AMS Care Wiltshire Limited

Bassett House

Inspection report

Cloatley Crescent
off Station Road
Wootton Bassett
Wiltshire
SN4 7FJ

Tel: 01793855415
Website: www.ams-care.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bassett House is registered to provide accommodation which includes nursing and personal care for up to 63 older people, some of who are living with dementia. At the time of our visit 57 people were using the service. Bedrooms are situated over three floors. There were communal lounges and dining areas with satellite kitchens on each floor with a central kitchen and laundry.

The service also provided five intermediate care beds. This service provides support to older people to help them avoid going into hospital unnecessarily and to help them to be as independent as possible after discharge from hospital before returning home.

We undertook a full comprehensive inspection on the 21 and 22 June 2017. The first day of the inspection was unannounced. During our last inspection at Bassett House in July 2016 we found the provider did not meet some of the legal requirements in the areas we looked at. After the previous inspection the provider wrote to us with an action plan of improvements that would be made to meet the legal requirements in relation to the law. We found on this inspection the provider had taken some steps to make the necessary improvements.

A registered manager was employed by the service and was present throughout our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were arrangements in place for the safe storage and administering of medicines as prescribed. However, where people were administered medicines covertly appropriate processes had not been followed and there was no evidence that decisions were undertaken in the person's best interest. Protocols for "as required" medicines were not of a consistent good quality.

The service did not always act in line with current legislation and guidance where people lacked the mental capacity to make certain decisions about their support needs. Mental capacity assessments had not been undertaken and there was no evidence that discussions had taken place to make decisions in the person's best interest. We saw that people were supported with making decisions around their care. Staff sought people's consent before providing them with care and support.

During our last inspection some care plans did not contain up to date assessments. Whilst improvements had been made some sections of care plans still lacked person centred information and guidance for staff.

Staff were aware of their responsibilities to keep people safe. They had the knowledge and confidence to identify safeguarding concerns and knew what actions to take should they suspect abuse was taking place. Whilst risks to people's personal safety had been assessed and plans were in place to minimise these risks

they did not always provide enough guidance for staff on how to reduce the risks.

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified these had not picked up the areas needing improvement we had noted.

Staff spoke passionately about wanting to provide people with a high standard of care. People were supported by staff that had gotten to know them well. People were treated with kindness and compassion in their day-to-day care. People and their relatives spoke highly of the staff and the care and support they provided.

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual care and support needs. People were supported by staff who received on-going training and support to enable them to deliver effective care and support. Safe recruitment practices were followed before new staff were employed to work with people. Checks were undertaken to ensure staff were of good character and suitable for their role.

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours. Regular maintenance of the home was undertaken to ensure the safety and suitability of the premises. A call bell alarm system was in place to ensure people who use the service could call for help when required.

People, relatives and staff spoke positively about the management of the service. People, those important to them and staff had opportunities to feedback their views about the service and the care and support people received. Processes were in place to ensure complaints were dealt with in a timely manner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Appropriate processes were not always followed relating to the management of covert medicines. Best interest discussion had not taken place to ensure this was best practice. Protocols for medicines "as required" were not of a consistent good quality.

Whilst risks to people's personal safety had been assessed and plans were in place to minimise these risks they did not always provide enough guidance for staff on how to reduce the risks.

Staff were aware of their responsibilities to keep people safe. They had the knowledge and confidence to identify safeguarding concerns and knew what actions to take should they suspect abuse was taking place.

Suitable numbers of staff were deployed to keep people safe and to meet their needs. The service followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not always act in line with current legislation and guidance where people lacked the mental capacity to make certain decisions about their support needs.

People were supported by staff that had the skills and knowledge they needed to carry out their roles and responsibilities. Staff spoke positively about access to training opportunities.

People were supported to eat and drink sufficient amounts. Monitoring charts in place were completed, monitored and any actions required were acted upon.

Is the service caring?

Good

The service was caring.

Staff spoke passionately about wanting to provide people with a high standard of care. People were supported by staff who knew them well.

People were treated with kindness and compassion in their day-to-day care. People and their relatives spoke highly of the staff and the care they received.

People's privacy and dignity were respected. Staff provided care in a way that maintained people's dignity and upheld their rights.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst improvements had been made to care plans since our last inspection some sections of plans lacked person centred detail.

People had access to a range of social and leisure activities.

People's views were actively sought, listened to and acted on. People and their relatives felt comfortable with raising suggestions and concerns because the staff and management team were approachable. Processes were in place to ensure complaints were dealt with in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified these had not picked up the areas of improvement we had noted.

There was a registered manager in post who was supported by a deputy manager. We received positive feedback from staff, people using the service, relatives and healthcare professionals about the overall management of the service.

The culture of the home was open and transparent and staff told us morale had improved since our last inspection.

Bassett 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 checked 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 was a comprehensive inspection and took place on 21and 22 June 2017. The first day of the inspection was unannounced. One inspector, a specialist nurse advisor and an expert by experience carried out this inspection. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.

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

We used a number of different methods to help us understand the experiences of people who use the service. We spoke with 10 people using the service and nine visiting relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether people had positive experiences.

We looked at documents relating to people's care and support and the management of the service. We reviewed a range of records which included 13 care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents.

During the visit we met people who use the service. We spoke with the registered manager, the director of care, the provider, deputy manager, four registered nurses, six care staff, two activity co-ordinators, three

hostesses and staff from the catering, maintenance and housekeeping departments. We received feedback from three healthcare professionals who supported the service to meet people's care needs.

Requires Improvement

Is the service safe?

Our findings

During our last inspection on 13 July 2016 we found that records pertaining to the safe administration of medicines were not always completed correctly. Medicine administration records did not always contain all relevant protocols and advice for administration, including detailed "as required" (PRN) protocols. This was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the previous inspection the provider wrote to us with an action plan of improvements that would be made to meet the legal requirements in relation to the law. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

Whilst improvements had been made to records pertaining to the safe administration of medicines being completed correctly, some areas of medicine management still required further improvement. The process for administering medicines covertly did not follow the provider's guidance and legislation. Covert administration is when medicines are "disguised" within food or drink. We looked at the documentation in place for four people who were receiving their medicines covertly. All of the forms stated the medicines should be crushed, but only one of the forms had a pharmacist signature to indicate that a pharmacist had been consulted. Crushing medicines may alter their effectiveness, and means they are being administered "off licence". Because of this, pharmacist input should be sought to ensure the medicines are safe to be given this way. In addition, care plans did not always correspond with the covert guidance held within the medicine administration record (MAR) file. For example, although two of the care plans referred to the person receiving their medicines "crushed in line with home policy", the other two plans did not. In one person's plan it was documented "now having covert medication" but the nurse said the person was taking their medicines independently, not covertly. Despite the reference made to crushing the medicines, only one of the plans detailed whether the crushed medicines were to be given in a drink or in food. In addition, there was no evidence of the decisions to administer covertly being formally reviewed. The records for one person showed that the GP, a nurse and the next of kin had signed the form on 17/11/2106, but there was nothing documented to indicate that the decision had been reviewed since.

The provider's medicines policy in relation to covert medicine administration stated "The method of administration should be agreed with the pharmacist and all such cases regularly reviewed" and "Any decision must be recorded in the plan and all details must be recorded". This meant that the provider's policy was not being followed.

Although PRN (as required) protocols were in place, not all of these had enough detail within them and not all were person centred. For example, although the protocols had the reasons listed why people might require additional medicine, the protocols did not always have details such as how people with communication difficulties might ask for them or how staff could recognise when they might be required.

Although the MAR charts had generally been completed in full, we did see four gaps in three people's charts where medicines had not been signed for. Topical administration records had generally been completed in

full by staff.

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

Medicines were stored safely. Bottles of liquids and eye drops had all been dated when opened. Items that required refrigeration were stored in a medicines fridge and the temperature of this was monitored daily. Stock levels had been checked regularly. We observed the process for disposing of medicines and this was done safely.

We observed parts of two medicines rounds. On both occasions the nurses took their time with people and made sure they had taken their medicines prior to signing for them. They asked people how they were feeling, had they slept well and whether they needed any pain relief.

We saw the latest pharmacy advice visit dated 22/03/2017. Nothing of note was highlighted during the visit.

Risks to people's safety had been assessed. Care plans contained risk assessments for areas such as moving and handling, mobility, skin integrity and nutrition. These had all been reviewed regularly. However when risks had been identified, care plans did not always provide enough guidance for staff on how to reduce the risks. For example, some people had been assessed as being at high risk of skin breakdown (pressure sores). Although the plans provided guidance such as the need to change people's position regularly, in one of the plans we looked at, the guidance was contradictory. This was because in the skin integrity section the guidance was "2 hourly position changes" and in the sleeping section of the plan it was "3-4 hourly position change".

Safe moving and handling practices were not always followed. One person did not like to be hoisted. A risk assessment had been put in place which documented how they were to receive personal care whilst in the hoist. There were no assessments in place to identify if this was safe practice and if the sling being used was appropriate for this.

Many people had an air mattress in place in order to reduce the pressure on areas of risk. On the first day of our inspection we checked the air mattress settings with the nurses on duty. The majority of these needed to be set in accordance with people's weights, but of the 24 mattresses we looked at, 16 were set incorrectly. There was nothing documented within the care plans to inform staff what the correct setting was, and nothing had been documented on the position change charts. Mattresses that are set at the incorrect pressure might increase the risk of pressure sores developing as well as being uncomfortable for the people using them. We discussed this with the registered manager and during the second day of the inspection we saw that care plans had been amended to show the correct setting of the mattress. Coloured dots had also been put on the mattress control units so that staff could see easily whether they were set correctly.

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

People told us they felt safe living at Bassett House. Their comments included "I'm very safe. Just feel happy here", "Feel really safe we don't want for anything", "Safe, staff know I can't hear too well so make sure I am alright day and night", "I'm really feel happy and safe. I talk to staff, they are there and about" and "Not a care in the world, feel totally secure".

People were kept safe by staff that recognised the signs of potential abuse and knew what to do when

safeguarding concerns were raised. Policies and procedures were in place to inform staff of the processes they needed to follow should they suspect abuse had taken place. Staff told us they had received training in safeguarding and all demonstrated that they knew how to report any concerns. Comments from staff included "I have no concerns about the care we provide here. If I did I would feel supported to report concerns. I know I can speak to the nurses or management" and "If we have any concerns then we need to write an incident report and then report to the nurse or management who will then decide what needs to be done. They always take action and I have confidence in speaking with them".

All staff were familiar with the term whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All of the staff we spoke with said they felt confident to raise concerns and that they would be taken seriously. One staff member told us "We are here to protect vulnerable people and must take that seriously. I feel happy to speak with staff about what they are doing and would report anything to the nurse in case that staff member needed any extra training".

The service used a dependency tool to ensure appropriate staff were deployed at all times. We saw staffing rotas reflected the staffing levels identified by the dependency tool. However, during our last inspection some staff members, people and relatives said there were on occasions not enough staff present and this concerned them. Since our last inspection the home had successfully employed more staff and had reduced the number of agency staff used to cover vacant posts. This meant people were receiving care from consistent members of staff who knew them well. Staff told us they felt the staffing had improved since our last inspection. Their comments included "We have more permanent staff here now which means we are more of a team. We have good team work here and support each other" and "It can be very busy during a morning and we could do with one more staff when we are getting people up. The afternoon is much better and we have time to spend with people. It's much better now we have more permanent staff".

All of the nurses said they felt that staffing levels had improved significantly. Comments included "We have enough now. Having hostesses at mealtimes has really helped" and "We have enough staff. We've managed to recruit and we rarely have to use agency nurses now".

Safe recruitment and selection processes were in place. We looked at the files for five of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. New staff were subject to a formal interview prior to being employed by the service.

The premises were well maintained and safe. We found that all areas of the home were clean and free from any odours. Staff had access to personal protective equipment such as gloves and aprons to minimise the risk of infection and cross contamination. Each floor was allocated a minimum of one housekeeping staff each day. Cleaning responsibilities were identified in cleaning schedules which housekeeping staff signed to say when tasks had been completed. People spoke positively about the cleanliness of the home. Their comments included "Room cleaned, and the laundry is done well", "Oh yes all so clean everywhere. Come in every morning give it a good do", "No problems with cleaning, all nice and clean and "I cannot fault the cleaners. They chat to me whilst they are cleaning".

Requires Improvement

Is the service effective?

Our findings

The CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this.

DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so. All necessary DoLS applications had been submitted by the provider. These applications were reviewed each year and the necessary reapplications submitted.

Consent to care and treatment was not always sought in line with legislation and guidance. We found in care plans that necessary records of assessments of capacity and best interest decisions were not in place for people who lacked capacity to decide on the care or treatment provided to them. For example, we looked at the care plan for one person where it had been documented that they had the capacity to consent to their care. However, although the person had signed the plan to indicate they consented to the contents, they had not signed the consent form for the use of bed rails. In two other plans it had been documented "Has variable capacity" for one person and "I am generally alert. I get anxious and confused at times" for another person, but there was nothing documented to show that mental capacity assessments had been completed. In addition, this person also had bed rails in place. There was nothing documented to demonstrate how staff had reached this decision. In discussion with the deputy and director of care it was unclear if any assessments had been undertaken.

In another person's care planned it documented the use of "wrapping towels" around the person's arm and hand during personal care to stop them from scratching themselves and staff. There was no evidence of a capacity assessment and a best interest meeting to identify if this was the least restrictive way to support the person. The guidance did not clearly document how the towel was to be wrapped around the person's arm which meant there was a risk that this could be inconsistently done by staff. We have spoken with the deputy manager who has agreed to look into this practice immediately.

For people who were receiving their medicines covertly, there was also no evidence of capacity assessments being completed and no documented evidence of best interest decision making.

We looked at the provider's MCA and DoLS policy. There was nothing within the policy to inform staff to assess people's capacity prior to making decisions in people's best interests. In addition, there was no detail of how best interest decisions should be made or documented. Despite this, nursing staff said they had received training on the Mental Capacity Act and understood their responsibilities.

We spoke with the deputy manager and director of care who confirmed that whilst these documents had been in place during our last inspection they were no longer available. They were unable to explain why.

They had identified this as an area for action and were currently completing appropriate assessments.

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

Staff had an understanding of the Mental Capacity Act 2005. Training in this subject had been undertaken by staff. We observed that people were asked for their consent before staff assisted them. For example, we heard staff asking people if they could assist them before providing support. Comments from staff included "To help people be involved in their daily care I will show them two things to help them make their decision. It's people's choice of when they want to get up or if they want a bath or shower" and "Even if people are forgetful I will still offer them everyday choices. For some decision we may need to involve other professionals".

During our last inspection on 13 July 2016 we found that people were not always supported to have enough to eat and drink. Staff told us they were not satisfied that when people were left with drinks they were supported to have these fluids. This was a breach of Regulation 9, person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the previous inspection the provider wrote to us with an action plan of improvements that would be made to meet the legal requirements in relation to the law. We found on this inspection the provider had taken all the actions required to make the necessary improvements.

Since our last inspection the service had created a hostess role. Their role included supporting people with accessing food and fluids outside of meal times. Staff spoke positively about this role confirming that people were getting their required food and fluids. Their comments included "The hostesses have taken a lot of pressure of us. They are a great help when they are here. Unfortunately they are not here every day and that can put pressure on us. However we are making sure that people are getting plenty of fluids" and "The hostesses are really helpful. They are very good at supporting the residents to have plenty to drink". Recording charts put in place to monitor people's food and fluid intake were completed, monitored and where required actions had been taken.

People were supported to have enough to eat and drink. People had been assessed for the risks of malnutrition and dehydration and people's weights were monitored. Care plans showed when people had been referred for specialist advice and support when concerns about their weight or intake had been noted. However, the guidance within the plans did not always correspond with the recommendations from the SALT team. For example, in one person's plan it had been documented that the person required "Stage 1 thickened fluids", but the latest guidance from the SALT team was for "Stage 2". In addition, the SALT team also recommended the use of an open cup rather than a spouted beaker, but this had not been added to the care plan, although there was detailed guidance for staff on how to provide assistance during meals. When we observed the person drinking, they did have an open cup and staff knew the person required Stage 2 thickened fluids. We also saw that a list of people's requirements in relation to food and drink was taped inside a kitchen cupboard so that staff could easily access the information.

When people were having their food or fluid intake monitored, all of the charts we looked at had been completed in full. The charts had been reviewed and daily records showed that staff were aware that people were having their intake monitored. Care plans contained details of people's preferences in relation to food and drink and staff were aware of these. On two occasions we saw staff giving one person a cup of tea and on both occasions they gave it to them in "their cup".

People and their relatives spoke positively about food options. Their comments included "Food is really lovey. The chef comes round from time to time and asks us what we like", "Nice food always. Good choice and well cooked, too much sometimes" and "Food is excellent. They do lovely roast dinners here. If she wants something else they will do scrambled eggs or jacket potatoes or omelettes. They are so accommodating".

We observed the lunchtime meal during both days of our inspection. People were offered a choice of main meal and when one person asked for something different, this was arranged. People who required assistance were supported in a dignified way by staff at a pace appropriate to them and were not rushed. There were sufficient staff to serve and support people who needed assistance.

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering staff; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes which staff would let them know each day. They explained that people had a choice of meals. Meal choices were made the day before and this information was given to the catering staff. They said if people did not like what was on the menu or had changed their mind about their choices then they were able to request alternatives.

People had access to on-going healthcare. Records showed that people were regularly reviewed by the GP, the speech and language team (SALT), and the Parkinson's nurse for example. Nurses said they had regular access to people's GP's and were able to discuss any concerns or queries outside of when the GP visited. For example one nurse said "One resident was having problems with nausea, so I discussed this with the GP, and we monitored it and then reviewed their tablets. Now the nausea has stopped". We spoke with a visiting health professional who told us they felt the service had improved since the last inspection. They told us "The care is good here and the staff have a good attitude. People are well looked after. The nurses take on board any suggestions made and will follow this up. Staff know people well and what is needed".

We looked at wound care plans. These were detailed and contained photographs of wounds in order that staff could assess the progress or deterioration. Tissue viability nurse input had been sought and this was documented within the plan.

People using the service told us they could see a chiropodist, dentist, optician and physiotherapist. People and relatives comments included "The GP is brilliant, explains everything so clearly and precisely. Willing to come out", "The GP comes out twice a week to see her, always very nice", and "Surgery is brilliant and GP is brilliant. Responsive when necessary".

People were supported by staff who received sufficient training that gave them the necessary skills to provide care in line with the person's needs. Nurses said they had access to training and development in order to meet professional requirements. They all said they had competency assessments regularly and were able to undertake specialist training. For example, one nurse said they were due to start End of Life training soon.

Training records showed staff received a wide range of training and qualifications on core topics required by the provider, and also topics relevant to the needs of the people using the service. For example staff had received training on topics such as dementia awareness, equality and diversity, safeguarding, safe moving and handling and infection control. A training matrix was in place to monitor the training each staff member had received and when it was due to be refreshed. Training was provided using a mixture of DVD's and questionnaires and external training providers.

New staff completed a thorough induction to ensure they had the skills and confidence to carry out their roles and responsibilities effectively. This included the Care Certificate which covers an identified set of standards which health and social care workers are expected to adhere to. The induction period also included staff shadowing experienced staff members.

Staff we spoke with said they felt they had received sufficient training to provide people with effective care. They said they were able to access training that supported them with their personal development and was additional to the core training required of their role. Their comments included "My induction was really good. I got plenty of support and received lots of training" and "Training is adequate and I can always ask questions if I am not sure".

Staff received regular supervisions (one to one meetings) with their line manager. These meetings enabled them to discuss progress in their work; their training needs and development opportunities. During these meetings there were opportunities to discuss any difficulties or concerns staff had and any other matters relating to the provision of care. Staff said they received regular supervision sessions and annual appraisals. All of the staff we spoke with said they felt well supported in their role. Comments included "I get plenty of support. If I need it then it's there" and "The management and nurses are all approachable. I get plenty of support".

Good

Is the service caring?

Our findings

People and their relatives spoke positively about staff and the care and support they received. Staff were described as kind, caring and approachable. People told us they were able to choose the gender of the staff that provided their care. Their comments included "Nice staff they have been very kind to Mum", "Cheerful staff who are so very kind", "Lovely staff. They are very caring" and "Very kind staff no worries at all".

People were treated in a kind and caring manner. We saw many positive interactions between staff and people using the service during our inspection. People responded well to staff and appeared relaxed in their company. For example, on one occasion we were speaking to one of the nurses and one person came up to them and hugged them. The nurse hugged them back and continued to gently stroke their back whist talking to us. It was particularly hot weather during the inspection and we heard one nurse frequently asking people "Are you ok? Are you too hot?" They ensured people had drinks, prompted people to drink them and checked that people had fans available.

Staff knew people and their needs well and had developed caring relationships. We observed kind and respectful interactions. Staff were responsive to requests for support and reassurance. For example, One person who was distressed was supported in a kind and caring manner by a staff member. They spoke with her in a kind way and held the person's hand to offer them reassurance.

On another occasion one person became anxious about taking their medicines. The nurse sat with them and explained what the medicines were. They offered the person a drink and after some reassurance they took their medicines. The nurse then reminded the person about drinking as it was such a hot day. The person smiled and responded saying "You think of everything".

Staff spent time interacting and chatting with people. For example, we saw one member of staff sitting with one person in the lounge. There was horse racing was on the television and the member of staff was discussing the horses, pointing out the Queen and generally chatting about what was happening. Every so often, they prompted the person to drink their tea. People told us "Staff do spend time talking to you", "Very nice staff, they pop in for chats. I am very lucky" and "I do talk to staff and mention little things. They will sort things out".

People's privacy and dignity was maintained. Staff knocked on doors prior to entering people's rooms and personal care took place behind closed doors. When people received personal care staff told us they made sure this was done behind closed doors and at a pace appropriate for the person. One staff member told us "I always speak with people and let them know what I am doing. For one gentleman this helps him relax which makes it easier to support him. I always include him and ask him to help where he can. Personal care is always done behind closed doors. I always make sure the person is covered to maintain their dignity and to make sure they do not get cold". Other comments form staff included "I always knock on the person's door and greet them as I go in. I keep the person's dignity by keeping them covered. Communication is important and I explain what I am doing. I don't rush and I take my time" and "You must respect them as an individual. I ask them what they would like and support them to be independent as much as possible".

One health professional who worked alongside the service told us "I can only speak of what I have observed during my visits, but I have found all the staff to be very caring and responding to customer's needs appropriately, ensuring that privacy is maintained i.e. if customer is not feeling well, moving them into a more private area, observing customer's being spoken to appropriately".

People told us they felt their privacy and dignity was respected. Their comments included "They do respect your privacy. If I am sleeping they do not disturb me", "Staff are very polite. They knock before coming in to my room" and "They maintain my dignity when I have a shower. They use towels to make it more private".

Staff spoke positively and passionately about the care people received. Comments included "It is important to have empathy and to understand what it is like to be cared for. You must respect your elder and treat them as individuals. It is important they receive the best care", "My job is to give people the best quality of life each day. You must treat people with compassion, love and care. It is important to make people as comfortable as possible" and "The care here is very good".

Where it was appropriate for a person to have a call bell we saw that they were accessible. Points near chairs and beds made it easy for people to reach their call bells. During the visit we saw that staff attended quickly to call bells. Some people called out. Generally staff were around to hear and provide support. On one occasion one person was calling for help. We quickly located a carer who informed us that the person constantly called out, even when, as in this instance, they had been attended to a few minutes earlier. Throughout the day we saw that staff were popping in and out of the person's room as they passed by. At one point we saw that an activity person was showing the person how to use their call bell.

People told us "There is not always enough staff around at night. Wait a while sometimes, probably the same everywhere", "I don't wait too long before help arrives, depends a bit on what the staff are doing at the time. If they are going to be long they come and let me know" and "Staff are around most of the time when I need them".

People were supported to maintain relationships with their family and friends. Relatives we spoke with said they were welcome to visit anytime and that there were no restrictions placed on when they could visit their family member.

People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as books, ornaments and photographs. Comments included "I have a very nice room. There is a shower and toilet built in. It's lovely" and "Full credit. What we want is here. Lovely bedroom".

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on 13 July 2016 we found that some care plans did not contain up to date assessments. This was a breach of Regulation 9, person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the previous inspection the provider wrote to us with an action plan of improvements that would be made to meet the legal requirements in relation to the law. We found on this inspection the provider had taken some of the actions required to make the necessary improvements.

Since our last inspection the service had continued with updating information held in people's care plans with some improvements. However, although parts of the care plans we looked at were detailed and provided clear guidance for staff on how to meet people's needs, this was not consistently seen. Alongside this, although some plans were person centred and contained details of people's choices and preferences, this was not seen throughout the care plans we looked at.

Some of the good examples we saw included people's preferences in relation to how they preferred certain things to be done. For example, in one person's plan it had been documented exactly where the person preferred their glasses to be put at night. In another plan it was documented that the person had restricted movement in one arm and detailed how staff should support the person whilst also helping them maintain their independence. In another person's care plan it stated "She likes to get up between 8am and 9am and likes a shower to be offered". Their night time routine included information relating to their preference to wear a nightdress and to have their door open and their light left on.

However, this level of detail was inconsistent. For example, although one person's preference for a daily shave had been documented, it did not detail whether they preferred a wet shave or an electric one.

We looked at the plan for one person who had a catheter in situ. The plan did not provide enough information for care staff on how to look after the catheter and how to stop it becoming blocked. The guidance documented was limited to "Ensure that catheter hygiene is being followed – check the catheter daily". There was no explanation documented of what "catheter hygiene" entailed.

We looked at the care plan for one person who had been admitted to the service for end of life care. Staff had documented in the pre-assessment document "Terminal illness recently identified. Psychological, emotional and spiritual support required". However, although the care plan detailed the person's needs in relation to safety, nutrition and skin integrity there was limited detail on how staff should provide the "emotional and spiritual support" that had been identified as a need. In the mental state and cognition section of the plan, staff were guided to "offer me support when anxious and confused. Try to find the cause and assist accordingly". There was not enough detail for staff on how to provide support. In the end of life section, the only detail written was the name of the funeral director and next of kin contact details. There was nothing documented to indicate that staff had discussed with the person their preferences in relation to their end of life care. In addition, it had been documented in the pre-assessment that the person was known

to have COPD (Chronic obstructive airways disease) and that anxiety increased their shortness of breath. But there was no plan in place to inform staff how to ease any breathlessness and the link between breathlessness and anxiety had not been documented within the plan.

In one person's mobility risk assessment it noted they could be resistive to personal care. This was not documented in their personal care plan and there was no guidance on what support staff should offer should this person not want personal care to take place.

It was not always clear how staff supported people with distressed behaviour because care plans did not always have clear guidance for staff. For example, in one person's care plan there was a risk assessment for "Challenging behaviour" which staff had documented as "e.g. pushing staff away when being supported". There was no plan in place on how staff should support the person when they were doing this. In this person's daily records it had been documented as recently as the day prior to our inspection "very aggressive when giving personal care" and on other dates during June 2017 "hitting out and kicking" and "punched out and hit me". It was not clear how staff would know how to manage this behaviour because there was no documented guidance in place.

Another person had been prescribed anti-anxiety medication when required. Although the care plan referred to the person's anxiety and what might trigger an episode and detailed what staff could try to do to alleviate any anxiety, the prescribed medicine was not referred to. This meant there was a risk that staff would not be aware that if other techniques did not work, that medicine could be used as a last resort.

Although some people using the service had signed the care plan to indicate their agreement, not all plans had been signed. Although care plans had been reviewed by staff regularly, there was no documentation in place to show that were able people or their advocates had been involved in any reviews.

This was a breach of Regulation 9, person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service also provided five intermediate care beds. This service provides support to older people to help them avoid going into hospital unnecessarily and to help them to be as independent as possible after discharge from hospital before returning home. One health professional told us "As intermediate care (IC) is all about customers improving their independence the staff at Bassett House have embraced this. The manager has identified staff who find this work easier to support the IC customers. It is difficult as many care homes have such frail residents that the culture is that of 'do unto' however with IC customers in a care home the rehab culture moves into the long term residents care too. I have found that the home manager speaks positively of the impacts that supporting IC customers has on the care home as a whole. The IC customers' outcomes, for those at Bassett House, have been positive. They have had good flow through the 5 IC beds, getting people back home, which the staff find improves their job satisfaction".

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they were interested in. A weekly activity programme was organised by two full time co-ordinators and a part time co-ordinator who worked mainly at the weekend.

Activities provided included craft, sensory days, gardening, a choir, manicure and hand massages, reminiscence, a baking group, cinema showings, visiting entertainers, themed days, games and quizzes. External entertainers also provided activities at Bassett House. Peoples' spiritual needs were met through, church services, church groups, and singing groups.

Since our last inspection the service had built a row of small shops which they used to support people with reminiscing. The shops contained familiar articles and included a tea shop and a haberdashery.

Comprehensive record show individuals' participation levels, helping the coordinators to identify people who may need more support to encourage them to join in or note people who would prefer not to take part.

People and relatives praised the work done by the activity co-ordinators. Comments included "We do all sorts of things, picnics in the garden, sitting out in the beautiful garden", "Really impressed with the activities, such a variety of things", "Activities people can't do enough" and "Marvellous activities. Activity people enjoy their work".

One activity co-ordinator told us "When X first came in he didn't want to do anything. Didn't do anything at first but gradually we established a relationship with him and he started to come down to a few things. Then all of sudden he started joining in, now he does everything".

During both days of our inspection we saw a number of activities taking place. On the first day of our inspection a Pimms/soft drinks party was held in the garden in the afternoon. On the second day of our visit there was a communion service taken by the newly appointed vicar of the local church. We visited the choir rehearsal where people were practising ready to open the garden fete. All these activities were fully inclusive.

A copy of Bassett House's complaints policy was available for people using the service and visitors to access. The policy outlined how the provider would respond to any complaints or concerns raised. Records reviewed confirmed that all complaints had been logged, investigated and responded to in a timely manner. A suggestion box was available in the reception area inviting people and their relatives to make compliments or comments on the service provided.

Requires Improvement

Is the service well-led?

Our findings

Audits were carried out periodically throughout the year by the registered manager, quality assurance lead and directors. The audits included safe medicine administration, staffing levels, health and safety, care planning training. Whenever necessary, action plans were put in place to address the improvements identified which had been signed off when actions were completed. Whilst regular audits and checks had been carried out these had not been effective in identifying the shortfalls we highlighted during our inspection. For example, in relation to the lack of capacity assessments and best interest decisions, medicines management and care files. Although improvements in care plans had been made some sections still lacked person centred information and guidance for staff. Medication audits had not identified that some people who required "as required" (PRN) medicines did not have protocols in place to guide staff about the administering of these medicines.

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

The service had a registered manager in place who demonstrated an understanding of their role and responsibility to provide quality care and support to people. However, prior to our inspection we had been alerted that incidents needing reporting or investigating by the police had not been reported to the Care Quality Commission or to the local authority safeguarding team. We discussed this with the registered manager and the provider who had been previously unaware of the need to report these events. The registered manager said this would be immediately rectified going forward.

This was a breach of Regulation 18 (2) (f) Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

Accidents and incidents were reported internally. When necessary, records showed that people had been assessed and monitored during the hours following an incident. Recent records showed that safeguarding alerts were now raised appropriately.

People and those important to them had opportunities to feedback their views about the quality of service provided. Resident and relative meetings took place periodically throughout the year. A satisfaction survey had been completed in November 2016 by people using the service and their relatives. Copies of the results of the survey were made available for people and relatives in the reception area. A meeting had taken place with people and their relatives to discuss the outcomes of the survey and any actions required to improve the service.

There was a clear organisational structure where all staff knew their roles and responsibilities. The service had a registered manager in post who was supported by a deputy manager and a recently appointed director of care. A registered manager is a person who has registered with CQC to manage the service. Staff were aware of the organisations visions and values which they told us included promoting people's independence, choice, dignity and privacy. One staff member told us "Our vision is to have a home that

provides the best possible care including end of life care. To value the people we look after".

Staff spoke positively about their work and the support they received from management. Their comments included "I love my job, it's fantastic. I have the opportunity to express myself and I feel well supported" and "I enjoy my job. I am proud of the work my manager does. I can raise concerns and help will be offered". Staff said they attended regular staff meetings and felt well informed.

Comments from healthcare professionals regarding management included "I generally raise any concerns with the home manager or deputy. They always listen well and are positive in their responses, finding solutions to any issues or concerns and are prepared to offer solutions and work with me to resolve any issues, promptly" and "The home has worked with us to implement a new admissions pack for people. They took on board our suggestions. They involve families and communication is working well".

Staff said they were aware of the improvements following the last inspection. Their comments included "Staffing has improved. We have more permanent staff now who know the residents really well. There is also a new deputy in post who is really helpful. They do a morning walk around which is makes them visible", "Having hostesses has really helped us with making sure people are getting enough food and drinks. It would be nice if we could have them every day" and "We have more permanent staff. We are all working well as a team".

The service continued to have appropriate arrangements in place for managing emergencies which included fire procedures. There was a contingency plan which contained information about what staff should do if an unexpected event occurred, such as loss of utilities or fire. The management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had a registered manager in place who demonstrated an understanding of their role and responsibility to provide quality care and support to people. However, prior to our inspection we had been alerted that incidents needing reporting or investigating by the police had not been reported to the Care Quality Commission or to the local authority safeguarding team. We discussed this with the registered manager and the provider who had been previously unaware of the need to report these events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Since our last inspection the service had continued with updating information held in people's care plans with some improvements. However, although parts of the care plans we looked at were detailed and provided clear guidance for staff on how to meet people's needs, this was not consistently seen. Alongside this, although some plans were person centred and contained details of people's choices and preferences, this was not seen throughout the care plans we looked at.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent

Consent to care and treatment was not always sought in line with legislation and guidance. We found in care plans that necessary records of assessments of capacity and best interest decisions were not in place for people who lacked capacity to decide on the care or treatment provided to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Where risks had been identified by the provider, care plans did not always provide enough guidance for staff on how to reduce the risks to ensure people received safe care and treatment Since our last inspection the provider had written to us with an action plan of improvements that would be made to meet the legal requirements in relation to the law. We found on this inspection the provider had not taken all the actions required to make the necessary improvements. Whilst improvements had been made to records pertaining to the safe administration of medicines being completed correctly, some areas of medicine management still required further improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were carried out periodically throughout the year by the registered manager, quality assurance lead and directors. Whilst regular audits and checks had been carried out these had not been effective in identifying the shortfalls we highlighted during our inspection.