Grandcross Limited

Chichester Court 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection which took place on 16 October 2017.

At the last inspection in September 2016 the service was not meeting all of the legal requirements with regard to person centred care. At this inspection we found improvements had been made and the service was no longer in breach of these requirements. However, we considered improvements were required with regard to other aspects of care.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to mental capacity and best interest decision making, record keeping and quality assurance. You can see what action we told the provider to take at the back of the full version of this report.

Chichester Court is registered to provide accommodation for personal or nursing care to a maximum of 52 older people including people who live with dementia or a dementia related condition. The home was separated into two units, the Riverside unit and the Haven unit. Nursing care is provided.

A registered manager was 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.

People said they felt safe and they could speak to staff as they were approachable. We considered that staffing levels needed to be reviewed. We have made a recommendation that staffing levels are kept under review and that staff are appropriately deployed to meet people's needs in a safe, timely and person centred way.

Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way. However, we have made a recommendation about the management of medicines.

Not all areas of the home were clean and well maintained for the comfort of people who used the service. The home was not designed to promote the orientation and independence of people who lived with dementia. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Improvements were needed to improve staff understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. 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.

Risk assessments were in place and they accurately identified current risks to people as well as ways for staff to minimise or appropriately manage those risks. Care was provided with kindness and people's dignity was respected. People's privacy was not always protected.

People had access to health care professionals to make sure they received appropriate care and treatment. People received a varied and balanced diet to meet their nutritional needs. However, we considered improvements were required to people's dining experience.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to staffing levels, medicines management, people's dining experience, environmental design, best interest decision making and respecting people's privacy and record keeping.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. Appropriate training was provided and staff were supervised and supported

Staff knew people's care and support requirements. However, record keeping required improvement to ensure it reflected the care provided by staff.

A complaints procedure was available. Staff and most relatives said the management team were approachable. People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. People had access to an advocate if required.

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.

We have made a recommendation that staffing levels are kept under review to ensure that staff are appropriately deployed to meet people's needs in a safe and timely way. People were protected from abuse as staff had received training with regard to safeguarding. Appropriate checks were carried out before staff began working with people

Checks were carried out regularly to ensure the building was safe and fit for purpose. Some areas of the home required attention as they were not clean and they were showing signs of wear and tear.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way. However, where people received their medicine covertly (without their knowledge) correct processes had not been followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure the environment was designed to promote the orientation of people who lived with dementia.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to make decisions about their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs. We considered improvements were required to the organisation of people's dining experience.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and cheerful.

Staff were aware of people's backgrounds and personalities. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity. We have made a recommendation to respect people's privacy with regard to the display of personal information.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff.

Staff in some areas of the home did not engage and interact with people except when they provided care and support. There were limited activities and entertainment available for some people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance programme was not robust. Audits carried out to assess the quality of the service had not identified the issues that we found during the inspection.

A registered manager was in place. Staff and relatives told us the management team were available to give advice and support.

Staff informed us that they enjoyed working at Chichester Court

and they worked as a team.

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

The inspection took place on 16 October 2017 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We observed care and support in communal areas and looked around the kitchen.

During the inspection we spoke with 11 people who lived at Chichester Court, five relatives, the regional manager, the registered manager, five support workers including one senior support worker, two registered nurses, one domestic member of staff, two members of catering staff and the activities co-ordinator. At the

end of the inspection during feedback we spoke with the care services director of the organisation.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, five people's medicines records, recruitment, training and induction records for five staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

We had concerns that not all areas of the home were clean and that a robust audit of the environment did not take place that ensured an adequate standard of hygiene and infection control and to ensure it was safe and comfortable for people who used the service.

At the time of inspection not all areas of the home were clean and there was a mal-odour in areas identified at inspection. A hallway and lounge carpet were marked and mal-odorous. Some lounges and bathrooms were untidy with items left lying around or mis-stored which were shown to the registered manager at the time of inspection. Bathrooms were not always tidied after use and we found a razor and toiletries which were accessible in one shower room on the Riverside unit and some soiled clothing and incontinence aids in another bathroom. As well as being untidy it was also a risk to people who lived with dementia, who may have tried to use the items without staff support.

Some communal bathrooms and shower rooms required re grouting and the seals replaced. The flooring in some communal lavatories required replacement for effective infection control. For example, the linoleum around some lavatory pedestals was discoloured and lifting from the base. The provider submitted an action plan straight after the inspection that showed an acceptable timescale for refurbishment and improvements to the environment.

We discussed the audits that took place should include these environmental aspects of safety and infection control to ensure the environment was hazard and clutter free.

People we spoke with said that they felt safe living at Chichester Court. One person told us, "I certainly feel safe here, I'm looked after." Another person commented, "Yes, I feel safe here, I'm pretty secure." A third person said, "I'm safe and happy here, there's nothing to fear."

Feedback about staffing was variable. A relative told us, "I think there are enough staff." However, not all people said they were well supported as staff were not always available. On the Haven Unit one person told us, "The staff are always busy." A second person said, "The girls [support staff] do a good job but it is short staffed." One relative commented, "They're short staffed, people are just left sitting around." Another relative said, "I think they could do with more staff. I come in now to make sure [Name] has got their food chopped up when they haven't enough staff to support them."

There were 41 people living at the home at the time of inspection. Staffing rosters and observations showed on the Riverside unit 15 people, who lived with dementia, were supported by one nurse and three support workers. Two people were provided with 1:1 support at different times of the day, one person was at high risk of falling and another person displayed distressed behaviours.

The Haven unit, which accommodated 26 people with nursing needs were staffed by one registered nurse and four support workers.

On the Haven unit several people were cared for in bed due to their health care needs. The majority of people on the unit required two members of staff for their moving and assisting needs. One staff member commented, "Even with four staff, it takes two staff members to get baths done and then when someone else needs hoisting, it takes two staff members and leaves no one on the floor. Activities can't even get done with four staff." This meant when staff were busy other people had to wait and were left unsupervised. On the day of inspection we observed in the morning only three support workers were available as one person had been escorted by a member of staff to an external appointment. They had not been replaced and we saw staff were very busy trying to ensure people did not have to wait too long when they summoned staff assistance.

Overnight staffing levels included one registered nurse and four support workers.

The registered manager told us an assessment tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. We considered from our observations that staffing levels should be reviewed to ensure there were sufficient staff to meet people's needs at all times.

We recommend that the provider takes into account feedback from relatives and staff, and that staffing levels are kept under review to ensure people receive care that meets their needs in a safe and timely way.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records and medicine labels to ensure people were receiving the correct medicine. They explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Appropriate arrangements were in place for the administration, storage and disposal of all medicines and this included the appropriate storage and checks of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed.

The provider's medicines policy included written guidance for the use of "when required" medicines, and when these should be administered to people who showed signs of agitation and distress. 'When required' medicines are those given only when needed such as for pain relief. A staff member told us, "You can tell by their face if a person is in pain if they can't tell you verbally."

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as the best interests decision had not been made with all the relevant people. Documentation for one person showed the GP had authorised the decision for the use of covert medicines. However, this did not include feedback from other parties relevant to a best interest decision such as the pharmacist, family members and care home staff. It is important for the pharmacist to be consulted when medicine is given covertly to take into account any safety considerations.

We recommend the registered manager considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the hoists and specialist baths.

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found 34 concerns had been logged appropriately. This included safeguarding alerts that had been raised by the home. All alerts were investigated and resolved to ensure people were protected. Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. One member of staff told us, "If I had any concerns I'd report it to the person in charge." All staff expressed confidence that the management team would respond to and address any concerns appropriately. One staff member told us, "I've done local authority safeguarding training."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care, distressed behaviours and nutrition.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls and distressed behaviours. Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour team. Staff were aware of the interventions and the support a person required to keep them safe. 1:1 staff support was in place for people who may be at risk of extreme distress to keep them and other people safe. We observed one staff member who was supporting a person who was becoming increasingly distressed. They managed the situation well and effectively diffused it and quickly calmed the person.

Staff personnel files showed that a robust recruitment system was in place. This helped to ensure only suitable people were employed to care for vulnerable adults. Staff confirmed that checks had been carried out before they began to work with people.

Requires Improvement

Is the service effective?

Our findings

We considered the environment required more attention as bathrooms were clinical and not homely or relaxing. The environment was not "enabling" to promote people's independence and involvement. It was not stimulating and therapeutic for the benefit of people who lived there. Pictures and signs were not available to keep people orientated and involved and to help maintain their independence. Memory boxes were not available that contained items about people's previous interests to help them identify their room. There were no displays or themed areas of interest on the corridors and around seating areas for people as they moved around. We discussed this with the area manager and registered manager who told us it would be addressed. We received an action plan after the inspection that showed the organisation's dementia support team were supporting the home to advise about the environment.

We recommend the service refers to the National Institute for Health and Clinical Excellence guidelines, Quality Improvement Resource in Social Care Settings, regarding the design of accommodation for people who live with dementia.

We observed the lunch time meals in the dining rooms. We considered improvements were required to the organisation of people's dining experience. People sat silently in one dining room and there was a noisy, disruptive atmosphere on the Riverside unit when people became agitated. Relaxing, tranquil music was not available to entertain people as they waited or to encourage people to eat their meal in either dining room. People were waiting at the table from 12:00pm until 12:50pm on the Riverside unit when the hot trollies arrived for staff to serve the food. Most people were served in the dining room and staff were available to provide support and encouragement or full assistance to people. However, due to the length of time waiting for their meal and to be served their next course some people with distressed behaviours became agitated as they waited and this upset other people.

On the Haven unit it took approximately 25 minutes for meals to be taken to people in their bedrooms by one staff member. Some people required prompting or assistance in the dining room to eat their meal. One nurse gave full assistance to two people with their meal in the dining room but as it took 20 minutes for one person to be assisted with their meal the other person who required support waited this length of time for assistance with their meal. Staff when they did provide assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. Staff talked to people as they helped them. For example, "Can I get you a drink?" and "Did you enjoy that, would you like some more?" The meal time organisation was discussed with the area manager and registered manager who told us it would be addressed

Handwritten menus were displayed but they were out of date and did not provide accurate information about the meals available each day. Pictorial menus were not available to help people make a choice if they no longer understood the written word. People were offered a choice of meal and drinks and staff showed the various food options to help people choose by sight or smell. People sat at tables that were set with tablecloths and place mats, people were offered protective aprons but napkins were not available. Some people preferred to remain in their bedrooms to eat.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 30 DoLS applications had been authorised by the relevant local authority and eight applications were waiting to be assessed. Where people were not subject to DoLS they were able to come and go in the home as they wanted. There was evidence the MCA principles were not consistently being followed or applied. For example, the principles were not applied to administration of covert medicine and display of people's personal information and obtaining consent.

Improvements were required to ensure that the best interest decision making process was followed to ensure that people without mental capacity to give their consent had their right to privacy respected.

Personal information, in the form of a life history, was displayed on the wall outside of each person's bedroom, where it could be read by anyone. We also had concerns some people without mental capacity were not involved in giving their consent to displaying this information in public. This information was very useful to give staff some insight into people's background and interests but would be more private in the person's own room.

We also discussed with the registered manager the display of pictures that had been filmed of people living in the home that were shown on the television in the home's foyer. We queried how people without mental capacity had been able to give their consent and if a 'best interest' decision had been made on their behalf. We also queried why people's photographs were being used in this way. It was shown in the entrance to the home where no people who used the service were able to congregate and watch.

This was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The staff training records showed and staff told us they had received training to meet people's needs and training in safe working practices. One staff member told us, "I've had training about dementia care." Another staff member commented, "We do e-learning training and face-to-face training." Other staff comments included, "I did fire training not long ago", "I've done a National Vocational Qualification (NVQ) at level 3, I'm waiting for my certificate." One relative commented, "I definitely think the staff are trained."

The staff training matrix showed that a variety of courses took place to ensure staff had the knowledge to meet people's care and treatment needs. Staff training courses included, pressure area care, equality and diversity, dementia care framework, dysphagia (swallowing difficulties), allergen awareness, oral health, mental capacity, basic life support and malnutrition. The training matrix showed the home's staff team achieved 93% in the e learning modules.

Staff members were able to describe their role and responsibilities. Newer staff told us when they began

work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. The registered manager told us staff studied for the Care Certificate in health and social care as part of their induction training. All staff told us they were supported in their role. Support staff said they received regular supervision every two months and nurses received supervision from the registered manager. An annual appraisal system was in place and one staff member told us, "My appraisal is due."

Staff told us communication was effective to keep them up to date with people's changing needs. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member told us, "Handovers give us all the information we need." Another member of staff commented, "All support staff attend the handover in the morning when we come in." This was to ensure staff were made aware of the current state of health and well-being of each person. A handover sheet was used that contained written prompts for staff as they passed over information about people's needs. However, the handover records were not all dated to provide an accurate chronology of events. We discussed this with the area manager and registered manager who told us it would be addressed.

People's special diets and any cultural or vegetarian preferences were respected. Food was well presented and looked appetising. A choice of main meal was available at each meal. People were offered regular drinks and snacks throughout the day in addition to the main meal. People and relatives were positive about the food saying there was enough to eat. One person said, "All the food is nice." Another person commented, "My meal is always tasty." A third person told us, "The food is good, there is always plenty of choice." Other people's comments included, "There is always plenty to eat" and "The food is alright." People's feedback within the provider's regular satisfaction surveys was positive. Comments included, 'I always enjoy breakfast' and 'I always enjoy the food.'

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Food and fluid charts recorded people's nutritional and fluid intake.

People were supported to maintain their healthcare needs. One relative commented, "[Name] has been able to keep their own GP since moving here." People's care records showed they had regular input from a range of health professionals such as, General Practitioners, psychiatrists, dieticians and a speech and language team (SALT). Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. The registered manager told us a link GP from a local medical practice visited weekly to give advice and treatment where required. This helped reduce people's admission to hospital.

Requires Improvement

Is the service caring?

Our findings

Care plans did not include details about peoples' choices to encourage the person to maintain some involvement and control in their care. They did not include details with regard to how people liked and needed their support from staff. It is important information to help ensure people receive person centred care and necessary for when a person can no longer tell staff themselves about their preferences.

An assessment was carried out that stated how a person communicated but care plans did inform staff how a person communicated. For example, if they were in pain or showing signs of distress if they were unable to communicate this information verbally.

People were encouraged to make choices about their day to day lives. Care plans however, did not document how staff could encourage people to remain involved, make choices and express their views. For example, with pictures, signs or symbols.

We observed on The Riverside, dementia care unit there was very limited engagement with people. The only staff interaction with people was at mealtimes and when the drinks trolley came around or when people were assisted with personal care. On this unit although some staff were sitting supervising people, they did not engage with them. They did not take the opportunity to talk to people and spend time listening to what they had to say. We observed around the home people remained in their bedrooms without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them.

From our observations we considered improvements were needed on the Riverside Unit to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person.

We discussed our observations with the area manager and registered manager who told us the home had achieved the organisation's dementia framework. We received an action plan immediately after the inspection that stated an advisor from the organisation was to provide training about person centred care.

Staff appeared to have a good relationship with people and knew their relatives as well. People and the majority of relatives we spoke with said staff were kind, caring and patient. One person told us, "Everyone is friendly." Another person commented, "Some of the staff are alright, some are different." Other people's comments included, "They [staff] are all lovely", "All the staff are good to me, one brings me in soup because they know it's my favourite", "I'm listened to" and "Staff are all nice here, I like it." A relative commented, "Staff look after [Name], they're great." A second relative told us, "The majority of staff are nice, some aren't." Other comments included, "Staff look after [Name] the best they can, they are great" and "If you ask something gets done."

When staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and sympathetic manner. Support workers were caring and patient. For example, they talked gently to a person

and reassured them as they assisted them.

People's dignity was respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. We observed staff knocked on people's doors before entering their rooms, including those who had open doors.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed and what they might like to do. One person told us, "I get to choose what I want to eat." Another person commented, "I can have a lie in bed when I want." A third person said, "Staff are pretty obliging, they treat me as a person. I get the choice of when I want to go to bed and get up, what I want to wear and what I eat." We heard staff ask people for permission before supporting them, for example with personal care or offering them protective clothing at the lunch time meal.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we had found a breach with regard to person centred care. Records at this inspection showed some improvements had been made to help ensure people received person centred care. However, we considered more improvements were needed with regard to record keeping to ensure they reflected the care provided by staff.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people. A relative commented, "I'm involved in [Name]'s care plan reviews and kept informed if there are changes."

Care plans were in place that provided some details for staff about how the person's care needs were to be met. However, not all care plans provided detail of what the person could do to be involved and to maintain some independence. For example, one care plan for personal hygiene stated, 'Needs assistance from two members of staff to maintain their dignity, personal hygiene needs and dressing.' Although it contained some information, it did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. Care plans did not detail what the person was able to do to take part in their care and to maintain some independence. Another care plan for personal hygiene which stated the person became distressed did not document what staff needed to do to de-escalate the situation when a person became agitated because of personal care interventions.

Some people with distressed behaviour were referred to the positive behaviour team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people's behavioural plans to help staff provide care to the person. However, care plans were vague for some other people who may show agitation or distress. They did not give staff detailed instructions with regard to supporting the person. Information was not always available that included what might trigger the distressed behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour. For people who were prescribed 'when required' medicine for agitation or distress their care plans did not provide guidance to staff when the medicine may be administered and if it was to be used as last resort to calm the person.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not

attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. However, information was not available with regard to people's spiritual and cultural preferences at this important time and for their wishes after death to ensure their final wishes could be met.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Some people confirmed they had a choice about getting involved in activities. One person told us, "I don't join in with the activities, staff hardly come in and ask if I want to either. I'm happy being by myself." Another person commented, "I'm not an activities person but staff do ask me to join in." One relative told us, "Activities are good, its lovely seeing people singing to the music." Another relative said, "As far as I am aware they go out on outings." A third relative told us, "[Name]'s been out once or twice, I've had to ask staff to take [Name] for the activities because they're just left in their room."

An activities coordinator was employed. On the day of inspection we observed some people on the Haven unit, were involved in a sing-a-long in the morning and a movie afternoon took place with people on the unit. Organised activities did not take place on the Riverside dementia care unit, on the day of inspection. An activities programme however, advertised planned events such as armchair exercises, hand massage, chats, board games, dominoes, singing, reminiscence, carpet bowls, visiting clergy and hairdresser and monthly outings with fish and chips for lunch.

An activities room was available on the Haven unit but it did not look well-used or organised. The sensory and musical equipment available in the room that may have been of interest to people was not accessible. Rummage boxes and items for reminiscence were not available for people who lived with dementia. On the day of inspection on The Riverside unit we saw most people sat sleeping in the lounge in front of a television and there was nothing of interest to keep them engaged and stimulated.

We recommend that staff receive training about person centred care and personhood to ensure that people who live with dementia are kept engaged and stimulated and offered meaningful activities if they wish to take part.

People's records contained information about people's history, likes, dislikes and preferred routines. People also had a 'This is Me' profile. The information had been collected with the person and their family and gave details about the person's preferences, interests and previous lifestyle.

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

People and their relatives were kept involved and consulted about the running of the service. Meetings took place with people who used the service and minutes were available for people who were unable to attend. Meeting minutes showed items discussed related to people's care.

People knew how to complain. People we spoke with said they had complained if they needed to. Not all

people spoken with said their concerns about their relative's daily care needs had always been addressed. One relative told us, "Things aren't always put right when I've complained." Another relative said, "I've complained, I know my sister has too and it still happens." A third relative commented, "I've never had to complain." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had become formally registered in July 2014. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

We found that the breach of regulation and areas for improvement identified at the last inspection had been acted upon. Although further work was required to ensure people received person centred care. After this inspection CQC received action plans that detailed the action that had been taken to improve outcomes for people who used the service.

We had concerns audits were not all effective to ensure the well-being at all times of people who used the service.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. Monthly audits included checks on care documentation, staff training, medicines management, home presentation, complaints management, health and safety and accidents and incidents. Other audits included for health and safety and infection control. All audits showed the action that had been taken as a result of previous audits. However, the audit and governance processes had failed to identify deficits in the environment, medicines management, record keeping, staffing levels, best interest decision making, aspects of people's privacy and people's dining experience.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Other quality assurance processes included a risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the registered manager and submitted to head office for analysis.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The registered manager told us a daily audit took place which involved them doing a daily walk around. It was completed electronically with an iPad and all responses and outcomes were received directly by head office each day. The responses were escalated electronically, and depending upon the category of severity, were triggered to senior management within the organisation to make them aware of any issues identified. The iPad was also used to collect feedback from people who used the service, relatives and staff, with a minimum number being encouraged to comment.

Monthly audits included checks on people's dining experience, staff supervision, medicines management, care documentation, training, kitchen audits, accidents and incidents, clinical governance and nutrition. All audits were available electronically and we saw the information was filtered to ensure any identified deficits were actioned.

Monthly visits were carried out by the regional manager who would speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Action plans were produced from monthly visits with timescales for action where deficits were identified.

The registered manager assisted us with the inspection, together with the area manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager told us they were well supported by the provider. They had regular contact with them, ensuring there was on-going communication about the running of the home. Regular meetings were held where the management were appraised of and discussed the operation and development of the home.

The running of the home was relaxed. Staff said they were supported by the registered manager. They said they could approach them to discuss any issues. A staff member commented, "The registered manager is very approachable." Relatives told us the manager was approachable but two relatives commented they were not always responsive. One relative told us, "Management are approachable but nothing gets done."

Relative and staff meeting minutes showed that some issues raised were repeated and although action may be taken it was not always effective and carried out in a timely way. For example, concerns raised by relatives in May 2017 about task centred care for their loved ones was still apparent at the inspection in October 2017.

Staff meeting minutes were available to show the staff meetings that took place to assist with communication and ensure the smooth running of the home. These included senior staff meetings, health and safety meetings and general staff meetings. Staff members told us staff meetings took place and minutes were made available for staff who were unable to attend. Minutes from a staff meeting in September showed the untidiness of the environment had been discussed, infection control, training, staff performance, staffing levels, fire drills, hand overs and laundry. One staff member told us, "Staff meetings do happen. We had one a couple of weeks ago." Staff meetings kept staff updated with any changes in the service and to discuss any issues.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to relatives and people who used the service and staff. We saw samples of the daily recent feedback from people who visited the home and people living there. Comments included, 'There is always choice of food', 'Staff are respectful toward me', If ever I've asked for help the staff would help me', 'Staff are very friendly' and 'I've been here a few years and it's a nice home to live in.'

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The best interest decision making process was not always followed to ensure that people without mental capacity to give their consent had their right to privacy respected. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)