SHC Clemsfold Group Limited

Upper Mead

Inspection report

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Date of inspection visit:
08 March 2016

Date of publication:
03 May 2016

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

The inspection took place on 8 March 2016 and was an unannounced inspection.

Upper Mead provides accommodation, care and nursing support for up to 48 older people. 11 of the rooms are within the Chestnut Unit, which cares for people living with dementia. There were 43 people in residence at the time of our visit, including nine in Chestnut Unit.

The service 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.

At our last inspection, in February 2015, we asked the provider to take action to improve the way that topical creams were administered and recorded. The registered manager took prompt action to address these concerns. At this visit, we found that improvements had been sustained and that people received their medicines safely. The new deputy manager, a registered nurse, was making improvements to how information about people's medicine was recorded to ensure that details on their individual needs and preferences were accurate.

The provider was unable to demonstrate that they were working within the principles of the Mental Capacity Act 2005 and respecting people's rights. The recommendation made at our previous inspection had not been addressed.

We found that people were at risk of harm because risks had not been minimised effectively through appropriate support and regular monitoring.

Staff and the registered manager were able to speak knowledgeably about safeguarding people from abuse but the registered manager had failed to notify the local authority safeguarding team about an incident of possible neglect.

The provider had failed to display the rating received following our last inspection, which meant that people using the service and relatives may not have been informed of our findings. The provider had also failed to notify the Commission of specified incidents as required by law.

The registered manager and provider used a series of checks and audits to monitor and improve the quality and safety of the service. There was evidence that this system of quality assurance had delivered improvements but it had failed to identify the issues we found during this inspection. We have made a recommendation to the provider that they review their quality assurance system to ensure that all aspects of the regulations are monitored.

The atmosphere in the main part of the service was warm and lively with people able to participate in a range of activities. We found, however, that people who lived in the Chestnut unit lacked social stimulation and that few opportunities to engage in activities were recorded. The registered manager had arranged for further staff training and support to help staff meet the needs of people living with dementia. We have made a recommendation about improving activities and social stimulation for people who are unable to access the main activities in the home.

The premises were well-equipped. Improvements were being made in the Chestnut unit to better adapt the décor and information to meet the needs of people living with dementia.

People were referred to healthcare professionals to promote good health and visiting professionals told us that staff made appropriate referrals.

People and their relatives spoke highly of service and told us that the staff team were marvellous. Staff had developed positive relationships with people and treated them with dignity and respect. Although there were no records of people being involved in planning their care, we saw that people were involved in day to day decisions and that staff knew them well.

People enjoyed the food and were involved in planning the menus. There were regular meetings for residents and relatives to share ideas or concerns and contribute to how the service was run. Everyone told us that the registered manager was approachable and that she responded promptly to any issues they had raised.

There were enough staff with the skills and experience to support people safely. Pre-employment checks were completed before new staff began work. All of the staff that we spoke with told us they enjoyed their work and felt well-supported by the registered manager.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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 safe.

People were at risk of harm because guidance on how to minimise risks was not sufficient and monitoring of risks was not always effective.

Although staff had been trained in safeguarding and knew what action to take, the registered manager had failed to report an allegation of neglect to the local authority safeguarding team.

Medicines were administered safely but guidance on how individuals preferred to take their medicine was not always available.

There were enough staff to meet people's needs and keep them safe. Pre-employment checks had been completed for new staff before they started work.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights may not have been protected because the provider was unable to demonstrate that they had acted in accordance with the Mental Capacity Act 2005 (MCA).

People were offered a choice of nutritious food and drink.

People had access to healthcare professionals to maintain good health.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles and received regular supervision and appraisal.

Is the service caring?

Good

The service was caring.

People received care from regular staff who knew them well and cared about them.

People felt involved in making decisions relating to their care and were encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service not always responsive.

People's care had been planned but did not always include detail for staff on how to engage effectively with people living with dementia.

Records of activity for people in Chestnut unit did not demonstrate that people received regular social support or stimulation. The registered manager had booked a programme of staff training and support to improve the delivery of care to people living with dementia.

People who were able to access communal areas received prompt support and were able to engage in a variety of activities but people in their rooms were not always responded to promptly if they were unable to use a call bell.

People were able to share their experiences and any concerns were quickly addressed

Is the service well-led?

Requires Improvement

The service was not well-led in all respects.

The provider had failed to display their rating received following our last inspection.

The registered manager had failed to notify the Commission of incidents in accordance with the law.

The quality assurance system had been effective at monitoring the service and driving improvement in some areas but had failed to identify that the service was not meeting the requirements of some regulations.

The registered manager was well respected and approachable. A new deputy manager who was a registered nurse had recently started to work at the service and was making improvements in clinical care and record keeping.

Upper Mead

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 8 March 2016 and was unannounced.

Two inspectors and a nurse specialist advisor undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed one previous inspection report and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We observed care and spoke with people, their relatives and staff. 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 looked at care records for eight people, medication administration records (MAR), monitoring records for food, fluid and people's weights, three staff files, staff training and supervision records, staff rotas, quality feedback surveys, accident and incident records, staff handover records, activity records, complaints, audits, and minutes of meetings.

During our inspection, we spoke with 13 people using the service, three relatives, the registered manager, the deputy manager, two registered nurses, five care staff, the activity coordinator, the chef, one housekeeper and a representative of the provider who was visiting. Following the inspection, we contacted professionals to ask for their views and experiences. These included a GP and a tissue viability nurse (TVN) who had involvement with the service. They consented to share their views in this report.

Requires Improvement

Is the service safe?

Our findings

Risks to people's wellbeing and safety had not always been effectively mitigated. People who had been identified as at risk of skin breakdown had equipment such as pressure relieving mattresses and cushions. We found, however, that the pressure relieving mattresses were not always set correctly, according to the person's weight. Having the mattress set too firm or too soft could result in pressure damage occurring. There was no guidance in people's care plans as to the correct setting. In one person's bedroom the chart used for checking the mattress referred to 'Setting 1' but the mattress in use did not have numbers, just a band that became thicker to indicate the firmness of the mattress. The deputy manager explained that they were in the process reviewing the mattress checking system, linking weight to pressure relieving mattress settings as described in the guidance for the different manufacturers. This work had been started the day prior to our visit and the mattress check sheets had been removed from people's rooms. By the end of the inspection all people with pressure relieving equipment had a chart reflecting their weight, the mattress being used and the correct setting.

Guidance on how to mitigate risks to people was not always sufficient. One person was taking medicine for low blood pressure but there was no guidance on how often their blood pressure should be checked or details on how they should be supported in relation to this health need. There was no evidence that the care team had received guidance or training to support oral hygiene. In the care plans that we reviewed there was no information relating to individual oral hygiene support needs. We observed, and staff confirmed, that one person had recently lost four lower front teeth which could impact on their ability to eat, drink and communicate. Following our visit, the registered manager informed us that oral care was now included in people's care plans and had been added to the daily recording of care delivered.

Records did not demonstrate that risks had been monitored to ensure people's safety. Where people were regularly losing weight, the care records did not demonstrate that action had been taken. One person who had lost weight between November and December 2015 had not been weighed in either January of February 2016 to determine whether the weight loss had continued or improved. The records for weight monitoring included a three-month check on cumulative weight loss but this had not been completed in the majority of cases. One person had lost 25kg since their admission to the home in 2014. In some months the person had lost 4kg but their care records did not demonstrate that staff had been instructed to make additional efforts to encourage and support this person with high calorie drinks and snacks, or to increase the frequency of weight monitoring. We read in one person's pre-admission assessment that they were, 'On fortified milk, one glass twice a day' but in their nutrition care plan it simply stated, 'Normal diet'. There was no recorded weight for this person on admission which meant that staff would be unable to make an informed decision about any loss or gain in weight until a baseline weight had been recorded, putting the person at risk in the first few weeks of care.

Where people had supra-pubic or urinary catheters the records did not demonstrate that the washouts had been completed as prescribed. This put people at increased risk of infection and catheter blockage which would cause distress and discomfort. For these people, care plans directed staff to ensure that fluid intake and output is recorded at all times. We found that fluid monitoring charts did not include the volume of

output and that intake had not always been totalled to demonstrate that the person had enough to drink. There was no information in the care plans of people who were at high risk of urinary tract infections (UTI) and dehydration in relation to target amounts of daily fluids to minimise infection and dehydration risks. Following one person's admission to hospital with an acute kidney infection, urinary tract infection and high blood sodium levels, most likely caused by dehydration, the care plan had not been reviewed to ensure staff had guidance to support improved fluid intake. Although the risk was known, the provider had not taken action to review the person's care and reduce the risk of reoccurrence.

The provider had not done all that was reasonably practicable to mitigate risks to people's safety because care records lacked detail and monitoring was not always effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety had been assessed. Mobility assessments included details of specific tasks such as 'sit up in bed', 'turn/roll in bed', 'sit/stand', 'walking', 'toilet', 'dressing' including where people could manage independently and when staff were required to support. Mobility aids that people required to promote independence were clearly recorded. Where people required the use of hoists, details of the specific equipment and sling size was not recorded, although photographs of the person's individual sling were available. We observed staff supporting one person to transfer from their wheelchair to an armchair using a stand aid. This was carried out safely, with guidance and reassurance provided to the person. One person told us, "I have a stick and a zimmer frame which makes me feel safe". A staff member said, "We make sure the environment is safe. If someone is assessed with mobility needs we walk in twos, we check the equipment". Other individual risks were also documented. For one person who was at risk of skin tears, staff were advised to use a patting motion and not to rub the person's legs when applying cream. Another person who could not use a call bell to summon assistance was checked every half an hour to ensure their wellbeing.

Although staff and the registered manager were able to describe the action to take in response to a safeguarding concern, we identified that the registered manager had failed to alert the local authority safeguarding team following an incident which may have constituted neglect. In the minutes of a nurses meeting dated October 2015 we read that one person's medicine for blood pressure had been missed from the monthly order and that they had therefore not received it. Nurses had reported that the person had high blood pressure and was feeling very unwell but had not identified that the medication had been missed. The registered manager had taken action by speaking with the GP, arranging further nurse training and ensuring that ordering of medicines was carried out by two staff. They had, however, failed to notify the local authority safeguarding team and had not notified the Commission. The registered manager told us, "In hindsight I should have safeguarded. All the action was taken but I didn't do that bit".

The failure to take the necessary action of informing the local authority safeguarding team in line with local protocols was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe and happy at the service. One person told us, "I have all I need". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One staff member said, "There is financial abuse, sexual abuse, demeaning people, physical abuse, shouting, the list goes on. It's awful to think of". Another told us, "I've got to know people so I would know if they behaved differently". Staff told us that they felt able to approach the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team. One staff member said, "There is a number you can call if you don't like something you

see. You must report it. They take up the reins on any concerns".

At our inspection in February 2015, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the records for administration of topical creams, prescribed to support people's tissue viability care, did not demonstrate that people had been supported to apply these creams as prescribed. The provider took prompt action to address the concerns. At this visit we found that a new system recording the administration of topical creams was in place and demonstrated that the changes in practice had been sustained. The steps taken meant that the requirement concerning the proper and safe management of medicines was met.

Medicines were stored safely. Records of administration were completed and demonstrated that people had received their medicines as prescribed. We observed that nursing staff supported people as they took their medicines, and ensured that they had been taken before leaving the person. We found, however, that photos of some people were more than two years old and did not always reflect the person's current appearance. Furthermore, information relating to how people preferred to take their medicines was missing in some cases. A new member of the nursing team told us how they may have struggled to support one person with their medicines had a colleague not told them that one person would only take their medicines after staff engaged with their toy giraffe. This information was not recorded. This highlighted the importance of providing updated information so that staff were able to meet people's specific needs, especially where new, temporary or agency staff were given responsibility for administering medicines.

We also found that information on when to give medicines prescribed on an 'as required' basis lacked detail or was missing. For example, where people were prescribed medicines to manage behaviours that might challenge, there was limited information on how to minimise distressed behaviours before administering a medicine with sedative effects. Similarly when laxatives had been prescribed there was no detail on when it should be given, for example after how many days without a bowel action. The new deputy manager had identified the need to improve the information recorded for each person. During our inspection the nursing team were in the process of updating the profile pages and protocols for administration of 'as needed' medicines.

There were enough staff to keep people safe. One person told us that the staff were very good and said there seemed to be enough staff on duty. Care staff were allocated to the ground and first floors as well as to the Chestnut unit. Staff told us that there was flexibility and that if they required additional support, for example at mealtimes in Chestnut unit, this was easily arranged. Two registered nurses were on shift during the day and one at night time. In addition the home employed activity, domestic, laundry, kitchen, administration and maintenance staff. This meant that care staff were able to focus on providing support to people. We observed that staff responded quickly to people when they asked for assistance. We noted, however, that they were slower to respond to those people who were known to call out on a regular basis. This has been detailed in the 'Responsive' section of this report. The registered manager used agency staff to maintain staffing levels when there was absence within the staff team. The rotas demonstrated that the service used regular members of agency staff which helped provide consistent care to people. The service checked the skills and competencies of agency staff before they were accepted to work in the home. Staff were happy with the staffing level and felt confident that they were able to support people safely and appropriately.

The service was recruiting and had appointed a registered nurse who was due to begin their employment. Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These

measures helped to ensure that new staff were safe to work with adults at risk. For overseas staff, their eligibility to work in the UK was checked prior to appointment. The service maintained a check on the professional registration of its registered nurses with their professional body. A copy of their current registration was in their staff files.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we made a recommendation about how decisions are recorded to demonstrate that people's rights under the Mental Capacity Act have been respected. At this inspection we found that the records did not demonstrate that people had been involved in decisions related to their care and that their rights may not have been respected.

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.

The service was unable to demonstrate that they were working within the principles of the MCA. We saw that assessments for bedrails had been signed by staff and the GP and that consent to the use of photography in care records had been signed by staff. There was no evidence of the person having being involved or of an assessment of their capacity in relation to the decisions in question. Most capacity assessments on people's files did not state the specific decision that was to be made. In one person's care file we found a capacity assessment from May 2014 which concluded that they lacked capacity and a second assessment dated August 2014 concluded that they had capacity. There was no information on either document as to what their capacity had been assessed in relation to. The Mental Capacity Act Code of Practice principles state that people should be assisted as much as possible to make decisions that affect them and that an assessment of their mental capacity should be specific to a particular decision at a particular time. The records we reviewed did not demonstrate that these principles had been followed.

Within the Chestnut unit, there was little evidence of reviewing practices to achieve the least restrictive care for people living within the keypad secured environment. Furthermore, where people expressed distressed behaviours when receiving personal and intimate care, there was little practical guidance within the care plan to help the care staff support the person in the least restrictive way. For example, one care plan for a person living in Chestnut unit stated, 'When (name of person) declines personal care on the first attempt, come back when she has calmed down and is less anxious'. People living with dementia often say "no" to direct questions as they can have difficulty in interpreting the question and don't always see the need for support. Therefore, care staff need to be confident rephrasing how they describe the support they will be giving, gaining trust and making care an 'emotionally safe' experience. There was no evidence in the care plan to detail the best approach, the best time for care or what to do if care is consistently refused.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Chestnut unit was secured by a keypad. The registered manager had submitted applications to deprive people who lived in this unit of their liberty and best interest meetings had been held with relatives and other professionals. One person who had recently moved to the Chestnut unit did not have a DoLS application in place. The registered manager told us this

was because a DoLS had been authorised at their previous nursing home, run by the same provider. This demonstrated a lack of understanding of the safeguards which state that, 'If a person who is subject to a standard authorisation moves to a different hospital or care home, the managing authority of the new hospital or care home must request a new standard authorisation. The application should be made before the move takes place'. The registered manager did not realise that the authorisation was not transferrable and this person had, therefore, been unlawfully deprived of their liberty.

The provider was unable to demonstrate that people had consented to their care or that they had acted in accordance with the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People enjoyed the food at the service. During lunch we heard comments including, "That looks very nice", "That's wonderful" and, "It was delicious". One person told us, "The food is very good. There is enough of it". The chef explained that they used a five week menu which consisted of two main meal choices and changed with the seasons. In addition there were special menus for celebrations such as Christmas and St. Patrick's Day. People had the opportunity to make suggestions at residents' meetings or directly to the chef. One person said, "They ask for special requests if you have a birthday". We observed that people were asked for their choice of meal during the morning and that this list was then passed to the kitchen. A pictorial menu was available to assist people in making choices but we did not see this in use.

When a person moved to the home they were asked about their dietary needs and preferences. In the kitchen there was a reference board which detailed specific needs such as, diabetic, vegetarian, no pork, fork-mashable or pureed diets. The chef told us that one person was particularly keen on creamed spinach so they made different meals using this as a base, such as with puff pastry. Where staff had concerns about a person's ability to swallow safely, referrals had been made to the Speech and Language Therapist (SALT). Recommendations of food and fluid textures had been incorporated into people's care. Where people needed aids such as plate guards, adapted cutlery or beakers to help them manage to eat and drink independently, these were available.

We had concerns over how the service monitored and responded to weight loss over a period of time. This has been detailed in the 'Safe' section of this report. There were also positive examples of people who had put on weight whilst living at the service. The mealtime experience in the main dining area was positive and enjoyable with plenty of conversation between staff and people themselves. A food diary was maintained for two people who were at risk of malnutrition and weight loss. This was completed in full by staff on a daily basis and detailed what had been offered and how much was consumed. Although we had concerns about fluid monitoring for people at risk of dehydration, we observed that drinks were readily available and were offered to people on a regular basis. We saw that a concern over fluids had been raised at a staff meeting in October 2015 with the registered manager highlighting the importance of supporting people to drink enough for their health and to avoid urinary tract infections (UTIs).

People had access to the GP and other health professionals such as the physiotherapist for mobility and the SALT when people were identified as having choking risks. Records of weight monitoring, however, suggested that people were not always referred to the dietician in a timely way. Healthcare professionals who visited people at the service told us that they received timely and appropriate referrals and felt that staff were knowledgeable about the needs of people they supported. The GP told us, "I have not had any concerns about a delay in seeking medical advice. Similarly, any changes or requests from myself, e.g. blood tests are carried out promptly".

People spoke highly of the staff who supported them. One person told us, "The staff are very good". Staff felt

confident in their roles and had received necessary training. One staff member said, "They're very hot on training here". Another told us, "The training here is unbelievable, it goes on and on. It is always good". The provider had its own training academy and ran regular courses in topics such as infection control, moving and handling, dementia care, fire safety and safeguarding. The registered manager kept a record of staff training, which was used to ensure that staff refresher training was updated. Where training had become due, we saw that staff had been booked on forthcoming courses. In addition to the training made mandatory by the provider, some staff had attended additional courses in end of life care, delivered by a local hospice, and in managing behaviour that might challenge.

New staff attended a four day programme of induction which included general and role-specific training. For staff employed to deliver care, role specific training included further dementia awareness training, personal and intimate care and epilepsy. Each new employee was allocated a mentor and spent two weeks shadowing more experienced staff on a supernumerary basis. This allowed them time to get to know the people they would be supporting and to understand their role and responsibilities. The provider had introduced the Care Certificate, which is a nationally recognised standard of training for staff in health and social care settings. We saw the records for one new staff member who had completed this qualification.

Staff felt supported in their roles and received regular supervision. One staff member said, "I've had loads of support and supervisions". Records confirmed that staff had attended three supervision meetings and an annual appraisal with their line managers. This provided an opportunity for them to discuss achievements, concerns and professional development. One staff member was being supported by the provider to train as a nurse. They told us, "I'm very thankful to my manager, she is putting me on my nursing training".

The service was spread over two floors, with the Chestnut unit located on the ground floor. At the centre of the building was a courtyard garden. The premises were well equipped and included quiet areas for people to rest or receive visitors. The Chestnut unit was in the process of being adapted to make it more suited to the needs of people living with dementia. Toilet doors were yellow to assist people to recognise the toilets and included clear signage depicting pictures and words. People had been invited to choose stickers which made their bedroom doors appear like a front door, in the colour of their choice. On the day of our visit the lounge in the Chestnut unit was due to be wall papered and was out of use during the morning. During this time people were cared for in their rooms.

Good

Is the service caring?

Our findings

People told us that they were very happy living at Upper Mead. One said, "The staff are lovely, we've not found one that we didn't feel at ease with". Another told us, "They're (the staff) very friendly. They're good as gold and very chirpy". A third person gave us the thumbs up and nodded when we asked if they were happy at the home. Relatives were equally complimentary. One said, "it couldn't be better; I will put my name down to come here when I need to". Another had written in the provider's feedback questionnaire, 'I would just like to say that the staff go the extra mile for people they care for, always so very friendly and welcoming'. We observed that staff were gentle and patient in the way that they supported people. When one person became upset, a staff member stopped immediately and provided reassurance. One staff member told us, "I know them very well. I know their needs, their moods, their facial expressions".

Although the records did not evidence that people had been involved in planning, reviewing and evaluating their care, people told us that they were quite happy. They said that staff involved them in decisions relating to their daily care and how they wished to spend their time. During our visit we observed staff offering people choice and respecting their decisions, such as on whether they wished to participate in the activity taking place in the lounge, or on what they wished to eat and drink. Staff described to us how they made sure people had a say in their care. One staff member said, "We give people choices. Mostly people can verbalise it or express it with facial expressions to show choices, they can choose clothes in the morning by pointing, smiling and nodding". Another said, "Don't assume that what you like is what they like. Even if it is not to your taste, if they want to wear it they should. It's not your choice". They added, "By finding out what they like and don't like we can deliver person centred care. Some need more time to communicate, it depends on their needs".

People's care plans described the tasks they could manage independently and those where staff support was required. In one, we read, '(Name of person) can still change his clothes independently. Staff to monitor if those clothes are clean and wash all dirty ones'. We observed that one person had a large button telephone in their bedroom and that another was using a mobile phone to make a call from their room. We observed a staff member supporting a person to drink. They placed the cup in their hands and gave verbal reassurance that they were holding a drink and to go ahead and have some. The person was able to take some sips independently. One staff member told us, "We encourage them with personal care to do things themselves". Another told us about a person who had a fall the previous month, explaining, "She lost her confidence, however we have encouraged her to stand up, then a few days later encouraged her to take a step forward, a few days later steps with the zimmer frame." This demonstrated that staff understood the importance of encouraging people, allowing time and promoting independence.

People told us that staff respected their privacy. One person explained how they enjoyed mealtimes in the main dining room but chose to spend some time quietly in their room during the afternoon. A member of housekeeping staff told us, "I generally don't go in people's bedrooms if they are eating, I knock before entering, I wait for permission. Sometimes I'm told to go away so I try again later". Another staff member said, "When we are doing care we shut doors, put towels on them if getting washed, close curtains when receiving care. If they don't want a man doing their care we don't put men in charge of their care". We

observed that staff respected people and treated them with dignity. At lunchtime one person was sitting in their wheelchair in a busy passing area. A staff member asked politely if it would be possible for them to move to the side. People were dressed individually and appeared well cared for. One person was particularly proud of their nails which had been colourfully varnished to include a pattern on each nail.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan describing how staff should meet their needs in areas such as personal care, communication, sleeping and continence. For some people additional relevant care plans were in place, for example describing how staff should support the person if they had an epileptic seizure. The care plans included people's preferences, such as to receive support from female staff or to wear trousers during the day because they felt the cold.

Staff were able to speak knowledgably about people's care and support needs. One staff member told us, "We make others aware of changes through handover and daily records". A GP who had recently started to work with the service told us, "I have found the nurses I have dealt with to be caring and well-informed about the patients". We found, however, that although care plans had been reviewed on a monthly basis, associated documents such as the hospital passport had not been reviewed. A hospital passport would be used to share key information about the person's needs and wishes if they were admitted to hospital. For example, in one care plan we read, 'I am no longer able to walk with my zimmer frame' and staff were advised that a wheelchair should be used. The hospital passport still referred to the person walking with the aid of a zimmer frame. We discussed this with the registered manager who informed us following the inspection that the hospital passport would now form part of the monthly review.

Staff were quick to respond to people's needs when they were in the communal areas or used their call bells to request assistance. We observed, however, that those who were known by staff to call out on a regular basis did not always receive a prompt response. When one person was calling out and staff explained that this was a usual pattern of behaviour. As a result they did not respond to the person in a timely way. When we visited the person they told us that their feet were cold and that they wanted their slippers on. On another occasion we heard a person calling for seven minutes. As no staff had come to attend to the person we informed the registered manager. When we went to this person's room their call bell was not in reach, although staff told us they were able to use it. The registered manager asked a staff member to perform a check throughout the home to ensure that people in their rooms who were able to use a call bell had theirs in easy reach. A third person began to undress in a communal area. A nurse who was monitoring the lounge told us, "He does this every evening" but did not offer any support or reassurance. The nurse only intervened when another person who lived at the service offered to assist the person to get undressed. The care plans for these people did not make reference to these behaviours or describe how staff should respond to improve the person's wellbeing or reduce social isolation.

People in the main part of the home were very positive about their experiences. The atmosphere was warm and friendly. A comment in the visitors' book read, 'Wonderful home, great staff, great atmosphere'. A staff member told us, "The first thing that struck me was the atmosphere. It was calm and friendly and that's still the case". Another staff member said, "We are very much a family here. Things get sorted. We talk to one another. We help each other out". On the day of our inspection the lounge in Chestnut unit was due to be wallpapered. As a result people were being asked to stay in their bedrooms. There did not appear to be any alternative provision, such as the use of another lounge area within the home or one to one activities in people's rooms. By the afternoon the lounge was back in operation. Our observations were that people

received task-based support but there was little by way of stimulation or activity for people to engage with.

Records of activity for people who lived in the Chestnut unit did not demonstrate that they received regular stimulation or opportunities to participate in activities. The registered manager told us that all activities were documented. Records showed that two people had been offered or participated in activities on seven occasions during 2016 to-date. This equates to less than one event or activity each week. One person told us, "I'm bored to tears". The activity coordinator told us, "Chestnut is really difficult for activity; they don't want to really interact". Similarly, for people who were cared for in their rooms, there was little evidence to demonstrate that they received opportunities for social interaction outside the delivery of care. In people's care records, there was limited information regarding their life story, hobbies or interests which could potentially be used to good effect by staff in providing activities and meaningful occupation. We recommend that that the registered manager considers opportunities to improve activities and social stimulation for people who live in the Chestnut unit and for those who are cared for in their rooms.

The registered manager had already taken action to improve the individual support that people living in the Chestnut unit received by requesting support from the dementia in-reach team. This team works in residential services to increase staff understanding and support improvements in care through the delivery of a 16 week programme of staff training and support. The registered manager hoped that the team would be able to start work within the home in the coming months.

For people who lived in the main part of the home and who were able to access the communal area, there was a varied activity programme on offer. Activity staff worked in the home Monday to Saturday each week and had developed a daily programme of entertainment including music, arts, games and flower arranging. In addition, visiting entertainers had been booked to deliver musical entertainment, pottery, pub skittles and a vintage tea party. One person told us, "Company is the number one priority; there is always someone to chat to". The atmosphere in the main lounge/dining area during the day of our visit was lively and full of fun. People were enjoying chatting to each other and during the morning were seen reading newspapers or completing puzzle books before being invited to join in with flower arranging. In the afternoon there was an animated game of bingo which appeared to be thoroughly enjoyed. The activity coordinator told us, "Activities are based on mood. Sometimes they start their own things, such as table games". The home had its own minibus. In the minutes of the residents' meeting from February 2016 the registered manager had informed people, 'As soon as the better weather comes we plan to go out twice a week when possible'.

People were invited to share their views during regular resident and relative meetings. We saw that the menu and activities were regular features on the agenda and that both the activity coordinator and chef attended these meetings so that they could respond to any questions and act on suggestions. At the end of the meeting the registered manager invited further feedback by saying, 'I would like to thank you all for coming, be sure to come and see me for anything you want however big or small the request'. People told us that they felt able to speak with the registered manager. Some relatives had attended individual meetings with the registered manager which were recorded. Suggestions from these meetings, such as for a weekly hair wash and set or for a physiotherapy referral had been acted upon.

People and relatives understood how to make a complaint, although everyone we spoke with was very happy with the service. One relative said, "We've been in other care homes, we have no complaints at all". The registered manager had responded to complaints in accordance with the provider's policy, inviting people to share their experiences and listening to concerns.

Requires Improvement

Is the service well-led?

Our findings

The provider had not displayed their rating received following our inspection in February 2015. From April 2015, providers are required to display performance assessments by law. This should be conspicuous and in a place accessible to people who use the service, as well as on their website. The provider had been in breach of this regulation following an inspection at another of their services in September 2015 but had not taken action to ensure that the rating was displayed at Upper Mead.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the evening of our inspection, a representative of the provider had displayed a laminated colour poster, showing the rating received at our last inspection alongside the folder containing our last inspection report. However, this had not been done until the inspection team prompted the provider to do so.

The registered manager had failed to notify the Commission of specified incidents that are required by law. We found that authorisations of DoLS had not been shared with us and that two allegations of abuse, raised by visiting healthcare professionals and investigated by the local authority safeguarding team, were not notified. The incident of missed blood pressure medication detailed in the 'Safe' section of this report was not notified to the Commission. In the nurse meeting minutes we read, 'I am going to offer you all a warning instead of being reported to the CQC by the Doctor'. The registered manager did not respond openly to this incident and failed to act in line with their legal responsibilities.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager described the purpose of quality assurance as, "To make sure the service users are happy, the families are happy and that anything brought up is dealt with straight away". There was a system in place to seek feedback from people and their relatives. This included regular meetings and an 'open door' for one to one meetings as required. People were asked for their feedback on the food served. This feedback was used by the chef to adapt the menus and to note specific requests, such as for a smaller portion size. The provider also sent surveys to relatives requesting feedback. Responses had been acknowledged in writing or by inviting the person to a meeting to discuss their concerns or ideas in further detail. Following a curry night at the end of the year, one relative had written, 'It was good to meet so many of the staff and their families and to get to know them better. The atmosphere was happy and homely, just what we all want'.

The quality assurance system in place consisted of service level, provider and external audits. On a weekly basis the manager sent a report to the provider covering an inspection of the premises, accidents and incidents, complaints, staffing and agency use. There was a monthly medication audit and hoist slings were checked each month to ensure that they were in good condition and safe to use. On a monthly basis a representative of the provider carried out a review of the service which included looking at a sample of care plans and staff files. For each of these audits an action plan had been drawn up and used by the registered

manager to make the suggested improvements. For example the suggestion to review the time that accidents and incidents occurred to determine if there was any pattern had been completed.

An audit of health and safety was conducted by an external company. We saw that the service had scored 89% in December 2015, which is at the top of the 'very good' category. This score had improved since the last visit in November 2014 which demonstrated that the audit had been used effectively to deliver improvements in the health and safety.

The service's compliance with the regulations had been assessed by an external auditor in March 2014 and October 2015. We noted that in the 2015 report that the auditor judged eight of the 18 recommendations they had made in 2014 to be either not addressed or partially addressed. We discussed this with the registered manager who showed us their action plan relating to the audit showing that they considered each action to be sufficiently addressed. There was an action plan in place relating to the 2015 visit. Many of the actions, such as cleaning and maintenance tasks had been signed off as complete during November 2015. The registered manager wrote to us following the inspection to say, 'There are no outstanding (actions) to be completed or any internal or external audits'.

Although the registered manager and provider had a quality assurance system in place, it had not been effective in identifying their failure to comply with the requirements of some regulations as identified in this inspection report. Although action had been taken to comply with the Regulation breach identified at the February 2015 inspection, additional areas requiring improvement were identified at this inspection. We recommend that the provider reviews its quality assurance system to ensure that learning is shared between services and that the requirements of all regulations are reviewed.

People, relatives and staff spoke positively about the registered manager. They told us that she was approachable and always willing to help. A staff member said, "I always feel supported. (The Registered manager) is an excellent manager. If I have any problems I know I can rely on her". A relative had written a card of thanks which said, 'A well run home. Thanks for all you did for my husband'.

The day prior to our inspection, a new deputy manager had started work at the service. The deputy manager was a registered nurse and was taking the lead in clinical care. Prior to this the service had not had a deputy manager since December 2014, other than for a period of three weeks during summer 2015. The deputy manager had already identified key areas for improvement such as restructuring the care files to include the information about weights and nutrition in individual care files, updating protocols for 'as needed' medicines and the front sheets on people's medication administration records. The deputy manager demonstrated a clear understanding and vision regarding improvements they intended to introduce.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of the incidents specified. Regulation 18 (1) (2)(e) (4A)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was unable to demonstrate that people had consented to their care or that they had acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not always provided in a safe way because the provider had not taken sufficient action to mitigate risks. Regulation 12 (1) (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	The provider had not operated an effective system to protect people from abuse and improper treatment. Regulation 13 (1) (2) (3)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display the rating received in its performance assessment by the Commission. Regulation 20A