Greensleeves Homes Trust

Kingston House

Inspection report

Lansdowne Crescent East
Derry Hill
Calne
Wiltshire
SN11 9NT

Tel: 01249815555
Website: www.greensleeves.org.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

Kingston House is registered to provide accommodation and personal care for up to 46 people. There were 42 people living in the home on the day of the visit and one person was in hospital. The home is divided into three areas, Primrose, Tulip and Lavender lodge. Lavender lodge was an addition to the original building and supported people who had a diagnosis of dementia. The inspection was unannounced and took place on 27and 28 March and 3 April 2017.

A registered manager was in post when we inspected the service and was available and approachable 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. At our previous inspection the home received a rating of good overall and a rating of outstanding in the responsive domain. At this inspection we found areas requiring improvement which was not consistent with the previously awarded rating.

There were sufficient staff to meet people's basic care needs. However there was not always enough staff available to meet the high level of social and emotional needs present in the dementia unit of the home. During our inspection we observed incidents that were not effectively managed due to a lack of available staff.

The home had risk assessments in place; however they were not always in place for all identified risks to people. We found that risks for individual people would sometimes be mentioned across several care plans instead of one overarching risk assessment being in place. Different actions would also be recorded for managing the same risks. We observed that at times people experienced anxiety and needed reassurance from staff. Although staff responded appropriately to people at these times, the recording of how to manage these situations was not always in place to ensure consistency.

There was often inconsistent or conflicting information in people's care plans and monitoring records which made it hard to ascertain a person's most current needs.

Although quality assurance systems were in place to monitor the running of the home, these had not picked up all of the shortfalls identified at this inspection in order to address and take the necessary action.

Staff were not given opportunities to meet the requirements of their role. Staff had not always been given the opportunity to renew their training within the provider set timescales to ensure they maintained their skills and knowledge. We saw that medicines training had expired for four staff and not been renewed. We observed one of these staff continuing to administer medicines during our inspection.

The home had not always obtained the appropriate consent before taking decisions on behalf of people to ensure care was given in line with their preferences. One person had a sensor mat in place to alert staff when

they moved around their bedroom but there was no consent to show their agreement or assessment of their capacity to take this decision.

People felt safe living at Kingston House and the comment form one person included, "I feel really safe being with other people in the home and living in a nice area. If I need help I am confident the staff would respond as I have seen them respond to others if they needed help or medical support." Staff had the knowledge and confidence to identify safeguarding of abuse concerns and knew to act on them to protect people.

We observed staff responding to people respectfully and engaging people in positive interactions including singing and chatting. One person told us "I like living here, we have things here we can do and look at."

The registered manager promoted a positive culture and was a visible presence around the home supporting people and staff when needed. People and their relatives praised the management of the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were sufficient staff to meet people's basic care needs. However there was not always enough staff available to meet the high level of social and emotional needs present in the dementia unit of the home.

The home had risk assessments in place; however they did not always cover some of the identified risks to people.

We saw that medicine administration was managed well; however there were some gaps in the recording of 'medicine administered as required (PRN) medicines.

People felt safe living in the home and staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always been given the opportunity to attend training and have supervisions in order to develop and maintain their skills and receive support.

The home had not always obtained the appropriate consent before taking decisions on behalf of people.

People's healthcare needs were monitored and they had regular access to a GP and other health care professionals where needed.

Is the service caring?

Good

The service was caring.

We saw that people were comfortable in the presence of staff and had developed caring relationships.

People and relatives were very positive about the staff and said

they were treated with kindness and respect.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was often inconsistent or conflicting information in people's care plans and monitoring records which made it hard to ascertain a person's most current needs.

Staff supported people in pursuing activities they enjoyed. People and their relatives praised the range of activities available to them.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

Although quality assurance systems were in place to monitor the running of the home, these had not picked up all of the shortfalls identified at this inspection.

The registered manager promoted a positive culture and was a visible presence around the home supporting people and staff when needed. People and their relatives praised the management of the home.

People and their relatives were encouraged to be part of the ethos of the home and participated regularly in meetings and events within the service.

Kingston House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 27, 28 March and 3 April 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The home was last inspected in November 2014 and received an overall rating of good. Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 12 people living at the home, six relatives, eight staff members, two health professionals, the registered manager and operations manager. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for six people, medicine administration records (MAR), five staff files, the provider's policies and a selection of the services other records relating to the management of the home. We observed care and support in the communal lounge and dining areas during the day and spoke with people around the home.

Requires Improvement

Is the service safe?

Our findings

There were sufficient staff to meet people's basic care needs. However there was not always enough staff available to meet the high level of social and emotional needs present in Lavender Lodge, the dementia unit of the home. The registered manager told us they employed three care staff in Lavender lodge and three care staff in the rest of the home and these numbers dropped by one in the afternoon. On the day of our inspection there was one member of staff short and the registered manager told us she was helping out. During our observations on Lavender lodge we saw that some people needed a lot of interaction and reassurance from staff. For example one person was seen walking about the corridors and going in and out of people's bedrooms but staff were not always available to monitor this. We saw one person who displayed anxious behaviours and would need a lot of time and reassurance from staff. Staff were very patient and kind but often had to leave another person or stop a medicine round in order to support this person.

On the second day of inspection three staff were available in Lavender lodge dining room to support people. We saw staff were balancing supporting some individuals with eating their meal, serving meals to people, topping up people's drinks and taking meals to people who stayed in their rooms. We saw one person's meal was left on the serving hatch for ten minutes before a member of staff was available to take it to the person. This person would frequently get up and walk during their meal and staff served their meal to them where they were sat in the corridor. Staff did not have time to stay and sit with this person to encourage them to eat and we later saw their meal had been left untouched in the corridor and had not been covered. We asked staff to remove this meal as it would no longer be suitable for the person to eat. Staff said they would prepare a sandwich instead for this person.

Another person was heard shouting from their room. We asked this person if they were ok and they told us "No" and continued to shout. We saw this person needed assistance from staff with their continence needs. This person did not have capacity to use a call bell and no staff had responded to the shouting. We found one member of staff and informed them this person needed help but they told us they were not allocated to these particular rooms. We asked the staff if they would not assist this person to find another member of staff who could. We waited with this person for a further five minutes until a member of the management team came to support them.

We observed one person eating in their room and saw they were putting their food into tissues and then down the side of their chair. This person was calling out for help so we offered reassurance and used the person's sensor mat on the floor to call for staff assistance. The sensor mat did not trigger an alarm so we further pressed the person's call bell which also did not set off an alarm. We had to leave the person to go and find someone to help. There was a lack of staff presence and we had to return to the dining room and ask a staff member who was supporting another person to assist. The staff tested this person's call bell and was unsure why it was not working. They said they would inform the maintenance staff and complete regular checks to this person until it was addressed. Fifteen minutes later we were informed this had now been resolved. We raised our concerns with the registered manager who told us "We are looking at more staff for Lavender lodge and are putting a case forward, we have had this conversation and I will again."

There were mixed reviews from people and relatives on the levels of staffing. Comments included "There are not a lot of staff, but when I had a headache the staff did respond quickly in getting me appropriate pain relief", "There are enough staff available to look after me", "If I call the staff they are not always quick, but when I was unwell staff cared for me very well", "Staff seem alright. Sometimes staff do not always respond quickly, I sometimes have to wait and I have been uncomfortable but generally they are very good", "I would say generally enough, there are times when it is stretched especially on weekends and "There is a lack of staffing. There is never enough staff in these kinds of places." Comments from staff included "The majority of time there is enough, sometimes if people go off sick not enough but I would cover. It would be nice to spend more time with residents, I love to chat and listen to them", "I think there's enough, we have enough time with people", "Yes and no there's enough, sometimes it's really busy and some days are ok", "There is enough staff, you always have busy periods but staff are in and out of people's rooms, we check them and have sensor mats in place" and "There are three cleaners on daily and one at weekends. We are meant to do three deep cleans in a week, but you are lucky to have a deep clean once a month, there is no back up plan."

We reviewed the rotas and saw that there were sometimes shortages in the staffing numbers. For housekeeping staff there should be three staff on in the week and we saw the week of 12 March on two days there was only one on the rota and on two days there was only two. We were told a bank member of staff would help out when there were shortages for housekeeping. The registered manager told us "We do cover shifts, we have got always from using agency on night, we try to use one company who give us staff who have been here before. We are recruiting at the moment." There was some confusion around whether a dependency tool had been used to calculate the staffing levels needed. The registered manager initially said there was a dependency tool, but when we asked to view this we were told us they had not previously had one in place. The operations manager confirmed a dependency tool was to be introduced and showed us a copy of the one they planned to put in place. This would look at Lavender lodge separately and people's individual needs around communication, tolerance and memory. The registered manager told us "Staff turnover has been high in the company; it's a big staff team."

This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service followed safe recruitment practices. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. The registered manager also told us they were starting "To verify references by a phone call as well as receiving paper confirmation."

The home had risk assessments in place; however they were not always in place for all identified risks to people. We found that risks for individual people would sometimes be mentioned across several care plans instead of one overarching risk assessment being in place. Different actions would also be recorded for managing the same risks. For example one person had a risk assessment around falling from their bed if left unattended. The assessment did not include measures in place or previous measures eliminated place and documented 'Two carers to attend, carers will chat and explain what they are doing, and ensure comfortable before leaving.' This assessment did not effectively manage the risk of falling from the bed. One person's nutritional care plan stated 'I may also sometimes need my food liquidised.' The risk assessment stated 'Cooks will liquidise food when necessary.' It did not provide information on why or when it would be necessary and there was no swallowing risk assessment in place to suggest the person had been reviewed as at risk of choking and needed their food in this form.

One person was at risk of self-neglect but risk assessments were not in place for managing this. We saw that

this person had high anxiety levels and was on medicine to alleviate symptoms. We found some risk management measures for only some aspects of their personal hygiene. One person's care plan that highlighted concerns around diet and weight had a risk assessment in place that only stated 'Weight is closely monitored'. There were no other actions documented to support this person. Staff told us one person would alternate sleeping in their bed and recliner chair. We saw that this person was at high risk of pressure sores. A risk assessment was in place for 'Potential sore areas not being checked', and the measures to take were recorded as 'Check daily and cream.' It did not state how often this person should be checked or if they needed assistance with repositioning or what cream should be applied. There was no risk assessment completed for the times when this person would sleep in their chair. One risk assessment had been completed for a person's dry skin and the measures listed was to 'Apply cream'. The action plan lacked detail on how staff were to assist the person with managing their sensitive skin. Two risk assessments for falling had been completed for one person and these contained different actions to take which had the potential to confuse staff in knowing how to effectively support this person.

We saw that at times a risk assessment had been completed which covered many risks in the assessment and this made it hard to review. For example one person had a risk assessment for slipping, drowning, the misuse of products, scalding, falling and becoming anxious or cross. However the management of these risks were covered in a few sentences. Risk assessments had also been put in place for things that were more of a daily check rather than an actual risk. For example one person had a risk assessment for 'Looking unkempt'. The care plan associated with this risk lacked detail. Other risk assessments included washing hair, having dementia and soiled nightwear. The assessments did not show what the risks were and while further information was added to the risk assessments they were not always reviewed.

There were some people in the home who at times would express themselves through physically challenging and emotional behaviours. We observed that although staff responded appropriately to people, the recording of these behaviours was not always in place to ensure consistency in the management and approach. We heard one person shouting out from their bedroom at various points during our inspection. We observed mixed reactions from staff to this persons' shouts. Some staff would enter the bedroom and talk with the person or ask what they would like. Other staff would walk past the bedroom and we heard one staff say "[X] is shouting out but it's a happy shouting out." We saw this person's care plan recorded that when they are shouting staff to give tea and toast but it did not give reasons for why this person may shout. In another part of the care plan it stated that the person was unable to use their call bell and would call out to alert staff when they needed support, however staff were not always responding to these shouts.

There had been a number of incidents between people and for two people the narrow corridor in Lavender lodge had been the cause of several altercations between them. The registered manager told us "We intercept them, one person has one to one staff in the afternoons, people do naturally not get on sometimes. The corridor is narrow, we have tried to reduce risk as much as possible, staff are aware and don't block it up with the laundry bin and we have removed furniture from it. We are trying to get continuous one to one staffing for one person." One health professional told us "If they don't give [X] one to one at the home they will end up at risk and having to move on. We have arranged a full review for this person."

The home was not always consistent in recording episodes of behaviour in order to monitor for any trends. For example on one person's behaviour recording only three episodes were documented from 2016 despite this person having displayed physical behaviours more recently. Staff told us they would record people's behaviours if the Care home liaison team had asked them too but did not always do it themselves. We spoke to the registered manager about the importance of documenting any episodes of behaviour that challenged and about the repetitive behaviours that some people displayed that were also a challenge in a different way. One person's care plan had a risk assessment around agitation, which discussed that 'Medicine was

available for times when the person was really distressed and other methods have not calmed [X]', however it did not state what these other methods were for staff to try. Another person's care plan for mood and behaviour stated the person may bite if they were unwell. In the personal care plan it mentioned the persons' escalated behaviour when they were anxious but there was no overarching risk assessment available for behaviour that may challenge. One person's care plan on personal care stated a person was becoming physically aggressive and it was unknown at the moment if this was temporary condition or if the person was in pain. There was no other information on how this was being monitored or any further updates in the care plan.

Staff were able to tell us how they supported people when they became anxious commenting, "I try to diffuse the situation, give the person time, let the senior know in case it's an underlying health reason, we go on our instinct to support people", "I talk to people calmly, change the subject, have a chat about their history or go away and come back. I had training in my last job", "It doesn't faze me, we have good links with the mental health team" and "The care home liaison team often put behaviour charts in place, we go through the care liaison team and work closely with them and they come and observe." One health professional told us "Staff are lovely with people; they have got people with challenging behaviour and are very patient." One relative commented "Staff respond brilliantly to my relative, particularly as her mental health was a concern but knowing staff are able to help and reassure is a great help. The manager telephones me, the staff are able to reassure me and the communication is very good. I felt [X] was in safe hands and that staff were able to cope and plan with me the best way to support."

We saw that medicine administration was managed well; however there were some gaps in the recording of medicines administered. For example, staff had not used the appropriate code to document on the medicine administration record (MAR) that 'Medicines as required' (PRN) had been offered but refused by the person. This meant it was unknown if staff were offering PRN to people. Staff confirmed with us that they did not record this each time.

For other people on PRN medicines staff were not recording on the MAR the reason as to why this person had received this medicine. We saw in two instances people on PRN medicine did not have protocols in place for staff to follow when giving this medicine. Where PRN protocols were in place they had been reviewed every three months. Pain assessments for people who were unable to always state if they were experiencing pain were not regularly completed. The registered manager and operations manager told us it was more about staff knowing people and looking to see if someone was unsettled. One health professional said "Pain needs to be looked at regularly, we are teaching homes to check and recognise pain." We observed staff completing medicines round and saw that they took time to explain to people what the medicines was for and ensured they had a drink available to take their medicines. Staff stayed with people whilst they took their medicines before returning to the MAR's to record their signature. We saw that staff had guidance available at the front of the MAR's on how to safely and appropriately administer medicine to people and staff had signed to say they had read the provider's medicine policy. Staff were competent in explaining what they would do if a person refused to take their medicine and how to store this medicine securely until it was disposed of.

People felt safe living at Kingston House and comments included, "I feel really safe being with other people in the home and living in a nice area. If I need help I am confident the staff would respond as I have seen them respond to others if they needed help or medical support", "I have been here two years, I feel very safe here 99 per cent of the staff are very good, but you will always get the odd one, to me they are tip top", "I have been here six years, I feel safe and the staff care about me. If I call the staff they come quickly" and "I'm glad I am at Kingston House, the staff are kind to me and respond well to my needs on the whole. I enjoy the security of knowing staff are close at hand if I need them." One relative told us "My relative is safe; I have no

concerns about safety. Staff check on [X] regularly and they come in to top up drinks and just generally check when I have been there." Another relative said "My relative is reasonably safe; it's fine for able bodied people."

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. Staff told us "It's about making sure each resident has the right to be safe in their own space in their home. If a person can't communicate we look for bruising, change of behaviour, or if they didn't want to come out of room and not eating", "We make sure everyone is safe, even if not sure we would ring and check if something is a safeguarding issue. We minimise risk, you are never going to eliminate all risks. I wouldn't have any doubt about speaking with the manager", "We protect residents to the best ability. It's like a family atmosphere, I would report concerns, I wouldn't think twice".

At this inspection we found the service to be clean. One relative said "I have no concerns; the standards of cleanliness are excellent it is never smelly or horrible here." However comments were made from staff and other relatives that at times it was hard to maintain the cleanliness due to staff shortages. One staff told us "People and relatives do make some comments about the standard of cleaning. The bins and toilets are always done but not time for polishing". One relative told us "The level of cleanliness in the home is on the whole very good in the week, but at the weekends sometimes things were not so good." We reviewed the cleaning schedules that staff completed and saw that most days only toilets and sinks were consistently cleaned but not always the hovering, polishing or communal bathrooms. Another staff member told us that one person had continence needs and although staff would clean it up the best they could at a weekend it was often left until Monday when more staff were on shift to properly clean. During our inspection we had to inform staff that one person needed support with their continence needs as this had not yet been attended to by staff.

Requires Improvement

Is the service effective?

Our findings

We reviewed the training matrix and saw that training was not always booked before the date it expired. For example we saw that safeguarding training had expired for six staff. The registered manager told us this had been rebooked for the following month. Not all staff had completed training in managing behaviours that could challenge. The registered manager showed us some staff had attended this training and a new trainer was now in place and this would be discussed and booked for the remaining staff who required this. We reviewed the training and development plan which confirmed that staff would be supported to develop skills and confidence in this area.

We saw that medicines training had expired for four people and not been renewed within the provider's expected timescales. We observed one of these staff continuing to administer medicines during our inspection, which had the potential for errors to arise if updated training had not yet been received. We raised this with the registered manager who told us these staff's competencies would be redone and their training booked. The registered manager confirmed on the last day of our inspection this had been booked for May. This meant staff had not always had the opportunity to keep their skills and knowledge up to date. Staff however spoke positively about the training they received commenting, "I have done my level two in health and social care, I enjoy training, the manager encourages us to ask for training", "I have got first aid training tomorrow, and dementia coming up", "I recently had safeguarding training, manual handling, mental capacity and do refreshers yearly" and "I have done manual handling, food hygiene, safeguarding and fire."

We saw that staff supervisions had not always been regular. One staff's supervision record showed they had received a supervision in July 2015 and then not again until November 2016. One staff member had received only one supervision during a year. Another staff had three supervisions recorded in 2010, 2013 and 2016. We raised this with the registered manager who told us "It's hard to catch this person as they do infrequent hours, sometimes only four or five a week but probably the policy says they should still have some." One staff member did not have medicine competencies recorded despite this staff member saying they had received them. The registered manager was unable to find documented evidence of the competency checks for this person during the inspection. Staff did not raise any concerns in relation to receiving supervisions and told us "I have had one and I am due one, they are informal, more of a chat", "Just had one supervision, you can have a chat, the manager is nice and welcoming" and "We have group supervisions as well and can raise things."

New staff were supported to complete an induction programme before working on their own. They told us, "The manager and team made me feel relaxed; they treated me as if I had been here for ages. At my interview I got to meet the residents. I shadowed a senior member of staff" and "The induction was really good, you do loads of training." Induction checklists were in place which demonstrated items relevant to the home and their job role had been explained. The registered manager told us "We have an informal induction prior to the start, and I spend time with them getting to know them. They have to learn such a lot so I tell them we are not expecting them to know it all straight away. There are checklists in place, and they are taken through the process and shadow staff who are patient and gentle."

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. We saw that where a person lacked capacity to consent to care or treatment this had not always been obtained from someone who had the appropriate legal authority to act on their behalf. For example one person had an advance care plan in place which had been signed by their Next of Kin (NOK) who did not have Lasting Power of Attorney (LPA, a legal document that lets an appointed person help make decisions on your behalf) and therefore could not lawfully make these decisions for this person. One person had a sensor mat in place to alert staff when they moved around their bedroom but there was no consent gained or mental capacity assessment in place to show they agreed to this restriction, or that other measures had been followed if the person was unable to consent.

One person's consent to being weighed, kept on a unit where all the doors were locked and having photos taken had been signed by someone who had LPA in place. However when we checked this document they only had LPA to make financial decisions and not decisions regarding the person's health and wellbeing. Another person also had their plan of care agreement signed by a staff member and also had a sensor mat in place. This person's decision making care plan stated they had 'Variable consent to care treatment' but there was no evidence a capacity assessment had been completed and staff were unable to find one when we asked.

Capacity assessments lacked detail for some people and were based on areas such as freedom to leave unsupervised and choice of meals, but not how each decision was reached. Capacity assessments in place were ticked by staff on the areas the person did not have capacity in and not how each decision had been assessed and reviewed. One person's medicine care plan stated they were unable to sign their consent to staff administering their medicines and instead a staff member had signed this document. This was what we saw for the majority of mental capacity assessments in place, which would record the areas such as freedom to leave unsupervised and choice of meals, but not how each decision was reached.

This was a breach of Regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one example of a clearly recorded mental capacity assessment where a person had been unable to consent to their medicines being managed by the home. The assessment set out the elements of the decision and if they were able to understand and the action to take. It recorded who had made the decision and this was observed over a month to see the support that needed to be given. The assessment would demonstrate to staff if they did not want something.

There were systems in place to restrict entry and exit to outside the home and between Lavender lodge (The dementia unit) and the rest of the home. People not in Lavender lodge had the key code to the main entrance and were able to come and go freely. In Lavender lodge we were told that everyone was subject to a Deprivation of Liberty Safeguards (DoLS) when they come into the home as they are in a secure building. The DoLS are part of the MCA and provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

People in Lavender Lodge had restricted access into the courtyard while other people living in the home were able to freely access to the outside space, People in Lavender Lodge had a large picture window where they were able to watch other people accessing an internal courtyard space This had the potential to cause

confusion as people in Lavender Lodge were not able to access outside without staff being present.

Staff lacked an understanding of the principles of the MCA in relation to ensuring the least restrictive option was in place. We spoke with staff about people in Lavender being able to go outside and were told "The doors are all locked and are open only in the summer weather", "We take people outside for their safety, not on their own" and "The doors stay locked, we have to be careful so in the summer with staff the doors will be open. We will unlock doors if people want to go out". However due to the level of some people's dementia they would be unable to ask staff to unlock the doors and this would also mean going to find a staff member first to ask. We spoke with the registered manager about the restrictions on people accessing outside space and the balance of the positive effects against the potential risks. The registered manager agreed that risk assessments could be put in place around this and staff could complete regular checks to ensure people were kept safe. We saw the garden was a secure area which had been paved for people to navigate around with ease. One relative told us "Any restrictions are in [X] best interests, as they are unsteady on their feet. The Manager was concerned about [X] moving without someone being there, it's hard to get that balance of independence and protecting people."

The dining experience we observed was different for people living in Lavender Lodge compared to the rest of the home. For example we saw that dining tables were laid with tablecloths, condiments, baskets of fresh fruit and jugs of flavoured squash or water. However in Lavender lodge the tables were left bare with no tablecloths or condiments available. The kitchen had two serving hatches into the two separate dining rooms and the dining hatch on Lavender lodge was not lifted until the kitchen had finished serving up meals for the other dining room. On both days of our inspection people in Lavender lodge were served their meals second although the registered manager told us this was not always the case. People in the Lavender lodge dining room could hear the kitchen staff serving meals to people on the other side and were observed asking each other and staff about their own meal. One person said "Perhaps there will be a plate of food soon." Other comments included "I can hear something going on" and "Well we have cutlery now we want the goods."

On the second day of inspection people on Lavender lodge were served a mixed grill. They were not asked if they wanted all the items of the mixed grill, however people in the other dining room had been asked. We were informed by staff that people were given all the items because it would take too long to try and ask them individually which ones they wanted. We saw when one person was presented with their meal they began to push one of the items off their plate onto the table stating they did not like it. At other mealtimes we saw staff show the choices of meal to people so they could visually choose. One person was supported into the dining room in a wheelchair and staff pushed them up to a table but did not offer the person a choice of where they would like to sit. We observed one person in the other dining room who was sat alone at a table. This person said to a staff member "This is a big table and it's just me". The staff replied that the person who normally sat there was in hospital, but did not ask the person if they wished to move and sit at another table with more people.

We saw in the rest of the home people were offered choices and when staff supported people they were respectful, responsive to their wishes and checked that people had enough and were enjoying their meal. The food looked appetising with good sized portions and people praised the food saying "The food is excellent, there is lots of choice", "We get to suggest meals and are always consulted about the food", "We get more than enough, we have the opposite problem we are trying to lose weight", "We had a high tea last night they laid it out on cake stands and we had sandwiches, cakes and vol-au-vents, it was lovely", "The food is marvellous and the lunch is particularly good, you always get fresh water and fruit with your breakfast. I have no time to be hungry as I am well fed. I choose my meal the day before and staff bring it to my room as I prefer to eat in my room" and "I had the vegetable lasagne and thoroughly enjoyed it." One

person chose to have their lunch in the lounge and staff took their lunch in on a tray with a gravy boat so the person could add gravy if they chose. One relative said "I see the food, it's very very good, [X] really enjoys it, I see the kitchen team, they work extremely hard".

We saw on Lavender lodge that snacks were not always left available for people to pick up if they wished. Staff were seen readily fetching things for people when they asked but people were not able to help themselves. We saw that the kitchenette area did not contain items that people would expect to find in a kitchen and the drawers were used for storage. One person told us "What is provided in terms of food is very good although snacks are not readily available, it is not a problem as you can ask for whatever you want and the staff will get it for you".

The home had been divided into three units, Primrose, Tulip and Lavender lodge. Lavender lodge was an addition to the original building and supported people who had a diagnosis of dementia. There was a sense of a divide between Lavender lodge and the rest of the home and staff referred to the building as 'The main home' and then Lavender lodge. This could be perceived by people on Lavender lodge as if they were not part of the whole home and we raised this with the registered manager. We saw that Lavender lodge had a separate dining room, separate garden and required a keypad entry to gain access to the unit. We asked staff about the opportunities people had to mix and come together and were informed that they would come together for some activities.

Lavender lodge had a very long narrow corridor which was all one colour with bathrooms and people's bedrooms leading off from this. It was hard to differentiate one door from another and we saw one person opening doors and going into other people's bedrooms trying to orientate themselves. This person tried to also open the bathroom doors which had a picture of a bathroom on but they were both locked. We saw they were being used to keep equipment in such as wheelchairs and transfer aids. Staff told us this was because there was no storage facility on Lavender lodge. Locking the bathroom doors could cause further confusion and frustration to people if they were trying to access the toilet. We raised this with the registered manager and found on the second day of our inspection the doors had been unlocked. A lot of incidents between people had occurred in this corridor and the design of this environment had the potential to increase people's frustrations. One staff told us "The home needs a bit colour on the walls." One health professional told us "The home is not purpose built, there have been incidents with one person in the corridors but there is not much they can do now".

People in Lavender Lodge were not able to access all parts of the building. We saw Lavender lodge had a conservatory area that overlooked the garden which people enjoyed during the day and the other parts of the home had several lounges, one of which was set up like a 'typical' living room with table, comfortable chairs and fireplace and had a very homely and welcoming feel to it. In this part of the home to access the garden people had to go out of the front door and around the side of the building as there was no internal access, only to an inner courtyard. The registered manager told us the possibility of inserting an inner door to access the garden had been raised.

People's changing needs were monitored to make sure their health needs were responded to promptly. One person told us "If I have been feeling unwell with a headache the staff have given me an aspirin or they will happily make an appointment with my GP." One relative said "Staff work closely with the GP and are supportive and work with the family". The home worked closely with the district nursing team and one staff member told us "We take the district nurses lead on this but we look at raising things." The registered manager said "Staff report concerns to seniors and then they will take action if needed. We are proactive in catching things before they are a concern. One surgery hold monthly in-house surgeries and another does a weekly surgery". A health and social care professional said "Staff are very good, if they have any problems

they are very quick and let us know any problems. They know people well. Staff are good at following guidance and let us know things."

Good

Is the service caring?

Our findings

We observed staff responding to people respectfully and engaging people in positive interactions including singing and chatting. People told us "I like living here, we have things here we can do and look at", "If you need anything they will help you. If I needed help I know I will get it", "No worries about living here, staff are very good to me" "I would recommend this home to friends and family. I came here because it was recommended to me and I have no worries about my care here" and "I like living here, it's a nice room I have." Staff told us they felt part of a family working in the home commenting "Residents treat you as a member of their family", "It's got a family feel, it's very friendly, staff are protective of the residents", "I feel like I'm making a difference to people, we listen to people and we work as a team." We saw that one person's relative had painted a picture and the home had displayed this on the wall near to the person's room for them and other's to enjoy.

People's relatives praised the home saying "I think we are incredibly lucky, the staff are so caring it's got that personal feeling", "I am extremely pleased with the home, they have done wonders with my relative. To see how my relative is now is fantastic", "I like the general ambience and care at Kingston House and that never in all the years that mum has been here, I have had no reason to think she is not being looked after or treated with respect. I often come unannounced and there are no restrictions to me coming, I have free access to mum whenever I like. The staff are always around when I come and I regularly see staff interacting with the residents" and "I like the fact that Kingston House is a smaller home. My relative has built a good relationship with the staff and they are very caring."

We observed that staff in Lavender Lodge did not wear a uniform and the registered manager told us "We don't want people to see us as staff, but instead see us as family, its policy for our homes to choose if they have staff uniforms. Staff are wearing uniforms in the main home but we are moving towards non uniform across the home. We have staff photos in the entrance so people still know who the staff are. It's about eliminating the boundary of staff and people." One health and social care professional told us "It is really good here, everyone seems happy, the people seem happy." Another health professional said "The care is good, their compassion, I couldn't really fault them."

Staff were able to explain how they maintained people's privacy during personal care commenting "We put towels over people, offer reassurance and keep curtains and doors closed", "We talk to people and explain what we are doing" and ""Inform people what we are going to do and give them the option to do it themselves." One person told us "Staff here are very good and they always knock on my door before coming in." Another person said "The majority of staff are very good, although some of the staff are not so thorough for example when washing my back, maybe not as I would like. Overall I am happy and the staff are good." A health professional told us "Staff know when to guide people, lead people and support people. There are appropriate ways to do things."

The home had a dignity tree displayed on the wall which had messages from people, their relatives and staff including 'I want to keep as much independence as possible. I will ask if I want help' and 'Valuing people as individuals.' The registered manager said "Our philosophy is being accepting of everyone, if staff are finding

supporting a person difficult, we look at the person's background so staff remember that person is an individual. We include this philosophy in training, induction and our interview questions. I can see that we have come a long way in staff understanding of behaviours. One staff told us "We encourage people to do anything, even if there is a small part of the task that they can do."

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. We saw that in a relatives meeting in December 2016 one relative had asked how people leave the building after they have died and the registered manager was recorded as saying 'They go out of the front door the same as they come in, through the lounge and people are asked if they wish to move from the lounge or stay and say goodbye. Staff gather at the entrance to say goodbye'. The registered manager told us that the relative had felt moved by this answer and further told us "We always gather for people who have died and see them out. People need a chance to say goodbye and it's about not being frightened."

Requires Improvement

Is the service responsive?

Our findings

During this inspection we found that people's care plans and monitoring records were not always correctly or consistently completed and managed. For example one person had a chart in place to ensure they were supported with daily eye cleaning. We saw that this had not been done since 25 March and prior to this the dates were inconsistent showing it had been done on the 1, 4 and 6 March and 8, 14 and 28 February. We spoke with staff who said it was meant to be daily but the person sometimes refused, however no further action was documented in relation to this. We saw this person also had a catheter in situ and their leg bag should be changed once a week. We saw this had last been changed on 20 March and was not changed again until nine days later on 29 March. Staff confirmed the recording of this was correct. This meant the person was not receiving care in line with their care plan.

One person had broken their hip in November 2016 and a mobility care plan was in place giving details of the support this person needed to mobilise. The care plan directed staff to some guidance which stated the person was unable to weight bear and needed the use of a full hoist for all transfers. However the care plan stated that 'Staff to reassess on each occasion how I am feeling as sometimes I can stand and transfer.' A moving and handling risk assessment further contradicted this by rating the person as low risk. This made it hard to ascertain the correct support this person needed.

We saw that where a person was at risk of losing weight this had not always been monitored consistently. One person's Malnutrition Universal Screening Tool (MUST) stated it should be completed monthly but had last been done December 2016 (MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese). On 23 June 2016 it stated the person weighed 53.5kg and was high risk and to monitor closely. It had also been written this may have been an error in the weighing scale recording; however this person was then not weighed again until two months later. Although at the next recording this person had a higher weight recording this had not been effectively monitored to ensure there was an error and that the person was not actually losing weight.

Another person had lost a lot of weight and the GP had been made aware. However the care plan had not been updated and stated that this person had a very good appetite and enjoyed meals despite a recorded weight loss of one stone and 13lbs in a three month period. One staff told us this person had been referred to the dietician; however another staff member said they were trying supplements first before other measures. We looked on this person's fluid recording chart and saw that on the 27 March no drinks had been recorded after lunch for the rest of the day. From the recording it was hard to establish if this person was being effectively supported. The registered manager told us "If someone is a concern we put them on a food or fluid chart. We put people on a supplement if they are identified on MUST as a risk, we don't ask the GP to prescribe, we buy it whatever people will take we try." We saw that 14 people were being given supplement once a day but this had not been recorded since 29 March. A staff member told us they had been off at the weekend and did not know why the recording had not happened. Two people receiving supplements were diabetic and it had not been checked with the GP first to ensure it was safe to give the person this on a regular basis. The registered manager told us she would ensure this was checked.

People's care plans did not always contain enough information for staff to follow. One person had no dietary preferences, likes or communication needs recorded. A mobility care plan had only one sentence which stated that the person 'Had a couple of falls previously'. One person's nutritional care plan had no likes and dislikes recorded and stated that the person sometimes needed their food liquidised but no reason for this was given and a risk assessment was not in place. A staff member informed us that not everyone's dietary needs were in place and that they were in the process of getting round to this. One person was experiencing frequent episodes of incontinence, however there was nothing documented in the care plan about this or how staff were to support the person in this. One care plan for personal care stated on 11 January that they needed two carers, 'To do the preparation, washing and creaming' but there was no personalised details on the persons preferred routine. This was not representative of all care plans we saw. One person's personal care plan was person centred and recorded 'If you pass me the flannel and help with the soap I can manage this. I do need help to wash my back and lower legs as I can't reach.'

For people that had been prescribed topical medicines for use 'As required' staff had not recorded if this had been offered and refused so there were a lot of gaps on some people's charts. This meant it could not be established from the recordings if people had received their prescribed cream or not. We saw two people's fluid monitoring charts that did not state the target amount a person should be drinking and the daily amounts had not been totalled up to ensure the person was drinking enough. Dates were often missing from paperwork which meant it was unknown when the recording had taken place and made it hard to effectively monitor a person's progress. For people that required hourly checks to be made at night to ensure they were safe there was no recording of this. This meant it was unknown if people were being checked at night in line with their care plan guidance. We raised these concerns with the registered manager to address.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans had a profile page with a photo of the person and information about their family and background recorded. Life history was recorded about a person's young and later life and their favourite things. We saw that communication guidance was available for staff on supporting people with dementia and appropriate sentences had been provided. Care plans were being reviewed people and their relatives were invited to be involved in this process. One relative said "I'm asked to review her care plan and if anything I feel needs adding I add it to the care plan." Other relative comments included "The staff got to know my father and understand his needs. I can go to them with any concerns. I have discussed things with his keyworker and they have been responsive and I am happy with his care" and "I have attended reviews and care planning meetings."

Staff attended a handover meeting prior to shift changes to share information and any concerns they had about people. A handover sheet was used to record this information and the times of the evening shift had changed to fifteen minutes earlier to allow for a better handover whilst also ensuring the floors were covered by staff. The registered manager told us "At handovers we talk about any concerns."

People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. We saw many people choosing to enjoy the quieter spaces afforded by the home to read or relax and one person sat in the front garden reading in the sunshine. We saw notices up advertising tomato plants for sale and staff told us one person grew these and sold them. Two people had their electronic tablet and enjoyed playing games together on these with one person saying "I taught [X] how to play scrabble on the iPad." We saw various activities happening during the inspection with one staff treating

people to manicures and nail painting and another staff holding a flower arranging activity. One person was observed folding napkins for mealtime and told us they enjoyed doing this daily task. The home also had its own shop which staff ran at different times so people could purchase any extras or treats they wanted including toiletries and chocolate. The registered manager told us "People respond well to the activities and have a higher engagement in life".

People spoke very positively about the activities available commenting "I have been out this morning on the minibus to do exercises but I'm feeling giddy now", "I do a lot, I went to the fete and won a cup. I go to the homes knitting club, go visiting twice a week, and out on the minibus when I want to. I have got an activity plan in my room", "I enjoy quizzes and crosswords in the lounge. Every Saturday I get a sheet with a list of the week's activities on it" and "I enjoy quizzes and reading books but the reality of it is you can get away to your room if you want to for a while as there is a TV in your room which is nice." We observed Holy Communion with the local parish vicar in which seven people attended. Hymn sheets had been provided and people were engaged in lively conversations and laughter demonstrating a good relationship with the local vicar. The vicar supported some people by turning the pages enabling them to keep up with the service. One person told us "I always go to church on a Sunday which I enjoy".

People were encouraged and supported to develop and maintain relationships with people that mattered to them and to avoid social isolation. Comments included "I like that my family can visit whenever they want, the access is unrestricted", "Staff here are very friendly and care for me. I have a family friend who takes me out and he can come whenever he can which is good" and "No pressure to join activities you can please yourself. I am happy just to sit and relax. I am happy here as my family is welcome anytime I am happy with that." Relatives praised the home and the invitations to be involved saying "Anything social I am invited to. They do so much more activities, there is always something going on. The staff try to get my relative out as much as they can he has been bowling and visiting local garden centres", "I get letters notifying me of events and the staffs encourage you to get involved. Recently I came into sing with my relative which we both enjoyed. When it was his birthday they made a cake and got him a gift which I thought was nice" and "[X] is encouraged to be active and the manager encourages her to go out on walks. [X] is involved in the arts and craft activities in the home and enjoys it very much. The activities co-ordinator is very good at getting her involved by doing quizzes to help her lift her mood and settle her". One health professional commented "The home is person centred, they have a lot of trips it's homely, people get out and about and family are quite involved if they want to be".

We saw that an Easter fayre had been planned to raise funds for a new minibus fund which we were informed had been achieved. People and their relatives had all been involved in fund raising events in the local community where they were all well known. We looked around the gardens and saw that these were safe and secure spaces for people to enjoy with bird aviaries, a summerhouse, vegetable patches, raised flower beds, a greenhouse, and lovely seating areas spread around. Daily diary of activities were recorded for people so staff could track what had been enjoyed and on Lavender lodge we saw people had scrap books in place of photos of them participating in activities which families and staff could use to reflect on with people and create talking points.

People were encouraged to raise any concerns they might have so these could be investigated and responded to in good time. We saw complaints, comments and suggestion forms were available for people to complete and people had filled these out praising the home and stating there were no improvements to be made. One person said "I am quite happy here, I would speak to staff if concerned." Another person said "The manager runs things very well I have no grumbles." Relatives told us "If I or the manager have any concerns we have been able to sit down and find a way forward", "I have no complaints they are extremely good at communication" and "I feel listened too when I raise concerns with staff."

Requires Improvement

Is the service well-led?

Our findings

Although quality assurance systems were in place to monitor the running of the home, these had not picked up all of the shortfalls identified at this inspection. This meant the registered manager was not able to address and take the necessary action. We saw that weights and food and fluid monitoring had not been audited by the home in order to monitor effectively and take preventative action in a timely manner. The registered manager told us "It's about how many things do we monitor. It's a learning thing for us and that's something we can look at and put into place". We saw that although daily records recorded if a person had experienced a fall and a body map was completed there was no on-going observations documented to show that staff were continuing to monitor and check people.

We reviewed the accident and incident log which showed a high number of falls had occurred in recent months. In December there had been 17 falls, in January 12 and February 14. The registered manager signed off any incident forms and any preventative measures would be considered. We saw a falls analysis was in place which looked at the times and place falls were occurring to highlight any patterns. The analysis also showed if the GP had been informed and involved. The registered manager said part of the analysis was to consider the environment to ensure this was not a contributing factor and commented "We always put sensor mats in place, look to purchase a low bed, put a crash mat on the floor, check for any infections and make a GP referral. Some are recorded as falls but they were a controlled lowered to the floor but we report everything". The registered manager had also completed infection control, kitchen, health and safety and medicine audits. Spot checks would be carried out on medicines and pharmacy visits took place six monthly.

The registered manager promoted a positive culture and was a visible presence around the home supporting people and staff when needed. People and their relatives praised the registered manager's approach and management of the home commenting "I am looked after very well and the home is well run. The manager is very capable", [X] the manager is very helpful and always up for a laugh", "I find the manger very approachable, she's been great, first rate, she's always smiling, extremely responsive and an excellent communicator", "It is a home, it feels like a home and has a caring warm feel to it. Without a doubt part of that is due to the management of the home and how it's managed, the tone is set", "The manager is a wonderful person" and "The manager has always made me feel I can approach her at any time." The registered manager will be leaving the service in a few months and staff expressed their sadness at this with one staff saying "I'm gutted [X] is leaving the home, she's always in and out of the office." One relative told us "The home is well managed, [X] is lovely, it is a shame she is leaving in three months."

The registered manager was regularly seen on the floor with people and showed affection and familiarity chatting easily, hugging and laughing with people, all of whom knew who she was. The registered manager told us she had an "Open door policy it's a revolving door, I encourage this, and the manager office has a window so people can see in." One relative said "I have a good relationship with [X]. I recently spoke to her about my mother's GP, and she was able to give me some insight and support which was helpful." One health professional said "There is always someone to verbally hand over to. I speak with the manager, I am always going in to talk to her, she's very approachable." Another health professional told us 'The manager is

brilliant, she will speak to me about people, all the staff are approachable".

The staff spoke about the support the registered manager provided commenting "The manager is responsive to people, she takes time to be with people and actions their enquiries promptly", "The manager always makes me laugh, she's very easy to talk to, I came in one weekend and she was working. That to me is a big shock to see a manager working at a weekend and getting their hands dirty", "The manager is encouraging with ideas, she's on the floor a lot, she likes to be out and seen by residents" and "The manager is approachable, she's very nice. I like the company it's all up together, nice people and a nice feel." The registered manager in return praised the staff saying "Staff genuinely care about people, and are prepared to give up their own time. There is a feeling of family and home and we have achieved this". We saw that staff were supported through regular team meetings and encouraged to progress. The registered manager told us "We develop people in a relief senior role, so if they have expressed an interest we have interviewed them and they can experience this.

The home followed a philosophy based on a culture change movement dedicated older people in long term care home. Information was available for people about this around the home and staff referred to it when we spoke with them. One staff member said "Part of the Eden alternative is to give people options, try to get them to do as much as possible for themselves." Another staff said "As a home it's about being respectful, honest and person centred". The registered manager told us "It's about creating a feeling of belonging, of being involved. The company adopts this approach and we were the first home to register in Wiltshire. It gives a name to what we are already doing, to make sure people aren't lonely."

We saw that people and their relatives were empowered to contribute to improve the service. Resident and relative meetings were regularly held and we saw a notice up advertising the next meeting. We reviewed the minutes of previous meetings and saw people and their relatives were encouraged to chair the meetings and given opportunities to have a say in events relating to the service. At one relative meeting information was given out about understanding dementia so relatives could be more informed on this area. One relative told us "Mum is actively involved in residents meetings and has made suggestions which the manager has moved forward with. I would definitely recommend the home as a place for a relative." Another relative said "Mum's keyworker calls me regularly and gives me updates, which is important. I know if anything untoward was to happen they would let me know, as I have a good relationship with all the staff. I know mum is not on her own and that staff will go the extra mile to make sure she is cared for."

A service user guide was in place informing people of necessary information on moving into the home; however the deputy had been working with people to update this. The new one would include information that people in the home considered useful for a new person to know, and suggestions included a local bus service timetable and the history of work that had been completed on the home. The registered manager also said that "We have worked on a relative's handbook; there was a gap about the day to day stuff. We worked on it at relatives meetings, it's now all done and on the front desk". One relative said "The home is good at communicating to us. I get asked quite a lot to give feedback to the home". At the time of this inspection the home were interviewing for an activity staff post and the registered manager told us that one person living in the home was going to be involved in this interviewing process.

The service worked in partnership with other health and social care professionals and we received positive feedback about the home from some of these professionals. One told us "We have good communication with them so they are understanding when we point things out". Another health professional commented "It's my easiest home to work with, they are very good. If they refer someone other things will have been ruled out first, they recognise signs to then up the intervention and support. They seem to have a good understanding". The registered manager told us "We have good partnerships with the community nurses

and they are really supportive."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We saw that where a person lacked capacity to consent to care or treatment this had not always been obtained from someone who had the appropriate legal authority to act on their behalf. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance During this inspection we found that people's care plans and monitoring records were not always correctly or consistently completed and managed. Regulation 17 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were sufficient staff to meet people's basic care needs. However there was not always enough staff available to meet the high level of social and emotional needs present in Lavender Lodge, the dementia unit of the home. Regulation 18 (1)