Jasmine Healthcare Limited

Southmoor Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 5 January 2017. The inspection was unannounced. Southmoor Lodge Care Home is registered to provide personal care to a maximum of 40 older people. On the day of our inspection 26 people were using the service.

The service did not have a registered manager in place at the time of our inspection and had not had one since September 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. However risks in relation to people's daily life were not properly assessed or planned for.

People were supported by enough staff to ensure they received care and support when they needed it, but were not regularly given the opportunity to engage with staff. Medicines were not always managed safely to ensure people received their medicines as prescribed.

People were supported by staff who did not all have the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions but people who did not have the capacity to make decisions were not protected because the provider did not adhere to the Mental Capacity Act 2005 (MCA).

People were supported to maintain their nutrition and staff were monitoring and responding to people's health conditions.

People lived in a service where their emotional needs were not always recognised and they were not being supported to enjoy a stimulating social life. People knew how to raise concerns and felt these concerns would be listened to.

The systems in place to monitor the quality of the service and to bring about improvements had failed. The management team were approachable and were working hard to bring about improvements. People were given the opportunity to give their views on how the service was run.

We found the provider was in breach of a number of regulations and this resulted in people not being supported in line with the MCA, not having risks to their wellbeing assessed and planned for, not always being protected from harm and living in a service which did not have effective systems to identify these shortfalls. 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 consistently safe.

Risks were not always planned for or managed appropriately. People did not always receive their medicines as prescribed and medicines were not always managed safely.

There were enough staff to provide care and support to people when they needed it, however the way staff were deployed did not provide time to regularly engage with people.

People felt safe in the service and there were systems in place to ensure staff knew how to escalate concerns. People lived in an environment which was well maintained and there were systems in place to ensure people would be supported in the event of an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had not all received appropriate training and supervision.

People made decisions in relation to their care and support but where they needed support to make decisions they were not protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People lived in a service where staff did not consistently show compassion for the individual they were supporting.

Staff respected people's rights to privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always involved in planning their care and support and they were not supported to have a social life and to follow their interests.

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service had not been consistently well led.

The systems in place to monitor and improve the quality of the service had failed. There had been a succession of managers employed and the service had deteriorated.

The new management team were approachable and were working hard to bring about improvements. People were involved in giving their views on how the service was run.

Southmoor Lodge Care Home

Detailed findings

Background to this inspection

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

We inspected the service on 5 January 2017. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with nine people who used the service and the relatives of one person. We also spoke with two health and social care professionals who regularly visited the service to provide input into the care some people were receiving.

We spoke with three members of support staff, catering and maintenance staff, two deputy managers and the manager. We looked at the care records of five people who used the service, medicines records for 26 people, staff training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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Requires Improvement

Is the service safe?

Our findings

Risks to individuals were not always assessed to ensure staff had access to information about how to manage potential risks. For example an evaluation of one person's care showed they were at risk of choking whilst eating due to a health condition. This information had not been assessed by the manager and there was no care plan in place informing staff how they should support the person to reduce the risk or how to respond if the person did choke. We spoke with two members of staff and they were not aware of this risk.

Prior to our inspection one person who lived with a dementia related illness had left the service without staff being aware and had been placed at risk of harm in the community. We looked at their care plan and the risk of this reoccurring had not been assessed and there was no information to guide staff in how to support this person in order to attempt to prevent a similar occurrence.

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

People we spoke with told us they felt safe in the service. One person told us, "Having staff around makes me feel safer." Another told us, "I do feel safe here, the staff know what they are doing."

However we found there was a lack of proper risk management for people who lived with a dementia related illness and sometimes communicated through their behaviour. One person who lived with a dementia related illness sometimes displayed behaviour which would need careful planning to ensure staff would know how to support the person and respond to this type of behaviour. We found there was a lack of risk management for this person to ensure other people who used the service would be protected from harm, despite there being recent incidents of this person assaulting other people. Staff described this person displaying this type of behaviour on a regular basis, however the care plan did not have any details about how to support the person with their dementia. Staff were not provided with any positive strategies to support them with this and the behaviour which arose from the person's illness. We observed this led to a negative approach from some staff who reacted negatively to their behaviour. The care plan asked that charts were maintained so there was a record of any incident of this type, however we found these were not being done. We observed staff supporting this person and it was clear that some staff did not understand how to support this person using a positive preventative approach to their behaviour. This placed other people using the service at risk of harm. Additionally the person was prescribed a medicine to be used as a last resort if the person's behaviour escalated but this was not detailed in the care plan as a strategy for staff to use or when to use it.

We looked at the care plans of another person who sometimes expressed themselves through their behaviour and there was a lack of care planning based on what might trigger the behaviour and how staff should try and minimise the triggers. For example the care plan informed staff the person could become 'aggressive' but the plan did not specify under what circumstances this might happen or what staff could do to avoid these circumstances and ensure the person or other people who used the service were protected from harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was taking action to improve the systems in place for safeguarding people from the risk of abuse. The staff we spoke with had the knowledge to recognise potential abuse and understood their role in relation to reporting any concerns to the manager. However staff had not referred a recent incident to the local authority and the manager told us this had been left for him to deal with when next on duty. The manager told us they were taking steps to ensure that all staff understood they should report any safeguarding concerns as soon as possible and not wait until they were next on duty in future.

The manager said when they took up post they had not felt there was an openness with regard to discussing safeguarding issues. They described how they had addressed this and were raising the profile of safeguarding in the service through training, providing information and having discussions in meetings and individual staff supervisions. Staff confirmed they had received training and guidance in relation to recognising potential abuse.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. We found that medicines were not always being managed safely and people could not be assured they would always receive their medicines as prescribed. We saw that in the week prior to our visit two people had not received some of their medicines, despite staff signing to say they had been given. We also found that although staff had been reminded of the importance of signing and having a witness sign any hand written entries on the medicines administration records, this was not always being done. Additionally staff were not always dating liquid medicines when they opened them. These are important aspects of medicines management as they are aimed at reducing errors in recording and making sure medicines are disposed of when they exceed their shelf life. A further lockable facility was available for the storage of drugs which required more secure storage. We found the cupboard used for these medicines did not meet the requirements as it did not have a multiple point lock.

We found the rest of the medicines systems were organised and staff had received training in the safe administration, storage and disposal of medicines. There were audits being carried out in relation to identifying medicines errors and where errors were found there was an investigation and action taken to reduce the risk of further errors of that nature.

We received mixed feedback about the staffing levels in the service. Some people felt they received the care and support they needed in a timely way but commented that they felt staff did not have enough time to sit and chat with them. One person told us, "I don't have to wait long if I buzz." A relative told us, "[Relation] has a buzzer and the staff come quickly. There is always someone about." Other people told us they felt they had to wait for staff sometimes as they were busy. One person said "Sometimes I have to wait a bit at night, it depends on where the staff are, it is such a big place. During the day staff come easier but I think it is very busy before meal times." Another person said "They don't always come immediately it depends on how busy they are." A third said, "They look after me really well it is just when they are short staffed I have to ask if I want a shower."

Two members of staff we spoke with told us they felt there should be more staff on duty at peak times. This included busier times such as mealtimes as well as other times of the day to give them the opportunity to sit and chat with people.

We spoke with two visiting health professionals and they told us that in the past it had been hard to find staff but that this had improved as staffing levels had been increased. They told us there were staff available

when they visited and that people were being given support in a more timely way. A deputy manager told us they had been able to attend to people's needs during the morning we visited in good time, along with the care staff on duty. During our visit we saw there were enough staff available to support people when they needed or asked for it. The manager expressed strongly that they believed there were sufficient staff on duty to meet the assessed needs of people living at the service. We were therefore unable to conclude if there were insufficient staff on duty or staff required further guidance on how they were deployed and undertook their roles.

The manager told us they had introduced a new staffing structure and along with some staff changes that had taken place since they had taken up employment they had needed to recruit a number of new staff. They described how they were trying to recruit staff who would "sign up to the values and positivity" they were looking to install within the staff team. The manager said that this had led to an increased use of agency staff to run the service during this time, which although they knew was not ideal they had needed to ensure they had the number of staff needed to keep the service running whilst the recruitment was carried out. There were some new staff on duty, including two new deputy managers and we were told about several new staff waiting to start once the recruitment checks had been completed. The manager told us the service used a minimum of six staff on duty to provide care and support to people and that they had assessed this was an adequate number of staff based on the needs of the people who used the service.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. These included acquiring references to show the applicants suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions. Staff described having undergone the required recruitment process and recruitment files showed the necessary recruitment checks had been carried out. We discussed with the manager the importance of recording investigations into any gaps in candidate's employment history and they told us this would be done in the future.

People were living in a well maintained service and there were systems in place in relation to minimizing the risk of fire and emergency plans for staff to use in the event of an emergency. People's care plans contained clear plans for staff to use to evacuate them in the event of an emergency, such as fire. The fire officer had asked the provider to make some improvements to the systems in place for fire safety and we saw the provider had implemented an action plan to address these.

The maintenance person showed us the records made of the daily, weekly and monthly checks they undertook in relation to fire and these showed they were completed as required. Where routine maintenance issues were identified, such as a call bell not working or hot water temperatures were too high action was taken to correct this. The manager told us they did not currently use a maintenance log book to communicate and record maintenance issues but would implement one.

Some areas of risk were well managed and steps were taken to reduce the risk. We looked at the support one person was receiving in relation to managing their falls risk and saw they had a care plan in place which detailed the risk and what steps were needed to reduce the risk of further falls. This included equipment to reduce the risk of injury if the person fell from their bed and to alert staff to any falls the person had. We checked this equipment was in place and was working and we found that it was. The manager described how they had responded to some risks another person faced in everyday living. This had involved purchasing new equipment when equipment that was already being used was not effective. This included a bed that could be lowered to floor level to prevent the person from falling out of bed. The manager told us how they had instigated meetings with the person's relations and other professionals to devise the safest

way for the person to be cared for. Another person had a health condition which required medicines and regular checks of their blood sugar levels and this person managed these independently. We observed staff monitored this to ensure the person was managing the risks around their health condition safely.

The manager told us that new care plans were going to be implemented across the service and that as a part of this an improved approach to assessing the risks people faced would be introduced. We saw the weekly return the manager completed which highlighted any adverse events such as falls, accidents or weight change. The manager described how this had led to action to increase the frequency they monitored someone's weight and make a referral for them to see a dietician. The manager also kept a falls log to monitor the number of falls that occurred and identify if they needed to take any preventative action or make a referral to a healthcare referral, such as to the falls prevention team, which they had done for one person.

Requires Improvement

Is the service effective?

Our findings

People who had the capacity to make decisions were supported to do so. People told us they were able to make decisions about their care and support. One person told us, "I do what I want when I want. I have everything I want here." Another person told us, "I usually get up a bit later and take things more steady."

However people who lacked the capacity to make certain decisions were not supported in line with the Mental Capacity Act 2005 (MCA). The 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 looked at the records of two people who lived with a dementia related illness and had been assessed as lacking the capacity to make certain decisions. These records showed these people's capacity to make certain decisions was not being assessed in line with the MCA. Assessments had been carried out and decisions made in their best interests for unnecessary decisions such as going to bed and sleeping, however they were lacking for fundamental decisions such as having bed rails in place. The assessment forms were not always completed as intended, for example the assessments carried out for one of these people did not include details of how their capacity had been tested.

Additionally there was information in both people's care plans which stated relations made decisions on their behalf. The relatives of both people had signed to consent to care and treatment for decisions such as their relation having an influenza vaccination, however the relatives did not have the legal authority to do so as there was not a Lasting Power of Attorney for health and welfare in place to give them this.

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

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager had made applications for DoLS where appropriate. For example, one person had been assessed as requiring support from staff if they went out into the community and that they were not free to leave the service alone. There was an up to date DoLS authorisation in place for this person. However we saw another person had a DoLS authorisation in place and this had been granted with conditions attached. The conditions were for the person to be engaged in meaningful one to one and group activities and for a specialist chair to be supplied as a matter of urgency. Neither of these conditions had been met. The manager told us that they had sought advice about the specialist chair and that it had not been deemed as

necessary, however this had not been brought to the attention of the DoLS granting authority to see if they were in agreement with this and whether they would continue to grant the DoLS without this condition.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who were not always trained to support them safely. People told us they felt some staff were trained well and knew how to carry out their roles but other people did not feel confident in some staff. One person said "The majority of the agency staff are very nice, but some don't know me as well as the permanent staff. I think the agency staff aren't as confident in what they do." Another person said "Agency staff don't know me as well, they don't seem to know what they are doing, we've had quite a few lately." Although they will listen if you tell them how you want something doing." A third person said, "Most of the staff are well trained but some are better than others."

The systems in place to induct new members of staff had not yet been implemented in a way which would ensure staff had the skills and knowledge they needed to support people appropriately. There was a new member of staff on duty on the day we visited who was 'shadowing' another staff member as part of their induction. Whilst it was recognised the staff member needed to have a period of induction to familiarise themselves with the people who used the service and the ways of working in the service, there was no plan in place to allow the new staff member to have time to reflect on and discuss the shadowing they undertook. Another recently recruited staff member said they had felt "a little thrown in at the deep end."

The majority of staff training was undertaken through completing workbooks about different topics which were then sent to an external examiner for marking. The manager told us at present there was no check in place to test the understanding and knowledge of staff once they had completed these workbooks and how they would put the learning from these into practice. The manager said they would be looking to introduce checks on this in the future. They also showed us the minutes of a recent staff meeting where staff had expressed a preference for more practical training and the manager said they were looking to introduce this in addition to the workbooks used. The manager told us they had already provided one practical session about dementia as part of a staff meeting. Staff we spoke with who had attended this were enthusiastic about how this training had been delivered and said they had learned a great deal from it.

The audit manager showed us the staff training matrix and this identified there were a number of staff who had yet to complete some of the training the provider had identified as being mandatory for them to complete. The audit manager explained that following a review of staff training they had found that there were a number of staff who they did not have certificates to show they had completed a number of training courses. They told us as a result of this they had changed their policy and now only recognised a training course as complete once they had received a copy of the certificate, which confirmed the staff member had successfully completed the course. As a result this meant a number of staff had now been identified as needing to complete courses they had previously been marked as having completed. The manager told us they had set a target for these courses to be completed by the end of the month.

The audit manager told us that any new staff without a relevant qualification would complete the care certificate. None of the staff working in the service were currently completing the care certificate and we were told that was because all care staff, including those recently appointed, had a health and social care qualification. The Care Certificate is a set of national standards for staff working in health and social care to follow and equip them with the knowledge and skills to provide safe, compassionate care and support.

The staff we spoke with told us they were being given training in various aspects of care delivery such as

medicines and safeguarding adults training. The new cook told us they had requested some additional training which the manager confirmed they were arranging for them.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the manager and were given feedback on their performance and we saw records which confirmed this.

People felt the food in the service had improved and they were aware of further improvements which were planned. We spoke with people about the food and they told us they had enough to eat. People told us there was a choice on the menu and if they didn't want was on the menu they could ask for something different. One person said, "The food is pretty good. I have lost a lot of weight so I am weighed weekly." Another person said, "We get good meals it depends on the cooks they have been using agency cooks for a while but we now have our own." A third person said, "There is always a choice at lunch and it is usually sandwiches at tea. I have the same every day usually cheese and pickle although today we have soup on the menu so I shall have that. I am looking forward to soup tonight." A fourth person said, "The food is a lot better than it used to be. They try their best to cater for my diet, for example, they don't add sweetener to my custard. There is always a good choice."

People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. We saw staff had noted when one person had some unplanned weight loss and they were now weighing the person more frequently and had referred the loss to the GP. The GP had prescribed some food supplements and we saw staff were giving these as prescribed. We observed there were jugs of juice and water available for people to help themselves in communal areas and people had access to drinks in their bedrooms.

The provider told us in the PIR that people had the right where they eat their meals with a choice of two dining rooms and their bedroom. We observed lunch being served in both dining rooms. There were sufficient numbers of staff to support people with their meal and those on a specialist diet, such as a soft diet, received these in line with guidance in their care plans. Meals were served individually on a tray and if people required aids such as plate guards or adapted cutlery this was provided. We saw some people, who were more independent, helping themselves to fresh fruit from the dining table between meals. Other people were provided with drinks and snacks from a trolley at various intervals through the day.

The manager told us how they had addressed issues with the quality of the food which included making changes within the catering team. This had included a senior care worker having a trial period as head cook which had been a success and made a permanent arrangement. This cook and one of the kitchen assistants, who were not on duty when we visited, arrived at the service to finalise the new menus they had prepared and spent some time explaining to us how they had set about making the improvements needed to the catering arrangements. They demonstrated a good knowledge of people's dietary needs and how they should be met, and described with enthusiasm how they were making the improvements. This had involved consulting with people about their choices and preferences as well as how to maximise the amount of nutritional benefit into people's meals. They told us, "We have a lot of new ideas for making the meal times a more social and pleasurable experience."

A deputy manager told us how the cook had involved people in discussions about the food and said they had heard a number of positive comments from people who used the service and relatives about the improvements to the standard of meals provided.

People were supported with their day to day healthcare. We saw people were supported to attend regular

appointments to get their health checked. People told us they felt well looked after and staff would discuss the local doctor coming to see them if there were any concerns. One person said, "I still have my own GP he comes here if I need him." Another person said, "I don't see the doctor routinely but if I needed to I would ask and they (staff) would sort me out a visit." People said they were able to see a chiropodist and optician if needed. One person said, "There is an optician who comes to the home. I got these glasses from him." Another person said, "I go out to my own optician the staff make the appointment and sort the taxi." A third person said, "The chiropodist comes every few weeks. I don't have problems with my feet."

The provider told us in the PIR that they worked closely with healthcare professionals such as district nurses, dieticians, occupational therapists and continence services to fully support and maintain people's health and well-being. We saw referrals were made to health professionals when needed. One person told us "The district nurse comes in to check my [health need] sometimes but if it blocks I have to go to hospital. One of the staff will come with me." We spoke with a visiting health professional and they told us that the health monitoring of people who used the service had improved and that staff were now much better at identifying early signs of any issues and calling for advice and support. They told us that staff followed the recommendations they gave and communicated any issues they found in relation to these.

Requires Improvement

Is the service caring?

Our findings

People did not always receive care which was dignified or delivered with compassion and in line with their choices. One two occasions we observed two staff transfer one person into or from an armchair using a hoist. This was done in an undignified and impersonal way, where the person's clothing was moved out of place and their underwear displayed to other people. On one of these occasions the person was not given any explanation, comfort or reassurance during the lifting process.

We observed another occasion when a staff member responded to a person who used the service who lived with a dementia related illness in a dismissive and offhand way when the person asked them a question. The way the staff member responded showed a lack of understanding and compassion about the person and how they were affected by their illness. On a further occasion a staff member went to change the television channel without asking people who were watching this if they wanted this to be changed. One person objected saying they were enjoying this programme so the staff member did not change it, however they returned a few minutes later and, again without asking, put a DVD on instead.

We observed one person who relied on staff to hold their drink for them and we saw staff did not always do this in a dignified manner, involving the person in having a choice. The person's care plan stated they could not communicate well verbally and so staff should communicate at eye level. We saw a staff member did not sit with the person whilst giving them a drink, instead they stood over them and appeared rushed. The staff member did not ask the person if they had been given enough and they just put the drink down and walked away. We told this member of staff we felt the person was enjoying the drink and would have had more if they had been given the time. The staff member returned to the person and gave them some more but still did not sit with them or facilitate effective communication by moving to their eye level. We looked at this person's care plan in relation to communication and there was very little information explaining how staff should communicate with them effectively. The plan stated that staff should observe the person for signs of discomfort or pain. We observed the person appeared to be in discomfort during the morning, but staff did not respond to this. We therefore had to suggest that staff followed the instructions from their care plan and placed a pillow behind the person's head and elevated their feet.

We observed during lunchtime in one dining room a group of staff who sat separately to people who used the service, who were eating their meal. The staff members were having a non-work related conversation and did not take this opportunity to engage or include people who used the service in a conversation. As a result of this people were not provided with any support or encouragement to eat their meal or to enhance their dining experience as a social occasion with staff.

Other staff interactions we observed provided examples of staff being kind and caring to people whilst they were supporting them. For example one person needed a lot of support to eat their lunchtime meal. We saw a staff member sat with them and showed patience and compassion as they gave the person the time and encouragement they needed to eat their meal. Another person needed extra supervision when they were mobilising and we observed a member of staff being very patient and understanding of the person's dementia related illness whilst they were walking with them. People looked comfortable with the staff and

for the most part people looked happy and content.

People who used the service and their relatives praised the staff for the way they showed kindness and patience to them. One person said, "They are a good set of staff. I think they are caring. They know me well enough now. They have a bit of a laugh and a joke with me. I get to know all their family history. I get on with them all very well, some of them bring their dogs in to see me, they know I love dogs." Another person said, "The staff are very good, they care. I have no complaints." A third told us, "The staff are very caring we couldn't have any better than the carers we've got. They are always popping their heads around the door to check on me." A fourth person said, "They are fantastic I have nothing but praise for them. They are so patient, they know my history. The staff are like family I love the girls here." A relative told us, "They are very nice staff, very pleasant. There are no restrictions on visiting. [Relation] was very poorly and we took it in turns to stay. The staff were brilliant they made us drinks and feel very welcome."

People told us they were now being supported to be more involved in making choices about what happened in the service, such as the food menu. One person said, [Manager] holds meetings and listens to suggestions." They gave an example and said, "We wanted butter on our sandwiches not spread and he got it sorted straight away."

People told us that staff supported their privacy and treated them with respect and dignity. One person told us, "They are always respectful, never raise their voice." Another person said, "Staff always make sure the door is closed and when I have a shower they make sure they wrap me up in a towel. They look after my modesty I have no problems." A relative told us, "I am here a lot of the time and I knew from the start everyone is treated respectfully. I have never heard anyone speaking or dealing with anyone inappropriately".

The provider told us in the PIR that staff were trained in privacy and dignity values and the staff we spoke with confirmed this and discussions showed they understood the values in relation to respecting privacy and dignity. The staff also told us they would report any concerns about people not being treated with dignity and respect. The manager told us they had identified a member of staff who would be a dignity champion and would lead other staff in this.

Requires Improvement

Is the service responsive?

Our findings

People were supported by staff who did not have accurate information about how they needed to be supported. People had care plans in place but we found these were repetitive and contradictory. For example one person was at high risk of developing a pressure ulcer and there were several risk assessments and care plans in place informing staff how to support the person and reduce the risk of them developing an ulcer. Each of the records gave different guidance and advice so that it was not clear how the person needed to be supported. We found this to be the case with all of the care plans we looked at, with a lack of person centred information based on the needs and preferences of people who used the service. Staff described the care plans as being too big and having too much information to be used effectively. Staff told us they found them "off putting" and some staff we spoke with had not had the chance to read them and did not display a good knowledge of some people's care needs.

There were officers from the local authority visiting the service to audit the quality of care provided on the same day we visited and they told us they had concerns about how people's care was being planned. This included having care plans in place in good time for people who had recently moved into the service. One person had been living in the service for three days but there was very little information to guide staff on how to support them. The manager told the local authority officers that they had completed a pre-admission assessment which detailed the person's needs, however this was not in the care file. This meant staff did not have information about how to safely support this person in line with their needs and preferences.

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

People were not always involved in planning their care and support. None of the people we spoke with could recall being involved in a review of their care plan or being asked if they were happy with the way their care was planned. Two people told us they knew they had a care plan but had not seen it as far as they could recall. The relative we spoke with felt they were kept up to date with information about their relation. They told us, "We know the staff will pick up any changes in (relation) and let us know." They told us, "We have been fully involved in [relation]'s care plan. I am always talking to the staff and if I feel [relation] needs anything extra I will say."

People were not being given the opportunity to follow their interests and take part in regular social activities. On the day of our visit, some of the people who were more independent were supported to have a game of dominoes and some people chose to read newspapers or magazines. One person who enjoyed gardening had been provided with a greenhouse within the grounds of the service for them to continue with their interest. Other people spent time in their bedrooms and told us there was very little for them to do.

One person said, "I am a bit of a loner and have my own hobbies to keep me occupied." Another person told us, "We could do with a bit more exercise even if it was just going around the village for some fresh air. We used to go on trips but we didn't have an outing at all last year. To go down to the dining room is a joy."

Other people who relied on staff were left without any stimulation throughout the day. One person's care plan stated they should be supported to access one to one or group activities, but we observed this person did not receive any stimulation throughout our visit. A relative told us, "There are no really regular activities. There was a lady who was brilliant, really right for that type of role, but she left and since then there has been a succession of staff who have been given the job whether or not they wanted it. I do believe now though [manager] has appointed someone so hopefully things will improve."

There were activity posters on display showing what activities were on offer each day, however when we asked the manager about these they said these were new boards they had purchased in preparation for the new activities coordinator who was due to staff work shortly. The activities that were advertised for this week were therefore not being provided. Staff told us they felt people were not given enough opportunity to take part in activities or follow their hobbies and interests. They described the impact a lack of an activities coordinator had on this and told us they rarely had time to carry out planned activities other than the odd game of dominoes. We spoke with the manager about the activities and they told us they had recognised this needed to improve and had recruited a new activities coordinator who was due to start soon after our visit.

The provider told us in the PIR that the complaints procedure was kept in the main entrance, with people being given a copy on admission, included in the welcome pack. We saw there was a complaints procedure in the service so that people would know how to escalate their concerns if they needed to. Although people we spoke with were not aware of the complaints procedure all of the people we spoke with told us they felt confident to raise concerns and felt they would be acted on. One person said, "I am not sure about the process for complaining but would feel comfortable to speak to [manager]." Another person said, "I would complain to the manager [name] he is a lovely man." A relative said, "We have had four managers in the last year and things have been terrible at times. I spoke to them on several occasions and didn't always get satisfaction. [Manager] is very approachable and listens."

People could be assured their complaints would be listened to and acted on by the new manager. The complaints log showed that people's complaints were recognised and acted upon. When a complaint was made an acknowledgement letter was sent followed by the outcome of any investigation. The manager spoke positively about how complaints could be used to identify improvements needed within the service. The manager said any complaints made were included in discussions in staff meetings as a way to improve practices within the service.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post at the time we visited. This meant the registered provider was solely legally responsible and accountable for monitoring and identifying improvements needed in the service. There was a quality manager employed by the provider who followed auditing systems to assess the quality of the service provided. Based on our findings, feedback from the local authority and what people who used the service and health professionals told us, these systems had failed.

People who used the service and staff told us of a high turnover of managers since the last time we visited and instability in the service which had caused a deterioration of the quality of care people had received. We too had received concerns from the local authority and visiting health professionals in relation to a lack of sustained improvements in the service and the impact this had on the quality of care being delivered. However we were told by people who used the service, relatives, visiting health professionals and staff that the current manager had made some significant improvements since they had taken up their post, which we also recognised.

We had not been notified of events in the service the provider was required to notify us about and therefore we could not rely on the provider giving us the information they are required to so we can monitor the service. For example there were at least two people who had been granted a DoLS by the local authority and we had not been notified of this.

Although the current manager was aware of some aspects of the service which still needed to be improved, such as care planning, we found areas of concern which had not been identified. For example, alarms had been fitted to external doors to alert staff if people who lived with a dementia related illness attempted to leave the building without staff supervision. However we tested two of these alarms and found that one was not working at all and staff did not hear the second one due to the distance from the alarm to where staff were located. This meant this method of security was not effective and audits of the environment had not identified this.

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

A new manager had been recruited four months prior to our visit and we consistently received positive feedback from people who used the service, their relatives, staff and visiting professionals about them and the improvements they were making. People who used the service and their relatives told us they hoped this manager would stay.

When we spoke with the manager about the standard of care within the service they told us they had been given a clear brief from the registered provider to improve the standards of care and felt they were receiving the support they needed to do so. This included a positive response when they had requested any new equipment. An audit manager supported the manager and said the provider was very concerned about the way standards at the home had fallen and they were committed to raising these. The provider also

contacted us following the inspection and told us they had identified that improvements were needed and had been working to address these prior to our visit.

People who used the service, relatives, staff and visiting professionals told us that although there was still work needed, the service had improved since the new manager had taken up their post. People told us that over the past year there had been many changes particularly within the management structure. However everyone said they thought the new manager was making a difference. One person told us, "[Manager] had a meeting when he arrived he wanted to know all about us." Another person said, "[Manager] is very approachable." A third told us, "[Manager] is trying hard to get things going." A relative told us, "I think [manager] is making a big difference, he is very open and listens. I think he is picking the right people for the job." When we asked the relative if they would recommend the service to others they responded saying, "If you'd asked me last summer I would have said no but things are getting better and I have recently recommended the place."

We spoke with two visiting health professionals who were regularly involved in the care of some people who used the service. They both praised the current manager and said they had seen a lot of improvements in the service since the manager came into post. They said the atmosphere of the service was more welcoming and communication had improved which was having a positive impact on people who used the service. They said that prior to the current manager starting work there they had a great deal of concerns about the care people were receiving. They told us this had improved now and gave an example that they had been asking for some time to have a designated room to see and treat people in. They told us this had not been acted on until the new manager had come into post. We saw the new treatment room had been installed to a high standard and there were systems in place to communicate changes from the health professionals to staff. The cook echoed this improvement by telling us they had been asked what equipment they needed when they took up their post and everything they had requested had been provided under the new manager.

The manager told us they had made contacts within the local community and was conscious that there had been some negative perceptions about the service. However they told us they had been pleased with a comment made to them recently that things were improving and were expected to continue to do so. The manager described how they were working to create a more open and inclusive atmosphere. This had included the information that was displayed on the notice boards around the home, such as resident meeting minutes, whistleblowing and safeguarding polices and the complaints procedure. They also described how they made sure they were seen around and about the home on a daily basis and that staff were able to contact them when they were not present at the home.

Our observations and discussions confirmed what the manager told us. People who used the service, their relations and other visitors were given the opportunity to have a say about the quality of the service. There were meetings held for people who used the service so the provider could capture their views and get their suggestions and choices. The provider told us in the PIR that people who used the service and their relatives were encouraged to participate in meetings and that suggestions and ideas were welcome for ways in which the service could improve. We saw the minutes of the last two meetings and saw people had been given the opportunity to have their say. People who used the service, and their relatives told us they felt their views were being listened to and acted upon. A relative told us, "We have had a few relative's meetings and brought things up. Things have improved and I trust they will continue to do so. My concern is what would happen if [manager] didn't stay." We saw there was information displayed in the service informing people of what was being discussed at meetings and what was being done to further improve the service. Staff confirmed that the manager spent time observing what was happening in the service and speaking with staff to see what support they needed.

The manager had a clear vision of the improvements which were still needed and described addressing the priorities first and then their vision for future improvements. They told us they had been made aware of the challenges their job faced and the improvements that were needed in the service. The manager recognised there was still considerable improvement needed to raise the standards of the service to those they intended to be provided, but felt they had made some good progress already from when they took up post. For example they had restructured the staffing structure and recruited more staff. They were in the process of identifying 'champions' from staff working in the service to take the lead on promoting various areas of the service such as dignity and dementia. We saw framed certificates identifying which staff member was the champion for each area ready to be displayed in the communal areas of the service. The manager said they would be working with the new activities coordinator when they took up post to make the environment more friendly and welcoming to people who were living with dementia.

The audit manager explained the three monthly cycle of audits they undertook. These required the findings from the previous audit to be completed before they could be signed off, if they had not been they were repeated as findings to be addressed on the new audit. The manager showed us some recent audits that had been completed and although some of these did have action plans prepared to address the findings of these audits, there were some when this had not yet been done. We looked at the audits in relation to care plans and we saw it was recorded that there had been a recognition that the care plans needed to be changed to ensure the plans met the needs of people living in the service. We found audits undertaken in relation to infection control were effective because we found the service to be clean and hygienic. There were also audits into other aspects of the service such as daily charts and staff recruitment files.

We saw that feedback forms had been sent to people who used the service and their relatives in September 2016. There was some positive feedback and some areas identified where improvements could be made. The manager had put in place an action plan to address the areas for improvement and were working toward this. For example the scoring for having management presence through the service was low and the manager had detailed on the action plan they would be recruiting deputy managers to address this. On the day we visited two new deputy managers had been recruited and were working in the service.

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 provider was not adhering to the principals of the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. The provider was not assessing the risks to the health and safety of service users or doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not operated effectively to ensure service users were protected from abuse and improper treatment. Regulation 13 (1)(2)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality of the service were not effective. Regulation 17 (1)(2)(a)(b)