Larchwood Care Homes (South) Limited

Highfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 June 2017 and was unannounced.

Highfield is a nursing home for up 34 older people. It is set in a rural location on the outskirts of the village of Bekesbourne. There were 20 people living at the service at the time of this inspection, some of whom lived with dementia type illnesses, impaired mobility, sensory impairment and other conditions such as epilepsy and diabetes.

Accommodation is set over two floors and upstairs bedrooms can be accessed by a passenger lift. However, because of reduced occupancy, the first floor was unoccupied and everybody was accommodated on the ground floor where there is a communal seating area, quiet lounge and dining area.

The last full inspection of Highfield took place in June 2016 where the service was rated overall as 'Requires Improvement'. Each of the five key areas looked at were rated Requires Improvement with the exception of 'Caring' which was rated as 'Good'. Improvement was needed because we found five of our regulations were breached. These related to concerns about people's nutritional and hydration needs not being appropriately monitored with issues arising not acted upon and failure to ensure care plans reflected people's needs and wishes to guide staff in accordance with best practice. There was a failure to ensure protocols for some medicines were in place or have effective systems for the assessment and administration of pain relief. People were placed at risk because of the condition of some parts of the building where improvement was required and some safety measures were not observed. Staffing levels placed people at risk of becoming isolated and the service had not fulfilled its statutory obligation to accurately inform the Commission of the number of deaths occurring of people registered at the service. Following this inspection requirement actions were made and the management of the service submitted actions plans to us setting out how and when improvements would be made.

A further inspection of the service took place in November 2016. This was a focussed inspection concentrating only on the key areas of 'Safe' and 'Well-led'. However, during that inspection we identified concerns about 'Caring', so we included this key area in the inspection too. Following this inspection, each of the three key areas looked at were rated as 'Inadequate' as well as an overall 'Inadequate' rating for the service. This was because there were continued breaches of our regulations relating to insufficient staff; adequate improvement had not been made to aspects of the building, as well as some lapsed safety critical checks, we also found medicines were sill not managed safely. In addition to these continued breaches of regulation we found other new breaches of our regulations. These related the failure to minimise risk to people through referrals to health specialists; the failure to ensure people were protected from neglect and abuse by appropriate referral of incidents to safeguarding authorities; the failure to have robust recruitment processes in place to ensure staff were suitable to work with vulnerable people; the failure to meet some people's care and social needs and the failure to ensure management processes identified and improved the quality and safety of the service provided, some of which stemmed from a failure to maintain accurate and complete records about people.

The decline in the standards and 'Inadequate' rating of the service meant it was placed into 'Special Measures'. Services in special measures are kept under review and immediate action may be taken to propose to cancel the provider's registration of the service. The latest inspection of this service found some improvement had been made. People and relatives gave positive feedback about the service, however, some aspects of practice potentially placed people at risk and further improvement was needed.

There was a registered manager in post; this was the same person who had been responsible for the day to day running of the service when the both of the previous inspections took place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were not managed safely, information about a dose of medicine was missing, some instructions were confusing and protocols about the administration of some medicines were not always complied with.

Risks to people had not been properly assessed or minimised and specialist advice intended to reduce risk was not always complied with.

Accidents and incidents were not consistently reviewed. A matter that should have been reported to the local authority safeguarding team was not.

Areas of the service and some equipment were not clean and posed a potential infection control risk.

Shortfalls in aspects of recruitment processes, previously pointed out, remained incomplete.

Poor communication had impacted upon the care and support some people needed; incontinence equipment had not been available and some people did not receive the care and support they required.

Elements of care planning did not fully establish some people's needs or reflect their wishes about how they wanted to be supported.

Although there had been some improvement to quality assurance, checks were not fully effective, they had failed to identify the concerns evident at this inspection or address some concerns highlighted at previous inspections.

There were sufficient staff to meet people's needs. Staff had received training in a range of topics and this had been regularly refreshed. Supervisions and appraisals had taken place to make sure staff were performing to the required standard and to identify developmental needs.

People's rights had been protected by assessments made under the Mental Capacity Act (MCA). Staff understood about restrictions and applications had been made to deprive people of their liberty when this was deemed necessary.

People enjoyed their meals, any risks of malnutrition or dehydration had been adequately addressed.

Staff treated people with kindness and respect for their privacy and dignity. Staff knew people well and remembered the things that were important to them. There were a range of activities.

This service has been in Special Measures. Services that are in Special Measures are kept under review and

inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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.

Medicines were not always safely managed.

Assessments intended to reduce risk were incorrect and some staff were unaware of mandatory measures intended to keep people safe.

Accidents and incidents were not consistently managed and safeguarding processes were not always observed.

There were sufficient staff to meet people's needs. However, recruitment processes were not sufficiently robust to ensure only suitable staff were employed.

Areas of the service were unclean and some equipment was unhygienic.

Is the service effective?

Good

The service was effective.

New staff received an induction and all staff received training to enable them to support people effectively.

Staff were well supported and had one to one meetings and appraisals to support them in their learning and development.

People's health was monitored to help maintain their well-being. People were provided with a range of nutritious foods and drinks.

Staff understood how to protect people's rights in line with the Mental Capacity Act (MCA) 2005.

Is the service caring?

Good

The service was caring.

Staff treated people respectfully and were compassionate and well-intentioned.

People and their visitors felt the service was friendly and welcoming.□

Is the service responsive?

Requires Improvement

The service was not always responsive.

Communication between staff was not always effective and resulted in some people's continence needs not being met.

Some individual needs and preferences had not been established.

Changes in health and social needs were responded to and people felt staff were supportive of their needs.

People enjoyed the activities provided.

An effective complaints system was in place; people and visitors were confident complaints would be listened to and dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance framework was improved but not always fully effective to ensure continuous oversight of all aspects of the service; some records were incomplete.

The service sought the views of people about the quality of service provided, however, action taken to resolve issues was unclear.

People and visitors found the management and staff friendly and approachable.

Highfield

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 20 and 21June 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor with nursing experience of older people 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.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met most of people who lived at Highfield and spoke with seven of them. We observed most people's care, including interaction with staff, the lunchtime meal, some medicine administration and some activities. We spoke with four people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with two nurses, three health care assistants, the activities coordinator, kitchen and housekeeping staff as well as the services' administrator, the registered manager and regional manager. We also spoke with a visiting dietician and an optician, both of whom had come to see people at the service.

We 'pathway tracked' three of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at some aspects of care records for nine other people. To help us collect evidence about the experience of people who were not able to fully describe their experiences of the service for themselves because of cognitive or other problems we used a Short Observational Framework for Inspection (SOFI) to observe people's responses to daily events,

their interaction with each other and with staff.

During the inspection we reviewed other records. These included staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Relatives visiting people at the service told us they felt their family members were safe and well looked after. One visitor told us, "I feel very safe leaving my husband in the care of the staff at Highfield". Another visitor commented of the reassurance they felt that their relative lived at the service, they told us, "The staff here, all the staff, are brilliant. I know there is someone here looking after her, especially when I'm not here. She's always clean and tidy, well fed; she eats well and is much happier since she has been here". Other visitors' comments included, "I feel very comfortable knowing that the staff are very experienced and look after her very well. She is always clean, always in different clothes, her own clothes, and her hair always looks nice. People living at the service gave very positive comments, which included, "If I use the call bell, they come quickly. I'm very safe and well looked after here" and, "The call bell is always within my reach; they never leave me without it. It's lovely here. I've got all my marbles and if it was like the last CQC report, I would move." Staff told us they enjoyed working at the service and were proud of the support they provided. However, our findings identified risks that may not be visible to people and relatives which meant people's safety could not be assured.

Our last inspection highlighted medicines had not always been safely managed, this was because the time it took to complete some medicine rounds meant there may not be safe gaps between some medicines being given and when the next dose was due. In addition, there were some gaps in the medicine administration records (MAR) of some medicines and others contained confusing information. Where hand written additions were made to MAR charts, these were not double signed to check the additions were correct. At this inspection we found the concerns identified at our last inspection had been addressed; notably because time sensitive medicines were given priority of administration at the beginning of the round, ensuring safe gaps were maintained between doses. However, other areas of concern identified during this inspection meant the administration of medicines remained unsafe. This was because some vital guidance about administration doses and the rate was missing; some instructions about when to give a medicine were confusing and some staff administering medicines were not aware of people's conditions or that they were giving them medicine to treat it.

One person received oxygen therapy, its purpose was to maintain oxygen levels in their body tissue at a functional level. Reduced oxygen concentration may cause serious or irreparable damage to vital organs. Oxygen therapy is regarded as a drug and therefore must be prescribed by a doctor and recorded on a MAR chart. This record should include the percentage of oxygen required, the flow rate, frequency of administration and delivery method. Examination of the MAR chart found this information was not recorded and there was no protocol in place for its administration. Effectively this meant there was no guidance for staff to establish if oxygen was being provided at the rate prescribed and its administration was not recorded. Following the inspection a MAR chart regarding the administration of oxygen was put in place.

Another person diagnosed with Type 1 Diabetes was dependent on insulin to ensure their blood sugar level was maintained within a safe range. They were prescribed two different types of insulin to achieve this. One insulin was given daily at 8am and the other type of insulin was only to be given if blood sugar levels exceeded 15 mmol/l (millimoles per litre). Although there were no instances when both types of insulin were

given together, guidance for staff did not make clear that the insulin should only be given on an either or basis and not together. This introduced a risk that upon testing blood sugar levels and finding them in excess of 15 mmol/l, both types of insulin may be given. This could result in hypoglycaemia, which is when blood sugar levels are too low. This can cause a wide variety of complications including loss of consciousness, seizures, visual disturbances and muddled thinking.

Another person diagnosed with epilepsy received daily medicine for their condition. This helped to control their symptoms and ensured seizures were kept to a minimum. However, when asked, the registered nurse administering medicines was not aware of their diagnosis. This introduced a concern that they were not aware of the medicine they were giving or the reason why. Furthermore, it introduced the risk that, should the person experience a seizure, staff may not recognise their symptoms or respond appropriately. Administering medicine without knowing what it was for did not promote safe practice or provide assurances of a positive outcome for people.

Where some people received as and when required medicines (PRN) protocols in place required staff to record on the back of MAR charts why and when these medicines were administered. A review of MAR charts found this did not always happen. One person was prescribed PRN paracetamol, eye ointment and tablets for the treatment of anxiety. Administration of these medicines was not always recorded on the MAR chart or the reason why they were given. MAR charts are the formal record of administration of medicine within the care setting and may be required to be used as evidence in clinical investigations and court cases. It is therefore important that they are clear, accurate and up to date. The failure to do so does not promote the safe management of medicines.

The failure to manage medicines safely is a continued breach of Regulation 12 of the Health and Social Carer Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found where some people had been assessed as at risk from not eating enough, information held about them was incorrect. This resulted in referrals not being made to health care professionals when they should have been and, consequently, risks to these people had not been minimised. At this inspection we found people's weight and referrals to dieticians were well managed, records corresponded and we saw some people's weight loss had stabilised and improved. We spoke with a dietician visiting the service, they were satisfied people's nutrition requirements were well managed and that referrals for help were being made when they needed to be. However, we found other risks that had been incorrectly assessed, some guidance for staff was not in place and some support provided by staff did not meet with advice provided by specialists and placed people at an increased risk of choking.

Most risk assessments, particularly around eating, drinking and choking considered twelve individual factors that may increase risks to people. These included people's cognitive function, breathing, posture, general and oral health as well as any medical conditions. Staff were required to enter the level of risk (low, medium, high or very high) for each area based upon individual assessment of people. Staff should then compile a risk assessment based upon the highest identified risk to inform care planning and practice. Care practices were then intended to reduce the highest identified risk, in turn also reducing the lesser risks. However, examination of risk assessments found staff averaged the level of risk and compiled risk assessments and care plans based upon this. For example, if staff identified one high risk and the remainder low risks, risk assessments and practices reflected measures intended to address the averaged low risk. Incident reports did not evidence choking, however, based on this method; measures in place were insufficient to address the most serious risk. We found this had happened for most people.

One person was restricted to 1100ml per day as the amount of fluid they could drink. This was because of

kidney disease. A daily fluid intake chart was in place, however, it did not reflect or provided any guidance for staff about the maximum quantity the person should drink. Fluid charts showed the daily intake was exceeded on two consecutive days, by 150ml on the first day and 215ml on the second day. The registered manager explained the person had been encouraged to drink because of the hot weather. However, they were unaware and had not sought medical advice to know if exceeding the daily intake amount may cause the person harm. Following the inspection the registered manager enquired and provided confirmation from the person's GP that the daily limit could be exceeded by 500ml per day. However, exceeding the fluid limit without at the time knowing if it was safe to do so does not promote safe care or mitigation of risk. Another person also received fluids limited to 1200ml per day due to a cardiac condition. Although a fluid consumption chart was in place it did not inform staff there was a daily limit, or how much it was. This placed the person at risk of receiving excess fluids.

Due to swallowing difficulties and an increased risk of choking, speech and language therapists (SALTs) had provided staff with specialist information about how some people needed to be supported to safely eat and drink. This included information about softened food, thickened drinks and the type of cup needed. Some cups and beakers help to control flow rates of drinks and some encourage sucking to help develop mouth function and swallowing. This helps to reduce the risks of aspirating drinks, which is when liquid is breathed into the lungs. This can cause choking, fits of coughing and cause pneumonia. We spoke with a member of staff providing people with drinks and also tracked information provided by SALTs about how people should be supported to drink safely. We found the member of staff gave one person the incorrect cup to drink from and saw another person had drunk from a cup SALTs had specifically said should not be used. Staff were not aware of choking risks for some people and how these should be reduced; specialist advice specifically obtained to reduce risk was not always put into practice. This increased the risks of choking and other associated complications.

The failure to minimise known risks to people is a continued breach of Regulation 12 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found incident reports of unexplained bruising had not consistently been discussed by the registered manager with the local safeguarding authority; to check whether it should be investigated by them. At this inspection we looked at incidents and accidents. One record showed a person had sustained a large skin tear to their forearm. We discussed this with the registered manager, who explained staff had used the incorrect type of gloves when delivering personal care. They explained the person has papery, very fragile skin and the gloves staff used, rather than gliding across the skin clung to the skin causing it to tear. When brought to the attention of the registered manager at that time, the gloves were withdrawn from use and correctly replaced. Further discussion with the registered manager found this incident had not been discussed with or reported to the local authority safeguarding body. Although staff had received safeguarding training and were aware of how to recognise and report safeguarding concerns and other matters had been reported to and discussed with the safeguarding authority, this illustrated a lack of consistency at management level about the correct steps to take to protect people.

The failure to ensure that people are protected for abuse and neglect is a continued breach of Regulation 13 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found areas of the service which were unsafe. Sluice rooms were unlocked; there was also a large dip in the floor in one area; one bathroom was very cold and, because the front lounge was located adjacent to the main entrance, people were exposed to interruptions and draughts. This inspection found storage and sluice room doors were locked, the dip in the floor had been repaired and the front lounge extended by removing a wall to reduce the size of the adjoining nursing station. Reclining seating

had been provided as well as leaving room for wheelchairs. People told us they were happy and comfortable in the front lounge adjacent to the main entrance; it overlooked a pond and the driveway, some enjoyed watching visitors come and go. Discussion with the regional manager found capital expenditure had been granted to renovate and improve an alternative seating area in the conservatory. This was scheduled to take place in October 2017. The management of the service felt this, together with the use of a separate quiet lounge would provide suitable alternative areas for people to use should they not wish to use the front lounge.

As part of this inspection, we looked at most areas and equipment to check if it was suitably clean. The vinyl flooring in the hair salon was visibly dirty. Housekeeping staff told us it was difficult to clean because of the texture of the flooring. We looked at two commodes, the underside of both of their frames were visibly dirty with dried urine stains which had built up over a period of time. This indicated they were not regularly or properly cleaned. We pointed this out to the registered manager who took immediate steps to have them cleaned. Cleaning schedules showed commodes should be cleaned weekly, however, the records seen were insufficiently detailed to establish when this was last done.

The failure to ensure the premises and equipment safe are clean is a continued breach of Regulation 15 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found people were not protected by robust recruitment procedures; this was because some required information was not received until after staff had started work at the service. At this inspection we found most checks had been made prior to new staff beginning work including photographic identification checks, Disclosure and Barring Services (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with vulnerable adults. Health checks and appropriate identification checks to ensure staff were suitable were also made. However, of three staff recruitment files viewed, one employment history contained gaps which, as is required, had not been fully explored. The reference obtained for another member of staff had not been provided by their previous employer. The registered manager said references from overseas were hard to obtain but they thought the reference they had received had been from another previous employer of the staff member, although they could not be sure. No action had been taken to follow this up.

The failure to operate a robust recruitment system is a continued breach of schedule 3 or Regulation 19 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found there were not enough staff deployed to consistently meet people's needs. At this inspection we found there were sufficient staff to meet people's needs. Daytime staffing comprised of five healthcare assistants in addition to a registered nurse. In addition the registered manager, who was also a nurse, and the activities coordinator, who was a former healthcare assistant, supported staff at busier times, for example, supporting people to eat at lunch times. Night support was provided by two wake night staff and a registered nurse.

During this inspection, of the people at the service, there were three people with clinical reasons why they could not leave their beds. Most people required the support of two members of staff to mobilise and to deliver personal care. On both days of inspection 11 people were up and dressed, receiving their lunch where they choose. Some people ate in the dining area and other people in front lounge. Some of these people were supported by staff to eat. We spoke with people and visitors about what they and their relatives preferred to do in terms of leaving their rooms. Most people who stayed in their bedrooms told us that was what they preferred to do. People and staff told us they thought there were enough staff on duty. People told us where they had used their call bells, staff came promptly. Half hourly checks were in place for people

who were unable to use their call bells. Our observation found call bells were within reach, clipped to people's beds or chairs. Discussion with the registered manager established a needs assessment tool was used to inform staffing numbers. This was reviewed monthly or as and when required. The calculated staff requirement matched the number of staff on duty. A review of the staff rota found the service had operated at the established staffing need. However, people were allocated to have a bath, this can be indicative of people's routines being tailored to meet staffing availability, rather that a person centred preference approach. This is an area we have identified as requiring improvement.

Checks took place to help ensure the safety of people, staff and visitors. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been reported. Records showed that portable electrical appliances and fire fighting equipment were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Records showed Health and Safety audits were completed monthly and that these were reviewed by management to see if any action was required. Fire risks had been thoroughly assessed and people had individual emergency evacuation plans. They gave details of the assistance each person would need in an urgent situation. Staff had regular fire safety training and could accurately describe the way in which people would be helped. Appropriate testing and monitoring of water temperatures ensured people were safe from risks of scalding; variations in water temperatures were addressed when identified.

Good

Is the service effective?

Our findings

People told us staff looked after them well. One person commented, "The staff are always cheerful and helpful, they are very kind and patient. A visitor commented, "If I wasn't happy with the care here, I would say so. It feels like a family. The staff are brilliant. They laugh and joke with us, and they have got to know him, and me, very well. As far as I'm concerned, I have no complaints. They are very good. If they go to get him up and he doesn't want to, they just leave him for a while, and then go back." Another visitor told us, "The food here is brilliant. My husband loves his food and it's lovely. I also eat here sometimes."

Our last inspection in November 2016 focussed only on the key areas of 'Safe', 'Caring' and 'Well-led' and did not look at whether the service was 'Effective'. The 'Effective' key area was previously inspected in June 2016, when the last full inspection took place. At that time we identified this area 'Required Improvement'. This was because people's nutritional and hydration needs were not appropriately monitored and arising issues had not been acted upon. At this inspection we spoke with a visiting dietician, looked at records of people's weight and provision of drinks and snacks. Instances of weight loss were appropriately monitored and acted upon; referrals were made to health care professionals and action taken when needed. Fortified drinks were given where prescribed. Fluids were monitored where needed and staff encouraged people to drink. People were weighed regularly and the registered manager actively monitored these records.

People's health was monitored to help maintain their well-being. Physiotherapists, speech and language therapists, occupational health practitioners, opticians, chiropodists and GPs all visited the service to assess people and contribute to their care and support on a regular basis. Where people had particular healthcare needs; such as, skin integrity concerns or catheters, care plans had been put in place. One visitor, speaking about their relative, commented, "In the winter, I noticed that she was very chesty. When I mentioned it to the staff, I discovered that the GP had already been called. That tells you that they really are on the ball."

Staff were aware of what people liked and disliked, people were invited to give feedback about the food provided by the service and make suggestions for menu planning. Menus were displayed on walls and also on the dining room tables, making them accessible to people in wheel chairs. During the inspection we observed staff discussing with people what was on the menu and recording their preferred meal choices. Staff respected people's choices about what they wanted to eat. People were supported and encouraged to eat a healthy and nutritious diet. Where needed plate guards were used to help people eat independently. Discussion with the cook found they were familiar with people's particular dietary needs. For example, softened and pureed food, allergies, high calorie fortified food and reduced sugar food for some diabetics. Food was brought out quickly, it was labelled to ensure people received the correct meals. People who were able to eat independently were served first and then staff supported people who needed assistance to eat. We did note some occasions when staff were distracted to other tasks while supporting people to eat, however, these were infrequent and staff soon returned. Each person spoken with said they thoroughly enjoyed their lunch; there was little or nothing left on people's plates. Throughout the inspection regular drinks and snacks were offered by staff. The kitchen had recently been awarded a five star Environmental Health rating, this being the highest rating.

The management and staff were aware of the need to involve relevant people if someone was unable to make a decision for themselves. If a person was unable to make a decision about medical treatment or any other big decisions records showed relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest.

The Mental Capacity Act 2005 MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

Applications had been made for deprivation of liberty safeguards (DoLS) authorisations for people who needed them, five authorisations were granted with a further 14 being processed. These authorisations were applied for when it was necessary to restrict people for their own safety. The service was responsible for making applications and the relevant supervisory body (local authority) considered each application, issuing authorisations as needed. These helped to ensure any restrictions on people's liberty were warranted and as least restrictive as possible. A review of granted authorisations found one had recently expired, however, it had been granted for an unusually short period of time; upon discovery a new application was immediately made to the local authority.

Records showed people's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. The management and staff had knowledge of and had completed training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff showed good knowledge and understanding of the MCA. We observed staff routinely offering people choices, for example, where they would like to sit, what they wanted to do, choices around food and drinks and various activities.

Staff told us they had an induction when they started working at the service, this involved office time with a manager where they spent time reading people's care records, policies and procedures and getting to know the service. They also spent several shifts shadowing experienced colleagues to get to know people and their individual routines. New staff received a comprehensive programme of training before they started working with people. New staff were completing the Care Certificate; a set of standards that social care workers follow in their daily working lives. Staff were supported through their induction, monitored and assessed to check that they had attained the right skills and knowledge to be able to care for, support and meet people's needs effectively. Staff told us they supported each other and could ask their colleagues for help or advice if they needed to.

Staff completed a mixture of e learning and face to face training in a range of subjects to perform their roles safely and to provide the right care and support to meet people's needs. Training in all mandatory subjects was up to date for most staff. Staff had also undertaken extra training in subjects such as dementia awareness and nutrition and hydration. Competency checks were completed after each training session to check staff knowledge and understanding. Staff commented positively about the training, feeling that it was of a suitable quality and level to provide the knowledge they required. Some staff had achieved National Vocational Qualifications (NVQ) in health and social care. NVQ's are work based qualifications which recognise the skills and knowledge staff need to do their job. Staff have to demonstrate their competency to be awarded each level.

Staff had individual supervision meetings and an annual appraisal with the registered manager. This gave staff the opportunity to discuss any issues or concerns they had about caring for and supporting people, and gave them the support that they needed to do their jobs more effectively.

Good

Is the service caring?

Our findings

All visitors spoken with described the service caring, their comments included, "I have no problems with this place at all. My wife has dementia but she is much more settled here. She thinks she is in a hotel, so that tells you how good it is. The staff are very good, very patient, and they treat us both with respect and dignity. It's comforting when I leave her. I know she is looked after. I don't have to worry about her" and "What's most important for me is they're kind and caring." Another visitor told us, "I walk in and they greet me like a member of the family. They not only look after my husband, but they also look after me. To me, the people here are like my family. I really enjoy coming here". One person told us, "The thing that impressed me the most was the kindness. All the Carers are patient and have tenderness. They are all so kind to me. They always ask how I am. They are always asking if I am alright." Other people told us they found the service comfortable, staff kind and pleasant; each person spoken with was happy and settled at the service and complimentary of the care and support provided.

Our last inspection found the service was not caring, a lack of staff meant people often spent all of their time in bed; staff did not routinely try to engage people in conversation as they supported them; some people were cold and blankets or bedding was not offered; menu boards were positioned high on the walls in small writing and pictures to support the menus did not correspond with what was written on the menu; menu positions did not consider the needs of people in wheel chairs and contradictory information was not helpful in supporting people to make independent choices. At this inspection, these issues had been resolved.

Staff were clear about how to treat people with dignity, kindness and respect. All of our observations were positive, staff used effective communication skills which demonstrated knowledge of people and showed them they were thought of as individuals. Staff spoke with people at the same level so it was easier to communicate with them or to understand what was being said. They made eye contact and listened to what people were saying, and responded according to people's wishes and choices. Staff told people what they were doing when they supported them. They gave some people a narrative, such as your lunch has arrived, tell me what you would like to drink and would you like me to assist you. This respectfully helped people to make decisions and introduced orientation to any support they might need within normal conversation. Staff were courteous and polite when speaking to people in private. They gave people time to respond and spoke in a way that was friendly and encouraged conversation.

Adequate staff numbers and the provision of new mobile chairs meant most people were supported to get out of bed and were taken to areas of the service of their choice. For people who remained in bed, call bells were left within reach and staff routinely and regularly monitored to see if people were comfortable or required assistance. Staff knocked on people's doors and tended to people who required support with personal care in a dignified manner. People were encouraged to be as independent as possible. Staff explained how they supported some people to wash their own hands and face, for example, and to choose their clothing. Staff told us how important it was for people to retain their independence. Staff described how they supported people with their personal care; explaining to people what they were doing before they carried out each personal care task. Staff were supportive in encouraging people to be independent. When

people were at the service they could choose whether they wanted to spend time in communal areas or time in the privacy of their bedrooms.

People told us menu choices reflected what staff said was on offer and supporting pictures reflected those choices. Picture menus on the tables were accessible to wheelchair users who may not be able to see and read menu boards. One person told us, "I don't need to look at the menu, staff always tell us what the choices are. If I don't want that, I can have something different. I have never gone hungry."

Staff showed attention to the details of care, people's hair was brushed; they were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. Relatives commented whenever they visited, people seemed well cared for and happy. They told us there were no restrictions on the times they could visit the service, they were always made welcome. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us how staff contacted them if they had any concerns about their family members.

People's care plans showed that discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had happened. Some people who could not easily express their wishes, or did not have family and friends to support them to make decisions about their care, were supported by staff and a local advocacy service. Advocacy means getting support from another person to help you express your views and wishes, and to help make sure your voice is heard. Someone who helps you in this way is called your advocate

Staff knew people well and demonstrated a high regard for each person. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about specific individual needs and provided us with a good background about people's lives prior to living at the service; including what was important to people. People were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, one person frequently became upset, calling out for staff. Staff spoke calmly and cheerfully with the person, encouraging them to speak and understand why they were unhappy. Staff told the person, "Don't worry, I'm here to look after you." They held the person's hand, sat with them and reassured them. They chatted with the person which helped to settle them. Staff knew about people individually and chatted about things that were relevant to them. For example, previous jobs, pets, where people used to live and what they did during the war.

Care records were stored securely and information kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this. Care plans contained specific information about people's wishes for end of life care.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff supported them well and responded to their needs, they said they were asked about their interests and preferences and were offered choice in all parts of their care. One person told us, "There is no shortage of information or choice." Another person commented, "I like to stay in my room, I'm happy in my own company, the staff do respect that."

Our last inspection in November 2016 focussed only on the key areas of 'Safe', 'Caring' and 'Well-led' and did not look at whether the service was 'Responsive'. The 'Responsive' key area was previously inspected in June 2016, when the last full inspection took place. At that time we identified this area 'Required Improvement'. This was because there was a failure to ensure that care plans reflected people's needs and wishes to guide care and nursing staff in accordance with current best practice. At this inspection we found some aspects had improved, however, other elements still required improvement.

During this inspection we found communication within the service not always effective and had impacted upon meeting people's care needs. Records showed an instance when night staff were left with an insufficient amount of incontinence pads. As a result, four people were unable to have their pads changed; night staff recorded they were unable to access stocks of new pads as they did not have keys to the storage area. Upon investigation, it was found the pads were in a different storage area and the required keys were in the nurse's station. This indicates poor communication and management, staff should have been aware of where to obtain stock.

The care and treatment provided to people was not appropriate and did not meet their needs. This is a breach of Regulation 9(1)(a)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where a person experienced epilepsy, although a recovery management flow chart was in place, informing staff of actions to take, there was no care plan in place to provide more detailed information for staff. For example, information about recognising any warning signs that a seizure may be imminent or the need for staff to note possible triggers or patterns which may help with treatment and medication reviews for the condition. Where people had other conditions such as diabetes, weight loss and choking risks, specific care plans were in place. Not having a care plan to support the person with epilepsy represented a departure from established working practice and introduced a risk, as was borne out in this inspection, that staff may be unaware of their condition and potentially how to recognise and support a seizure.

There was a failure to ensure care plans reflected people's needs and provided information that was reasonably needed. This is a continued breach of Regulation 9 (3)(b)(g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, admission assessments and resulting care plans captured an inclusive approach to care and included the support people required for their physical, emotional and social well-being. These included all aspects of care, and formed the basis for care planning after they moved to the service. Care plans included people's personal hygiene care, moving and handling, nutritional needs, continence, sleeping, skin care,

and pain management. A section contained details about people's lives, this included their work, family, hobbies holidays as well as more personal information about if people preferred a bath or a shower; if they needed help with dressing and undressing; when they liked to get up and go to bed, and preferences about their food, their clothes, and their social activities. People's care plans were discussed with them and their family members if this was their wish. Care reviews were carried out each month and were up to date. People and visitors we spoke with felt care provided met individual needs.

Changes in health or social needs were responded to. Short term care plans were written for people with acute conditions, for example, chest and urinary infections. Care plans identified if people could communicate their needs clearly and recognised how people living with dementia could suffer from confusion. Staff realised that if people presented a behaviour that may challenge, it may be that they were trying to communicate their needs. There was information for staff on how to best communicate with people. Staff spoke about the importance of understanding body language, posture and facial expression in communicating effectively with people with dementia. Throughout the inspection our observations and people's daily notes showed they were cared for and supported in accordance with their individual wishes.

The service employed a full time activity coordinator. People described them as enthusiastic and knowledgeable about people's specific interests. People spoke positively of their role in providing for people's social needs. Some activities were delivered on a one to one basis where this was more suited to these people's needs. Other activities were carried out with small groups of people. There was a good recognition of people's needs and ability to benefit or not from group activities. Group activities included music therapy, physiotherapy, quizzes, bingo, singers and entertainers. Individual activities included reading and chatting to people, finger nail painting and hand massages. A visitor told us their relative was, "Not an activities person" and did not like to join in with group activities; their wishes were respected. Other people told us the location of the service was pleasant, they enjoyed looking out of the windows at the tranquillity of the countryside, the pond and watching the birds.

The service responded to complaints appropriately, a complaints procedure was displayed for people to view. There were systems in place outlining timescales of the complaints process and details of what actions the complainant should expect throughout the investigation process. When concerns or complaints were made these were recorded and follow up action taken and recorded. Relatives were also provided with opportunities through relative meetings to express any matters of concern which would be reported to the registered manager. There were no open complaints at the time of the inspection, a total of seven complaints had been received and dealt with in the current year.

Requires Improvement

Is the service well-led?

Our findings

People and visitors told us staff were pleasant and the registered manager was helpful, attentive and approachable. People were concerned about the rating of the service and its future. They found it difficult to reconcile their experiences of the service with published reports. Staff told us they enjoyed working in the service, they were proud of the support and care the provided. They described improved morale and a culture where they encouraged to speak out with any concerns or ideas to improve the quality of the service.

Our last inspection found the service was not well led. This was because staffing issues had not been fully addressed and consequently impacted on quality, record keeping and lapsed safety checks. Checks and audits completed by the registered manager and service provider had failed to identify or address many of the concerns found.

At this inspection some improvement had been made and all risks pointed out during this inspection were acted upon immediately, significantly reducing the likelihood of any occurrence. Drinking and eating risk assessments were reviewed, corrected where needed and checks made to ensure correct staff practice when supporting people. Communication concerns were addressed to ensure supplies needed to meet people's continence needs were available. Missing and contradictory information for some medicine administration procedures were reviewed and addressed and further information acquired to ensure care plans fully represented people's care needs.

The provider had maintained an increased monitoring of the service since our last inspection; with the regional manager visiting at least once a week to check that progress was being made. A development plan had been devised for the service to maintain a focus on areas previously identified as in breach of regulations. However, the level of effectiveness and critical review of the increased monitoring was not wholly effective. This was because processes had not become embedded into everyday practice and therefore some regulations previously identified as breached had not been fully addressed.

The failure to assess, monitor and mitigate the risks to people and maintain complete records is a continued breach of Regulation 17 (a)(b)(c)(d)(i)(ii) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Surveys had been introduced to enable people and or relatives to comment about the service. These had been collected and analysed, with results and responses displayed on notice boards around the service. However, it was sometimes difficult to distinguish if responses given were proposals or had taken place.

The staffing structure was unclear, with staff referring to senior carers when this role no longer existed. This introduced a risk that staff may not be familiar with each other's roles and responsibilities. We discussed this with the registered manager who agreed to publish a staffing structure chart to ensure all staff were aware of their roles and line management.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where

a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception and on their website.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way and had done so since our last inspection.

Policy and procedure information was available within the service and, in discussion, staff knew where to access this information and told us they were kept informed of any policy changes made.