful." Another said, "Staff treat me properly; I like living here." A relative told us, "The staff are very good with my relative; they are patient and treat her well."

Staff understood the importance of ensuring people's dignity, privacy and being respectful when they provided people's care. One staff said, "It's their home; we are the visitors here; we respect and help them in any way we can." Throughout our inspection we saw that interactions between staff, people receiving care and their relatives, were warm and good natured.

Throughout of inspection we observed that staff were consistently kind, courteous and respectful towards people. Staff were discreet and mindful of people's privacy when they provided their care. For example, staff knocked on people's bedroom doors and waited to be invited in before entering. They also closed doors or window curtains to ensure people's privacy when required before providing people's personal care in their own rooms, bathrooms or toilets. When staff supported people to move to lounge or dining areas they checked people were comfortable, had drinks and any personal equipment they needed to hand. For example, walking frames. Staff also checked people were wearing any relevant aids, such as spectacles.

Staff were caring and compassionate. One person's care records showed they sometimes experience pain because of their health condition. We saw that staff responsible for the person's medicines checked with them to see if they were experiencing any pain and needed their pain relief medicines, which were prescribed to be taken when the person needed them. We also saw the staff member returned later to check with the person if their pain relief medicine had worked. This helped to ensure the person's comfort. Staff acted when one person was in an uncomfortable position in their easy chair, to assist them to move to a more comfortable position with the use of a supporting cushion.

Staff told us about one person who often became upset or distressed because of their health condition. When this began to occur we saw staff gently supported the person in a caring, patient, thoughtful manner and in a way which helped to comfort and reassure them. We observed staff explained what they were going to do before they provided people's care; checked to make sure they understood and listened to what people were saying. We observed staff supporting one person to move from one area of the home to another using their walking frame. When the person said they were tired part way; staff provided a chair for them to sit and rest until they were ready to continue to a comfortable seat in the lounge where they wanted to be. This showed that staff, were caring and compassionate when they provided people's care.

People and their relatives were involved and informed in the care provided. People felt they had good relationships with staff who treated them well and tried to give choices in their care. One person said, "They always check if I'm happy; where I want to spend my time; whether I want to go out with my family." Another said, "I go to bed and get up when I want to; staff help me when I'm ready." Staff we spoke with knew people well; understood what mattered and what was important to them. This included people's preferred daily care routines and involvement of family and friends. Relatives said they could visit at any time to suit the

person and described staff as friendly and welcoming. They also said that staff kept them informed and involved in people's care. For example, following any changes in people's health condition. We also saw people's own rooms were personalised and homely, which they said they were comfortable and happy with.

Record showed the registered manager held periodic meetings with people receiving care and their relatives to help keep them informed and consulted about people's care and daily living arrangements at the service. People who did not have representatives had access to an independent local advocacy service if they needed someone to speak up on their behalf

Requires Improvement

Is the service responsive?

Our findings

Following our last inspection the provider told us about their improvements to enable people's regular access to meaningful social, recreational and leisure occupation of their choice. This included provision of equipment and materials to promote people's mental and sensory stimulation. The provider also advised they aimed to increase opportunities for people to access the local community and intended to survey people and relatives about people known hobbies and interests in order to assist their improvements.

At this inspection we found people said there were often activities they could join, such as manicures, board games singing or visiting entertainers, which they enjoyed. They also said that seasonal celebrations were organised, which friends and family could attend. One person told us they usually played dominoes each afternoon with another person living in the home, which we observed they independently participated in and enjoyed. Another person's care records showed they regularly went out to a local day centre, to meet and participate with others there who had similar interests. Two other people regularly went out with their relatives, shopping or for meals and drives out into the countryside. We saw that large interactive televisions were more recently provided for both communal lounges, which people enjoyed watching at given periods. For example, we saw two people enjoyed watching cricket together. Minutes of meetings regularly held with people showed plans to provide interactive TV's in people's own rooms as they chose. We also saw a few people spent time with their visitors; others listened to music together and were offered refreshments. This showed people were supported to participate in social, occupational and recreational activities within and outside the home. However, we also found this was not always planned or considered to optimise people's independence, choice and control.

One person told us they usually preferred to spend their time in their own room where they enjoyed listening to music there and receiving their family visitors, which they enjoyed. However, the person also said they were often became bored and said, "I'd love to go out in the fresh air or to church once in a while, but it never happens – there's not enough staff." A senior care staff member advised that a referral had been made and accepted by a local befriending service to help support the person to achieve this, which records showed. However, we found the person had been waiting some time and with no timescale for this to be achieved. This was because the befriending service gave priority to isolated people who were living alone in the local area. Action was not taken by staff to seek any alternative solution, such as providing a staff member to support the person to achieve this. Another person we spoke with said they would like to do more around the home. They gave an example of drying cutlery or pots, but said when they raised this they were told by the registered manager this was not possible, as they 'could not go into the kitchen for safety reasons.' Alternative solutions were not considered or employed by staff to help meet the person's wishes.

Since our last inspection, the provider had consulted with people and their relatives to develop comprehensive care plan information about people's individual family, social and lifestyle history; and also their known hobbies and interests. Information was displayed in communal areas for people about activities provided. This included films, board games, knitting, manicures, reading and singing. We looked at the provider's statement of purpose and their service guide, which provided information for people about the care and services they could expect to receive at the home. This referred to, 'A wide range of activities and

support to pursue your own hobbies interests.' A supporting list included activities such as IT, gardening and outings. However, during both of our inspection days we found the provider's arrangements, including their staffing provision, did not support this.

The provider regularly sought to obtain people's views about their care and those of their relatives. This included from regular survey type questionnaires and meetings held with them. However, findings from this were not consistently used to make care and service improvements. For example, to improve garden provision and access for people. The provider's last full care survey conducted with people and relatives was at the year end of 2016. This found almost 40 percent of respondents felt people were not regularly supported to access the local community to participate in leisure activities they enjoyed. Sixty-two percent said they, 'Never got to do daily living tasks they would like, such as shopping, cooking or tidying' and felt they would like to be more involved in home life in this way. There was no related action plan to show how improvements would be made from people's views. This meant people's care was not always individualised or responsive to their assessed needs or expressed wishes.

Before our inspection the provider told us about some of their planned improvements over the coming 12 months to help make the service more responsive in relation to people's care. This included environmental improvements to promote people's freedom of movement, independence and orientation using nationally recognised practice concerned with dementia care. At our inspection, staff told us about two people who were living with dementia or sensory health conditions; who could easily become distressed because they struggled to recognise and make sense of their environment, which their individual care plan showed. With the exception of some signage, we saw the environment was not designed to fully optimise people's understanding, independence and orientation. For example, by use of appropriate décor, lighting, directional signage or other suitable orientation aids. The décor and lighting in one person's room was particularly unhelpful in relation to their sensory and perceptual experiences from their health condition. We also saw another person struggled and was unable to eat their lunchtime meal independently with the standard cutlery provided. Staff had not considered whether adapted cutlery may assist the person to eat independently. We discussed our findings with the provider, who told us they had sourced specialist external advice to help them improve their care approach for people living with dementia, which related records showed. The provider also agreed to review the provision of adapted eating utensils for people who may require this.

Most people and relatives knew how to raise any concerns they may have or make a complaint. Information was visibly displayed about how to make a complaint and also provided in the provider's service guide, which was given to people or their representative on their arrival at the service. This information included the contact details of relevant external authorities that may be concerned with people's care, such as local authority care commissioners and the Care Quality Commission. The contact details of the Care Quality Commission provided on the displayed complaints procedure were incorrect and that of a predecessor organisation, which did accurately inform people. A senior manager for the provider agreed to take the required action to address this. The provider's complaints record showed there had been no complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

The provider's management arrangements did not always ensure improvements to the quality and safety of people's care when required. The provider told us they carried out regular checks of the quality and safety of people's care. However, related records we looked at together with our inspection findings; showed the provider's arrangements for this did not consistently help to ensure the safety or the quality of people's care. This was because the provider's checks were not always sufficient to identify improvements needed; or the provider did not always act on the results of their management checks to ensure quality improvements were made when required. For example, the provider had not fully ensured environmental hygiene and cleanliness at the home; or that staff understood and followed the Mental Capacity Act 2005 (MCA) for people's care until CQC or other external agencies told them to. Related governance and management arrangements did not always assure how this would continue to be monitored and ensured.

People, relatives and staff felt the registered manager was visible and accessible. Some felt the registered manager did not always listen or act on their views or feedback obtained from them to help improve the quality of people's care. Examples, they gave us from this related to their views about improvements for people's care. This included staffing, the environment and in relation to peoples' daily living and lifestyle arrangements.

Some improvements had been made since our last inspection to regularly consult with people, to seek their involvement and views about the quality of their care, together with those of relatives and staff. However, the findings from this were not always acted on to make improvements when needed. This included improvements to optimise people's timely care, independence, choice and control in relation to their environment meals, daily living activities, lifestyle preferences and related staffing arrangements where required.

We found the provider did not have wholly effective arrangements to monitor or fully ensure the quality and safety of people's care. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

The provider was able to show some improvements were made to people's care following our last inspection and from some of their related management checks. For example, in relation people's medicines, care plans and the environment and equipment used for their care. Accidents, incidents and people's health status were also regularly monitored. The findings from this were analysed and often used to help inform and make care and service improvements when required. Examples of recent improvements made or planned from this included care plans, medicines arrangements, record keeping, staff training and some environmental repairs.

There were clear procedures for staff to follow for communication and reporting in relation to people's care, safety and health monitoring. Staff understood their related roles and responsibilities. For example, they understood how to raise concerns or communicate any changes in people's needs. This included reporting accidents, incidents and safeguarding concerns. The provider's procedures, which included a whistle

blowing procedure, helped them to do this. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their rights and how to raise serious concerns about people's care if they needed to.

Records relating to the management and running of the service and people's care were accurately maintained and securely stored. The provider had met their legal obligations with us. For example, they had sent us written notifications when required telling us about important events when they occurred at the service. For example, to tell us about a person's death in the home. This helped to ensure accountability and continuous improvement for people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person's arrangements to assess, monitor and improve the quality and safety of people's care were not wholly effective or consistently operated and evaluated to ensure this. Regulation 17(1) and (2) (a) (e) & (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not sufficient to consistently ensure environmental cleanliness and people's timely or individualised care. Regulation 18(1).