Mr David Lewis & Mr Robert Hebbes

Normanhurst Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 June and 4 and 5 July 2016. It was unannounced. We inspected Normanhurst Care Home at the same time as we inspected the service's sister homes, which were next door. There were 58 people living at Normanhurst Care Home when we inspected. People cared for were all older people. They were living with a range of care needs, including arthritis, breathing difficulties and heart conditions. Some people were also living with dementia. While some people lived largely independent lives, others needed support with their personal care and mobility needs. The registered manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

Normanhurst Care Home was a large building. Accommodation was provided over four upper floors, ground floor and a semi-basement. Two passenger lifts were available to support people in getting between each floor. Lounges and a separate dining room were provided on the ground floor. The home was situated on the sea-front in Bexhill on Sea.

Normanhurst Care Home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the registered manager for Normanhurst EMI Home, which was next door to Normanhurst Care Home. The providers for the service were Mr David Lewis and Mr Robert Hebbes. They also owned Normanhurst Nursing Home and Normanhurst EMI Home.

Normanhurst Care Home was last inspected on 9 September 2014. No issues were identified at that inspection.

During their audits of service provision, the provider had not identified a range of areas. This included some assessments of risk for people. For example where people had an accident, their individual accident reports were not used to assess and reduce their risk. The provider's audits had not identified that people did not consistently have care plans developed, including where people lived with dementia or had specific care needs. Some documentation about people was not completed, to ensure people received consistent care. The provider had also not identified that parts of the home environment did not follow guidelines on supporting people who were living with a disability or dementia. There was a lack of audit of staff supervisions, to ensure relevant areas were identified. Recruitment systems were not audited to ensure that all staff folders included all required information and the provider's policies were consistently followed.

Some staff had not been trained in their responsibilities under the Mental Capacity Act 2005 (MCA). People's assessments in relation to the MCA were not decision specific and did not ensure the requirements of the Act were followed. Deprivation of Liberties (DoLS) applications were made, however there was a lack of best interest decisions documentation where people needed to have their liberties restricted, for example by the use of bed rails.

Some staff did not fully engage with people who were frail and living with dementia, this included in the dining room, lounges and where people remained in their own room all the time. Other staff were responsive and consistently supported people in the way they needed.

Certain areas for supporting people with medicines relating to individual assessments and protocols, required improvement. In other areas, staff supported people in taking their medicines safely and ensured appropriate systems for storage of medicine. Staff had effective systems for liaison with external healthcare professionals where people needed support.

There were a wide range of meals offered to people. People commented favourably on the meals service. Where people required support with their food and drinks, they were helped in the way they needed. There were a wide range of activities provided for people. People could come and go from the home as and when they wanted.

People said they were supported by kindly, caring staff. They said there were enough staff on duty to meet their needs, and they felt safe in the home.

Staff said they were supported by the provider's induction and training programme. Staff showed a clear understanding of how to protect people from risk, including risk of abuse.

We found a number of breaches of the HSCA 2014 Regulations. 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.

Some assessments of risk for people did not include relevant information to reduce their risk. Other areas relating to risk were addressed appropriately.

The provider's own systems for recruitment were not being consistently followed.

Medicines were stored and administered safely by staff who were trained to do so. Improvements to as required medicines were needed.

People were safeguarded from risk of abuse and there were enough staff deployed to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) were not being consistently followed, and some staff were not aware of their responsibilities.

The provider had not ensured the home environment followed current guidelines for people who were living with a dementia or a disability, in all relevant areas.

People largely received the support they needed with their diet and fluids. People commented favourably on the meals.

Staff were supported by the provider's training plan.

People's healthcare needs were largely met and referrals were made to relevant healthcare professionals to support people when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people were not always responded to by staff who supported them in the way they needed.

People's privacy, dignity, involvement and independence were respected.

Staff were consistently polite and respectful to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessments and care plans did not always ensure they were responded to in a consistent way, including people who were living with a disability or dementia.

People said they enjoyed the activities programme. The activities manager regularly reviewed what people wanted to be involved with.

There was a system for making complaints. There was no system for the audit of smaller concerns raised by people.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's systems did not always ensure relevant action was taken in relation to people's quality of life, their welfare or the audit and maintenance of all relevant records.

The provider and registered manager were open to developing new areas, to improve service provision.

Staff commented on the effective teamwork in the home and felt they were listened to by managers.

Normanhurst Care Home

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.

The inspection took place on 28 and 29 June and 4 and 5 July 2016. It was unannounced. The inspection took place over four days because we inspected Normanhurst Care Home's sister homes – Normanhurst Nursing Home and Normanhurst EMI Home at the same time. We did this because some services like catering, cleaning, training and human resources were managed centrally for all three homes. The inspection was undertaken by three inspectors.

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

We met 24 of the people who lived at Normanhurst Care Home and observed their care, including the lunchtime meal. We spoke with three people's relatives. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We inspected the home, including some people's bedrooms, bathrooms and toilets. We spoke with three visiting professionals, including a healthcare professional. We spoke with 12 of the staff, including a domestic worker and training manager. We met with the registered manager, one of her deputies and one of the providers.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture

information about a sample of people receiving care.

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

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home, for example a person told us "I definitely feel safe here." However we found some areas required improvement to fully ensure the safety of people.

We looked at systems for assessing risk where people had an accident or sustained an injury like a skin tear or bruising. When accidents and injuries occurred, a form was completed. These documents were then placed in a plastic folder in people's individual folders. This information was not used to review people's risk assessments and care plans, and was not otherwise collated to ensure assessment of their risk over time. For example when we looked at a person's records, their folder showed they had sustained at least six falls during the past 12 months. This information had not been used as part of their risk assessments and care plans to identify how their risk of falling could be reduced. The registered manager confirmed that when people fell, there was no system for monitoring and reviewing their condition over the next few hours and days after their accident. This is relevant because underlying injuries to frail and older people may not be apparent immediately after an incident, but may become evident during the next hours, or day or so later.

Where people were assessed as being at risk in other areas, the home were not consistent in their approach. Several people had pressure mats in their rooms. We asked staff about why equipment like pressure mats were being used for certain people. They gave us varying replies. For example a member of staff told us they thought a person had a pressure mat to ensure their safety because of falls. The person's records showed they had not fallen since they decided to live at the home. One person had been assessed as being at high risk of pressure damage. They did not have a care plan about how this risk was to be reduced and staff could not tell us about actions they took to reduce the person's risk. However another person who was also assessed as being at high risk of pressure damage, had a clear care plan about actions staff were to take to reduce their risk, which we saw staff followed when supporting the person.

People had a personal emergency evacuation plan (PEEP). These did not outline a range of factors which could place them at risk, such as whether they were living with memory loss or anxiety, or if they had a disability such as difficulties with vision and hearing, all of which could affect them if they needed to be evacuated in an emergency. The PEEPs were not dated to ensure they were regularly reviewed over time and as people's conditions changed. We discussed this with the registered manager and provider at the end of the inspection and they agreed to review the plans.

The provider was not always ensuring care was provided in a safe way to people. This was because they did not consistently assess risks to people and do all they could to mitigate such risks. This is a breach of Regulation 12 of the HSCA Regulations 2010

Some systems for recruitment of staff required improvement to ensure staff had been employed in a safe way. For one recent employee, the section on their application form for reasons for leaving their previous post had not been completed. For another recent employee, they had put down a former work colleague for their last employment as a referee, not their previous manager. They had also not recorded their reasons for leaving their previous employer on their application form. The reasons for both these matters had not been

probed at interview. We discussed this with the registered manager. They were able to tell us about reasons for such omissions, but as such reasons had not been documented, they would not be available for review at a future date. The provider had a procedure for assessing the suitability of prospective members of staff. This procedure involved interview assessment forms, but most had not been completed, to ensure there was clear evidence of why the prospective member of staff had been judged to be safe to work with people. The provider was not auditing compliance with its own recruitment and selection processes, so they could not ensure all staff were being consistently recruited in a safe way.

All other systems for safe recruitment of prospective staff were followed. This included checks with the Disclosure and Barring Service (DBS) to check prospective staff were safe to work with people, two references and a previous employment record.

Staff supported people with taking their medicines. Where people were prescribed 'as required' medicines (prn), their protocols for these medicines were not individualised. Prn protocols stated only phrases such as 'for pain.' They did not outline what type of pain the person was experiencing or from what part(s) of their body. This meant review of the effectiveness of the medicine and changes for the person would be more complex to assess. Such relevant information may also not be available to advise the person's GP of how effective the medicine was for the person. Some improvements were also needed in other areas when supporting people with their medicines. Some people managed some of their own medicines. We saw a person who had some difficulties with breathing. They took out an inhaler and used it to relieve their symptoms. The person appeared to be frail and their records showed they needed support with their personal care and daily life. Their records also showed they had additional needs relating to memory difficulties. The service had not completed an assessment to ensure this person was supported in continuing to self-administer their own medicine, including if they still had the dexterity to administer their inhaler independently and of how they were to be supported in in view of their memory loss.

All other areas relating to supporting people with their medicines were safe. This included secure storage of medicines, full records of medicines received into the home, given to people and disposed of from the home. There were clear systems where people were prescribed skin creams, including body charts to inform staff of where creams were to be applied on the person's body and records to show how often they had been applied.

Staff gave people their medicines in a safe way. A member of staff checked the medicines administration record (MAR) before they gave a person their tablets. They waited while the person slowly took their individual tablets separately and did not rush them in any way. The member of staff did not sign the MAR until the person had finished taking all of their tablets. A person said to a member of staff at lunchtime "I want you to put some cream on my back after lunch." The member of staff replied "I will come up to your room after lunch and do that for you," which we observed they did. A person asked at reception for some painkillers. The receptionist very politely explained why they could not do this. They then told the manager, who took prompt action to support the person.

The provider regularly monitored the safety of other systems in the home, including the maintenance of lifts, monitoring of water temperatures and fire safety checks. The fire alarm went off during the inspection, due to a false alarm. Staff at all levels responded promptly to the fire alarm and followed the home's fire safety procedure. A person told us "I'm impressed by the way they respond to the fire drill, it makes me feel safe."

Some people had difficulties with mobility. Where people needed assistance, they were supported by staff in a safe way with staff following relevant guidelines on this. All people had clear assessments and care plans in relation to their mobility. These were reviewed, including when people's needs changed. A few people

remained in bed or their rooms. When their call bell was used, staff promptly responded to their call.

We asked a wide range of staff about their understanding of safeguarding people from risk of abuse. All of them showed a good understanding of protecting people from risk of abuse. For example a domestic worker described scenarios where they would inform the registered manager of their concerns. They said they were sure the registered manager would respond to any concerns, but if they did not, they would inform the provider and the local authority. All staff were trained in awareness of safeguarding people from risk of abuse when they started employment, and were regularly updated in the area during their employment.

All people we spoke with confirmed there were enough staff deployed to support them. One person told us they felt particularly safe at night because there were always staff on duty, who came to see them promptly if they needed help. There were always staff available to support people in the sitting areas of the home. A receptionist was on duty every day, and at weekends, to ensure people received a quick response if they wanted to find a senior member of staff. Staff also confirmed there were enough staff. One member of staff told us "We're well staffed." Domestic workers confirmed there were enough of them on duty to perform their role and all parts of the home we inspected showed high standards of cleanliness. An external healthcare professional told us they thought there were always enough staff on duty, saying unlike some other places they visited, they were "Always able to find staff here." We saw there consistently enough staff on duty to respond to people. This included when people who remained in their rooms all the time requested support.

Requires Improvement

Is the service effective?

Our findings

People said they received effective care, particularly in relation to choice of meals and support with healthcare needs. One person told us "The food's always very good and we get lots of choice", another person told us they appreciated the way the staff supported them in going to the GP surgery "Just like I did at home," rather than calling their GP in to see them. However we found some areas required improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Several people had been assessed as lacking capacity. These people had assessments for capacity, but all of their assessments were generic and none were decision specific. For example a person remained in their room all the time. Staff told us this was due to their dementia. Staff also told us the person's condition had changed during the past six months. The person's last capacity assessment was dated over eight months ago. This assessment did not assess if they were able to make a decision about leaving their room. None of the people's records showed best interests meetings had taken place to ensure their care was being provided in their best interests and in the least restrictive way possible, among other people, this included a person who remained in bed with bed rails in the raised position all the time and people who had pressure mats in their rooms.

DoLS application had been applied for people where relevant. MCA and DoLS training were included in the home's training plan. However many of the staff we spoke with had not received this training. Staff we spoke with were also not aware of how to ensure the principals of the MCA were followed in practice. Many staff were unaware that the use of equipment such as pressure mats and bed rails were restrictive and therefore their use needed to be assessed for people and only used if people wanted them, or they were in their best interests.

People did not have individual, decision specific mental capacity assessments, including best interests' decisions where restrictive practice was implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's statement of purpose stated that one of their aims was to provide a 'hotel setting' for people to live in. It also stated they 'pride ourselves on attention to detail." Despite these statements, the provider's audits had not identified areas in the home environment which would not support people, including those who were living with a disability or dementia. This included a lack of suitable signage across the home. When a person came out of the lift on one of the five different bedroom floors, unlike at a hotel, there was no

signage to direct people to their rooms or other facilities, like toilets. The floor and wall colouring was similar on all bedroom floors, so different floors could not be distinguished from each other. Some carpets were of a flecked design. Flecked design carpets have been identified as inappropriate and a risk factor for people who are living with dementia and visual difficulties. There are a wide range of guidelines available about appropriate environments for people who are living with a disability or dementia. This is an area which requires improvement.

People ate their meals in the dining room and could choose to eat elsewhere in the home if they wished to. A wide range of different meal choices were offered. We observed a contrast between two of the days of the inspection at lunchtime. For example, on one of the days a person changed their mind about what they wanted to eat. The person waited a long time to be served this second choice and then asked a member of staff about it. The member of staff told the person that they had not been waiting long and did not acknowledge how the person felt. At this mealtime, after people were given their meal they were not supported to engage with other people, or by staff. Contact between staff and people was functional, such as "Have you had enough?" Several of the people were living with dementia and had difficulties with engagement. Mealtimes can be a significant event in people's lives and supporting people with engagement can enhance their experience. On the other day, we saw staff supported people in an appropriate way, this included a member of staff taking time to talk with people and engage them in conversation, as well as explaining what was for lunch, and the options.

Some people were frail and needed support with their diet and fluids. People were regularly assessed for nutritional and dehydration risk. Where people were assessed as being at risk, a care plan was put in place to identify how their risk was to be reduced. Staff monitored people's dietary and fluid intake to ensure they received the nutrition they needed and drank enough. There was a lack of consistency in some areas, which required improvement. One of the people who was assessed as being at nutritional risk was living with dementia. They showed a behaviour when they ate and drank which meant they did not eat or drink some of what was given to them. We discussed this with staff. They were all aware of the behaviour and said the person always did this. This was not documented in the person's care plan or other records such as food and fluid charts. This meant there was not accurate information for staff, and external healthcare professionals, on what the person had eaten and drunk each day, so their risk could be accurately assessed. However another person's records showed their weight was regularly assessed because they were at risk of losing weight. Their weight loss had been referred to their GP and care plan had been up-dated to show how they were to be supported. Staff told us the person's condition was being kept closely under review, to ensure risk to them was reduced.

Several of the people had additional healthcare needs. One was living with diabetes. Their records showed staff regularly checked the person's blood sugar levels. A record showed the person had a high blood sugar level shortly before the inspection. The person did not have a care plan to outline what staff were to do if the person showed high or low blood sugar levels. The person's records did not document what action staff had taken to support them when they had this high blood sugar level. We asked a senior member of staff what action had been taken when the person had a high blood sugar level, but they said they did not know. As unstable diabetes can affect a person's health and well-being, staff need clear instructions on actions healthcare professionals wish them to take, so they can appropriately support the person in managing their diabetes. The registered manager agreed this was an area which needed review. This is an area which requires improvement

Records showed people were referred to their GP or other healthcare professionals such as the dietician or speech and language therapist when needed. For example a person was seeing a healthcare professional about a heart condition during the inspection. We met with a district nurse who confirmed staff followed any

instructions they gave and contacted them whenever relevant about people's healthcare needs.

Staff said they were supported in providing effective care as there was a training and supervision programme. One member of staff told us enthusiastically "It seems like we're always on a course." A domestic worker told us they were "Glad" that they could be trained in dementia, because several of the people in the home were living with the condition and they thought this training gave them more insight in how to support people. The provider's training plan included relevant areas to ensure staff were supported in caring for people effectively, this included moving and handling people, fire safety and infection control. Records of training were maintained. Where a member of staff did not attend mandatory training, the provider had systems ensure this was followed up and action taken within their policies and procedures. Staff told us they were supervised regularly and could raise issues with their manager if they needed to.

A training manager was in charge of inducting staff into their roles. The home's induction programme followed national guidelines on the inducting of staff into their roles. This training manager knew all the staff who had recently been employed and was aware of staff who needed additional support, for example because they had not worked in a caring role before. This training manager was flexible in their approach to supporting new employees, this included supporting staff who worked only on night duty.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care provided to them at the home. One person said "I don't want for anything." However there were some areas which required improvement to ensure all staff consistently supported people in a caring way.

During our SOFI we observed staff interactions with people who sat in the main lounge, during periods when activities were not being provided, these showed a variance in a caring approach between staff, particularly for people who were living with dementia. Some of the people who sat in the lounge were disengaged and sat staring about the room, some people appeared withdrawn. Some staff made a point of stopping and holding a brief chats and engaging with people as they went through the lounge, others did not and walked through the lounge with no contact with people. For example, a person who had been disengaged with anything, recognised a member of staff who was walking through the lounge, they called them over and began a conversation with them. Two other people who were readily able to converse, joined in the conversation. The person who had initiated the conversation was not able to engage with all that was being talked about and the member of staff did not support them with continued engagement in the conversation. The person who had initiated the discussion, slowly stopped their involvement and returned to being disengaged, while the member of staff and two other people continued their lively discussion. Such interactions did not show a consistently caring approach by all staff where people had difficulties with engagement.

A few people remained in their rooms all the time. One of these people told us how much they liked it when staff came to visit them because they could get "Lonely" at times. There was a lack of consistency between staff when they supported such people. On some occasions the member of staff would go into the person and hold a brief conversation with the person, on others the member of staff used the opportunity to engage with the person.

We discussed these observations with the registered manager. She agreed this was an area which needed to be developed and would look at strategies for supporting staff in making improvements in this area, particularly where people needed support with engagement. This was an area which required improvement.

Staff were consistently polite to people. Where people needed assistance, staff always asked people's permission to support them when helping them to stand or supporting them with drinks and meals. A domestic worker checked with a person if it was alright to clean their room. While they were doing their role, they used it as an opportunity to open up a conversation with the person. The domestic worker clearly knew the person well. While we were in the reception area, a person phoned down to the receptionist because they were anxious about something. The receptionist was very polite and supportive to the person, listening to what they said and giving them accurate information about the matter which was concerning them.

Staff ensured people's dignity. A person who had difficulty with ensuring they kept their clothes clean when eating and drinking was discretely supported in changing their clothes when they needed to, to ensure their appearance continued to be as they wished. We visited a person who remained in their room all the time.

They had removed some of their outer garments. We asked a member of staff for assistance. The member of staff was very friendly and supportive to the person and acted promptly to ensure the person's dignity. Staff were aware of the importance of ensuring people's dignity by keeping them out of pain. One person could experience pain due to a medical condition. They had clear records about how staff were to support them. There were also records about how staff maintained close links with the person's GP to ensure the person was as comfortable as they could be.

People said staff supported their independence and involvement. One person told us "I like way staff let you do what want, but are there to support if need as well." People were able to come and go about all of the home and outside as they wanted to. Some people walked out to the sea front or local shops. They said how much they appreciated being able to do this. One person said "I'm free to come and go just as I like." A person told us "Staff absolutely sort things out for me when I need them to." We saw a person who forgot they needed a walking aid to move around, a member of staff noticed this quickly and went to find the right aid. The person smiled at the member of staff, saying they were so pleased because they could now "Go off and do what I want to do." People said they chose what they did every day, including when they got up to went to bed, what activities they participated in and where they spent their day. A person said if they chose to eat in their room for any reason, this was not a problem.

Staff we met with knew about people's past lives and said they used such information when discussing issues with people and planning their care. Staff spoke about people in a warm, empathetic way and recognised the importance of supporting people in the way they wanted.

Requires Improvement

Is the service responsive?

Our findings

People said staff were responsive to their needs. A person told us they knew about their care plan, and had agreed it with staff. They said staff followed their care plan. However we found there were areas where improvements were required to ensure staff responded effectively to people's needs.

We saw a person who was living with dementia, they showed behaviours which may have challenged others. We heard people who were sitting in the person's vicinity comment to each other on their concerns about the behaviours the person was showing, as if it were a familiar occurrence to them. We asked staff about the person's behaviours. They also confirmed the person showed these behaviours. There was no system for monitoring the person's behaviours, their duration, frequency or any triggers. There was no record made in the person's daily record about what we observed.. When we asked staff about how they responded when the person showed these behaviours, they told us about different ways they did so. The person did not have an assessment of their behaviours or a care plan about their management. Because an assessment had not been completed and no care plan was in place, the provider could not ensure the person was consistently responded to by staff in the way they needed.

Some other people's care plans were generic. For example a person had a care plan which stated they were to be supported to 'continue to communicate effectively.' The person was not able to communicate verbally but the care plan did not state how the person communicated their needs to staff. The support staff were to give the person documented in their care plan was also generic, stating staff were to 'show patience,' it did not state interventions which supported this person. This did not show a person-centred approach to care. The person had a care plan about how they liked to walk about and risks to them due to this at night. We discussed this care plan with staff, who said the person's condition had changed over time and they no longer walked about at night. The person's care plan had been regularly reviewed but it did not reflect this change in the person's condition. This showed people's care plans were not always being accurately reviewed to reflect their current care needs.

People had care plans relating to recreational activities. Where people did not, or were unable to attend activities, their plans did not show how they were to be supported. For example one person who now remained in their room all the time had an activities care plan dated November 2015, which related to when they were more able. There was no plan about how staff were to support the person with their current engagement needs. There were also no records in the person's daily notes about how staff were supporting them with their current activities needs. The person's activities plan review stated their social care needs were met, but there was no evidence for the basis of this statement. Another person who remained in their room all day had music playing. There was no information in their care plan about the types of music they preferred and other interventions to support them, now they no longer went to the lounge.

The provider was not ensuring people's care was appropriate and met their individual needs. This was because they were not carrying out individual assessments of people's needs and designing their care to meet such needs. This is a breach of Regulation 9 of the HSCA Regulations 2010.

Where people were able to engage and become involved with activities, a wide range of choice was offered. One person told us "There's lots of choice and lots of things going on," and another "Whatever you ask for it's there," about activities. We saw the activities manager led a range of different group activities during the inspection. These were well attended and people clearly enjoyed participating in them. When the activities manager was not available, care staff supported people. This included staff who played the piano and sang. The activities manager kept a record of the activities each person took part in or declined. They also kept record of whether the person enjoyed the activity and how they participated. They used this information, and information from the person themselves, to develop a brief overview of each person and what they liked to be engaged with.

Where people had other needs, including mobility needs, continence needs and swallowing difficulties, people had assessments of these needs. Where relevant, advice was sought from external health care professionals. People had care plans put in place about how staff were to meet such needs. A record was maintained of how such needs were met on a daily basis. People's care plans about such areas were regularly reviewed to ensure people's needs were still being met.

The provider did not have a system for documenting smaller concerns and issues raised individually by people. For example a member of staff told us about a person who had raised concerns about the darkness of their room, caused by the scaffolding from the building works to the home. The member of staff told us about how they had discussed the issue with the person and offered support in resolving the issue. In the registered manager's 2016 questionnaire, one person stated they thought a problem which they had, had not been resolved quickly, but there was no further information on this. Because such matters were not always documented and collated, the provider would not be able as part of quality audits to review the types of informal issues raised, whether there were any trends and if all staff responded to such matters in a consistent way. This is an area which required improvement.

People said they could raise issues of concern to them. The home had a complaints procedure which was available to people. All formal complaints were dealt with by the provider. No formal complaints had been made to the provider recently. People told us about the box in the entrance area where people could raise issues or make suggestions. A person told us they used this box to make suggestions to the chef. People felt they could bring up issues with managers and they would be acted on. A person told us about bringing up issues of concern to themselves "It wouldn't worry me, talk to anyone here and they'd do something." A person described the regular residents' meetings and told us these were meetings "Where you can have your say". We observed a residents' meeting taking place on one of the inspection days, it was well attended and chaired by one of the providers. People clearly felt able to raise issues as they wished to.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with were positive about the management of the home. One person told us "It's brilliant here," and another "I cannot fault it." A visitor to the home described it as "Fine," and another said "I'm well impressed." However we found there were a range of areas which required improvement.

The provider had systems to audit the quality and safety of the service, however the audit had not identified a range of areas, and action plans had not been developed to ensure service improvement. This included where people were living with continence care needs. Staff were aware there could be a period of time between the person's assessment by the continence nurse and the delivery of continence aids. During such periods the person's dignity could be compromised by the lack of suitable aids. This had not been identified by the provider in their audits and suitable arrangements made to ensure people could be treated with dignity, until they received delivery of continence aids. Other areas had not been identified. We asked staff about training in supporting people with activities but although they regularly supported people with activities, we were told only the activities manager had been trained in the area. People who had difficulties with engagement, and people who did not go down to the lounge, would need support from staff to ensure they were appropriately supported. The provider had not identified this as an issue in their training plan.

Some audits were not taking place. We looked at supervision records. Some issues raised by staff were not followed through. For example two members of staff were documented as raising different areas where they felt they needed additional support. We looked at these members of staffs' next records. The issues raised by the members of staff had not been followed through to their next supervision meeting, to assess if the training need they had raised had been met or not. Some supervision records had not been completed in all relevant sections. We asked about audit of staff supervision records. The registered manager reported there was no current system to audit such records and ensure all relevant areas had been followed through.

The provider completed a report on their visits. These visits took place regularly. These reports had not identified that regular audits in key areas, including audits of systems for safe recruitment of staff were not being followed. Although the home's statement of purpose outlined their systems for working only with the consent of people, the provider's audits had not identified they were not doing so. There were systems for audit of care plans, but these were not taking place. This meant it had not been identified that some people's care plans were not up to date and did not reflect people's current care needs. For example we saw a person who had difficulties with their breathing. They were attended to by a member of staff, who was supportive to them. Staff confirmed the person did have some breathing difficulties. The provider's systems for audit had not identified that the person did not have a care plan to inform staff on what actions to take when the person experienced breathing difficulties and to ensure they were supported in a consistent way by staff. Because the provider had not identified the person did not have a care plan about this need, they also could not audit if the person's condition was being regularly reviewed.

Audits had not identified that relevant records about people had not been made. When we looked at the person who had breathing difficulties' daily record, no record had been made about this. Another person had bruising on their arm. When we looked on their file they had some body charts completed for when they

had experienced bruising in the past, but a record had not been made of this bruise. We asked a member of staff who said the person could bruise easily, they thought a member of staff may have forgotten to follow the home's policy and document it on a body chart.

People were asked about their views on a range of areas. The registered manager had a system for reviewing responses from people. They developed plans of action as part of their reviews, for example 'reduce the percentage on satisfactory and bring it up to either good or excellent.' The audits did not outline how this was to be done by identifying factors where people had assessed the home as only satisfactory, or how they planned to progress improvements. The registered manager performed an audit of falls which demonstrated factors like how many falls there had been in the past month and factors relating to individual people which may have been a factor like a urine infection. Such audits did not identify action plans for the future to reduce risk to people.

The provider's systems to assess, monitor, mitigate risk to people and improve care did not operate effectively. People did not always have accurate, complete and contemporaneous records about their care. This is a breach of Regulation 17 of the HSCA Regulations 2010.

The registered manager audited other areas. Where issues were identified, action was taken. For example records showed issues had been identified because people's tablets had on occasion been left with them in dining room and they were then found later on in the day, when the person had left the room. An action plan had been developed to address this. It had been regularly reviewed. Reviews showed all staff now followed the home's medicines policy. We also observed staff followed the medicines policy during the inspection. The provider ensured the building was regularly maintained. Scaffolding was in place during the inspection to the rear of the building, due to necessary building works. The provider and contractors had made sure people and staff were safe from risk due to the building works.

The provider, registered manager and their staff were open to new ideas and keen to develop the service as much as possible to support people. For example, by the end of the inspection the registered manager was already considering a range of different options for ensuring that audit of care plans would take place in the future.

Staff commented on the philosophy of care. They said they felt part of a team and that they could contribute ideas, and be listened to. A domestic worker said they were given enough time to do their role, saying "They're very particular here" about cleaning. They said they were pleased this was the case because they had worked in other places where their role had not been seen as important. A member of staff summed up positive comments about working in the home by saying "It's wonderful, I love it."

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring people's care was appropriate and met their needs. This was because they were not carrying out assessment of people's needs and designing care to meet such needs. Regulation 9 (1)(a)(b)(c)(3)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have individual, decision specific mental capacity assessments, including best interests decisions where restrictive practice was implemented.. Regulation 11 (1)(2)(3)(4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always ensuring care was provided in a safe way to people. This was because they did not consistently assess risks to people and do all they could to mitigate such risks. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to assess, monitor, mitigate risk to people and improve care did

not operate effectively. People did not always have accurate, complete and contemporaneous records about their care. Regulation 17 (1)(2)(a)(b)(c).