Quantum Care Limited

Fosse House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 18June 2015 and was unannounced. At our last inspection on 04 July 2013, the service was found to be meeting the required standards. Fosse House is a purpose built residential care home. It provides accommodation and personal care for up to 81 older people, some of whom live with dementia. The home is comprised of residential, dementia care and enablement units spread over two floors where staff look after people with varying needs and levels of dependency. At the time of our inspection there were 76 people living at the home.

There is a manager in post who has registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

The CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS

Summary of findings

are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection we found that some people had aspects of their freedoms restricted. It was unclear in some cases as to whether appropriate applications had been made in full compliance with the DoLS and relevant requirements of the MCA 2005.

Staff obtained people's consent before providing the day to day care they required. However, where 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions were in place, we found that some had not been made with the proper consent of the people concerned or in line with the MCA 2005.

People told us they felt safe at the home. Staff had received training in how to safeguard people against the risks of abuse. However, not all staff knew how to report concerns externally.

We found that the effectiveness of staff deployment lacked consistency across different units at the home. In some units we saw there were sufficient numbers of staff to meet people's needs promptly in a calm and patient way. However, in 'Swallow' unit on the first floor we found there were often insufficient staff to cope with the demands placed upon them.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs. We saw that plans and guidance had been put in place to help staff deal with unforeseen events and emergencies.

People were positive about the skills, experience and abilities of the staff who supported them. We found that staff had received training and refresher updates relevant to their roles. Staff had regular supervisions to discuss and review their performance and professional development.

We found that people had not always been supported to take their medicines safely or as prescribed. People's health needs were not met in a safe and effective way in all cases. The environment and equipment used, including mobility aids and safety equipment, were well maintained and kept people safe.

People expressed mixed views about the standard and choice of food provided at the home. We saw that the meals served were hot and that people were regularly offered a choice of drinks. However, although care staff were familiar with people's dietary requirements, we found that the information was not always shared with the chef in an effective way.

People had access to health care professionals when necessary. However, we found that their health needs had not always been met in a safe and effective way.

Most people told us they were looked after in a kind and compassionate staff who knew them well. However, we found some examples of where support was provided in a way that did not respect or promote people's dignity. We also found that the quality of care provided often lacked consistency across different units and floors at the home. In some areas we saw that staff provided support in a patient, calm and reassuring way that best suited people's individual needs. In other areas for example in the 'Swallow' unit on the first floor, staff appeared rushed and did not interact with people in a positive or caring way.

People had access to information and guidance about local advocacy services. Information contained in records about people's medical histories was held securely and confidentiality sufficiently maintained. Although not always obvious in the guidance given to staff, people and their relatives told us they were involved in the planning, delivery and reviews of the care provided.

People told us they received personalised care that met their needs and took account of their preferences. We found that most staff had taken time to get to know the people they supported and were knowledgeable about their likes, dislikes and personal circumstances. However, we found that the guidance and information provided about people's backgrounds and life histories was both incomplete and inconsistent in many cases.

People expressed mixed views about the opportunities available to pursue their social interests or take part in meaningful activities relevant to their individual needs. We saw that where complaints had been made they were recorded and investigated properly. People and their relatives told us that staff listened to them and responded to any concerns they had in a positive way.

Summary of findings

People were positive about the management and leadership arrangements at the home. However, we found that the methods used to reduce risks, monitor the quality of services and drive improvement were not as effective as they could have been in all areas.

At this inspection we found the service to be in breach of Regulations 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were not always sufficient numbers of suitable staff available to meet people's needs at all times and in all areas of the home.

People were not always supported to take their medicines safely and in an appropriate way.

People told us they felt safe at the home. However, some staff members did not know how to 'whistle blow' and report signs of abuse externally.

Potential risks to people's health were identified and effective steps taken to reduce them.

Safe and effective recruitment practices were followed.

Is the service effective?

Requires improvement

The service was not always effective.

Some people's day to day health needs had not always been met in a safe, effective or timely way.

Consent in relation to 'do not attempt cardio pulmonary resuscitation' decisions had not always been obtained in line with the Mental Capacity Act (MCA) 20015.

Some people's freedom of movement had been restricted in a way that did not always satisfy the Deprivation of Liberty Safeguards (DoLS) or MCA 2005.

People were supported to eat a healthy balanced diet.

Staff received regular supervision and training.

Is the service caring?

Requires improvement

The service was not always caring.

Care and support was not always provided in a way that respected and promoted people's dignity.

The confidentiality of people's medical histories and personal information had not been adequately maintained in all cases.

People were looked after in a kind and compassionate way by staff who knew them well and were familiar with their needs.

People and their relatives were involved in the planning, reviews and delivery of care.

Information and guidance was provided to help people access independent advocacy services.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us they received personalised care that met their needs and took account of their preferences.

However, the guidance provided to staff did not always contain sufficient information about how to provide person centred care that reflected people's individual needs.

People expressed mixed views about the opportunities provided to pursue their hobbies and social interests.

People were confident to raise concerns and were given the opportunity to provide feedback about service provided at the home.

Is the service well-led?

Requires improvement

The service has not always been well led.

Systems used to quality assure services, manage risks and drive improvement had not always been as effective as they could have been.

People, their relatives, staff and healthcare professionals were all very positive about the management arrangements at the home. However, we found that leadership lacked consistency across different areas of the home.

Staff told us they understood their roles and responsibilities and were well supported by the manager.

Fosse House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 18 June 2015 and was unannounced. The inspection team consisted of two Inspectors, an expert by experience and a specialist professional nurse advisor. The nursing advisor was used to check that people's health and care needs were met in a safe and effective way. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, the provider to completed a Provider Information Return (PIR). This is a form that requires the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 14 people who lived at the home, three relatives, 10 staff members, the home manager and deputy manager and representatives of the provider. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to 10 people who lived at the home, together with four 'do not attempt cardio pulmonary resuscitation' records and two staff files. We also carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires improvement

Is the service safe?

Our findings

People and some of their relatives expressed mixed views about staffing levels and, in particular, about whether there were enough staff available to meet everyone's needs in all areas of the home. One person said, "I believe we've got enough staff to take care of those of us that need taking care of." Another person told us that staff were often stretched and took quite a while to answer calls bells. A relative commented, "Sometimes it [staffing levels] seem limited, particularly at weekends and evenings."

Staff members also expressed mixed views and some concerns about staffing levels which they felt varied significantly across different units at the home. Most were positive about arrangements on the ground floor and told us there were enough staff deployed there to meet people's needs. One staff member who worked that area on the day of our visit said, "There are plenty of staff here. We all work well as a team. There are enough of us." A colleague on the same floor commented, "There are enough of us [staff] here." However, some staff members expressed concerns about staffing arrangements in the dementia care units on the first floor. One staff member told us, "We need more staff; lots of them are new and inexperienced. We sometimes struggle to cope with changing dependency needs." Another member of staff, who also worked on the first floor, commented, "There is an 'upstairs, downstairs' issue, a big difference between the two. We need to be better at putting staff where needed and being flexible, particularly at busy times."

Our observations found that the effectiveness of staffing levels and deployment were inconsistent and varied across the home, particularly during busy periods such as first thing in the morning and at meal times. This was more evident in 'Swallow' unit on the first floor whereas in other units, on the ground floor in particular, we found there were sufficient numbers of staff available to meet people's needs. For example, call bells were answered promptly and staff provided care and support in a calm and patient manner that best suited people's individual needs. However, on the first floor we found that staff were stretched and struggled to cope with the demands placed upon them.

For example, we saw that staff failed to respond to a call bell, pressed by a person who required assistance in their bedroom, until alerted by a member of the inspection team. The dining experience at lunchtime appeared rushed, with little or no interaction between staff and the people they supported. Although lunch was served between 12:30 and 1:15 pm, some people who stayed in their rooms told us they were kept waiting and had to wait too long to be served. One person said, "I don't know when staff will bring me my lunch, I just wait, but I am hungry I must say." We also saw that some people sat in communal areas with no interaction from staff or meaningful activities provided for over four hours. We spoke with staff about this who told us they only had time to complete personal care tasks and had no capacity to provide activities or person centred support because they were so busy.

This meant that there were not always sufficient numbers of staff available to meet people's needs in all areas of the home and was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff helped them take the medicines when they needed them. One person said, "They [staff] give them to me [medicines] when I need them so I don't get any pain." People were supported to take their medicines by staff who had been trained and there were suitable arrangements for the safe storage, management and disposal of medicines. We found that people who lived on the ground floor were helped with their medicines in a patient, methodical and safe way.

However, our observations in 'Swallow' unit on the first floor found that some people were not supported to take their medicines safely or in an appropriate way. For example, some people had been prescribed pain relief tablets to be taken as and when required. The guidance given to staff about how, when and in what circumstances they needed to help people take these was limited. We saw pain relief medicines given to a number of people without any prior discussion or consideration as to whether they were actually needed. This meant that some pain relief medicines may have been given unnecessarily and not as prescribed.

One staff member, who was unfamiliar with both the type and purpose of some medicines they handled, supported people without any explanation, positive interaction or reassurance, even when they appeared reluctant or unsure. In some cases, it was clear that people were not given the time or sufficient quantities of water to help them take their medicines comfortably and at a pace that best suited

Requires improvement

Is the service safe?

them. We saw that the administration guidance provided was not always followed properly. This meant that some people may have been at risk of not taking their medicines safely and in the manner prescribed.

A member of the inspection team found it necessary to intervene on more than one occasion to highlight errors and prevent further mistakes. We were told that the staff member in question acted out of character and may have been unduly anxious and nervous as a direct result of the inspection. However, our concerns were raised at the time with a senior member of staff who failed to intervene or take remedial action.

These findings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's physical health and mental well-being had been identified, assessed and reviewed. This included in areas such as malnutrition, dehydration, falls and risks associated with pressure ulcers. However, we found that staff were not always sufficiently knowledgeable about the risks identified and that in some cases the measures put in place to monitor, review and reduce them were either absent, not followed or ineffective. For example, we saw that one person had been identified as being at high risk of developing pressure ulcers but no preventative steps had been taken. In another case, where a person at risk had developed pressure ulcers, staff did not know how to check whether the specialist mattress used was on the correct setting or whether repositioning guidance had been followed because the relevant information could not be found. We also saw that the circumstances surrounding some people identified as being at high risk of injury through falling had not been reviewed for over two months.

This meant that steps taken to reduce identified risks to people's health may not have been as effective as they could have been. This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. One person said, "I feel safe, there is no harm in here." Another person told us, "Yes, I feel it's quite safe staying here." Staff were trained in how to safeguard people from harm and keep them safe. Information about how to report concerns, including contact details for the local authority, was prominently displayed at the home. However, although staff were knowledgeable about the risks of abuse and how to raise concerns internally, some did not know who to contact if they wanted how to report matters externally. For example, one staff member told us they would research the internet to find out, while another said they would contact their 'trade union.' This meant that the guidance provided may not have been as effective as it could have been. Safe recruitment practices, including relevant background checks, were followed to ensure staff were fit, able and qualified to do their jobs.

Requires improvement

Is the service effective?

Our findings

People told us they were happy at the home, well looked after and had their day to day health needs met. One person said, "It's quite a good life. I don't think they [staff] would be able to go to any greater lengths [to look after me]." Another person told us, "It's quite alright here, I am well looked after." A relative commented, "My [family member] is very well looked after." People also told us they had access to health and social care professionals when necessary. One person said, "An optician was here on Monday and brought me a pair of glasses." A relative explained that their family member had been seen by a GP because they had fallen over a few times. They were diagnosed with a condition that may have affected their balance and a treatment plan was put in place to address the situation.

However, we found that some people had not always had their health needs met in a safe or effective way. For example, a number of goals had been identified for a person in the enablement unit who had a range of complex health conditions. These were intended to help promote independence and improve their health so they could return home. Plans put in place to achieve these goals included the involvement of a physiotherapist, occupational therapist and community respiratory nursing specialists.

However, despite having been at the home for three weeks at the time of our visit, they had not been seen by any of the healthcare professionals identified and neither their health or dependency levels had improved. They were also identified as being at risk of pressure ulcers, but had not been seen by a district nurse since they arrived, contrary to the care plans and enablement goals that had been put in place. During our inspection we found them to have been left in the same position in bed for nearly three hours which had resulted in some discomfort. When we spoke with them about this they commented, "Well, I haven't seen anybody since eight o'clock this morning."

Another person needed specific oral health and hygiene care as a consequence of a particular condition they lived with. However, this had not been identified or treated properly which, in turn, had led to some discomfort because the person's mouth was dirty and they had not been adequately hydrated. We found that the guidance provided to staff about how to meet this particular health need was both limited and inadequate. The person also lived with epilepsy and had been prescribed a medicine to help them recover from seizures if they occurred. The medicine was prescribed in a form that meant it could only be administered by staff who had received specific training. We were told that no staff had been trained which meant the medicine could not be administered in the event of a seizure without the assistance of emergency paramedics or other trained healthcare professionals.

Adequate steps had not been taken to ensure that people's health needs were always met in a safe and effective which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff obtained their consent before they provided day to day care. One person said, "They [staff] come up to you and ask if it's alright before they do anything." During our inspection we saw that staff explained what was happening and asked people for permission before providing personal care and support. For example, we saw staff ask people if they wanted help and support to wash their hands or put on a clothes protector in preparation for lunch.

However, people's consent had not been obtained in line with the Mental Capacity Act (MCA) 2005 in all cases.

For example, where 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions were in place, we found they had not always involved or been agreed by the people concerned or, where appropriate, their family members. In one case, a person who lacked capacity was not involved in the decision because they were 'non-communicable', so care staff were consulted rather than a relative who was legally entitled to act on their behalf.

In another case, the person was not consulted because they were 'not there' and, because they had no next of kin, it was stated that a neighbour would be informed of the decision in due course. Staff were unable to confirm whether any person, legally entitled or otherwise, had been informed or consulted about what was a fundamentally important decision. This meant that some DNACPR decisions may not have been in people's best interests or satisfy the requirements of the MCA 2005.

People who lived in the dementia care units on the first floor of the home had their freedom of movement restricted because they were unable to leave at will. This was because access to and from the floor was restricted by

Requires improvement

Is the service effective?

a key coded security system. Most people were unable to use the system and move about freely without assistance from staff or family. However, it was unclear as to whether authority had not been sought or obtained in line with the MCA 2005 and deprivation of liberty safeguards (DoLS). We spoke with the manager about this who agreed that some people's liberty may have been restricted in a way that did not fully comply with the DoLS. They told us the situation would be reviewed in light of the blanket restrictions imposed by the security system.

This meant that adequate steps had not always been taken to ensure that consent was properly obtained which was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed views about the standard of food provided at the home. One person said, "The food is very good, not perfect." Another person told us, "You get good food." However, somebody else commented, "I don't think much of it [food], it hasn't got any taste. Last night was a lump of meat with lots of fat on it."

We observed lunchtime meals in a number of communal dining areas during our inspection. People were offered a choice of main courses and desserts from a menu together with alternatives if they preferred. The food served was hot and people were frequently offered a choice hot and cold drinks. The dining experience varied and lacked consistency across different units at the home. On the ground floor we saw that people were provided appropriate levels of support to help them eat and drink were necessary, both in communal areas and bedrooms. However, on the first floor we saw that some people were left unsupported for long periods of time which meant that, in some cases, food went cold or people fell asleep without having eaten. We also saw that people who stayed in their bedrooms did not always have easy access to water or juice.

People at risk of not eating enough were provided with supplementary drinks and fortified food appropriate to their needs. Advice and support was obtained where necessary from relevant, for example speech and language therapists. Care staff were familiar with people's dietary needs and menus were designed to ensure a healthy balanced diet was provided. However, information about specific needs and risks was not shared with the chef in an effective. This meant they did not always have the most up to date information about people's changing needs.

People were positive about the skills, experience and abilities of the staff who supported them. Staff received regular training relevant to their roles and felt well supported by the management team. One staff member said, "I feel very well supported and the training is brilliant here." Another commented, "We have regular supervisions and staff meetings, training is kept updated."

Requires improvement

Is the service caring?

Our findings

People and their relatives told us that staff were courteous, friendly and respected their privacy. One person said, "My room is private, they [staff] knock." A relative of another person commented, "They [staff] come and knock on the door if they want to enter [family member's] room." In most cases we saw that staff cared for people in a dignified and respectful way that took full account of their views and wishes. One staff member told us, "I love the residents like family."

However, during our inspection we found the levels of dignity and respect demonstrated by staff sometimes varied and lacked consistency across different units of the home. In 'Swallow' unit on the first floor we saw that personal care and support was not always provided in a way that either promoted or respected people's dignity.

For example, one staff member went into a person's bedroom to help them eat their lunch and closed the door. A member of the inspection team entered the room to observe the interaction and noted that a radio had been left on high volume but had not been tuned in properly. This meant that the room was filled with the loud and unpleasant sound of interference. The staff member appeared oblivious to this and prepared to help the person with their meal. We found it necessary to highlight the noise, and the potential adverse effect it had on the dining experience, on three occasions before the radio was eventually turned off.

In communal dining areas elsewhere in the home some people had chosen to have soup and sandwiches for their lunch. We saw that they were served the soup as a starter followed by a selection of sandwiches as the main course. However, we saw that two people supported to eat in their bedrooms on the first floor, again behind closed doors, were given both courses at the same time; with the sandwiches immersed in the soup. This meant that the meal was both unappetising in appearance and served in a way that failed to adequately recognise or promote the person's dignity and self-respect. Neither staff member was able to adequately explain why they had served the meal that way and it was not a preferred or necessary method.

In a communal dining area on the first floor we saw a staff member support a person with their medicines during the lunchtime meal. The person concerned had remnants of toast from breakfast in their lap and their fingers rested in spilt tea that had collected in a saucer. The staff member completed their task but took no action to clear away the cold tea or food waste in question. This meant that the person was unnecessarily left in an undignified situation and environment.

These failures to provide some people with care and support in a dignified and respectful way amounted to a breach of Regulation 10 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The manager agreed that the practices observed were unacceptable and immediately started a disciplinary investigation.

However, most people told us they were happy at the home and had been supported in a kind and compassionate way by staff who were familiar with their needs and personal circumstances. One person said, "Living here to me is quite good, staff are kind and caring and I get treated well. We've got good staff, real good." Another person commented, "Most staff are lovely and very obliging." A relative told us they had "absolutely no doubt" that staff were kind and caring from what they had seen and experienced.

We saw that in most areas of the home staff had developed positive and caring relationships with the people they supported. Staff were knowledgeable about people's needs and knew them all by name. It was a hot day when we visited and some people decided to sit in the garden. We saw that staff made sure they were protected from the sun by offering them hats, a place in the shade and plenty to drink. One staff member told us, "I love all of the residents. It's part of my life; I love this place and the residents." Friends and relatives told us they were free to visit at any time and were always made to feel welcome.

However, we found that the quality of the care and support provided sometimes varied and lacked consistency. For example, on the ground floor staff provided help and assistance in a patient, calm and reassuring way that best suited people's individual needs, whereas on the first floor were staff were rushed and had appeared to have little time for conversation or positive interactions with the people they supported. We saw that one person on the first floor had dirty finger nails that appeared too long and in need of attention. When this was highlighted to a staff member they said they didn't know whether or not the person's nails should be cleaned and cut and then walked off to carry on with other tasks.

Requires improvement

Is the service caring?

Although not always clear or obvious from the guidance and information provided to staff, people and their relatives told us they had been involved in the planning, reviews and delivery of the care and support received. One person told us that they had access to information about the care they received in a folder kept in their bedroom. A person's relative said, "Staff are very friendly and keep me informed of [family member's] progress." Another relative explained they had regular meetings and updates about the medicines and care provided.

We found that the confidentiality of information held in records about people's medical and personal histories was kept secure and had been sufficiently maintained across all areas of the home. However, we attended a staff handover briefing, where confidential information was discussed, and saw that a resident was allowed to remain in the room within earshot of what was said. We also noted that a door leading to the reception area, together with a hatch style window, were propped open throughout. This meant that steps taken to maintain confidentiality were not always as effective as they could have been and was therefore, an area that requires improvement.

Information about local and national advocacy services was displayed and contained in resident guidebooks to support people who wished to obtain independent advice or guidance.

Requires improvement

Is the service responsive?

Our findings

People told us they received personalised care that met their needs and took account of their preferences. One person said, "They [staff] ask me several times about things that I do like and things that I don't like." A relative explained that although he had not been asked anything specific about their [family member], staff had asked about general things. They commented, "If I ask them [staff] anything or tell them anything, they take that into account [regarding the family member's care]." We saw that some people's bedrooms had been personalised with decorations, family photographs, flowers and ornaments of their choice.

People told us they were able to decide when they got up, how and where they spent their time and who with. One person said, "It's very casual for getting out of bed. There's times when I've got up late and nobody's even said anything to me. They [staff] just let you get on with life."

Another person told us they were supported to carry out their own personal care because that was their preference. They commented, "It's very important that you can do that." Somebody else explained that they did not like to be disturbed while asleep at night, so a 'do not disturb' sign had been obtained to display on their bedroom door.

However, we again found that the quality of person centred care and information held about people was inconsistent and varied across different units at the home, particularly between the ground and first floor. In some cases we found that staff were very knowledgeable about how people wanted to be supported and had access to detailed information about their likes, dislikes, preferences and background history to help them perform their roles more effectively.

For example, information gathered about one person included details about their favourite colour and what they liked to wear, together with guidance about jewellery and make-up preferences. One staff member commented, "The care plans are really useful, I look at them all the time. They give good guidance about how to look after people." Another member of staff told us, "I know what my residents like and dislike. We are like one large family. I am so privileged to work here and I love every day." In other cases however, we found that either very little or no detailed information had been collected, made available or used to inform the planning and delivery of person centred care or in the preparation of guidance provided to staff.

Most people told us they received care and support that was responsive to their individual needs and personal circumstances. One person said, "There is good care here, people are well looked after, the care is good." Another person commented, "Staff know me and what I need." We found that most staff had sufficient knowledge about people's health needs to provide safe and effective care that best suited them. For example, on the ground floor we saw a staff member intervene when a new colleague was about to serve orange juice to a person in a lounge. They quietly explained that the juice may interfere with some prescribed medicines and that it therefore would be better to offer water or weak squash, both of which the person concerned liked to drink. They commented, "I think that they [staff] think about my needs and, if it is possible, they will get that secured for me."

However, we again found inconsistency across different floors and units in terms of the knowledge of staff and the personalisation of both the guidance and care provided. On the first floor we found examples of where staff lacked sufficient guidance and knowledge about how to meet people's personal care needs or support them with their medicines.

In one case, we found that staff had been given information and guidance about how to care for and meet the needs of a person who lived with dementia. However, the person concerned had not been diagnosed with that condition and had in fact been assessed as having capacity to make their own decisions. Information given to staff about another person explained how their behaviour had become 'more aggressive toward staff' but did not provide any guidance on how to deal with it, other than advising staff to 'walk away.' This meant that the guidance provided to staff may not have accurately reflected people's individual health and care needs in all cases.

People and their relatives expressed mixed views about the opportunities available for people to pursue social interests or take part in meaningful activities relevant to their needs. Some people were positive about the activity opportunities provided at the home. One person said, "I went on a trip a couple of months ago. I went to Slough. We had a look at the museum and things like that." Another

Requires improvement

Is the service responsive?

person told us, "We went out the other day on a coach trip…It was a lovely day out. I wish I had a trip like that every week." A relative commented, "If there's something going on when I'm here I will help [family member] join in."

However, some people were far less positive and expressed concerns about being left with nothing to do for long periods of time. One person told us, "I sit here all day and nobody comes and talks to me." Another person commented, "Occasionally they [staff] have time to sit and chat." Somebody else told us they had spent much of their life outdoors but had not been given the opportunity to sit in the gardens when the weather permitted. When asked about their plans for the day they told us and a staff member that they hoped to enjoy the sun in the garden. We noted that they were left to sit in a communal lounge for most of the day and were not supported to access the gardens despite the warm weather.

On a number of occasions, particularly on the first floor, we saw that staff entered communal areas to complete tasks without acknowledging or entering into conversation with the people who sat there. We saw that a significant number of people stayed in their bedrooms for the duration of our visit, in the main due to complex health conditions that restricted their mobility. Some watched TV and one or two knitted, read or did word puzzles. However, the majority did nothing and were not supported or encouraged to take part in activities by staff, either on a 'one to one' or group basis. We saw that people were left unattended and unsupported in communal areas for long periods of time without any meaningful activity opportunities provided. Again, some watched TV or read while many slept. One person was left in the same chair in a first floor dining area for nearly four hours with little or no interaction from staff who explained they were too busy with other tasks.

On the ground floor we saw that a few people were helped to access and enjoy the garden. One person, who had been a builder, was encouraged and supported to paint garden furniture, which he thoroughly enjoyed. They showed us a raised planting bed they had constructed in another part of the garden. The home had a large and well stocked activities room on the ground floor with arts and crafts materials, books and music. A dedicated 'Namaste' therapy room had been set up in the next room with a range of visual, sound and touch sensory equipment. We checked these rooms a number of times during our inspection but did not see anybody in them. A number of staff were responsible for coordinating and providing activities across the home every day of the week. We were shown details of a rolling activity programme and told that a number of themed events and trips had taken place. These had included a 'onesie' day, cheese and wine session for relatives and visiting entertainment.

We were told that an outing involving twelve people from all areas of the home had taken place on the afternoon of our inspection. However, we did not see any organised or coordinated group or individual activities take place during our visit.

Information and guidance about how to make a complaint or provide feedback was displayed and contained in the resident guidebook. People felt confident about raising issues with staff and had the opportunity to discuss any concerns they had at regular meetings held for their benefit.

Requires improvement

Is the service well-led?

Our findings

Both the provider and management team had taken steps to ensure that potential risks, both to people who lived at the home and the service as a whole, were identified, monitored and reviewed on a regular basis. Information and feedback about the quality of services provided was also obtained from residents, their relatives and stakeholders through use of survey questionnaires, regular meetings and a suggestion scheme.

As part of this process, the manager was responsible for coordinating a wide range of audits, checks and observations designed to assess all aspects of the home and the experiences of the people who lived there. These included areas such as medicines, care planning and delivery, health and safety, the environment, accidents and incidents, complaints, infection control and mealtimes. Information about the outcomes of these checks, together with any areas for improvement identified, was reported to the provider each month with details of actions taken and progress made. Representatives of the provider also attended the home regularly to carry out similar audits independent of checks carried out by the manager.

However, we found that the steps taken to monitor services and reduce potential risks were not as effective as they could have been. For example, a number of audits carried out in recent months identified that some care plans lacked sufficient information about people's involvement, consent and background histories. During our inspection we similarly found a number of examples of where the guidance provided contained little or no information about people's involvement in planning their care or the important aspects of their life necessary for a person centred approach.

We also found that audits had failed to identify that people's consent had not always been obtained in line with the MCA 2005, for example in relation to some DNACPR decisions. In addition, the checks undertaken had not always identified that some people's health and care needs had not been met in a safe and effective way, particularly on the enablement unit.

People and their relatives were all very positive about the management of the home and thought that it was well run. They were complimentary about the registered manager in particular who they felt was approachable, supportive and demonstrated strong, visible leadership. One person's relative said, "I'm really pleased with it here. I'm hoping [family member] can stay." A number of relatives told us that the management team were good at keeping them informed about any developments, progress and changes that took place, particularly where there family members were had fallen or become unwell.

Staff were also positive about the levels of support, guidance and leadership displayed by the manager and their senior team. One staff member said, "The manager makes it very clear what is expected. Treating residents with respect and dignity, that is at the heart of what we do; tender loving care." Another member of staff told us, "[The manager] says that it's all about the residents and a homely environment, they are very much into the residents."

However, during our inspection we found that the quality of care provided, the levels of respect and dignity displayed by staff and people's experiences, lacked consistency and varied significantly between different units and floors at the home. When problems or difficulties arose, for example in connection with medicine rounds, insufficient staffing levels at mealtimes or a lack of meaningful activities, we noted that some team managers failed to take the action or positive steps necessary to improve or rectify matters.

For example, staff on the first floor appeared stretched and unable to cope throughout our visit which had a direct and adverse effect on people's experiences in some cases. This meant that the leadership and supervisory arrangements were not as effective as they could have been in all areas of the home.

The systems used failed to identify or address effectively the risks, breaches and areas for improvement identified at our inspection which was a breach of Regulation 17 of the Health and Social Care Act (regulated Activities) 2014.

Most staff felt well supported and told us they enjoyed working at the home. One staff member said, "I love working here, there's a lovely atmosphere and a lovely manager. The manager is really very good, any problems and they are on the case dealing with it." Another member of staff commented, "The manager is brilliant with residents and staff."

High performance of individual staff members has been recognised through nominations for the providers annual care awards. Staff were supported to obtain nationally recognised vocational qualifications relevant to their role

Requires improvement

Is the service well-led?

and some were chosen to take lead responsibility or 'champion' key areas. These included dementia care, infection control and the provider's 'rhythm of life' initiative. We also saw examples of where the manager used formal discipline procedures to tackle and address poor performance, for example where a staff member was found sleeping on duty.

People and their relatives said they were kept well informed about services provided at the home through a variety of means. These included information about important events displayed on noticeboards and the opportunity to attend meetings or talk with the manager and senior staff on a 'one to one' basis. A relative told us, "There is always someone who I can communicate with about issues or concerns."

The manager has supported the development of strong links with professional support organisations that offer additional training, development and improvement opportunities for both staff and the service as a whole. These have included participation in an infection control programme sponsored by the local authority and a community based 'dementia friends' initiative.

Links have also been forged with local schools, supermarkets and other organisations to obtain support for initiatives and events that may benefit both the residents and people from the community who take part. For example, some residents have helped local school children feed their chickens and a supermarket has supported food tasting and fund raising events in the past.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing How the regulation was not being met: The registered person did not take proper steps to ensure that there were sufficient numbers staff available to meet people's needs at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment (risks) How the regulation was not being met: The registered person did not take proper steps to ensure that the risks to people's health and safety were managed in a safe and effective way.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment (medicines). How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person did not take proper steps to ensure that people were supported to take their medicines safely in all cases.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. How the regulation was not being met: The registered person did not take proper steps to ensure that people's liberty and freedom of movement were only restricted where necessary in line with the MCA 2005 and DoLS.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Governance How the regulation was not being met: The registered person did not take proper steps to ensure that systems to assess, monitor and reduce risks, and to improve the quality of services, were operated effectively.
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met:

The registered person did not take proper steps to ensure that consent to care and treatment was obtained in all cases.