Larchwood Care Homes (North) Limited

Ravenstone

Inspection report

7a St Andrews Road
Droitwich
Worcestershire
WR9 8DJ

Tel: 01905773265

Date of inspection visit:
22 August 2016
23 August 2016

Date of publication:
26 October 2016

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

The inspection took place on 22 and 23 August 2016 and was unannounced.

The provider of Ravenstone is registered to provide accommodation and nursing care for up to 43 people who have nursing needs. At the time of this inspection 38 people lived at the home. Bedrooms, bathrooms and toilets are situated over two floors with stairs and passenger lift access to the first floor. People have use of communal areas including lounges, conservatory and dining room.

Since our previous inspection a new manager had come into post in October 2015. The manager had said they would make an application to register with us but at the time of this inspection the application had not been made to us. However, at the time of this inspection the provider was recruiting to ensure they were fulfilling their legal responsibility in having a manager who was registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the provider needed to make improvements to ensure people's needs were effectively met and they were safe. We saw staffing arrangements did not ensure people's individual needs were met in a timely way which significantly compromised people's wellbeing and safety. Staff believed they did not have time to spend with people to promote good care.

People's medicines were stored securely and made available to people as prescribed. Although, we were concerned about two people who did not receive one of their particular medicines at the right time. For one person this had impacted on their emotional wellbeing and health needs.

People had different reasons for feeling safe whilst living at the home which included feeling secure and having staff 'on hand' so they could request support. Staff showed a good understanding of how to recognise abuse and how to report if concerns were raised. Staff were aware of how to minimise risks to people's safety. We saw they used specialist equipment to ensure people's needs were met and the risks of injuries were reduced.

There were staff recruitment and selection processes in place to make sure the providers recruitment arrangements did not compromise people's safety. Improvements were being made to ensure all staff had the opportunity of receiving regular training and one to one meetings to support them in their roles. We saw staff did not always apply their knowledge into their daily practices and staff felt unsupported due to the inconsistency in staffing arrangements.

People were asked before support was provided and their wishes were respected. We saw people were given choice about day to day decisions such as what they would like to wear and where they would like to sit.

However, there were inconsistencies in assessing people's ability to make their own decisions. Where decisions had been made on people's behalf the records did not always reflect whether best interest decisions were made by people who had the authority to do this.

People were supported to have a choice of meals from the menu which was being developed further. Improvements were being made to provide people with further opportunities throughout the day to boost their calories if their appetites were poor, such as snacks. More consideration was needed to make sure people had the support they required to eat their meals without any unreasonable delays and it was a sociable occasion for people.

Health and social care professionals were involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were caring and supportive. However, staffing arrangements and the lack of leadership had impacted upon the time staff invested into providing care which was not always led by tasks staff needed to do. There was also little consideration made in how people were supported to maintain their dignity which reflected people were not always placed at the heart of staff practices.

Record keeping required strengthening to ensure people's care and health needs were accurately recorded especially where people's needs had changed. Work was in progress to update people's records with people's involvement so they accurately reflected their individual needs.

Opportunities for people to follow their own interests and socialise was continuing to be embedded into daily life. However, staff missed opportunities to introduce into their caring roles time to spend socialising with people. There was also a culture of people sitting in wheelchairs for long periods of time in communal areas of the home whereby staff could have taken the time to encourage people to sit in armchairs.

The provider had a system in place for dealing with people's concerns and complaints and these had been followed. However, the opportunities for people to voice their opinions about the quality of the service were informal so it was difficult to see what changes had been made as a result of their feedback.

The provider had management procedures in place to ensure people received safe and effective care. However the service people received was under internal scrutiny by the regional manager to ensure the provider's required standards were achieved and people received high quality care.

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 consistently safe.

Staffing arrangements did not ensure staff were available to meet people's needs in a timely way.

Staff practices were inconsistent in making sure people's medicines were available to them at the specific times they were prescribed.

People were supported to feel safe and secure and staff knew how to recognise signs of potential abuse and how to report any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effectively.

Staff did not consistently apply their training and knowledge to make sure their practices remained effective and safe.

People's best interest decisions were not consistently followed through and recorded evidence to reflect people were not deprived of their legal rights. Staff sought people's consent before supporting them.

People received support from healthcare professionals which included assisting staff to meet their nutritional needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff who were kind and respectful but people's dignity was not consistently maintained.

The provider's commitment to providing care which was centred on each person was not always a value which was reflected in staff practices to enhance people's quality of life.

People's histories, likes and dislikes were well known by staff who strived to support people in maintaining their own levels of

independence by including them in their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care which was personalised to them and people believed staff did not have time to spend with them.

People's care plans were being improved so they consistently held accurate details to support staff in providing care in accordance with people's needs and preferences.

People were supported to follow their interests and have fun things to do which was continuing to be developed to enhance people's quality of life.

People were aware of how they were able to raise complaints and any received had been responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were on-going changes in the management position and the manager in post had not submitted an application to be registered with us.

Through the quality checks improvement actions had been identified which were on-going and had yet to be achieved to ensure people received high quality care.

People had wishes for staff to spend more time with them as they believed staff were rushed.

Staff did not feel consistently supported to provide good care.

Ravenstone

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 August 2016 and was unannounced. The inspection team consisted of one inspector and a specialist advisor who was an advanced nurse practitioner. They had the knowledge, skills and experience of managing people's health needs. The inspector returned to the home to continue the inspection on 23 August 2016.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

We looked at the information we held about the provider and the service. This included information received from the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also sought information from Healthwatch who are who are an independent consumer champion who promote the views and experiences of people who use health and social care. We used this information to help us plan this inspection.

During our inspection visit we spent time looking at how staff provided care for people to help us better understand their experiences of the care they received. We spoke with 10 people who lived in the home, four visiting relatives, the manager, the regional manager, five members of the care staff team and two nurses, the housekeeper, maintenance person, kitchen assistant and chef.

We looked at a range of documents and written records including three people's care records and staff training and the recording of incidents and accidents. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Additionally the regional manager sent us information which included action plans they had developed following our inspection visits.

Requires Improvement

Is the service safe?

Our findings

Although people spoken with told us they felt safe living at the home we received different experiences about how staffing arrangements impacted upon the care they received. We consistently heard from people about how they believed the provider was short staffed and how this had an impact upon their experiences of the care provided. One person said, "I do as much as I can for myself, as they are very short staffed all the time. Sometimes I have been left in bed until 11.30 in the morning, but since my family complained I tend to be got up earlier." One relative said, "Staff do their best but it's not very good" as there was a lack of staff and at "Weekends it could be really bad." A further relative believed staffing levels needed to increase as , "Sometimes my wife is not washed until 11am due to staff shortages."

The manager told us in the provider information request [PIR], 'Staff cover is arranged in line with the number and dependency of residents.' However, we received mixed responses from staff about the staffing arrangements. One staff member felt most days as long as there were the planned staff on duty they felt able to meet people's needs in a timely way. Another staff member told us they often worried about, "Would they have enough staff to get through the day."

We saw examples of what people and their relatives had described to us during our inspection. These included people's needs not always being met within a reasonable time period. For example, one person's safety and emotional wellbeing had been impacted upon as staff had not met their needs in a timely way. The person was reliant upon staff to meet all their needs due to their health condition. The person was very distressed when their relative visited because they had had an accident due to waiting for staff which had left them in an uncomfortable position. The person said they had been using their call alarm to request support from staff to meet their needs for a long time. However staff had said to the person they would have to wait as they were busy. The person went on to say although staff were kind, "They just rush in turn off the buzzer and leave you stranded." The person's relative confirmed to us the person had been left unattended. We found the staffing arrangements did not ensure the management of people's care was positive and their needs were met and requests for support were answered in a timely way. In addition the relative of this person also expressed concern about the delays experienced in delivering basic care requests.

Another person who relied upon support from staff to move was unable to summons staff when they needed assistance with their personal care needs. There were no staff in the lounge area to assist the person and they became more visibly upset due to believing they had had an accident. We alerted a staff member to the person's distress so the person was supported. We noted in the person's care records staff always needed to be aware of where this person was to ensure their safety. However, we saw this was not the case as the activities co-ordinator had left the lounge area to support another person and other staff were in other parts of the home. One staff member told us they were not always in a position to meet people's needs and ensure their safety due to being busy supporting other people.

Additionally we saw both nurses on each of the two floors had the day to day management of the care staff. One nurse told us this was to ensure there was a delegation of care tasks, direction and support provided to

care staff. The nurses did not always reflect these aspects in their leadership of the care staff team. We saw one example where at lunchtime the kitchen assistant told us they arrived at 12.30 to serve people's lunches on the first floor but they were unable to find staff until 1pm to assist them. The kitchen assistant came to the dining room of the first floor trying to find staff to assist them due to meals being delayed for people.

We spoke with the manager about people experiencing delays because staff were not always immediately available to provide the care people required. The manager told us staffing levels were assessed against each person's individual needs and when there were staff shortages agency staff were used. We saw this happened on the day of our inspection. The manager said they reviewed staffing levels on an on-going basis and they were currently recruiting for staff.

The manager acknowledged the layout of the home environment needed to be reconsidered alongside the numbers of staff, deployment of staff and nurse leadership. This was because the shortfalls in the way staffing arrangements were managed increased the risk people would not safely receive all of the care they needed and in a timely manner.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with said staff supported them with their medicines. One person told us, "I do get my tablets regularly." We checked the arrangements in place for the management of medicines on both floors of the home and saw people's medicine was ordered in a timely way, stored and disposed of safely. We saw one nurse worked on each floor of the home to support people with their medicines and nursing needs. Nurses we spoke with told us they had the training and skills they needed to administer medicine safely. We saw nurses' practices assisted people to take their medicines comfortably, such as making sure people had drinks so they were able to swallow their medicines safely. Medicine records had been completed and provided a clear record of when people had taken their medicine.

However, during our inspection we found where two people needed their medicine at a specific time, it had not been offered to them at this time. We saw and heard how for one person this had impacted on their health and emotional wellbeing on the day of our inspection. The person told us, "I've been waiting since 6 o'clock when they got me up for my water tablet, my leg is full of fluid." When we asked the nurse about this person's request for their medicine they said, "I'm sorry I'm very tired" then added "No, no he doesn't have any medication at 8 o'clock." We suggested to the nurse we could look at the person's medicine records to check for the person. When we did this we saw the person was prescribed a particular medicine at 8am and the nurse did then assist the person in taking this medicine.

We discussed with the manager the particular issues around the importance of people receiving their medicines as prescribed. They told us nurses did have their competencies regularly checked to make sure their medicine practices remained safe. However, in the light of our findings they would review medicines administration to ensure peoples' safety and wellbeing was not impacted upon due to nurses practices.

People we spoke with gave us different reasons of what safe meant for them. One person told us, "I know the doors are locked and staff are on hand if I need anything which makes me feel secure and comfortable so I have no worries." Another person said, "I have this to press (call alarm) if I need them (staff) which is very reassuring." A further person told us, "They (staff) make sure I have my tablets, this is a real blessing as I worry I would forget what to take and when to take them. I know I would not be safe now in taking my tablets without staff to help me."
Staff were able to describe the different types of harm people could experience. They were able to identify

changes in people's personalities or interactions with other people which could indicate there was something wrong. Staff told us they would always raise any concerns with the manager. They said the manager could be relied upon to raise a concern with the appropriate external organisation. We saw the manager had worked with the local authority when incidents which could affect people's safety were reported and also notified the Care Quality Commission as required by law. In addition, staff could also approach external agencies and their contact numbers were displayed and available for staff, relatives and other visitors.

People spoken with told us they were confident in the staff's ability to support and manage any risks to their care. One person told us, "I can fall but staff know this, I have my wheelchair and they help me to move as well." Staff spoken with were able to tell us how they kept people safe. One example provided was of how two staff always assisted people with specialist equipment, such as, a hoist to safely move from wheelchairs into armchairs. We saw this practice was undertaken in a safe way on the day of our inspection and risk plans were in place to guide staff. Another example staff told us about was how they met people's skin needs, such as by ensuring people had matresses which were specifically designed to reduce the risk of people getting sore skin.

We saw when incidents and/or accidents had occurred steps had been taken to help prevent them from happening again. For example, when people had been identified to be at risk of falling, arrangements had been made for staff to more frequently ask them if they needed assistance. This had been done to enable staff to more readily check the person was safe and quickly ensure they had all of the assistance they needed if they wanted to leave their armchair. The manager told us they were improving the recording and analysis of incidents and/or accidents. This was to provide them with an oversight so risks to people's safety and wellbeing were effectively managed.

Staff spoken with confirmed the required employment checks had been undertaken before they started working. One staff member told us, "My references and a police check on my background was done all before I started to work here." The manager also explained recruitment arrangements and how potential staff had a number of checks carried out which included Disclosure and Barring Service (DBS) checks, references and records of employment history. They also showed us how three nurses registrations with the National Midwifery Council (NMC) had been checked to ensure they were fit to undertake clinical practices to meet people's nursing needs. These checks helped the provider make sure suitable people with the right skills were employed so people who lived at the home were not placed at risk through their recruitment practices.

Requires Improvement

Is the service effective?

Our findings

People we spoke with had different views about how effective staff practices were in meeting their needs. One person told us, "Staff are really good at knowing how to meet my needs so they must have received the right training." Another person said, "They (staff) seem to know what they're doing." One relative told us, "I believe [person's name] is cared for, just needs to be more staff as they seem rushed."

Staff told us they felt they had the skills they needed to care for people who lived at the home. One staff member said, "I am booked onto training courses and can ask for different courses where I have a particular interest." Another staff member told us, "[Manager's name] is making sure we all have updated training so our knowledge is refreshed." Staff told us staff meetings were now being held more regularly and believed these were supportive in assisting them to share their views and share information.

The manager told us in the PIR, 'The home has access to a Regional Trainer. Six monthly training plan has been implemented by the Regional Manager.' We saw there was a proposed training plan in place so gaps in staff knowledge and skills could be met. However, we saw examples where staff did not always use the knowledge they had gained from their training. For example one nurse's practice did not consistently reflect their knowledge around decreasing the risks of cross infection whilst administering medicines. This was because the nurse handled some tablets by touching these with their bare fingers before they assisted people in taking these. The nurse acknowledged they should have used other precautionary methods when handling medicines as per their training and good practice guidance.

We spoke with one staff member who told us when they first started to work at the home they were provided with an induction. They explained how this included helping them to get to know people who they supported by working with more experienced staff as part of their induction programme. Staff felt they worked well as a team but believed the inconsistencies in the staffing levels did not support them in providing quality care at all times.

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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made of their behalf must be in their best interests and as least restrictive as possible. We found there were inconsistencies in following through capacity assessments and best interests decisions to ensure they reflected the principles of the Act. Where issues were identified with people's capacity to make a decision, capacity assessments had not always been reviewed to reflect changes in people's needs. Additionally best interest decisions were not always clearly documented to show the legal processes had been followed through. For example, one person's relative had been part of a decision making process to inform staff practices so their family member's safety and wellbeing was met. However, there was no documentation to show the person's relative had the legal authority to make this decision and staff were unable to confirm they had followed this through. During our inspection the deputy manager showed us they were in the process of reviewing people's mental capacity assessments to ensure these reflected why a person lacked capacity in making specific decisions.

Staff spoken with showed they had a basic understanding of how the MCA and DoLS impacted upon their caring roles and how to support people in line with the Act. One staff member told us, "I always explain to people what is happening, we can't force people to do things." Another staff member said, "It's about ensuring people are given choices about their support in a way they understand." On a daily basis staff asked for people's consent before supporting them with their individual care needs and waited for people's responses before they proceeded with any assistance.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The deputy manager showed us they had started to submit applications under DoLS for people who had restrictions in place to meet their needs.

The manager and regional manager knew about the further work which required to be completed to ensure they were consistently compliant with the law around MCA and DoLS.

People told us they were offered a choice of meals. One person told us, "They will come and tell me what's on offer and I will choose." Another person said, "The food is quite nice and they offer more if you want it." We saw staff talking with people about the meals for the day to help them decide which meal they would like to eat. Although at times there was a delay in staff assisting people with their meals we saw staff did encourage a person who was reluctant to eat by gentle reassurance. Staff we spoke with could identify people at risk of weight loss. People's ability to maintain a healthy weight was monitored by checks staff completed. This was to make sure people received effective care and risks of weight loss were being effectively managed. Where people were at risk of being unable to eat enough to stay healthy we saw they were referred to their doctor for further support. Staff and the chef were aware of which people required a diabetic diet. We saw people's diets were catered for together with people who had cultural needs whereby their meals needed to be right to suit their particular tastes. For example, one person did not eat a certain type of meat.

People were supported to access care from a host of healthcare professionals. A chiropodist, optician and dentist all visited people in the home. Access to doctors was arranged by staff and paramedics had been called promptly in times of emergencies. One person said they were able to see the doctor when they visited and if they needed to see the optician staff arranged this. One relative told us, "The doctor visits regularly and they'll (staff) get them in if needed." In addition to the doctor, social workers and mental health professionals had been involved in people's care when appropriate.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home and relatives felt staff had a caring approach but did not always have the time to spend with them. One person told us, "Staff are caring but they don't always have the time to spare for a chat." Another person told us, "They (staff) work so hard but seem rushed, they are always very respectful towards me."

The manager told us in the PIR, 'Our staff are trained to treat people with compassion dignity and respect. On-going training is provided to make sure all our staff are updated in regard to dignity, respect and compassion.' However, we saw this commitment to maintaining people's dignity needed strengthening as people had mixed experiences of care. For example, we saw one person had to wait and watch other people having their lunch as they required staff assistance to help them with their meal. The impact for this person was they were left sitting at the dining table where people had finished their main meals before there was a staff member available to assist them. One staff member we spoke with about this told us they felt "Really bad" about the person sitting at the table watching other people eat their meals. They recognised this was not good for the person and placed their self-worth at risk.

We noticed there was no longer an unpleasant smell in the ground floor dining room which had been present at our previous inspection visit on 22 September 2015 whilst people were eating their meals. Whilst this was a positive improvement we saw little consideration had been given to making sure the lunchtime experience for people was managed in a caring way. We saw examples where staff were not always on hand to assist people who struggled at times to eat their meal. There was little communication between people and staff during the course of lunch other than staff asking people if they wanted their meat cut up. There was only one staff member for the majority of time in the dining room and the care provided was centred on tasks which did not promote a sociable occasion. We spoke with one staff member who told us they had tried their best but recognised what we saw did not reflect a caring approach. We discussed this with the manager who told us they would look to improve people's lunchtime experiences further so these were positive and managed to reflect people remained at the heart of all staff practices.

People told us their relatives were able to visit at any time and staff made them feel welcome. We saw relatives were welcomed by staff and staff made time to talk with relatives. A relative told us, "I come quite regular and the staff make me feel welcome." People we spoke with told us they felt staff knew them and were aware of their needs. One person said, "The staff know how I like things and when I need help." Another person told us how they enjoyed reading books and staff had supported them to go to the library. Staff we spoke with had an understanding of people's needs and their history and we saw they used their knowledge of the person during conversations with them in a caring way. We saw staff were respectful when communicating with people and there was humour between them and people they supported.

People told us staff gave them choices and felt they listened to them. One person said, "They (staff) are very good they will ask me if I want anything and will get it for me." Another person told us, "I can make my own choices, I chose what I am wearing today." We saw people were offered choices, such as what they wanted to eat or drink or where they would like to sit.

We saw there were some arrangements in place for people to be involved in making decisions. If people needed an advocate staff had access to information about this resource to support people in their lives and speak up on their behalf when this was required.

We heard some positive examples from people about their experiences of staff respecting their dignity and privacy. One person told us how they liked to remain as independent as possible. They said staff respected this by supporting them to do some aspects of their personal care themselves which gave them dignity. Another person described how they preferred to spend time in their room as it allowed them, "A little privacy as I like some time on my own." We saw staff respected this person's wishes. Staff were seen to knock on people's personal doors before entering and closed the door before supporting the person with their personal care.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information, which was accessible to all staff. Staff showed they were aware of the importance of protecting people's personal information.

Requires Improvement

Is the service responsive?

Our findings

In the PIR the manager commented, 'We provide person centred care based on our residents' individual needs' but we saw and heard examples from people and their relatives whereby this was not a consistent approach. People we spoke with had differing experiences of receiving care which was individual to them and responded to their needs in a timely way. One person told us, "Staff try their best but I do have to wait at times. When they do come they do know how I like my care provided." Another person said, "If they (staff) were not always rushed it would be easier to ask for help." A further person who had sensory impairments told us, "I don't go out, I don't do anything, I would love somebody to talk to." We saw this person had a cold cup of tea on their bedside table. When we brought this to their attention they told us nobody had told them it was there. We made sure this was replaced with hot tea and biscuits which the person finished completely and enjoyed.

During our inspection we saw examples where people's individual needs were not consistently responded to. For example, we saw people were sitting in communal areas of the home for long periods of time in wheelchairs including whilst having their lunchtime meals. One person expressed to us they were uncomfortable sitting in a wheelchair. The manager responded to this by ensuring staff were made aware so the person received the support they required. When we asked staff about the reasons people were not being encouraged to sit in more comfy chairs we received mixed responses. Staff comments varied from, "We don't always have time to support people", to, "People want to sit in wheelchairs." We noted the regional manager had commented in their internal report staff should be encouraging people to sit in more comfy chairs. The manager told us they would be reviewing these practices with their staff team.

One relative described to us how they had displayed information about the care their family member needed on a daily basis in their room. They told us this provided them with the confidence all staff would consistently respond to their family members individual care needs in their preferred way. Another relative told us, "Staff do their best but it's not very good" and went on to describe how they believed staff shortages prevented staff from always providing good care. What people who lived at the home and relatives expressed to us reflected the examples we saw of how staff were not always responsive to people's care and support needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff spoken with were able to tell us about individual people's needs and their preferences. Although we saw some people's care plans while not rewritten for some time, were being reviewed to ensure they accurately reflected people's needs. This was being undertaken through auditing procedures with notes for nurses where amendments and/or inclusions were required. The manager and regional manager assured us people's care plans would continue to be improved to guide staff practices in providing both consistent and responsive care.

Staff we spoke with told us they learnt about people's changes in needs through staff meetings and daily

between shifts to handover information about people's needs and by reading people's care plans. We saw on the handover information there was information which staff shared when a person's needs had changed and/or when the doctor for a person was required.
We found developments were continuing to support people to follow their pastimes and have opportunities to socialise as a group. We saw people took part in a sing-a-long and a quiz. One person said, "I really enjoy this, it's lovely." Another person told us, "It's always good to have things to do as otherwise I feel bored." In addition to this we saw people gained great pleasure from a dog who came into the home. People's facial expressions and body language reflected their delight in stroking the dog and making fuss of it. One person said, "I love it as we always had animals around at home."

We spoke with the activities co-ordinator who showed they were enthusiastic about continuing to develop the things for people to do for fun and interest. They spoke about people going on outings, such as going to the local park to hear music played and people setting up a stall in the town market. They also told us about how they provided companionship to people who spent time the majority of their time in their rooms to prevent social isolation.

It was positive to hear from people and see how improvements had been made to the support they were now offered to meet their social wellbeing. However, the manager was aware this needed to continue to be developed and the improvements sustained over a longer period of time. They were also aware care staff needed to be consistently involved in meeting people's social wellbeing. This was because we saw a culture had developed whereby care staff mainly supported people with care tasks, such as personal care and meals. The regional manager had also commented care staff needed to be involved in supporting people with their social wellbeing needs within their internal report.

People told us they knew how to raise complaints or concerns if they wanted to. One person said, "I have no complaints but if I did I would go straight to the top." Staff told us they supported people and relatives to raise complaints or concerns if they wanted. They told us that complaints were resolved quickly and efficiently. We saw records of two complaints raised which showed they were responded to and resolved in line with the provider's complaints procedures. The manager told us in the PIR they ensured, 'That any complaints are dealt with to ensure satisfaction and then share good practice and learn from poor practice with the staff team.' We saw this commitment was followed through in practice as in response to the feedback from one person staff made sure they involved them when their family member's needs changed.

Requires Improvement

Is the service well-led?

Our findings

Since our previous inspection on 22 and 23 September 2015 the provider had arranged for Healthcare Management Solutions (HCMS) to take over as managing provider of the home from the previous managing provider. In addition to this a new manager had been recruited since our previous inspection and a regional manager. The manager had been in post since October 2015 but had not submitted their application to register with us. However, it was confirmed with us there would be some further changes in the management of the home and interviews were taking place. The regional manager was aware the provider requires a registered manager in post at the home and was taking action to meet this legal requirement.

There was a clearly defined management structure with a manager and a newly recruited deputy manager in post. It was the manager's responsibility to undertake regular checks to ensure people received safe, effective and responsive care. However, we found examples during our inspection whereby staffing arrangements and staff practices had negatively impacted upon people's experiences. When we asked the manager about how they had monitored other elements of risk to people, such as weight loss, they were unable to show us how they assured themselves of any trends emerging, or if people's needs were being effectively managed.

We also found the management team had not been responsive to our previous concerns around the doorbell entry system. For example, the doorbell system continues to be confusing for people due to no information on entry to the home to make it clear which doorbell visitors should use. This was important as there had been a previous incident which involved a delayed response to paramedics when they arrived at the home. The regional manager's internal report also highlighted the requirement for the doorbell system to improve. The manager and regional manager assured us improvements would be made.

In the PIR the manager confirmed to us, 'Home Manager and Deputy Manager to audit four care plans each week to ensure a person centred care is continuously provided.' This was also a consistent improvement in the regional manager's internal reports. We found the commitment to achieve this goal had started but it had been slow to implement. We were able to see some improvements to records had been made although the findings from our inspection visit showed further improvements were needed.

We saw further examples of improvement actions not always being implemented in a timely way. These had been noted on the regional manager's report over the span of three months. One example was for the manager to take action to ensure the provider was compliant with the law. This included submitting DoLS applications for assessment to the local authority to make sure people's liberty was not restricted unlawfully. We found DoLS applications had started to be completed and two had been submitted at the time of our inspection visit.

The manager was open and responsive to the concerns we discussed with them and acknowledged they knew improvements were required. The manager was supported in their role by the regional manager who had appointed a clinical deputy manager to assist the manager in making the required improvements. The manager told us they believed with the support of the clinical deputy manager improvements would be

made. We saw the manager was well known to people who lived at the home and was visible around the home during our inspection to answer any queries raised by staff in order to support them.

Regular meetings for people, their relatives and friends were not taking place on a regular basis and recent previous meetings had not been well attended. Therefore we were unable to evidence how people's views and suggestions were being gathered and used towards checking the quality of care people experienced. We heard mixed views about how approachable people found the manager. One person said, "If I have something to say or an issue with anything I have no qualms about speaking with the manager." One relative told us, "I'm so glad (manager's name) came here, I have a deep regard for her." Another two relatives said they would appreciate a more open culture within the home. These two relatives said they had raised their complaints with the manager about their family member frequently having to wait for help due to staffing issues. The manager was aware and assured us they would be reassessing staffing arrangements.

The manager told us satisfaction surveys to give people and their relative's further opportunities to provide feedback on the service they received were planned to be reintroduced in September 2016. These would also be sent to staff so they were able to provide their views and any suggestions for improvements.

Staff told us they felt the manager was approachable and would listen to them. However, staff we spoke with had mixed views about the support they received. One staff member said, "I like [manager's name] they always listen but staffing numbers are not always right." Another staff member told us, "I can ask for certain training if I wish, like diabetes and staff meetings are more regular now. Staffing is an issue as it is not always consistent." We received comments from other staff which included, "We work like a dog and don't get any thanks," "Fed up really" and "Not very happy to be honest" as feels there is no team working or leadership. Staff knew about the provider's whistle blowing procedure and said they would not hesitate to use it if they had concerns about the running of the home or the company, which could not be addressed internally.

The regional manager visited regularly and was well known to staff. One staff member told us, "[The regional manager] visit regularly and is approachable. They go round the home chatting to people and asking them if they are happy with everything." The regional manager shared with us their recent quality checking visits. We saw they had completed actions for the manager to address any issues they had found and regularly monitored to assure themselves improvement actions were being taken. They showed us they had a very open and accountable leadership style and acknowledged improvements were required. Following our inspection visit they sent us action plans with timescales for improvements to be done by to evidence their commitment to make sure people's care was safe, effective, responsive and well led.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and support in a timely way to reflect their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels and the deployment of staff was not effectively managed to meet people's needs in a safe and consistent manner.