# Care UK Community Partnerships Ltd

# Mill View

## Inspection report

Sunnyside Close
East Grinstead
West Sussex
RH19 4AT

Tel: 01342337220

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20 September 2016

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## Ratings

| Overall rating for this service | Requires Improvement |
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| 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

The inspection took place on 15 and 20 September 2016 and was unannounced.

Mill View is a purpose built home providing residential and nursing care for up to 70 people including people who live with dementia, mental health conditions and have general nursing needs. The service provides both long term and respite placements and at the time of the inspection there were 67 people living at the home. Some people were independent but others were living with dementia and had a mixture of dependency levels and needs. Many of the people had difficulties in communicating their needs. This meant that they were vulnerable as they were unable to raise concerns or make basic decisions about their care and welfare needs.

The service had a newly 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 previous inspection of 23 February 2016 identified a number of continued breaches of the regulations, with regard to inadequate staffing levels, failures in meeting people's nutrition and hydration needs, poor record keeping, and ineffective quality monitoring systems. We also found a number of areas of practice that needed to improve, including protecting people's dignity and supporting people to follow their interests. The provider produced an action plan in June 2016 to tell us what they would do to meet the legal requirements.

We undertook a comprehensive inspection on 15 and 20 September 2016 to check whether the required actions had been taken to address the breaches previously identified. Improvements had been made in some areas. However we found continuing breaches in relation to nutrition and hydration and good governance.

We continued to have concerns that records were not always complete and accurate and governance systems and processes were not always robust and effective. There had been improvements in the personalisation of care plans. However this had not been fully embedded and some records were not complete and accurate. It remained that not everyone's care plan was focussed on their individual needs for example one person's care plans did not reflect the support that they required to eat even though the care plan had been reviewed. The registered manager had put a number of systems in place to improve monitoring of service delivery such as introducing hydration calendars to ensure people were receiving adequate fluids and introducing mechanisms to check that recording was maintained. However, these systems were not yet all embedded and were not always effective in driving service improvement.

There had been improvements to the meal time experience. However, it remained that not all people were always given the support they needed to eat and drink. The risks of dehydration and malnutrition were not

always effectively monitored.  We observed one person at risk of malnutrition who was not offered the support they needed to eat their meal. Records showed that they were losing weight. People told us that they didn't receive a hot drink, or anything to eat following the evening meal until breakfast the next morning. One person said, "Between 5:00pm and 9:30am we get nothing offered to us." One relative said, "My relative has type two diabetes and I think they should have something in the night between 5:00pm and 9:00am, he has been quite poorly in the mornings. Recording of people's food and fluid intake was inconsistent and contained gaps and inaccuracies, a member of staff told us "It depends who is on duty." This meant that the registered manager could not be assured that people were always receiving the food and fluids that they needed.

Although there was a wide range of organised activities available at the home, some people remained at risk of becoming isolated and lacked opportunities for social interaction and stimulation. People told us that this was because only the activities co-ordinators had time to spend with people. We made a recommendation to the provider regarding seeking advice on how to support people's need for social interaction and occupation. Our observations were that staff were sometimes too busy to provide more than a task focussed approach. This meant that although people were getting the care they needed their social needs were not always able to be met. We made a recommendation to the provider about meeting people's needs for social engagement and occupation.

Risks to people were identified and assessed to keep people safe. Staff were effectively managing risks associated with people's nursing needs. However, manual handling guidelines were not always followed and this put people and staff at potential risk of injury. The registered manager had recognised this issue and had put training in place to ensure that staff had the necessary skills to help people to move safely.

At the last inspection we found that people's dignity was not always respected. At this inspection staff were protecting people's dignity. People told us that they had developed positive relationships with staff and that they were treated with respect. One person said "They are really caring and they always treat me with kindness and respect, and they always knock on my door before they go into my room and they always close the door when there doing anything for me."

Staff recruitment was ongoing, but the registered manager told us that they had employed seven new staff members since the last inspection, and more were due to start during the next month. Staffing levels had improved and feedback also confirmed this. One staff member said, "The new staffing levels have made a big difference, we can cover all areas of the floor now."  People told us that staff were well trained and knew how to care for them.  One person said, "I think they have a lot of training and they are very good." There was a robust induction process in place and recruitment procedures were safe and ensured that staff were suitable to work with people.

People received their medicines safely and had access to health care services for ongoing support. A visiting health care professional told us that staff listened to and acted upon the advice they gave them.

The registered manager was committed to improving the standard of care and had made a number of improvements at the service. People and staff spoke highly of the registered manager.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Risks to individuals were not always effectively managed to ensure people were assisted to transfer in a safe way.

There were enough staff to keep people safe, but the deployment of staff did not always meet people's needs. There were robust recruitment procedures in place.

People received their medicines safely.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People were not always supported to receive the food and fluids they needed.

People had access to health care services.

Staff were supported with effective training and supervision and understood their responsibilities with regard to the Mental Capacity Act.

### Is the service caring?

**Good**

Staff were caring.

Staff knew people well and had a caring approach

People's privacy and dignity were respected.

People's views were listened to and respected.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People did not always receive care that was responsive to their needs, and people's needs for social interaction and occupation were not consistently met.

People knew how to complain and there were systems in place to record and respond to complaints.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Governance and quality assurance systems were not always effective in driving improvements in the service.

Management and leadership was not consistently effective at all levels.

People, relatives and staff were encouraged to contribute to service developments.

# Mill View

**Detailed findings**

## Background to this inspection

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

This inspection took place on 15 and 20 September 2016 and was unannounced. The previous inspection of February 2016 had identified breaches of regulations. We issued two warning notices telling the provider how they were failing to meet the regulations and requiring them to make improvements and become compliant within a specified timeframe. The provider sent us an action plan to tell us how they would meet these requirements. We undertook this comprehensive inspection to check that the improvements planned by the provider had been made.

The inspection team on the first day of the inspection consisted of two inspectors, an inspection manager who provided nursing expertise 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 service. Two inspectors returned on the second day of the inspection.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This enabled us to ensure we were addressing relevant areas at the inspection.

We spoke in detail with 10 people who used the service and four relatives. We observed care provided and spoke with other people during the inspection. We interviewed 12 members of staff and spoke with the registered manager and the deputy manager. We looked at a range of documents including policies and procedures, care records for 13 people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the

providers systems for allocating care visits and other information systems.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection in February 2016 the provider remained in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider had not ensured that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to provide safe care to people. We issued a warning notice to the provider to notify them that they were failing to meet the requirements of Regulation 18. This told them they were required to become compliant within a specific timescale. The provider sent us an action plan to tell us how they would meet the legal requirement by the end of April 2016.

At this inspection we checked to see if the provider had followed their action plan. Improvements had been made to the level of staffing since the last inspection, and there were enough staff to care for people safely, therefore the provider had addressed this breach.

The number of vacant posts for day staff had reduced. The registered manager said that the provider had changed its recruitment practice to ensure that Mill View received better support to recruit new staff. They told us that they were expecting recently recruited staff to start their induction during October 2016. The registered manager told us, "We have been supported to get more staff. We have employed about seven new staff since the last inspection."

The registered manager used a dependency tool to determine the number of staff that were needed to care for people. This tool was based upon the assessed needs of the people living at the home and was reviewed on a weekly basis. A member of staff explained that the dependency tool was used to generate the number of staff hours that were needed and the staff rota was based upon this. Analysis of staff rotas confirmed that staffing levels had increased since the last inspection. The registered manager ensured that the staffing level remained under review and were flexible depending upon the needs of people living at Mill View.

Agency staff were regularly used to cover approximately 25% of the total hours. During the previous two months this percentage had increased due to staff annual leave. The registered manager told us that they tried to maintain consistency by using regular agency staff. One staff member said, "We have some agency staff on most days, but they are good and they always show up. We are rarely short of staff on a shift." Another staff member told us, "It is very busy, but we always have enough staff on shift." A third staff member said, "We have agency staff who are regular and do around two or three shifts a week." Most of the staff we spoke with felt that staffing levels had improved since the last inspection. One staff member said, "The new staffing levels have made a big difference, we can cover all areas of the floor now."

Relatives told us that communication with staff was not always consistent. For example, one relative said, "I would like a bit more regular information, I want to know how (my relative) is sleeping, whether they are happy and well. I sometimes have to search for a member of staff who can tell me." Another visiting relative said, "Communication is usually alright, but sometimes it goes wrong. We are not always kept informed about what's going on." The example they gave was of a recent hospital appointment that they were unaware of, this meant that they were not able to support their relative even though this was what their

relative had requested. Both relatives told us that they felt lack of staff continuity was a contributory factor regarding communication. One relative said, "It would be good to have a more stable staff group, there are a lot of agency staff here." The registered manager said that recruitment was an on-going process, but they tried to maintain continuity using the same agency staff as much as possible.

People had mixed views about whether there were always enough staff on duty. One person said, "There's not enough staff here really, sometimes we are rushed." A second person told us, "I think there's adequate staff, but not always," and a third person said, "I think there could be more, especially at weekends, they are always busy." A further person added, "Sometimes we have to wait for help, staff are always very busy." Some people who were spending time in their rooms said that they didn't regularly see staff unless they called them. One person told us, "I get lonely, but I'm not one for sitting in the lounge area. It would be nice if staff could spend more time with us, but they are always busy. I get lonely on my own a lot." Another person told us, "There is not enough staff, I use my call bell and it varies how quickly they come, it's always much slower during the night."

Some staff were still concerned that the deployment of staff was not always good at certain busy times, such as meal times. A number of staff told us that having a hostess to serve and assist with the preparation of meals made a big difference, but they were not available every day. People we spoke with confirmed that having a hostess on duty had improved the meal time experience. One person said, "When we don't have a hostess in the dining room the tables aren't laid properly and sometimes we don't get a drinks trolley coming round, some days are better than others," and "Sometimes we are rushed and lunch is just plonked in front of you." One staff member said "There is a big impact on the days when a hostess isn't working, the hostesses really help." Another staff member said, "It sometimes get scary when the hostess is not working, we can't split ourselves in half and be in two places at once. The managers sometimes help out." A third staff member said, "It's hard to get everything done, we need hostesses every day on each floor." One staff member said they were too busy to talk to the inspector because they needed to prepare drinks for people, this was indicative that staff did not have time to have conversations. The registered manager told us they were giving consideration to whether more hostesses were needed.

We noted that staff were present in the communal areas of the home and were seen to be offering people support with personal care needs throughout the day. People's call bells were answered promptly throughout both days of the inspection and people told us that staff usually came quickly if they used their call bells. One person said, "They (staff) are good at responding, if I need help they come quickly." We asked the registered manager how they ensured that staff were responding quickly to call bells. They said this was monitored through observation. However, following the inspection, the registered manager sent us a report from the call bell system. This confirmed what people had told us. It showed that the majority of call bells were answered within five minutes, and a small number (approximately 2%) took more than 10 minutes to be answered.

Although improvements had been made to the numbers of staff on duty each day, the new staffing structure was yet to be fully embedded. Our observations were that staff were busy and had little time to spend with people to meet their social needs. We have therefore identified this as an area of practice that needs improvement.

We observed most staff assisting people using correct moving and handling techniques and noted examples of good practice, staff were seen to be reassuring and competent. However staff did not always follow the guidance in people's individual risk assessments and care plans. This meant that people were not always supported in a safe way. For example, one member of staff was seen using an unsafe technique when supporting someone to stand. This meant that the person and the staff member were at potential risk of

being injured. We have identified this as an area of practice that needs improvement. We asked the registered manager how they would ensure that all staff members knew how to assist people to move safely. The registered manager said they were aware that the member of staff needed to refresh their manual handling training and told us that they were booked to attend a training course the following week. The registered manager discussed the incident with the staff member and confirmed that they would seek support from experienced staff before assisting people to move, until they had completed their refresh of manual handling training.

Risks to people were identified, assessed and managed appropriately. Staff used risk assessment tools to determine the level of risk for individuals. For example one person had been assessed as at high risk of developing a pressure sore. The accompanying care plan detailed the measures that were needed to reduce the risk. This included using a pressure relieving mattress, regular repositioning and use of a barrier cream to prevent pressure sores developing. Another person had developed a small pressure sore on their heel. Recording showed that staff had noticed this and alerted the nurse on duty .The risk assessment and care plan had been reviewed and a wound plan was put in place. A referral to the tissue viability nurse was made and there was a clear record of wound care until it had healed. This showed that staff were effectively managing risks associated with people's nursing needs.

Staff had a good understanding of how to identify if people were at risk of abuse and knew what to do in these circumstances. They told us they had received training and understood how to report any concerns if they suspected abuse. People told us that they felt safe, one person said, "It's safe here, the atmosphere here makes you feel safe and that's because of the staff." Another person said, "I do feel comfortable and safe here, I like the staff they are always helping me."

People's medicines were stored, disposed of and administered safely. We observed people receiving their medicines and noted that the staff member administered their medicine sensitively. The staff member showed a good understanding of the medicine system and was knowledgeable about people's medicines. For example, they knew who required thickened fluids to take their medicine to reduce the risk of choking. Medication Administration Record (MAR) charts were completed correctly and there were no gaps in the recording.

There were robust recruitment procedures in place to ensure that staff were suitable to work with people. Appropriate checks had been undertaken before staff began work. Criminal records checks had been taken with the Disclosure and Barring Service (DBS). This meant that staff were suitable to work with people. Recruitment checks included professional registration checks for nurses to ensure they were appropriately registered with the Nursing and Midwifery Council.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in February 2016 the provider remained in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider had not ensured that people were being given sufficient support to eat and drink. Risks of dehydration and malnutrition were not being appropriately monitored and managed. We issued a warning notice to the provider to notify them that they were failing to meet the requirements of Regulation 14. This told them that they were required to become compliant within a specific timescale. The provider sent us an action plan to tell us how they would meet the legal requirement by the end of April 2016.

At this inspection we checked to see if the provider had followed their action plan to address this breach. We found that some improvements had been made. Although some improvements were evident we found that some areas of practice were not effective.

We observed the lunchtime meal. Staff were supporting some people to eat their food and ensuring that they had a drink. However, two people were not managing to eat their food independently and staff were not supporting them. One person was not able to bring the fork to their mouth successfully. This meant that although they were trying to eat independently they were not managing to get the food into their mouth. Staff did not notice this person was struggling and offered no support. After some time a staff member took the meal away, the person had eaten less than a quarter of the food on their plate. The care plan for this person showed that they were at high risk of malnutrition. Their food record for that day was not an accurate reflection of what they had eaten. It stated that they had eaten half the chicken meal and half a bowl of custard. Our observations showed they had eaten less than a quarter of their chicken and had been offered a sandwich, which was not recorded, and a few spoonful's of fruit salad, not custard as stated. On the second day of the inspection we noted that the recording for this person's main meal was again inaccurate, stating that they had eaten all the meal when they had eaten half the food. Therefore staff were unable to ascertained whether the person was receiving adequate nutrition. Records showed that they had an unplanned weight loss of 1.6kg in the previous month. The care plan for this person had been reviewed and reflected the risks that this person faced. However it did not accurately determine what additional support might be needed around mealtimes or what actions had been taken as a result of their unplanned weight loss.

Another person was offered a choice of two meals, but firmly stated that they did not like either. They were not offered an alternative. The staff member put a meal in front of them. The person said "I don't want it," and did not attempt to eat the food. After half an hour a staff member took the plate away and asked them if they would like a sandwich instead. The person ate a few mouthfuls of the sandwich. A pudding was brought and they ate a few spoonful's. The registered manager told us that the chef was happy to prepare alternative meals for people if they didn't want what was on offer, but this was not offered to this person. The care plan for this person stated 'Needs encouragement from the staff all the time to have her meals,' however staff had not offered any support or encouragement. The food record for the meal did not accurately reflect what they had eaten. The care plan for this person had been reviewed, however it also did not accurately determine what additional support might be needed.

One person was being assisted to eat their food. The care worker was focussed on the task, but did not speak or engage with the person throughout the meal other than saying "Swallow your food." A visitor arrived towards the end of the meal and took over the task, the contrast was notable, with conversation and encouragement the person finished most of their meal within a few minutes. We noted that this person had an unplanned weight loss of 2.2kg over the previous month. Other observations were more positive, we saw one care worker supporting someone to eat in a sensitive and attentive way.

People told us they were not offered anything to eat or hot drinks after the evening meal finished and before they went to bed. One person said, "I think supper is much too early at 5:00pm, and between 5:00pm and 9:30am we get nothing offered to us." One relative said, "My relative has type two diabetes and I think they should have something in the night between 5:00pm and 9:00am, he has been quite poorly in the mornings." Another comment was "They have supper at 5:00pm and not a hot drink or a snack until 9:00am. I think it's too long to go without a hot drink and a snack." Records showed that people were offered juice or water, but nothing else. There were no records of snacks offered between the evening meal at 5:00pm and bedtime. One person said that they came downstairs themselves in the late evening to make a hot drink because staff were too busy to do so. Some people told us they kept snacks such as biscuits in their bedrooms and could help themselves, but not everyone was able to do this. We asked the registered manager how they ensured that people had enough to eat and drink between mealtimes and through the night. They said that food and hot drinks were always available for people if they asked, however we noted that not everyone was able to ask or aware of this.

Although improvements have been made, the above evidence demonstrated that practice remained inconsistent. People were not always being effectively supported to have sufficient to eat and drink. Risks of dehydration and malnutrition were not always appropriately monitored and managed. This meant that the provider had failed to fully implement and sustain improvements therefore remains a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had introduced 'protected' meal times, this meant that during the meal time period all staff would focus on providing meal time support to people and no other work, such as staff meetings would be arranged. The introduction of hostesses to serve meals meant that staff could concentrate on helping people.  Staff members were allocated a role and all staff including kitchen staff would help with meal times if needed. One staff member told us, "Mealtimes are better now that everyone helps out." The registered manager said that this had made a real difference and "Mealtimes usually run like clockwork now."  Hydration calendars had been introduced to provide an overview of people's hydration record, so that staff were clear about who needed additional fluids to meet their target. Senior staff had to check and sign food and fluid charts and hydration calendars to ensure they were being completed. We noted that these changes had improved practice since the last inspection. For example, the volume of fluids that people were receiving had generally increased.

The registered manager spoke about the hydration project that began in May 2016 and said that this had provided a positive impact for people at Mill View. They explained that staff awareness had increased and people were being offered fluids more frequently. For example, people were being offered jelly as a more palatable way of taking fluids. The registered manager acknowledged that recording was not always accurate, for example, jellies were not always recorded on the food or fluid charts. However, they felt the hydration project was successful since the number of urine infections had decreased during this period. Incident monitoring confirmed that there had been noticeably fewer incidents of urine infections during this period, with seven recorded in May and only two in July and one in September.

People told us the standard of food was good and we saw that it was nicely presented and looked

appetising. One person said, "The food is very good here, you get a good choice and the chef will cook you something that you want. At night I have biscuits and I drink water." Another person said "On the average it's excellent, some of the veg is not cooked the same and we get a good choice. The menus are on the tables in the dining rooms and there's a good supper menu."

People had access to health care services and referrals were made when people's health needs changed. For example, a Speech and Language Therapist (SALT) had been contacted promptly when staff recognised that they had difficulty with swallowing. A diabetic nurse visited regularly to monitor someone with diabetes and a district nurse was called to examine a wound on a person's leg. A relative told us they were confident that staff would contact the GP quickly if they noticed a change. They said, "I know they would call the doctor, but I visit frequently, so I would notice if something was wrong." A visiting health care professional told us, "The level of service is good, better than other homes I go to. Staff have had a lot of training and take on board what we suggest."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Consent to care and treatment was sought, staff had a good understanding of MCA and DoLS. Records showed that MCA assessments were in place for people who lacked capacity to make specific decisions. For example someone who was living with dementia had bed rails. Records showed that a mental capacity assessment had been completed and they lacked capacity to make this decision. A best interest decision had been made that bed rails were needed to keep the person safe and that this was the least restrictive option. This decision making process was documented clearly. The registered manager had made an appropriate DoLS application and an authorisation was in place. This showed that the provider was working within the principles of the MCA.

Staff told us that they received the training and support they needed to care for people effectively. One staff member said "There is good training for staff, it's regular and supervisions go ahead." Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. These meetings should provide staff with the opportunity to raise any concerns or discuss practice issues. Another staff member said, "I have supervision and I talk about training and any problems." A third staff member told us, "I have regular supervision. I talk about evaluation of my work, how good we are and where we can improve, or anything I need to report."

Records confirmed that supervisions were planned and happened on a regular basis. Staff spoke positively of training opportunities, their comments included, "They listen to us about training, I was interested in pressure care and they got training for me," and "The training is good and so is the induction for new staff." We asked a new member of staff about what training they received when they started their role. They told us, "I had a two week induction which covered everything from personal care to moving and handling. It was useful and so was shadowing." An agency worker told us, "I work here two or three times a week and I shadowed staff when I first arrived get to know the residents." The registered manager told us that training was open to their regular agency staff as well as for permanent staff.

People told us they felt staff were well trained, one person said, "I think they have a lot of training and they

are very good." Another person said "I am confident that they know what they are doing, I think they are trying to be professionals and the training helps." Training records confirmed that staff were receiving regular mandatory training as well as specific training relevant to the needs of people they were looking after, such as dementia awareness and diabetes.

Good

# Is the service caring?

## Our findings

People and their relatives told us that staff were caring and kind. One relative told us "In many ways the staff are excellent, they are willing, helpful and kind." We saw people appeared relaxed with staff members and we observed staff's interactions to be gentle and reassuring. Most staff interactions with people were happening as part of their care provision and were positive. Staff demonstrated that they knew people well and had a caring approach.

At the last inspection we found that people's privacy and dignity had not always been respected. This was because people had been left without support when they needed help with personal care. We found this to be an area of practice that needed to improve. At this inspection our observations showed that people were respected. People were being supported with their personal care and continence needs. We saw staff offering to help people in a discreet way to maintain their privacy and dignity.
A relative said, "Staff are always very careful to respect people's dignity." One person told us, "They (staff) always tap on my door before they come in." Another person said, "They are really caring and they always treat me with kindness and respect and they always knock on my door before they go into my room and they always close the door when there doing anything for me."

We observed staff assisting one person to transfer with the use of a hoist. Staff were attentive throughout the procedure, when the person showed signs of becoming anxious they recognised this and gave reassurance to calm the person and protect their dignity. One relative told us, "The laundry staff are very good here, I never see my relative dressed in clothes that are not his own. The staff take time to make him look smart and he always has fresh clothes on."

People told us they felt their views were listened to and respected, one person said, "When I get up the staff member helps me chose what I'm going to put on, but it's my choice. They always ask me and respect my opinion." A staff member told us, "The residents get plenty of choice, for example, some people like to sleep with no clothes on. We respect the residents as them." Another person said "The staff are all very nice and kind, especially the lady that does the activities, she always talks to me and she listens to me."

People had developed positive relationships with staff. One person said, "I think the staff are very helpful and they are really good." A staff member said, "I read the care plans to get to know people, we respect them and talk to them like family and friends." A relative said, "The staff are helpful and caring and they usually have a smile on their faces." Another relative said, "The staff make an effort to find out about people, they do their best." We observed staff welcoming back a person who had been in hospital. They showed affection and empathy and told the person they were pleased to have them back at the home. The person was clearly touched by this.

We asked people if they had been involved in developing their care plans. Nobody we spoke with could remember being involved, but some relatives confirmed they had. One relative said, "We did have some involvement, they asked a lot of questions when he first came here." One person told us, "I haven't seen my care plan, but my daughter has and it's been updated." Care plans were comprehensive and included

information about most aspects of people's lives including any nursing needs. Information in the care plan was worded sensitively and promoted people's dignity. For example, one needs summary included a section on communication for someone who was living with dementia. It reminded staff that the person has difficulty in finding the right words to express themselves and guided staff in how best to communicate. We observed a staff member communicating with this person in a calm and patient way, giving them time to assimilate the information and checking that they understood ,before beginning to assist them.

People told us that they felt their views were listened to. One person said, "I am asked how I want things to be done, they (staff) check out that I'm happy and give me choices." Another person said, "They promote my independence, I deliver the newspapers I help with the bingo on Friday mornings and I make tea and coffee and I check the flowers."

Staff told us there were regular resident's meetings when people were invited to express their views on care at the home. One of the residents chaired the meeting and told us that people were encouraged and supported to attend and the meetings were usually well attended. Notes from the meetings showed that people could raise issues about the running of the home and the registered manager and other staff answered questions and made notes of issues raised.

Relatives told us that they felt welcomed at the home and that there were no restrictions on when they could visit. One relative said, "I come at different times and it's never an issue," another said, "Staff are always pleasant and offer me a drink when I arrive."

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection in February 2016 the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to maintain accurate, complete and contemporaneous records. This meant that care provided was not always responsive to people's needs.

At this inspection we found that there had been improvements in the level of personalisation within care plans. Most care plans were detailed and included personal preferences, wishes and their interests. Some had detailed information about people's history including previous occupation, places they had lived or enjoyed visiting and things they had enjoyed doing. This helped to give a picture of the person and staff said that they used this information to help them care for people. One staff member said "I read the care plan to get to know people, it helps to know their background." Care plans were regularly reviewed. The registered manager said that each day one person was chosen to be resident of the day. This meant that they would have their needs reviewed to ensure that care plans remained accurate and up to date. We saw evidence that this system was embedded and reviews were undertaken regularly.

Although there were improvements, it remained that not everyone's care plan was focussed on their individual needs. For example, one person's care plans did not reflect the support that they required to eat even though the care plan had been reviewed. It stated that they were able to eat independently however this was not always the case.

Another person had been assessed by a physiotherapist as being able to walk for short distances if accompanied by two members of staff. Although this was stated clearly within the care record there was no indication of how often this was or should be happening. The person's relative told us that the physiotherapist's recommendations had been discussed with staff because they were concerned that their relative was not getting the support they needed to mobilise on a regular basis. They felt this was because staff were too busy to assist people to walk and felt that they used a wheelchair at all times even for short distances as it was less time-consuming. We observed that staff were using a wheelchair to support this person throughout the inspection. The care plan did not give clear guidance for staff about how often they should be assisting this person to walk and staff had not recorded when they had done so.

Some records did not include a target amount for fluids, so this made it difficult for staff to know if the person had taken enough fluids that day. Staff told us that everyone had a fluid target of 1.6Litres per day. This was not personalised according to the weight of the individual. This meant that the minimum target was not sufficient for some people who were at risk of becoming dehydrated.

Although there had been improvements in the personalisation of care plans this had not been fully embedded and some records were not complete and accurate. This means that there remains a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations were that staff were sometimes too busy to provide more than a task focussed approach.

This meant that although people were getting the care they needed, staff did not have time to provide care in a person centred way and people's social needs were not always met. Staff told us that they would like to have more time to spend with people, but they were too busy. One staff member spoke of the impact that this had on people. They told us about someone who liked to go for a regular walk, but was not always able to because staff did not have time to go with them.

We noted that most people had nothing to occupy them throughout the first day of the inspection. Four people had gone on a day trip with the activities co-ordinator. There were no activities arranged for the majority of people who remained at the home. Some people remained in their bedrooms and there was a risk of potential isolation as staff, we observed, provided little contact which usually related to specific care needs. One person said, "Staff have got so little time to talk to me, I do get lonely and bored, I don't really know what to do." On the second day of the inspection when the activities co-ordinators were in the building, we noted that people were enjoying a quiz in the morning and a bowling game in the afternoon. However, some people who were living with dementia were not able to take part and they had no occupation to stimulate them. Other people remained in their bedrooms and the activities co-ordinator spoke about providing some one- to-one time with people. However, they acknowledged that this was difficult due to pressure on staff resources.

There were a number of areas around the home that were designed to be stimulating for people who were living with dementia however we did not see evidence that these areas were used by people. For example, one area was created to look like a garden with a washing line and clothes pegged out. We asked if people ever used this area but staff told us that they didn't and that staff changed the items on the line now and again. The activities co-ordinator told us of plans to provide training for staff who were not always confident to lead activities with people. They explained " We need some simple things that people can pick up for two minutes, like a bag containing newspapers, magazines, poems anything that staff can do with them for short periods."

People told us that they were happy with the range of activities on offer and they spoke highly of the activities staff who arranged the activities programme. The programme provided activities on every day of the week in the morning and afternoon and included some 1:1 sessions when people were supported to follow their interests. People told us that activities were only undertaken by the activity co-ordinators and that staff did not usually take part. This meant that if there was no activity co-ordinator in the building then activities did not usually take place. This was reflected in the notes from recent residents and relatives meetings, were people had stated that care staff didn't do anything to facilitate the activities programme. Staff acknowledged that there were times when people were not supported with stimulating occupations because staff did not have time to support them.

The activities co-ordinator spoke enthusiastically about the activities programme, describing it as resident led. They were knowledgeable about individuals and described how people's preferences and interests were woven into the programme. For example, one person had a love of poetry and particularly enjoyed inviting a friend to recite poetry or Shakespeare. Other people enjoyed music and liked having outside entertainers. People and their relatives spoke highly of the activities programme and the two activities co-ordinators. A person said, "They are so enthusiastic, they throw themselves into things in a big way." A relative said, "They are fantastic, they really go the extra mile." Despite these positive comments some people's needs for interaction and stimulation were not being met and this is an area of practice that needs to improve. We recommend that the provider seeks further guidance on providing activities that meet people's individual need for social interaction and occupation.

There was a system in place to monitor complaints. People told us they knew how to make a complaint.

One person said, "I would speak to any of the staff if I had a complaint, the manager is good too." Another person said, "I have complained once or twice to the manager and they always takes notice of me." Complaints were responded to in writing and the registered manager told us, "We have learned that it is best to respond to people's complaints quickly and we changed our process to ensure that happens."

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection in February 2016 the provider remained in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because monitoring systems were not always effective in regularly assessing and improving the quality and safety of the service. The provider had also failed to implement the improvements detailed in their action plan.

At this inspection we continued to have concerns regarding the effectiveness of quality monitoring and governance. Some aspects of the provider's action plan had not been successfully implemented and improvements were not yet embedded. This meant that the provider remained in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had supplied CQC with an action plan in June 2016 detailing how they would implement improvements to address concerns and breaches identified at the previous inspection. In June 2016 we asked the provider to send us a monthly update of the action plan, so we could monitor their progress in address the concerns. The provider agreed to send us the action plan, however this did not happen and the registered manager explained that this was an oversight. At this inspection we saw a recently updated version of the action plan and noted that it had been regularly updated. Some issues that we had identified in the course of our inspection had also been identified by the provider when reviewing progress against their action plan. For example, a number of audits noted there were gaps in records relating to food and fluid intake. The registered manager confirmed that our findings in this regard were not unexpected. Despite awareness that there continued to be failings with the recording system, the registered manager was not able to demonstrate what steps had been taken to address the management of this area of practice.

The system for monitoring the outcomes from the provider's action plan was not effective. For example the action plan included details of how care records would be improved to ensure people received the fluids they needed. It stated, 'All care plans should reflect the following as basic guidance for fluid intake: Males: 2000mls Females 1600mls. Any reason for deviation from these guidelines MUST be documented in the residents care plan and summary. All daily record sheets must specify the daily fluid intake target for the individual resident.' The action plan update stated that this was in place on all care plans and regularly checked through a monitoring process. However, we found that not all care plans contained the target amount as described, and where this was the case there was no explanation for the deviation documented in the care plan. For example, some men had target amounts of 1600mls, but no explanation as to why. Not all daily record sheets showed a target amount. This showed that the mechanism for monitoring outcomes remained ineffective and the registered manager could not be assured that improvements were being made and embedded.

Recording of people's food and fluid intake was inconsistent and contained gaps and inaccuracies. Some people were assessed as having hydration or nutritional needs. Risks had been assessed and a recording system was in place to monitor the amount of food and fluids that were taken on a daily basis. However, there were some gaps in this recording. For example, hydrations calendars were present in peoples care plans and staff were aware that they were being used with the intention of providing a clear overview of the

amount of fluids that people were drinking. However, we noted that hydration calendars were not always complete or accurate. For example, one calendar had not been completed on five of the last 14 days, and another had not been completed on three of the last 14 days. The registered manager said they were aware that there were some gaps in recording.

Some people had been referred to dietary and nutritional specialists and their recommendations were included in people's care plans. Records did not always show that their recommendations had been carried out. For example, one person had seen a dietician who recommended that they needed to have fruit juice on a daily basis and also two bananas every day to increase the amount of potassium in their diet. We asked them if they were regularly having two bananas to eat and fruit juice to drink. They told us, "I do get a banana sometimes in the morning, but not every day, I think I get fruit juice to drink." The recording for this person did not show that they had been offered two bananas a day as recommended. Their fluid record showed that they were regularly offered juice however it was not clear if this was fruit juice as recommended by the dietician, or fruit squash that was offered to everyone. We asked the person if they had been given fruit juice earlier in the day, they could not remember, but indicated that the squash they were drinking was fruit juice, saying "I think this is it."

Another person had been referred to a dietician who had recommended offering the person two high calorie desserts every day and a dietary supplement twice a day. Records indicated that the person had not received these items as suggested. We asked staff about this, they told us that they had not yet received the dietary supplement from the GP. This meant that six weeks had passed without the person receiving the recommended supplement. There was no indication in their care record that this was being followed up, however staff gave assurances that this was happening. A third person who was identified as being at risk of malnutrition was prescribed a high calorie milkshake daily. However, food and fluid charts did not indicate that they had received this. The person could not tell us if they had received this and we did not observe them receiving a milkshake. We asked a staff member about this, they said "Some people do have milkshakes. I think they have them."

A further person was assessed as being at high risk of malnutrition. Food and fluid charts were completed daily, but showed that they had not met the fluid intake target for the three days prior to the inspection. There was no indication of what action had been taken to address this. The provider's action plan stated that 'Under consumption for 48 hours or longer to be reported to the clinical lead for review.' Staff told us that this did happen, and could not find any evidence to confirm this or to indicate what actions had been taken as a result of a review. These examples showed that the systems for updating and maintaining accurate, complete and contemporaneous records were not always effective.

Electronic records did not always match paper records, for example, one person's total fluid intake had been recorded as 1025ml for a particular day. The electronic record for the same day stated their total intake was 1.7 litres. There was no indication of why the total was different. Some of the records we looked at showed that people were not meeting the minimum target amount set and they were therefore at risk of becoming dehydrated. We could not always identify what actions had been taken. Some records showed that staff were identifying when people were not meeting their fluid targets, for example, one entry on a staff handover sheet stated 'Fluid in- take 1000ml- increase fluid intake.' Another stated, 'pushed fluids.' This showed that staff were sometimes identifying when people at risk of dehydration had not received adequate fluids and had taken action to address this. However, this was not happening consistently and a member of staff told us "It depends who is on duty." This showed that practice in this area was not consistent and embedded.

Leadership was not consistent at all levels, for example shift leaders were not effective in ensuring that staff

always completed recording tasks accurately. The registered manager had introduced a system that ensured food and fluid charts were signed off as being complete and accurate records. However, we saw examples where shift leaders had signed charts even though there were clear gaps in the recording. It was not clear what actions had been taken to address these inconsistencies.

There was a range of monitoring systems in place including a number of regular audits. However, it was not always clear what actions were taken as a result of this monitoring or how this contributed to service improvements. For example, there was a clear system in place to record incidents and accidents. The registered manager analysed the information and recorded learning from this. Following analysis of data on falls in the home the learning outcomes stated, 'Ensure all care plans updated to reflect falls.' However, there was no indication of who would do this, when it was done or what had been changed in the care plan to make a difference and prevent further falls. Similarly with complaints monitoring there was a clear system in place to record complaints and take action to respond to the complainants, but there was no indication of what had changed or improved as a result of the complaint. This meant that the registered manager was not able to demonstrate how continuous improvement was implemented by using quality information effectively. We discussed this with the registered manager who confirmed that this was an area of practice that needed to improve.

Lack of robust management systems and poor governance arrangements places people at risk and demonstrates a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulations) 2014.

The registered manager was aware of their responsibility to notify CQC of particular events however a number of safeguarding alerts had been made without sending an appropriate notification to CQC. When this was brought to the attention of the registered manager they rectified this error straight away and explained this was due to an administrative error.

The registered manager had been in post since March 2015 and they were registered with CQC in September 2016. People and staff spoke highly of the registered manager. People's comments included, "I think they do a good job, and so do most of the staff, they are good," and "I think on the whole the manager does a good job." Most people knew who the manager was and said they were approachable. One person said, "Oh yes, they are really nice, a very kind person." Staff also spoke highly of the registered manager. One staff member said, "The manager is good and listens to me, the deputy manager is good too and helps out a lot. All of them help at mealtimes." Another staff member said, "The manager listens to us, they are helpful. They are always free for us."

Staff meetings were held regularly. Notes from the meetings confirmed that issues relating to care and quality in the home were discussed and areas for improvement were identified and agreed with staff. For example, recording issues were discussed in recent staff meetings where it was noted that consistency in this area was not yet embedded.

People were supported to be involved in the development of the home. Regular resident's meetings were held. Notes from one meeting showed that people could contribute to the agenda and where they raised questions or made suggested the registered manager would ensure they received consideration. For example, one person suggested that an additional area in the garden should be paved to make more usable space for people. Actions following the meeting recorded that this suggestion was taken forward by the registered manager and action was taken to order new paving slabs. The registered manager held regular meeting with relatives and notes from the meetings also included dates when key actions were taken.

The registered manager and deputy manager told us they had been working hard with their team to address the issues identified at the previous inspection and they would continue to work on the action plan until all areas of concern were resolved. They told us that they had recognised a number of improvements since the last inspection and felt that the staff team was working more effectively as a result. Staff that we spoke with echoed these views, one staff member said "I worked here at the last inspection and it is better now," another said, "I like working here, we support each other and we provide good care." A third said, "Things are getting better now, the staffing is better, I like working here and I feel listened to." Staff described an open culture where they were able to raise their concerns with the Registered Manager. One staff member said, "They all support me so I can get on with the job," another said, "They do listen."

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<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The nutritional and hydration needs of service users were not always met.<br>Regulation14 (1), (2)(a)(i),(2)(b),(4)(d). |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Systems and process were not always operating effectively, service user records were not always accurate, completed and contemporaneous. Regulation 17,(1), (2)(a), (c),(f). |

**The enforcement action we took:**

enforcement action