Sandhall Park (Goole) Limited

Sandhall Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 21 December 2017 and 3 January 2018. The first day was unannounced with a further two days announced.

Sandhall Park provides accommodation for up to 50 people who require support with their personal care. The service provided personal care and support for older people and people living with dementia. The premises are on ground floor level and split into two separate areas. The Honeysuckle area supports people with residential needs and Jasmine area supports people living with dementia. On the first day of the inspection there were 46 people living at this service.

The provider is required to have a registered manager in post. There was a registered manager and they had been in post since August 2014. 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.

At our previous inspection in December 2016 we rated the service Good. During this inspection we found the provider to be 'Requires Improvement' in safe and well-led. We found evidence to support that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality assurance systems and audits were in place. However, these did not identify all the issues we raised during the inspection. In addition, where the internal audits had highlighted areas that required improvements, at the time of our visit these had not been fully actioned.

People received care and support from care workers that had good knowledge about their needs and preferences. However, risk assessments when reviewed did not always take into account deterioration in people's health needs and some scores were incorrectly totalled. Records showed us that people's consent to their care was sought and documented in care plans.

People's health care needs were recorded and monitored so that appropriate referrals could be made to health professionals for advice and guidance.

Relatives told us they always felt welcomed when they visited the home and that they had no restrictions around visiting times within reasonable hours of the day. The majority of relatives felt the communication was good and that they knew what was going on, although some felt concerns were not always addressed effectively.

Care workers completed online and face to face training courses. Senior care workers checked that staff completed refresher training to ensure that skills and knowledge were current. The majority of care workers

felt supported, although we received mixed feedback about whether they would feel comfortable raising concerns to the registered manager.

Care workers received monthly supervisions and annual appraisals. Recruitment checks were conducted but improvements were required to make recruitment practices more robust.

Safeguarding concerns were recorded in accidents and incidents, and individual's care folders. The central safeguarding log did not contain all the concerns, or always show actions taken or the lessons learnt. Overall medicines were administered and stored safely. People were supported if necessary to attend their annual medicine reviews. However, some labels for creams did not include sufficient information to guide staff on where they should be applied. Records for pain relief were not monitored for their effectiveness and when required medicines protocols were not in place.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The majority of people told us they felt safe and care workers had good knowledge of how to protect people from potential harm and abuse. However, improvements needed to be made in the recording and overall analysis of safeguarding incidents.

Medicines were administered, stored, disposed of and managed safely. We identified some minor improvements which the provider put in place during the inspection process.

Although recruitment checks were in place, they were not robust. Some gaps in employment had not been questioned and references had not been verified.

Is the service effective?

Good

The service was effective.

Inductions ensured new recruits had a period of training and shadowing before working unsupervised. All staff received regular refresher training and opportunities to obtain further qualifications.

Care workers were knowledgeable about people's needs and could tell us how they liked to be supported, in that their preferences, likes and dislikes were considered.

Best interests meetings had been held and decisions clearly recorded for those lacking the capacity to make decisions for themselves.

Is the service caring?

Good

The service was caring.

People living at the service felt that the care workers genuinely cared for them and showed kindness. Relatives told us they often heard positive interactions between care workers and their relatives.

We observed some positive and meaningful interactions during the inspection. However, it was noted that care workers were busy and at times working to complete tasks rather than utilising time effectively to engage people.

Care workers had good knowledge of how they could promote people's privacy and dignity whilst maintaining their trust and keeping all personal information confidential.

Is the service responsive?

Good

The service was responsive.

Care plans included information about people's life histories including people that were important to them, likes, dislikes and individual preferences.

Complaints were dealt with in line with the organisation's policies and procedures.

The new activities co-ordinator was in the process of liaising with people living at the service to find out preferences for different activities. The emphasis was to ensure that the schedule of future activities encouraged everyone to participate and was reflective of people's preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems and audits were in place. However, they did not identify all the areas that required improvements.

Management oversight, records and analysis were not sufficient in relation accidents, incidents, and safeguarding concerns. Risk assessments had been reviewed but changes in people's health needs had not always been reflected.

Complaints had been responded to in line with the policies in place. However, several concerns were raised during the inspection as people had not been fully satisfied with the outcomes.

Sandhall Park

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 over three days between 13 December 2017 and 3 January 2018. The first day was unannounced and we made arrangements to return on the following two days.

On the first day the inspection team consisted of one adult social care inspector and two experts-by-experience. The second and third day of the inspection were conducted by an adult social care inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One of the experts-by-experience had personal experience of working with people that had physical and/or sensory impairment and the other had knowledge of caring for people living with dementia.

Prior to the inspection we gathered information from the local authority in relation to safeguarding concerns and quality assurance visits that had taken place. We contacted five health professionals who had regular involvement with the service. We also considered information sent to us in the Provider Information Return form (PIR). This form is completed by the provider and gives us information on how the service is being run, any improvements that are planned and information on the management of the service.

During the inspection we spoke with ten people who used the service and nine of their relatives. We had discussions with four care assistants, three senior carers, the activities co-ordinator, catering staff, deputy manager, registered manager, operational manager and the regional manager. Following the inspection we spoke with another member of staff and also contacted two relatives for feedback.

As part of the inspection we carried out observations on both units of the home and completed a Short Observational Framework for Inspection (SOFI). SOFI allows us to observe and assess interactions taking place between people living at the service and the care workers. Information in relation to the management and running of the service was reviewed, this included recruitment, staffing, training and maintenance

records.

Requires Improvement

Is the service safe?

Our findings

People living at the service told us they felt safe. One person told us, "If I was worried I would speak to one of the staff" and another said, "If I asked for something, they'd help me". Others told us, "The staff know how to look after me" and, "When they use the hoist there are always two people to help me". One relative told us, "[Name of person] is safe and has a sensor mat so the staff know when they get out of bed."

The safeguarding folder detailed referrals that had been made to the local authority safeguarding team. We saw information about additional incidents that had occurred within one person's file. The registered manager told us that the local authority safeguarding team had been made aware of these incidents but they had not met the threshold to submit a referral. We also saw some safeguarding incidents recorded in the accidents and incidents file. We discussed with the registered manager ensuring they maintained clearer records in relation to incidents of abuse or allegations of abuse in order to show how decisions had been reached and the actions taken.
Some of these recording issues have been addressed in the well-led section of this report.

There was an accidents and incidents policy and we saw that accidents and incidents were recorded in a central file. However, follow ups and overall analysis were not recorded. This meant that opportunities to learn from accidents and incidents could have been missed.

We looked at six staff recruitment files and could see that some checks had been carried out to ensure suitable staff were employed to work at the service. Two employment references had been requested for each applicant. However, these had been completed on a standard form provided by the service. We reviewed twelve references, two out of those ten were on letter headed paper or had a company email attached to them. The provider could not show us that any additional checks had been made to verify the person/company providing the reference. In addition, there were some gaps in employment dates on application forms that had not been explored during interviews.

We discussed this with the registered manager who assured us that plans would be put in place to ensure all future references were verified verbally with the previous employer and any gaps in employment checked and the reasons recorded.

Staff knew about the whistle blowing policy and actions to take should they need to use it. When we asked staff if they felt comfortable approaching the registered manager with any concerns, we received a mixed response.

We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. This included the management of controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. The room and fridge temperatures were recorded daily to ensure the right temperatures were maintained. Dates were recorded on the boxes for those medicines that needed to be used within a specific timeframe once opened, such as eye drops.

We noticed that some creams did not have sufficient information from the prescriber on the labels. For example, three creams advised, 'use as directed' or 'for external use only'. We discussed this with the provider, who agreed to ensure there were clear instructions for staff about where to apply the cream on the body. On the first day of our inspection PRN or 'when required' medicine protocols were not in place. These were completed and put in place for each individual PRN medicine during this inspection.

Records kept in relation to drugs administered for pain relief required monitoring to check whether they were effective in reducing people's pain. The regional manager developed documentation to commence recording of this information. We could see that people had annual medicines reviews at the GP surgery and staff supported their attendance, when needed.

Care workers had a good awareness of how to protect people's human rights, respect their choices and ensure they were not discriminated against. One care worker told us, "We have a couple of people that prefer female carers and we accommodate their wishes." We could see that policies were in place and staff received training on equality and diversity which incorporated information on the protected characteristics and topics such as labelling and stereotyping.

Risk assessments had been completed and included areas such as, falls, choking and pressure sores. This enabled the care team to identify those most at risk, put measures in place to mitigate those risks and monitor closely, to ensure any issues were dealt with in a timely manner.

One person who didn't always feel safe said, "One or two residents come into my room that shouldn't be there". We discussed this with the registered manager who confirmed they were aware that this had been happening. They had put a fringed door curtain up as a deterrent. We also witnessed one person wander into another person's room and lay on their bed. This caused the occupant to become quite anxious and distressed. We discussed both incidents with the registered manager and they advised us they would continue to monitor and ensure risk assessments were in place. On the last day of inspection they advised us that the person that had wandered into another room was looking for the previous occupant and appeared to have settled as they had not had any further issues.

Staffing levels were sufficient to meet people's practical care needs. However, staff were busy at all times and we asked if they felt they had enough time to meet people's social needs and interact with them. Care workers comments included, "We don't have enough time. We get the odd 10-15 minutes" and, "Over the years it has become more difficult with residents having greater needs. I don't agree with the introduction of twelve hour shifts, we seem to be full pelt and flag towards the end of the shift." Another told us there were, "Not enough staff or skill mix of staff to meet people's needs."

There were mixed views about staffing levels from people and relatives. Some people living at the service told us, "There are plenty of staff" and, "There are enough staff floating about." However, others said, "Sometimes they are short staffed and have to move staff between the two sides of the home" and, "There aren't enough. I sometimes have to wait a while when I ring my bell. I know there are probably other people waiting to go to the toilet so I just have to wait." A relative advised, "Yes we have no problem with the levels of staffing", and another told us, "The staff do an amazing job, at times there could do to be more staff."

Our observations showed us that people were assisted with their needs in a timely manner and were able to do things at their own pace. On occasions we could see there were missed opportunities where care workers could have utilised their time better and interacted with people more. This was discussed with the registered manager and we did observe improvements over the course of the inspection.

We observed two carer workers (one in training) transferring a lady from a lounge chair to a wheelchair using a hoist. The experienced carer guided and encouraged the resident during the process. Care was taken by the carer in training who brought all wheelchair users into the dining room, checking they were comfortable once they had put the chairs in place.

We looked at documents relating to the servicing of equipment and maintenance of the home. The records included service agreements that were in place to check equipment at regular intervals, such as; electrical systems, moving and handling equipment, bed rails, water systems and fire safety equipment. The provider employed a designated maintenance person who ensured repairs to the premises were carried out.

Care workers had a good awareness of infection control measures and we observed that they washed their hands regularly and used the correct personal protective equipment (PPE) when needed, such as aprons and gloves. All bathrooms and toilets had sufficient products available, such as paper towels, hand wash and toilet rolls.

On the initial day of inspection one bathroom on the honeysuckle area of the home was in bad repair; the bath panel was warped and paint had worn off around the edges. The registered manager told us that they were awaiting a new bath that was on order and at present this bathroom was out of use. During the second day of our inspection we noticed an out of order sign had been put on the bathroom door and maintenance records showed us that equipment had been ordered to replace the full bath unit.

Good

Is the service effective?

Our findings

All new employees completed a four week induction that included shadowing more experienced care workers. The induction included information on the provider's emergency procedures, introductions to care workers and people living at the service, policies and procedures, introduction to the Care Certificate and further qualifications. The Care Certificate is a set of standards that social care and health workers work to. It is the minimum standards that should be covered as part of induction training of new care workers. Some practical aspects of training such as, moving and handling were delivered during the period of shadowing by a competent in-house trainer.

We observed one care worker being mentored by a more experienced person during the lunchtime period. Support and guidance was given to show them how to move a person's wheelchair closer to the table so the person could eat safely.

The training matrix and individual training records confirmed that staff had received the relevant training to carry out their roles. On the first day of inspection we identified that some staff had not received training to support them to manage more complex behaviours to protect themselves, people living at the service and other people who used the service from potential harm. We discussed this with the registered manager and on the second day of our inspection we were shown that additional training had taken place. The registered manager told us that this would be refreshed at regular intervals to ensure staff had the right skills and support to manage more complex behaviours.

People were happy that staff had enough knowledge and skills to meet their needs. They told us, "[Care workers] explain things as they go along", "When they use the hoist there are always two people to help me" and, "The staff seem to know what they are doing." Relatives said, "The staff are capable but sometimes busy, they do the best they can" and, "[Name of person] doesn't need a lot of help but staff know their likes and dislikes."

Care workers were knowledgeable about people's care and support needs. One care worker told us, "[Name of person] likes to get up at 05:30am and we have another person that likes to stay up late watching television and has a lay in the following morning – we respect this, both have capacity to make their own decisions." Staff told us about information specific to individual's preferences and we saw this information outlined in their care plans. People's life histories and how they preferred to live their lives was included in the initial assessments. This provided vital information so that staff could support people to achieve outcomes that were important to them.

Training records confirmed that care workers had received training in understanding the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

The Act requires that as far as possible people make their own decisions and are helped to do so when

needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw the provider was following the principles of the MCA. For example, people were encouraged to make decisions for themselves where possible, and assessments of people's capacity were completed where there were concerns about people's capacity to make specific decisions.

People were supported by care workers who sought their consent to care and support. One care worker told us, "We always ask and read through care plans before we provide support." We observed one care worker asking for a person's consent prior to taking them away to enjoy a bath. Care plans detailed people's capacity to consent when making daily decisions and choices, including any additional support they may need.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive people of their liberty. The registered manager had made appropriate applications where it was deemed that a person was being deprived of their liberty. The only conditions we saw were those to renew the applications prior to their expiry dates. The registered manager regularly reviewed these to ensure renewal applications were submitted on time and any that were no longer in use were reported to the appropriate supervisory body.

Records showed us that regular contact was made with health professionals and people were supported to attend hospital appointments when needed. We saw that GP's had been visiting the service on each day of our inspection and the chiropodist was present on the second day. District nurses also regularly attended the home.

Staff advised, "We have regular supervisions and I'm not afraid to ask if I need to know anything. I feel supported by my manager" and, "We have monthly supervisions and in between we can ask the managers or seniors if we need anything. I feel supported." Records showed us that regular monthly supervisions were taking place and in between there were 'situational supervisions.' These addressed any immediate issues, such as changes to policies and procedures within the service or a change in relation to people living at the service.

Daily handovers were completed and flash meetings held prior to shift changeover. This ensured any important messages were given and issues discussed. However, some staff did tell us they did not attend these meetings as they were held 15 minutes before the start of their shift and they were expected to attend in their own time. In addition, staff meetings were held monthly – one for care workers and another for the seniors. Some staff felt this worked well and others told us they felt that important information was sometimes not communicated effectively between the separate meetings and that they didn't always get to hear about changes until later the same day.

To ensure smooth transitions between services all care plans included hospital passports detailing people's current needs and important contact details of health professionals and people's representatives should they be admitted into hospital at short notice.

We looked at the support people received with their nutrition and hydration needs. We spoke with the one cook who received support from a kitchen assistant to prepare meals for both units. They showed us documentation which outlined people's dietary requirements, such as pureed or soft diets, diabetic diets and known allergies. Menus were on a four week rota and changed between the seasons and when people

who used the service had suggested changes. There was a good selection of both hot and cold foods, main meals and pudding choices. The majority of meals included fresh vegetables and there was a choice of home cooked cakes and buns.

When asked if they liked the food people who used the service commented that it was, "Not bad at all", "Fairly good", "Meals are cooked well" and "It's good, and it's given to you, not thrown at you." Relatives told us, "We can visit anytime, but mealtimes are protected and that is right." The provider discouraged visitors from coming at mealtime, so that people could eat without distraction. Signage around the home clearly informed any visitors so they could respect the allocated mealtimes.

The premises had been adapted to meet people's needs. Each corridor was named after streets and the walls had historical pictures of landmarks of local and surrounding areas. The corridors on both units were mainly straight and wide, making it easy for people to manoeuvre around. There were good lines of sight down the corridors to identify any people that may require assistance. The corridors were decorated with pictures relevant to the era of those who lived in the home, including LP cover sleeves from the 50's and 60's. They also had tactile items such as pictures of animals and soft fabrics for people to touch. Sensory items were kept within different areas of the home for people to use.

Communal rooms had mock fireplaces making them feel cosy. One dining room had a bar area in the corner named 'Sandhall Tavern.' The reception was bright and cheery with a large arts and crafts area. The bedrooms we saw were of a good size and well maintained. People living at the service had access to call bells and were encouraged to personalise the rooms to make them feel more familiar and homely. This included bringing in their own furniture and photographs. Bedroom doors were numbered and many had memory boxes outside them to help people living with dementia to recognise which room was theirs.

There were pictorial signs on rooms such as the toilets and bathrooms. There was only limited directional signage around the home which would help the residents to move around independently. However, none of the residents we spoke to were concerned by this as they were able to find their way around. We discussed with the provider that further signage would help to highlight to people when they were moving from one unit into another. We noted these were in place when we commenced the second day of our visit.

The home had an inner courtyard garden accessed from the dining room which could be used safely by residents. One relative expressed concerns that people were smoking outside windows during the nightshift. We discussed this with the registered manager who assured us that this had been risk assessed and appropriate checks completed at regular intervals to remove any waste. However, due to the concerns raised they advised that the metal bucket would be moved to another location so that no one would be disturbed by those smoking and chatting during the evening.

Good

Is the service caring?

Our findings

People living at the service felt they were well cared for. Their comments included, "They (staff) treat me with kindness" "When you buzz they come as soon as they can" and, "The staff look after me well." One person though told us, "I don't always know the staff. Sometimes they say their name when they come into my room. They should say who they are every time."

We asked relatives whether they felt their loved ones were cared for and responses were positive. Comments about staff included, "They talk to [name of person] like I talk to [name of person] they like a bit of banter", "They seem to genuinely care about [name of person]", "Yes [name of person] says the staff are really good to them" and, "[Name of person] has a good rapport with staff."

Whilst we saw some care workers engaging with people consistently in a very caring, encouraging and patient way, we did note that some others care workers spent less time engaging with people socially. Their interactions were more task focussed. Overall though it was clear that staff knew people and their likes and dislikes. We could see that people were comfortable in the presence of staff.

We observed positive interactions on our final day between care workers and people living in the Jasmine area of the home. One person was quite vocal asking whether they could be taken to the bus stop to get home. The care worker acknowledged this person's reality and then engaged them in a meaningful conversation. The person calmed down and was laughing about which chocolates they would like bringing from the local shops. This showed us that care workers had the skills and expertise to manage and distract people that were showing signs of distress in a way that validated their experiences and did not exacerbate their anxieties.
To help people whose closest companion was a canine friend, the home was pet friendly. This supported people in making the transition from their home into the service. One person had their own dog and another had a cat. We observed staff supporting people to look after their pets and maintain the environments safety.

There was an equality and diversity policy in place to guide staff. The service had two couples living at the home and for one couple they had adapted one of the two bedrooms into a lounge to accommodate their requests for a larger living area. The other couple had a bedroom each next door to one another so they were close together.

We were advised by the registered manager that meetings were held for people living at the service to discuss their views or raise any concerns. However, relatives we spoke to could not confirm that this happened. We were shown records that confirmed the last meeting was held in October 2017 and had notes from several relatives that had participated. The agenda had been planned for a meeting in November 2017 which was not attended and so this had been brought forward to February 2018. On the last date of our inspection we could see posters on the entrance doors to the reception to inform families of the forthcoming meeting dates to encourage their participation.

We saw records that showed information about different health conditions had been shared with staff. During our inspection a relative had concerns in relation to their loved ones skin condition. As part of future communication the home agreed to ensure they supported both people living at the service and their relatives to understand and receive information about their care and support needs including newly diagnosed health conditions.

Information was clearly displayed in the reception area for those people that may find it difficult to express themselves and so require an independent advocate to represent their views. The registered manager told us that one person had an advocate in place to support them and another was in the process of being appointed for someone else.

Care workers gave us examples of how they promoted people's privacy and dignity. One person told us, "I always knock before entering people's rooms and cover any exposed skin with a towel when providing personal cares" and another advised, "I ask the person before carrying out any care or support and ensure curtains and doors are closed when delivering personal cares or toileting."

We observed care interactions around the home which showed staff were polite and sensitive to people's needs. They knocked on the doors of people's rooms before entering. Staff also helped people to move around the home, including taking them to the dining room or the lounges. People looked well presented, clothing was clean and suitable footwear was worn. One person said, "They tell me if my shirt or top is dirty and I need to put a clean one on". A relative told us, "My [relative] and their bedding are always clean."

We saw records to show when people received a bath or shower. One person living at the service raised concerns about a male carer delivering personal cares; they did not feel able to voice their concerns at the time. This was discussed with the registered manager during our visit; they made a note to ensure the care plan was updated with a preference for female carers to carry out personal care support. We observed care workers speaking quietly to staff when asking them about whether they needed to use any of the facilities around the home.

Confidentiality policies were in place and care workers understood the importance of maintaining people's trust and confidentiality. Records were locked away in the main offices and security key pads only allowed those with authorisation to access personal information.

People said that they felt the staff encouraged them to be as independent as possible and they were treated with dignity and respect. One relative confirmed to us, "[Name of person] does most things for themselves but the staff help if it is needed".

Good

Is the service responsive?

Our findings

People we spoke with were happy that care workers knew about their individual care and support needs. One relative told us, "My [relative] likes a particular chair in the lounge and the staff know this."

Care plans included people's life histories, likes, dislikes, preferences, religious needs and outlined end of life plans that were in place.

When we spoke to care workers we asked what person centred care meant to them. They told us, "It's about knowing the people you are looking after and treating them with respect, allowing them time and encouraging their independence" and "We read care plans to check people's likes and personal preferences. A couple of ladies prefer female carers."

People told us that they felt they could choose how they wished to live their lives. We observed people making decisions to eat within their rooms which care workers respected and accommodated.

Some people were unable to speak with us so we spent time making observations, in order to understand people's experience of care at the home. Although we observed many good interactions between people living at the service and care workers, at times people's immediate needs were not met in a timely way. For example, one person was sat in the dining area after lunch, as their room was being cleaned. They were showing visible and audible signs of distress. One care worker was in the dining area updating people's care records, but did not respond to the person. Several minutes later another care worker stopped to engage with the person. They sat in front of the person and started singing. The person immediately calmed down and started singing along with the care worker. This showed us that care workers knew about people's likes and could have meaningful interactions with them. However, this needed to be delivered in a timely manner to consistently meet people's needs.

This was discussed with the registered manager and throughout the last two days of the inspection we could see that improvements had been made. We observed positive interactions and meaningful conversations taking place between care workers and people living at the service.

We received mixed feedback in relation to relative's involvement with the planning and review of people's care needs. Although some relatives felt they were involved, others told us, "Only when [Name of person] was admitted and that meeting was led by a social worker with a member of the care home staff sitting in", "Not unless we approach the staff, they don't come to us, the communication is not good."

The registered manager advised that people and their relatives were encouraged to take part in review meetings. These were held annually or when there was a significant change to a person's needs. The registered manager was looking at ways they could increase involvement of people and their relatives in reviews meetings and discussions around care and support planning.

The complaints procedure was in the reception area for people and their relatives should they need to use

it. One person told us, "If I had a problem I would speak to a member of staff". Two relatives we spoke with were confident to approach senior carers and knew where to find them. They said, "I have spoken to [Name of senior care worker] several times when I've had concerns and they always respond." Despite the positive comments above, some relatives and people we spoke with told us they were unsure of the complaints process.

We could see from records that complaints were dealt with in line with the company procedures and included a letter of acknowledgement, details of any actions that had been taken to resolve the complaint and an apology. The people living at the service told us they felt comfortable approaching their care workers with any problems. The registered manager told us they operated an open door policy so that people could raise any concerns or speak to them if they wished to do so.

However, during the inspection relatives raised several complaints with us that the provider had been made aware of and which they felt had not yet been resolved. For instance, one relative told us that two pairs of glasses were missing. The registered manager told us on the second day of our inspection that they had found the missing glasses and informed the relative. Another relative felt staff could be more proactive in relation to their loved one's health condition. A health professional had also recently implemented a handover sheet to improve communication and ensure advice was followed.

The home had employed a new activities co-ordinator who had been working at the service for about a month at the start of our inspection. They told us, "I have met with some people and will see the rest so I can find out what they like." We were shown an activities book which was to be used as a framework to plan a full programme of activities to meet everyone's needs.

During the inspection we observed people moving between the Honeysuckle and Jasmine areas of the home to attend different activities. A carol service was well attended by 23 people and six visitors/relatives. Musical instruments were offered to each person, encouraging them to participate. Feedback from people who used the service included, "I used to like to play bingo but we don't do that anymore", "There are lots of craft things to do" and "One of the staff helped me decorate the little tree in my room." Relatives comments included, "[Name of person] used to like someone to do their nails that doesn't happen so much now" and "[Name of person] doesn't like lots of people, prefers to be in their room."

During some activities, such as colouring in gift bags we did not see the activities co-ordinator spending one to one time with people and they intermittently left and re-entered the room during the activities. Care workers did advise that other members of the team sometimes supported with activities. However, we observed the presence of additional support was limited. For example, at the carol service only two care workers supported 23 people. During that time we saw at least one person that required one to one support to stay involved with the activity.

We discussed our concerns with the registered manager and they advised that some activities that were previously completed regularly, such as bingo and dominoes, were still part of the activities plan but not played as frequently. We did observe several people playing dominoes after their lunch in the dining area. The registered manager had been unaware of the low ratio of staff that we had observed supporting with the carol service activities. They advised that this would be addressed as part of the activities planning schedule. The registered manager told us that they regularly walked around the premises to oversee care delivery and to check people were happy with their care and support.

Friends and relatives told us they were able to visit at any time and were always made welcome. If people wanted to speak with their relatives in private they could go to their rooms or use one of the quieter dining

areas or lounge.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place and audits were regularly completed. An 'independent care inspection' had also been completed by the provider in November 2017. However, despite systems being in place to monitor the service, they did not identify all of the concerns we found in our inspection. For instance, we found that some risk assessments when reviewed had not considered the deterioration in people's health needs. For instance, two people's pressure area risk assessments should have been scored slightly higher to reflect their increased risk in relation to deterioration in their health needs.

In addition, risk assessments for behaviours which could be challenging to staff or others did not always include sufficient guidance to support staff in managing these behaviours. The registered manager told us they would be reviewing these and providing support to those completing future risk assessments. Additional training to manage challenging behaviours was scheduled and completed by care workers over the course of this inspection. However, auditing and quality assurance systems failed to identify this.

In addition we found that policies and procedures included review dates which had expired and although the 'Business Review' audit covered these issues, the majority had not been reviewed since April 2015. This meant that some of the policies and procedures did not reflect current information. For example, the equality and diversity policy did not contain all the protected characteristics as stated in the Equality Act 2010.

We found some information was not always clear. For example, some people's hospital passports did not contain clear information about whether a 'do not attempt cardiopulmonary resuscitation' order (DNACPR) was in place. Another file stated that a person's relative had lasting Power of Attorney (LPOA), but when questioned this appeared not to be the case and no LPOA was in place. The registered manager was in the process of updating this information and ensuring copies of all legal documents for dealing with finances and/or health and well-being were kept in their office.

Complaints, safeguarding information and accidents and incidents lacked analysis and management oversight. Records did not always document actions that had been taken when safeguarding incidents had occurred. For example, one medicine error on the safeguarding log sheet had no summary detailed and the action stated a threshold score sheet had been completed – this was not attached and not in the folder. Others had a summary but no details of actions taken and those that had actions noted were not always clearly recorded. Some safeguarding issues were recorded under accidents and incidents or within people's individual folders. This made it difficult to identify any patterns or themes where lessons could be learnt and improvements made.

Since our inspection we have received a notification in relation to a safeguarding incident about support with medicines that took place in the later part of 2017. This incident had not been reported to the Care Quality Commission (CQC) at the time it happened and appears to be a one off incident. However, we have reiterated to the provider that they must familiarise themselves with the notifications policy so that they submit any referrals of abuse or allegations of abuse to CQC in a timely manner.

Collectively, the above information demonstrated a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

One care workers described the culture of the home as, "Open and honest" and another member of staff told us, "I walk into [name of registered manager]'s office and voice my ideas. I find they are very receptive and take my suggestions on board." The majority of care workers told us they felt supported. However, two staff felt the management of the service was not approachable. One advised, "[Name of registered manager] is not very approachable at times, but depends as on another day they may be fine. [Name of deputy manager] is very approachable, she is nice" and, "If I go to the registered manager or deputy with any issues they say there busy and can't see you." One relative advised, "They are good at keeping in touch" and another said, "I know what is going on."

We could see that satisfaction surveys had been completed by both staff and people living at the service. During 'residents meetings' requests had been made about adding items to the menu. This information had been passed to the cook and people's preferences had been accommodated. However, the last staff survey was dated 2016 and where concerns had been raised there was no analysis or actions taken to show improvements had been made. During our inspection some care workers told us they did not feel valued but others felt their views and suggestions were taken on board.

The registered manager told us they tried to have regular chats with care workers and people living at the service on a daily basis during walks around the home. This enabled them to gain valuable information and made them visible so that concerns could be reported to them. However, we received mixed feedback from relatives about the availability and visibility of the registered manager; some felt they were based in their office too much. One person said, "As a family we've not noticed much interaction between staff and residents" and another relative advised, "We've only had communication from the service when we have had to complain. That's been our only form of communication, we don't hear anything otherwise."

A suggestions box was in the reception area for relatives, visitors and staff to anonymously raise any issues. Communication books were also being used by seniors and care workers in each unit. However, the registered manager took on board the feedback given and told us they would be looking to be more visible and consider different ways they could engage people's relatives.

We could see that the service had regular visits from health professionals, such as doctors, chiropodist and district nurses. However, concerns had been raised about the service following the advice given. Care workers supported people to attend appointments and advice had been sought from the local authority in relation to some safeguarding concerns. We could see that appropriate referrals were made, such as referrals to the speech and language therapists (SALT) when people were at risk of choking. The registered manager attended local authority training courses and took part in local provider forums. They told us that meeting other providers gave them opportunities to share and discuss best practice.

The provider made information available for visitors in the entrance hall. This included notes from health and safety meetings, advocacy services, annual survey results, safeguarding contacts and the complaints policy and procedures - including an easy read version.

The registered manager told us they had over ten years' experience within their role. They had recently attended refresher training for MCA, distressed behaviours, level three safeguarding vulnerable adults and reporting concerns. They attended the local authorities training and provider forums to keep up to date with any changes in best practice. The regional manager was responsible for checking any updates to legislation

or best practice guidance. Information was regularly communicated in monthly managers meetings and the service included new updates in team meetings. We saw that 'situational supervisions' had been introduced to deliver any important messages on a shorter supervision format. Changes in relation to people's needs had been documented using this format.

Audits were conducted, including daily spot checks on medicines, carried out by senior carers. This included cross referencing total amounts of tablets held in stock with the totals recorded on the medication administration records. This ensured that people had the right amount of medicines available at all times and did not run out of them. A more detailed audit was completed on a weekly basis to identify any areas for improvement. We saw that any minor issues identified were addressed immediately.

Champion roles had been allocated to care workers and included champions for dignity, infection control, Christmas, activities and dementia. This meant that someone was responsible for raising awareness and sharing practical information with the team, relatives and people living at the service.

We spoke with a person that had previously worked at the service that had just been interviewed. They told us they were returning because, "It's a good place to work."

Security measures were in place. All doors into and out of the building including both units had key pad locks on them. There were signs in reception warning any visitors not to hold locked doors open in case one of the people living at the service tried to exit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that quality assurance, auditing systems and processes were effective in highlighting shortfalls in the service. The systems in place did not always effectively monitor and mitigate risks relating to health, safety and welfare of people using the services and others. Records in respect of people using the service, staff and the overall management of the regulated activity were not always accurately maintained, complete and sufficiently detailed. The provider had not sought current feedback from all staff and relatives of people using the service to continually evaluate and drive service improvements.