Barchester Healthcare Homes Limited

Henford House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 January 2018 and was unannounced.

Henford House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Henford House accommodates up to 58 people in a two storey building set in its own grounds on the outskirts of Warminster. At time of our inspection, 41 people were living at the home, three of whom were on respite care.

The service had a registered manager in post. 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.

The administering of medicines were not always managed safely. Although, we found that medicines were stored and disposed of safely.

There was sufficient staff to meet people's basic care needs. However, we found that staff were not always visible and people who were unable to use their call bells, were unable to alert staff, unless staff were in the vicinity or another person rang their bell.

Staff showed a good understanding of the principles of the MCA (2005). However, some people who lacked capacity to consent to living at Henford House still had no capacity assessment in place. The service had not taken the necessary action following a recommendation from our previous inspection.

Where people had specific health conditions, we found not all care plans had the necessary detail and guidance for staff on how to manage these conditions. We also found staff had access to a variety of training, but had not always received relevant training for specific health conditions, such as Parkinson's disease.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. However, we received mixed feedback from people and their relatives about the promptness of these referrals.

People told us they felt safe living at Henford House and were happy with the care they received. Relatives told us the home was friendly and welcoming and they could visit at any time.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect

people. They told us they would not hesitate to raise their concerns and felt confident it would be dealt with appropriately.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. However, we found charts to monitor risks such as pressure sores and dehydration, were not always fully completed.

Most people said that they enjoyed the food and the variety of choices. People's nutritional needs were met and where people were losing weight, appropriate action was taken, for example the use of a fortified diet.

The home was spacious, which allowed people to spend time on their own if they wished to do so. People had access to the gardens, and we observed some people going out with relatives. We found though the home had not been developed to support people living with dementia.

People told us that staff always respected their privacy, knocked on the door before entering and asked permission before supporting them. People said that they were offered everyday choices about their care.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. However, this was not always the case for people staying in their bedrooms or for people living with dementia.

The registered manager had made various community links and was working with different agencies to involve the community more within the home.

Quality assurance systems were in place to monitor the quality of care. However, these were not robust and did not identify the concerns we found during the inspection. People and their relatives had an opportunity to feedback their views of the care through resident and relative meetings and through annual surveys. The registered manager told us they encouraged people's feedback.

This is the second consecutive time the service has been rated Requires Improvement. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the 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 administering of medicines were not always managed safely.

There were sufficient staff to meet people's basic care needs. However, we found staff were not always visible and people who were unable to use their call bells, were not able to alert staff unless they were in the vicinity.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. However, repositioning and fluid charts to monitor risks were not always fully completed.

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff showed a good understanding of the principles of the MCA (2005). However, some people who lacked capacity to consent to living at Henford House, still had no capacity assessment in place. Where necessary, the registered manager had made applications for Deprivation of liberty safeguards (DoLS).

Staff had access to a range of training to provide them with the skills and knowledge. We found some staff could benefit from more specialist training to be able to fulfil their role.

Staff told us they received regular supervisions (one-to-one meetings) which supported them in their role.

People's nutritional needs were met and people told us they enjoyed the food.

Is the service caring?

Good

This service was caring.

People were treated with kindness and compassion in their day to day care and support.

People said that they were offered everyday choices about their care.

Staff demonstrated they cared a great deal for the people they supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were individual to each person, however some care plans lacked in detail and guidance for staff on people's preferences for their daily routine and management of specific health conditions.

People were encouraged and supported to take part in activities within the home. People who stayed in their rooms, received some one-to-one interaction, however this was limited. People living with dementia did not have suitable activities to meet their social needs.

The majority of people and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. They were confident their concerns would be listened to and appropriate action taken. We found though that some felt unable to raise their concerns.

Is the service well-led?

Requires Improvement

The service wasn't always well-led.

We found recommendations we made during our previous inspection had not been followed in a timely way. The management team had been slow in implementing changes and making improvements.

We received mixed feedback about the approachability and responsiveness of management.

Quality assurance systems were in place to monitor the quality of care. However, this did not identify the concerns we found during

the inspection. Records were not always kept up to date and did not always reflect people's current needs.

The service had made good links with the local community and worked in a multi-disciplinary way.

Henford House

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.

We carried out this inspection over two days on the 9 and 10 January 2018. The first day of the inspection was unannounced. One inspector, a specialist nurse adviser and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with 20 people and 10 visiting relatives about their views on the quality of the care and support being provided.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included seven care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, deputy manager (clinical lead), three care staff, an agency nurse, housekeeping staff, staff from the catering department, maintenance and the activities coordinator. We received feedback from one health and social care professional who worked alongside the service.

Requires Improvement

Is the service safe?

Our findings

The majority of people's medicines were managed and administered safely. However, during review and discussion of the medicine administration records (MAR) following a medicines round, it was identified that medicines administration via a PEG (Percutaneous endoscopic gastrostomy) tube for a person with swallowing difficulties, was not always safe. The medicines administration was not in line with current guidelines and posed a risk to staff, who were opening the capsules and preparing the medicine for the PEG. We raised this with management during our inspection, who told us they were acting on advice from the GP and pharmacist. Management took immediate action to seek further medical advice and following our inspection, the medicines in question have now been changed to liquid form.

A thickener powder had been prescribed for some people who had difficulty swallowing. A container of thickener had been left out in one person's room with the lid not secured. We also found the consistency of the drink, which had been prepared for the person in the room, was thicker than prescribed. Thickener powders are to be used as directed and if these directions are not followed i.e. the wrong quantity used, or is taken incorrectly, there is a risk of choking. As this thickener had not been stored securely, there was the risk this may be taken by someone who is not aware of the potential risks. We raised this with the deputy manager during our inspection, who told us they would take immediate action.

We found where people were prescribed topical creams associated body maps were completed to ensure staff knew which area to apply it to. However accompanying pharmacy administration charts were not always fully completed with clear instructions and staff did not always sign that they had applied the creams. For example a person's administration record stated "Sudocrem 2 – 4 times a day", with no further instruction on where to apply. This meant there was not always evidence that the creams had been applied as prescribed."

Safe practices for storing medicines were followed. All medicines were stored safely and in a locked cupboard and fridge, and disposed of safely in a locked returns box when no longer required. Where people were prescribed medicines to be taken 'as required', there were clear procedures in place to inform staff when they should support the person to take the medicine. Where people chose to take homely remedies, these were checked by the GP and signed.

Where people refused to take their medicines, we saw there was clear guidance in people's care plans on what action to take. For example one person didn't like to take their medicines from staff they didn't know. Staff knew the person was more likely to take their medicines if left on a table in front of them. The carer would stand to the side to make sure the person had taken it.

We found that repositioning charts were inconsistently completed and there were contradicting information in people's care plans on the frequency of turning the person. Staff recorded that they checked the air mattress daily; however there was no indication on the form they used what setting the air mattress should be on. This increased the risk of people developing pressure sores. People who were at risk of dehydration, had their fluid intake monitored. We saw though that where people's intake was below their target, it was

not clear what action staff took to address the concern. For example we saw for one person their target was 2070mls, but their intake ranged between 510 – 1135mls for seven consecutive days. Another person's fluid chart had not been fully recorded, which meant staff would not be aware if the person wasn't meeting their target.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately, if it occurred. Staff told us they had received safeguarding training and we confirmed this from the training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. They said they would report abuse if they were concerned and were confident senior staff in the organisation would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service, if they felt they were not being dealt with. They also told us they had knowledge of the whistleblowing policy. Whistleblowing is a dedicated phone number that workers can call to report certain types of wrongdoing, and are protected from unfair treatment in their decision to report events.

People told us they felt safe living at Henford House and speaking with relatives they confirmed they had no concerns about the safety of their family member. Comments included "I have no hesitation that [my relative] is safe. There's open communication and you can raise anything you need to", "I feel totally confident in the staff, I know they'll inform me if [my relative] is unwell and I can rely on them" and "I'm confident because they keep us in the loop."

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, in respect of falls, manual handling and malnutrition. Where a risk had been identified, we saw evidence that action had been taken to minimise those risks, for example, a person at high risk of falling was given a sensor mat, which would alert staff straight away if the person started to move. The person was still able to maintain their independence as they enjoyed walking, while actions were in place to minimise their risk of falling.

The registered manager told us incidents and accidents were recorded and any lessons learnt were taken to staff meetings to discuss further. For example, a person who was independent with their mobility, had falls in their bedroom when going to bed at night. Staff realised that the person's bedside light was switched off when staff left the room, which meant the person had to walk in the dark to their bed. Staff now ensure the person's light is left on during the night.

The service used a 'dependency indicated care equation' form (DICE) to work out nursing and care staffing levels. The deputy manager told us they did not feel this tool was always effective in calculating the number of staff needed as it was not a person centred tool. It also did not give a true reflection of staff needed where people were living with dementia. We received mixed feedback about staffing levels. Some people and relatives commented "They are staffed at the minimum levels which the company sets, not what's needed" and "It's adequate most of the time, but at weekends they can be thin on the ground." The registered manager told us staffing levels were currently above the assessed level due to lower occupancy within the home. They also said that weekends were staffed at the same level as during the week.

We received a mixed response from people as to whether staff responded to call bells in a timely way. They said the response time to answer call bells varied, and some people felt this was too slow at meal times,

during the morning when people were receiving personal care or at weekends. We observed this was the case during a lunchtime observation, with two call bells ringing between eight and ten minutes. We saw though for the majority of calls, staff responded within two to three minutes.
There were pendant style call bells which people could take with them into any part of the home. We found not all people were able to use the call bell system and this was identified in their care plans. However, we observed two people calling out and due to the lay out of the building, staff would not be able to hear the person, unless they were in the vicinity. We observed that no staff were available to respond to the two people who were calling out. This meant they relied on others to alert staff to their needs. A person told us "I always ring for her [resident], poor soul, as otherwise she bangs on the table, she doesn't remember to use the bell."

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. Where agency staff was used, the necessary checks were made by the agency. The registered manager told us they tried to use the same agency staff to ensure continuity.

We found the home to be clean, tidy and free from any odours. Staff were able to explain how standards of cleanliness were maintained and cleaning schedules were in place to record that all areas of the home were being cleaned. However, we found that records for cleaning schedules for equipment, such as commodes, raised toilet seats, hoist slings and weighing scales were not always recorded. This meant it was not clear if the equipment had been cleaned or if it was a case of poor recording. Though, visual checks during our inspection confirmed that the equipment appeared clean. We also saw evidence of a feeding liquid splashed against a feeding pump, making it dirty and a potential risk of bacterial growth.

We saw staff had access to aprons and gloves and were able to tell us what procedure to follow in case of an outbreak of infection. We saw though that various staff entering the kitchen were using a fabric apron, which was used and hung back up each time. This meant there was a risk of cross contamination.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met."

At our last inspection, we recommended the service sought advice on the implementation of the MCA in relation to carrying out assessments of people's capacity to make decisions when necessary and making a record of Lasting Powers of Attorney (LPA)s where people had them. We found there was a delay in following the recommendation and a quality monitoring visit from the local authority in August 2017; also recommended the service sought advice from them with regards to MCA, best interest decisions and DoLS.

During this inspection we found people who were unable to consent to receiving care and treatment at Henford House, still had no mental capacity assessments in place. We saw the registered manager had made applications to the supervisory body for DoLS authorisations, some of which had been approved, but others still awaiting assessment. We raised this with the registered manager who told us it had been difficult to get the support in a timely way, but they had started the process of completing the necessary mental capacity assessments. They are due to arrange a visit with the quality assurance team for their support.

Staff showed a good understanding of the principles of the MCA. A staff member commented "Always assume people have capacity, making an unwise decision doesn't mean they lack capacity and any decision made should be in their best interest and the least restrictive option." We saw people's consent was sought before any care intervention. Where people had to provide signed consent, for example for flu vaccinations, we saw this was in place. However, at times when people were unable to sign, but could provide verbal consent, the service would ask a relative or representative to sign and consent on their behalf. We saw this was also the case for a person who was able to consent to photographs, however their relative was asked on their behalf. This meant that people who had the capacity to consent, were not always involved in the decision making process.

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

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. We checked the training matrix and saw staff completed training such

as manual handling, mental capacity, safeguarding of vulnerable adults and infection control. The registered manager told us Henford House had achieved almost 100% in all staff completing the relevant training. We found some people in Henford House was living with dementia and staff received level one dementia training, which was a basic introduction to dementia awareness. Some staff told us they did not feel it prepared them to support people who may have behaviours that could be seen as challenging by others. Following our inspection the registered manager informed us that they had employed a registered nurse who was experienced and trained in dementia care and would be taking the lead within the home.

Staff told us there were opportunities for professional development. A staff member said "Barchester is very pro-active with training. They offer NVQ's (National vocational qualification) and you can work your way up."

Staff told us they received regular supervisions (one-to-one meetings) which supported them in their role. At our last inspection not all staff had received an appraisal, however during this inspection we found staff had had their yearly appraisal. There was a matrix in place, which detailed when staff had received their supervision. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had.

People said that they enjoyed the food and the variety of choices. Comments included "I'm not eating too well at the moment because I haven't been well, but you can get something light, they'll always make you an omelette or a sandwich", "The food is excellent, there's plenty of choice and it's nicely served", "I really enjoy the food, I'm lucky to have a good appetite and there's plenty for me – I just thought today's starter of fruit was a bit odd, you usually get the fruit after the meal." We observed lunch provided in the dining room. Staff were attentive and showed people plated up examples of the day's dishes to help them choose their meal. Where people did not want what was on offer, staff offered an alternative. We saw one person declining to have any lunch and a staff member spent a lot of time, trying to identify something the person might want to eat.

Fruit, fluids and snacks were seen to be readily available during the day. One relative told us "I come in most days to eat with my husband; it's a very good three course meal with wine for £5 so it saves me the work at home and we enjoy it." People's preferences including their dislikes and any allergies were recorded and visible in the kitchen. We observed on our visit that there was a menu available on display in the communal area for people to see and be reminded what the choices for lunch were. The chef was knowledgeable about any special dietary requirements, for example soft or pureed food where people had swallowing difficulties. Where people were losing weight, the chef would fortify foods with cream and butter to increase the calories. The chef also baked a cake for each person on f their birthday.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. However, we received mixed feedback about the promptness of these referrals. A relative commented "Getting access to Speech and Language Therapy was really difficult." Many people told us they had good access to medical care and felt staff understood their needs. A relative said "They know [family member] so well that they pick up quickly if something's wrong."

Where people had specific health conditions, we found not all care plans had the necessary detail and guidance for staff on how to manage these conditions. For example the management of a PEG site (Percutaneous endoscopic gastrostomy). There was no clear instructions on how to keep the site clean, cleaning of the administration device and the position the person had to be in when administering the feed. Conditions such as Parkinson's disease and diabetes also did not have individual care plans. We found that a person, who was insulin diabetic, did not have a hypoglycaemic agent prescribed. There was a

recommendation in the care plan to use Lucozade, however this was out of date as Lucozade was no longer high in sugar. This meant the person would be at risk if they became hypoglycaemic.

The home was spacious, which allowed people to spend time on their own if they wished to do so. People had access to the gardens, and we observed some people going out with relatives. There were various lounges, as well as drink making facilities, which people and their visitors could use. The deputy manager told us people sometimes had their breakfast in the garden in good weather. Where people chose to smoke and they were able to do so independently, they were allocated a downstairs room to enable them to access the smoking area easily. We found the home was not developed to support people living with dementia. The registered manager told us Henford House did not specialise in dementia. We found that many people were living with various degrees of dementia in Henford House. The registered manager told us people would have developed their dementia over time and not when they were first admitted.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People told us staff were caring. Even people who had reservations about some aspects of their experience within the home, spoke positively of the staff and their kindness. Comments included "I'm very happy, the staff are so kind, I've got nothing bad to say about them", "Generally the staff are very kind and caring and that's so important" and "I get on well with all of them, we have a laugh and a joke which is important when they're doing personal things. You have to feel comfortable with them." People knew the staff looking after them, as they were either permanent care staff or agency nurses who worked in the home regularly. Relatives told us they felt welcomed and comfortable when they visited the home. They said the home had an open visiting policy and they could visit at any time.

People told us that staff always respected their privacy, knocked on the door before entering and asked permission before supporting them. Relatives confirmed that this was the case. Bedrooms all had labels on the door handle indicating that care was being delivered and requesting to knock and wait. Doors were kept closed during care delivery and these notices were in use. Staff carefully explained care interventions to people. A staff member told us they would always treat people with dignity. For example when they are supporting a person with personal care, they would always ensure the person is covered.

People said that they were offered everyday choices about their care: "I can have a shower or bath; the option is there, but I really prefer a strip wash", "I can go to the sitting room but I'd rather be in my room quietly, watching television and looking out at the birds." Those who were more dependent felt there were sometimes fewer choices: "I would really like more baths, I've only had one since I came here last February. I have asked but they just say they haven't got time" and "My relative would like to have a shower, but it's not offered, possibly because it's too much work or they don't think it's safe, it was never a problem at home."

Staff knew people's individual communication skills, abilities and preferences. We saw people had communication care plans in place, providing staff with instructions on how best to communicate with a person. For example for a person who was confused and disorientated to place and time, the care plan guided staff to speak to the person in a gentle and calming way and to give the person time to respond. Staff told us if people were hard of hearing or had poor eyesight, they would ensure they had their hearing aids in and glasses on. They would also stand in a position where the person is most likely to hear and see them.

During our conversations with staff they demonstrated they cared a great deal for the people they supported. A staff member told us they had made a suggestion to work in a different way in the morning when supporting people, which meant they would have more time to spend with residents and not rushing. They also told us the home did not use agency staff as carers, only nurses, which meant people had continuity in care and people would feel comfortable in their home with staff they knew. They commented "We [carers] come in to cover each other rather than let the residents not get the care they should.'' Some staff had relatives resident in the home and they told us they felt care staff provided a high quality of care. Staff comments included "Care is very good here" and "I love care."

People were encouraged to be involved in the service, however some people and relatives felt this was more the case where people were less dependent. For example one person delivered the newspapers to others within the home and the registered manager told us they had involved people in interviewing staff in the past. People spending a lot of time in bed or their rooms, were not as much involved. Staff told us they encouraged people to be as independent as possible. For example a person with hearing and visual impairments would be supported and encouraged to choose what clothes they wanted to wear.

Information about advocacy services was available to people. We saw where needed, people were referred to advocacy and were supported in decision making.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Care plans were personalised and included various aspects of the person's daily living, for example communication, personal hygiene, mobility, nutrition, sleeping and mental health. Most care plans had detailed information about people's preferences, however some care plans lacked information on people's preferences for their daily routine, for example what time they wanted to get up and when they liked to go to bed. Some people had clear information for staff on how they would like their personal care attended to, however others had limited information. The registered manager told us they were in the process of reviewing care plans with people and their relatives. A relative showed us a document which the home recently introduced and summarised the likes and dislikes of the person, and said they had been involved in writing this.

We saw care reviews took place, however it was not evident if the person had been involved. Some care reviews only evidenced the view of the relative. Care plans were updated on a monthly basis, but again this was updated by staff and no evidence that this had been discussed with the person. The deputy manager told us they had a system called "Resident of the day", which meant they would look at a specific person's care plans, auditing those to ensure all was up to date. The resident of the day would also have their room deep cleaned and other checks would be completed within their room.

Some people and relatives told us information sharing and communication could be improved on. Comments included: "Communication isn't always good, the clinical support hasn't been good, but it's got better now there's a clinical lead", "Sometimes you're made to feel that they know best, when you know your relative so well and what they need – they don't always listen" and "I feel the care needs to be reviewed but I don't want to say anything because I don't want to make bad relationships."

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. There was also a daily stand up meeting with various departments, such as maintenance, catering, housekeeping and nursing staff to ensure any important updates were shared. A health and social care professional said "Communication within and to the home was very good, staff are incredibly helpful and residents are well looked after."

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. We found though that activities such as reminiscence, which could be beneficial to people living with dementia, were not available to people. There were also no reminiscence objects around the home.

An activities coordinator was available six days a week from 11am – 5pm. Other than activities the coordinator involved people in such as scrabble or pottery session, the service also had external entertainers visiting the home. For example they offered numerous types of musical sessions from a man with an accordion, to a Frank Sinatra sing-along, and a karaoke session. In addition to group activities

people were able to maintain hobbies and interests, for example one person had an allotment as he enjoyed gardening. His garden products were brought in for harvest festival and cooked and shared with all the residents.

People told us they enjoyed the activities but if they didn't want to take part, they could choose not to. Comments included "It's pottery this morning, I've tried it but didn't particularly care for it, but it's baking this afternoon, I will do that and probably make some cakes", "I'm keen to have a go at the pottery but my wife has just arrived, so I'll try next week", "I prefer my reading and crosswords, or looking out of the window" and "I do sometimes join in the singing."

The registered manager also offered a "knit and natter" group for people where they would have coffee, cake and do some knitting. People were knitting bonding squares for neonatal babies as well as baby hats. A person said "I don't go to many activities but I do love knitting and I've enjoyed the knitting circle and making the squares for the special baby unit".

Both the activities coordinator and registered manager said they offered one-to-one sessions for people who were not able to attend the activities and could potentially be socially isolated. We saw the activities coordinator kept a monthly activity evaluation. We found this did not always focus on the person's emotional well-being and did not evidence what interaction or activities were tried with the person. Some of the language used within the evaluation was not always respectful towards people. For example for one person it stated "Sometimes is polite, sometimes not. [Person] is transferred from bed to chair. [Person] has her TV on and reads the newspaper. Eats her meals in her chair. [Person] hasn't been as rude as usual to me, but doesn't want to get involved with any activities."

The registered manager told us they also visited people who stayed in their rooms and we saw evidence of the recording. However, these were brief visits, checking if people were happy and did not always involve specific activities, which the person might have been interested in. We saw for many people who stayed in their rooms, that the majority of the time they were on their own in their room, with the only interaction, when staff visited to provide care. The registered manager told us they also had volunteers who visited people in their rooms.

People's concerns and complaints were encouraged, investigated and responded to. Some people told us they had made complaints. They said that "little niggles" had been easy to resolve, while others reported their concerns were on-going and not yet resolved. Comments included "We raised something and it wasn't handled very well by management; so it has caused some additional problems, although in the end it had a good outcome" and "I want to sort an on-going problem out, and will get back to it again soon; as there have been other things going on. I need to gather the energy first."

People and their relatives were given support when making decisions about their preferences for end of life care. We saw people had advanced care plans in place; however these were not always person centred but focussed on what medical intervention people would prefer. A relative told us they had been spoken to about End of Life care and the pathway, but had not been offered care plan reviews before, or now that their relative's needs had changed. Another relative spoke positively about their family member's End of Life care. They said "They were so kind when my mother died and gave the whole family their support and genuine condolences. My sister was able to stay here and my father (who still lives here) was well supported too."

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post who was responsible for the day to day running of the service. The registered manager was supported by a deputy manager who was also the clinical lead as well as a regional manager from Barchester [provider]. The registered manager told us the service had been without a clinical lead for nine months since our last inspection, which meant they had not been able to make all the necessary improvements. They told us since the clinical lead started in October 2017, clinical governance had improved. However, the clinical lead was due to leave the service and the registered manager was in the process of recruiting a replacement. The registered manager did not have a clinical background and a clinical lead was needed to support the registered nurses.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The registered manager completed their own internal audits, and Barchester [provider] also visited regularly to complete quality checks. This enabled the service to identify any shortfalls and put actions in place where needed. However, we found that areas of concern identified at our last inspection, had not been resolved and the service remains Requires improvement for a second consecutive time. Records were not always accurate and reflective of people's current needs. The registered manager told us there was a central action plan in place, which was regularly reviewed and updated by the registered manager and regional director to ensure necessary improvements were made.

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

We found the registered manager to be visible around the home. The registered manager told us they went around the home each day, visiting people in their rooms. Some people and relatives told us it was difficult to identify a senior member of staff over the weekends as the registered manager was not on duty. People commented "It's not always clear who's in charge at the weekends" and "There's no manager on duty at the weekend, and sometimes that's difficult." The registered manager told us there was always a senior member of staff on duty over weekends. The registered manager visited the home at least monthly at weekends as part of the out of hours checks and quality assurance process. The clinical lead and head of services worked alternate weekends and there was a 24hr on-call system if staff needed advice or support.

We received mixed feedback about the approachability and responsiveness of the management team. Staff told us they felt well supported by management. Comments included "Can't speak highly enough of [the manager]. Fantastic. They try to be as fair as they can" and "It's easy to talk to the manager. We're more like a family than a workforce." Some staff told us though that they did not always feel comfortable with the way management spoke to them. Some relatives also told us that they had stopped raising issues with the manager as they didn't find them approachable. One relative said "I find the manager can be defensive and that isn't good."

There were regular residents and relatives meetings and people could raise any issues if needed. Some relatives had found the meetings useful. A relative told us they raised the issue of an unpleasant odour. They

said "We were able to get action eventually taken to reduce the smell coming from a neighbouring room. The soiled carpet was taken up and replaced with washable flooring." Another relative commented "Feedback is given at the next meeting about things that have been raised and what they've done about it." Others said they didn't find them helpful and would rather raise issues that were relevant to their family member privately. A few people said they thought they'd been asked to complete a questionnaire about the service and their satisfaction, but some didn't think they'd ever done one or been asked about their experiences.

People and their relatives were invited to complete an annual survey to feedback their views on the quality of care. However, the results of these surveys had not been available to us during our inspection. The registered manager told us people and relatives were always encouraged to feedback and there was also a comments book at reception. People and relatives were also able to leave reviews online on a website.

The registered manager had made links with the local community and told us they had plans to expand these further. They were in the process of liaising with other agencies to encourage them to use facilities at Henford House. For example the registered manager was liaising with the carer support service to hold their meetings at the home. People from the community would be able to use the home activities, while their carer joined the support meeting. The service was having meetings with other agencies, who were able to identify any isolated or vulnerable people in the community. They would encourage and support people to visit Henford House for a meal or social stimulation.

The registered manager told us a person passed away before Christmas and their spouse still visited the home and enjoyed sitting in reception. The service had put posters up over the Christmas period for emergency staff such as paramedics and police, inviting them in for a cup of tea and cake. They said people enjoyed meeting the emergency staff. They were also in contact with the local neighbourhood watch to look at reducing the speed limit in the road next to Henford House, as some residents enjoyed walking down the road.

The service had a good understanding of equality, diversity and human rights and the registered manager told us how these were put into practice. They recognised, for example when people had different cultural or religious needs and respected people's wishes. They told us some people had specific religious beliefs and did not celebrate Christmas or their birthday. This was respected and the person would be informed if there was going to be any Christmas activity, to enable them to avoid it if they wished. However, the registered manager told us people were still welcome to join in if they wished to do so. For another person who was from Jamaican decent, we saw what was culturally important to the person, was recorded in their records. Staff would play Jamaican music in their room.

The registered manager told us they valued their staff. For example they had an employee of the month award, where all staff were encouraged to nominate a member of staff who they thought had been exceptional in their duties. Staff who got the most votes received a £25 voucher to spend as they chose. They said they would happily work alongside staff and had helped out in the past when needed.

We also saw the service worked closely within a multidisciplinary way, involving various professionals such as community physiotherapists, tissue viability nurses, speech and language therapists as well as dieticians.

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 11 HSCA RA Regulations 2014 Need for consent The service did not follow the recommendation made from our last inspection. The service did not always work within the principles of the Mental Capacity Act (2005). Not all people who lacked capacity to consent to living at Henford House had a capacity assessment in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines management were not always safe. There was sufficient staff to meet people's basic care needs, however we found staff were not always visible and available to support people who were unable to use their call bells. Risks to people's personal safety had been assessed and plans were in place to minimise these risks. However, repositioning and fluid charts to monitor risks were not always fully completed. The service had not done everything practicable to minimise the risk of cross contamination within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is the second consecutive time the service is rated Requires improvement. The necessary improvements identified at our last inspection, had not been made. Quality assurance systems were in place, but an action plan was not

developed to make the necessary improvements.