Larchwood Care Homes (South) Limited

Great Horkesley Manor

Inspection report

Nayland Road
Great Horkesley
Colchester
Essex
CO6 4ET

Tel: 01206271394

Date of inspection visit:
07 July 2016
08 July 2016
11 July 2016

Date of publication:
10 October 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

Great Horkesley Manor provides accommodation and personal care for up to 73 older people. Some people have dementia related needs.

The inspection was completed on 7, 8 and 11 July 2016 and there were 49 people living at the service at the time.

A manager was in post but they were not registered with the Care Quality Commission. 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. This service has had managers in post, but there were times that they were absent for long periods and no one has been registered since April 2014.

The last inspection on 14 November 2014, found that the provider was not meeting the requirements of the Health and Social Care Act 2008 in relation to the management of complaints, the management of safeguarding concerns and the poor management of health care records. An action plan was provided to us by the provider on 29 May 2015. This told us of the steps they had taken and that the provider believed that they were already meeting the relevant legal requirements. During this inspection we looked to see if these improvements had been made.

We found that some improvements had been made in some areas but that there were other areas that gave us concern and were falling short of the respective regulations.

There was not always enough staff on duty to care for people when they wanted or needed it or to help keep people safe. Before our inspection, individual needs assessments had not been carried out to calculate the necessary staffing levels that people needed so that the necessary numbers of staff would be on duty. We have been informed that these were now being done.

Risks were not always managed in a way that kept people safe from preventable harm. Equipment was in use that were potential risks to people and no risks assessments had been done to determine what safeguards could be put in place to minimise risks to people. Fire risks were not recognised or attended to, there was no up to date fire risk assessment in place.

This service did not always protect people's rights under the Mental Capacity Act. The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and are required to report on what we find. The MCA sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The DoLS are a code of practice to supplement the main MCA code of practice. Where people lacked capacity to make day-to-day decisions about their care and support, we saw that decisions had been mostly made in their

best interests, however there was an example where decisions had been made in relation to one person without making sure their legal rights were being protected.

People were not always given the choice of when to get up in the morning or when they could have their breakfast, sometimes they were got up earlier than they wanted and had to wait to have breakfast.

People's care plans did not always reflect the current needs of the person. They had not been updated as their needs changed or their health had deteriorated.

Arrangements were in place to regularly assess and monitor the quality of the service provided. However, the concerns and breaches to regulations that we have highlighted during our inspection were not identified or dealt with. This indicated that the service did not have an effective quality assurance monitoring process in place.

Effective arrangements were now in place to demonstrate that where safeguarding concerns were raised these had been responded to appropriately.

People enjoyed their meals and had enough to eat and drink to meet their needs and staff assisted or prompted people with meals and fluids if they needed support.

Staff treated people with warmth and compassion. They were respectful of people's dignity and offered comfort and reassurance when people were distressed or unsettled. People's privacy was protected at times like personal care, but their care notes were sometimes left unattended in open cupboards and could be easily seen by people not authorised to see them.

Staff showed commitment to understanding and responding to each person's needs and made sure that people who were becoming unwell were referred promptly to healthcare professionals for treatment and advice about their health and welfare.

Outings and outside entertainment was offered to people and staff offered activities on a daily basis. People thought that changes in the way activities were presented meant they had less choice, but the manager had plans to make improvements and had introduced areas of interest around the service, such as a replica bar where people could spend time relaxing in a sociable area.

Staff understood the importance of responding to and resolving concerns quickly if they were able to do so. Staff also ensured that more serious complaints were passed on to the management team for investigation. People and their representatives told us that any complaints they made would be addressed by the manager.

People told us that they enjoyed their meals and had enough to eat, although the lack of sufficient numbers of staff sometimes had a negative effect on their mealtime experience. The management of medicines was suitable and people received their medication safely.

Staff felt supported and believed that the new manager would make changes for the better in the service. Staff received regular training opportunities. Staff received a robust induction and supervision and appraisal.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding and complaints management. 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 did not provide a consistently safe service.

Equipment that was not safe was in use without risk assessments being done and safeguards in place to protect people.

Fire risks were not dealt with or recognised and there was no up to date fire risk assessment in place.

There were not sufficient numbers of staff to keep people safe. Recruitment and selection procedures were appropriate.

The arrangements for the management of medicines were safe and the improvements the provider had told us they would make had been implemented.

Is the service effective?

Requires Improvement

The service was not always effective.

This service does not always protect people's rights under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards.

Staff received appropriate opportunities for induction and training to carry out their roles.

People received a varied diet and were supported to have their needs met. People's nutritional needs were assessed and action was taken where people were considered to be at risk of poor nutrition and dehydration.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

Staff demonstrated a good understanding and awareness of how to treat people with respect.

People who used the service and those acting on their behalf were positive about the care and support provided at the service by the care staff. Our observations demonstrated that staff were friendly, kind and caring towards the people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs were assessed but people's care plans did not always reflect their needs.

Complaints were dealt with and recorded and people were given the opportunity to comment on the quality of care they received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a manager in position, but they were not yet registered with the Commission and the service has not had a registered manager since April 2014.

Quality assurance audits were carried out in some areas, but were not comprehensive to effectively cover all aspects of the running of this service.

Great Horkesley Manor

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 7, 8 and 11 July 2016 and was unannounced.

The inspection team consisted of one inspector and two experts by experience who had experience of working with or caring for older people living with dementia.

Before the inspection reviewed the information we held about the service by looking at notifications received from the provider and from contacting the Local Authority. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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.

Over the three days of our inspection we spoke with 21 people who used the service, seven relatives, 14 members of staff and the manager and their deputy manager. We also spoke with two healthcare professionals and one medical professional. During the inspection the manager was supported by the organisation's regional manager.

We reviewed six people's care plans and care records. We looked at staff training, recruitment and support records for five members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information, safeguarding alerts and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

We found that the service was not always safe but the people we spoke with told us that they felt safe living in the service, some people were not able to talk to us because they were living with dementia, but we spent time with some of those people, chatting with them generally. On the whole they were relaxed and did not give the impression of being worried about their safety. One person told us, "I do feel safe here; someone will come to me if I press my buzzer." Another person told us, "There is someone I can talk to if I am worried." However, we found that this service did not always protect people's safety.

Great Horkesley Manor had two units, Chestnut was specifically for people living with dementia and there were a high percentage of people with dementia related difficulties living on the other unit, Willow.

Risks were not managed in a way that kept people safe from preventable harm. Heated food trollies were used on both units of the service and were accessible to everyone, staff and people who used the service. The trollies were left plugged in and were unsupervised by staff when there were people in the dining room waiting to be served their meal. The surface of the food trollies were burning hot to touch and would have burnt people who came in contact with them. There was also an electric porridge maker in the same area, it also had hot surfaces.

In the Willow lounge there was an oil filled radiator that was on and radiating a lot of heat and the surface was very hot and would have burnt anyone who came in contact with if, particularly if they fell and leant against it. Access to it was not restricted.

There was no risk assessments in place for the use of any of the equipment listed above in the unsupervised proximity of the people who used the service. This is a breach of Regulation 12(1) (2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection the oil fired heater was removed from use and risk assessments were put in place to minimise the risk to people in regards to the use of the heated trollies, although the risk remained high because, although the trollies were turned off immediately they were no longer in use, they took a long time to cool down and staff were not always with them during the cooling period. Since our inspection we have been told that action has been taken to make sure the food trollies are not left unattended in the dining areas when there is no staff available to ensure people's safety. When they were not in use they would be removed from the communal areas and locked away.

The ceiling in a cupboard in the manager's office had part of the plater removed exposing the wooden structure under the plaster, this was the wooden floor above. The cupboard housed paper files and records as well as a fridge and a kettle, the presence of the stored paper and electrical equipment increased the risk of a fire outbreak in the cupboard. This meant that the underfloor, and the space between floors, were exposed and was not protected from fire should it break out in the office. There was no up to date fire risk assessment for the building and no understanding of the fire risk this situation posed to the safety of the people living in the service, their visitors and the staff.

There were no hand or grab rails in the service to enable people to move safely along the corridors. There are areas where the floors were sloped and we saw that people were unsteady in some of the areas, particularly along a part of the corridor in front of the Willow lounge. The flooring of that corridor changes level at several locations and there was one short run when the drop was more noticeable. There were no hand rails to use as a steadying support when negotiating the slope. We watched one person making their way unsteadily down the slope. They were so unsteady that we were concerned that they might fall due to the ground sloping away from them and asked a staff member to assist them.

Both of the above examples are breaches of Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other risk assessments in place that were designed to minimise the risk to people in their day to day lives so that they could keep their independence and self-determination as much as possible. For example the risk of falling, there was guidance for staff on what support people required to reduce the risk. Staff were able to correctly describe the care and support needs for each person and understood the risks and how to minimise them. Records showed us that people who had developed pressure areas and those that had been assessed as being at risk of developing them were receiving the care they needed to prevent deterioration and aid recovery. Their wounds were being dealt with by visiting district nurses and specialist equipment was being used, such as pressure reliving mattresses and seat cushions.

There was also other specialist equipment that safeguarded people. For example, there were pressure mats by beds and easy chairs that alerted staff if people who were considered to be at risk stood on the mat. This enabled staff to be able to quickly offer that person support if they were at risk of falling.

Prior to our inspection we had been contacted by people who shared their concerns that the staffing levels were insufficient to keep people safe from harm. We were also told that because of the poor staffing levels the people who lived at the service were woken in the morning and got up without being given the choice to lie in. There not being enough staff on duty also led to visitors having to wait a long time at the front door waiting to be let in.

To be better able to judge if this information was correct, we arrived at the service at 7am, it took eight minutes and three rings of the doorbell before we were let into the building. There were five staff on duty including the senior staff. We asked to be shown around the building. Without opening bedroom doors and risk disturbing people while asleep, we saw 15 people up and dressed. This meant that just over 30% of the total number of people living in the service were up and dressed at 7.15am. Of those up many were asleep in their chair. We asked one person if they had chosen to get up at this time and they said, "I'd rather be tucked up in bed, but I don't mind helping out if the girls [staff] are busy." Another person said, "I'm used to it, they just come in, wake me and say 'time to get up' and I do."

We were told by staff that people living with dementia often wake up early. However, of the people that were up and dressed in the dementia unit seven were asleep in a chair in the lounge, which did not indicate that they had chosen to get up early. The care plans that we looked at did not indicate people's preferences for getting up that were individual to people, if a preference was mentioned it was vague, just stating 'likes to get up between six and eight' for example. It appeared that people were not given a choice when they get up, one person told us, "I would like to not get up so early, but if you are awake you are talked into getting up." Another said, "We have to get up very early some days but do not always want to."

This practice of getting people up before they are ready to get up may be an indication that there was not enough staff on duty. However, it is also an example of the service not respecting people's right of choice or

their dignity. Which is a breach of Regulation 10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the rest of our inspection we saw other indicators that indicated that there were not enough staff on duty. During dinner on the dementia unit there were three staff on duty, one was the senior staff who was administering the medicines and two care staff. One staff member was distributing people's meals and drinks and then cleared away. The other staff member was assisting people to eat. They stood over a person and gave them a fork full of food then moved onto the next person, they did the same and then moved on again to the next and so on. We were told that they did not have time to sit and help each person in turn; if they did it would take too long.

As in our experience of having to wait a long time for the door to be answered on our arrival, we observed that when people came to the front door it took a long time for it to be opened. On one occasion, we were sitting in the front lounge and a visitor got fed up of waiting for the door to be opened and knocked on our window and asked for assistance. We went and fetched a staff member to answer the door. One healthcare professional we spoke with told us that it sometimes took a long time for staff to let them in when they visited and that it also took a long time for the phone to be answered.

People and their relatives said that they thought there was not always enough staff on duty and that they often had to wait a long time for attention.

One person told us, "I pulled my buzzer for someone to come to help me to the toilet and they came and said they had to go and get gloves but they didn't come back for a long while. When I asked why, they said they were short staffed." A relative told us, "I arrived one day and it took a while for someone to answer the door to me. When I went into the dining area where my [relative] was, there was no staff in there and I saw my [relative] sagging out of the chair saying [they] needed the toilet badly. A staff member appeared and I said how annoyed I was. The answer was 'we have two staff off sick today and I was bathing someone'."

One staff member told us, "There is frequently a shortage of staff and we have to rush from resident to resident." Another said, "Sometimes we are getting someone up and then you have to go and help with the breakfast, and after that go back to get someone else up and they get a late breakfast." And another staff commented, "I am always trying to do two peoples work."

The manager told us that before the change of the care management company in January 2016, Healthcare Management Solutions took over the running of the service and there was no form of assessing people's needs to ensure that there were enough staff on duty to help people stay safe and to feel well cared for. They told us that the staffing levels being used at the time of our inspection were those as set by the previous care management company. The manager told us that when they started work at the service three weeks before our inspection and they had started assessing people's needs using a recognised dependency tool. However, not everyone's assessment had been done. Meaning that a 'needs assessments' had not been carried out or any changes made to the staffing levels since the changes to the care management company running the service in January 2016.

There was not always enough staff on duty to care for people when they wanted or needed it or to help keep people safe. Nor had a needs assessment been carried out to calculate the necessary staffing levels. This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection we have been informed that the care needs assessments have been completed and that there had been an increase in staffing levels.

Recruitment procedures were in place to ensure that only suitable staff were employed which were followed. Some of the staff files we looked at contained the required paperwork needed to evidence that staff had completed an application form and attended an interview and that the provider had obtained written references from previous employers and had done Disclosure and Barring Service (DBS) checks to check that the staff were of a good character and suitable to work with vulnerable people. However, the newer staff recruitment files we saw did not all contain all the necessary records.

The regional manager explained that the personnel department of the organisation managed the collection of personnel files centrally and would pass the documents onto the service once the files were complete. Staff we spoke with confirmed that the service had followed the procedure during their recruitment.

During our last inspection of the service on 14 November 2014, we were concerned about how the service managed safeguarding concerns, during this inspection we found that the manager demonstrated an understanding of keeping people safe from abusive situations. Where concerns had been raised, we saw that they had taken appropriate action in reporting suspected abusive situations and had liaised with the local authority to ensure the safety and welfare of the people involved.

Staff told us and records confirmed, they had received training in protecting adults from abuse and how to raise concerns. They were able to demonstrate the action they would take and tell us who they would report concerns to in order to protect people. Staff understood the different types of abuse and knew how to recognise signs of harm and understood their responsibilities to report issues if they suspected harm or poor practice. They were confident that the manager would take action if they reported any concerns and were aware of the whistleblowing policy and said they would feel confident to use the process if they thought it was necessary.

One staff member told us, "Yes I have completed SOVA [the Safeguarding of Vulnerable Adults] training. If someone had a change in their behaviour, appetite or mood, had unexplained bruising or was not at ease around a person I would tell my team leader or the manager so that they could check that no abuse was occurring. If I saw a staff member speaking to a person disrespectfully or not respecting their dignity I would report them to my team leader."

Medicines, including controlled drugs, were well managed by the service. We checked all areas of how the controlled drugs were managed, the Medication Administration Records (MAR) and the way the medicines were stored. The medicines were physically present, all accounted for and they were securely stored.

We observed staff supporting people to take their medicines, the interaction was very gentle with positive interaction, which was person centred. Where people needed medicines only occasionally (PRN) there were protocols to inform staff when to use them. Records showed that staff had received the appropriate training to enable them to administer medicines and competency was assessed to check they were capable of doing the task safely. Spot checks were carried out by the manager and senior staff to check practice.

Requires Improvement

Is the service effective?

Our findings

People told us that they were supported well and that staff made sure that they got what they needed. One person told us, "They [the staff] are OK, some have been around a long time." A relative told us, "The staff were well trained and know what they were doing, but they are always busy."

Staff had attended Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The manager had a good understanding of both the MCA and DoLS and when these should be applied to the people who lived in the service, including how to consider their capacity to make decisions.

The service had made DoLS applications to the relevant bodies for the people who were restricted from leaving the service to protect their wellbeing. We saw that staff gave people choices about food and drink and in other small ways and the wording of the care plans talked about preserving people's independence and giving people choice. However, people's capacity to make day to day decisions for themselves was not assessed. Whether to accept assistance with personal care or to be assisted to take their medication for example.

We saw one example where a decision had been made without making sure that due process had been followed to ensure that it was a decision the person could not make for themselves or that it was made in the person's best interest.

The person smoked cigarettes, which they obviously enjoyed because they spent long periods of the day waiting in an area the staff frequented and kept asking them for a cigarette whenever they passed by. But they were constantly being told that it was not their time for one without being given an explanation why they were being restricted or how long it would be before they could have one. We asked how many cigarettes the person was allowed each day and was told five.

No mental capacity assessment was made to test whether or not this was a decision the person could made for themselves. Nor was there any evidence that a best interest meeting had been held to discuss the reasons why the cigarettes needed to be restricted, whether the person was able understand the reasons why it was considered in their best interest or whether, as a long standing smoker, they would agree to cut their consumption if they had the capacity to make that decision. Neither was it considered if restricting a smoker to five cigarettes a day was the least restrictive option

When asked, staff told us that the doctor had advised that they should cut down their smoking. Seemingly, the decision had been made unilaterally without the person's thoughts being taken into consideration. Their care plans held no reference to the person's smoking habits or where and when they would be able to smoke, apart from the comment in the personal care section of their care plane, '[They are] a smoker but cigarettes are restricted.'

This person had had their right to make this decision for themselves taken out of their control unlawfully.

Their care plan clearly identified that a relative had been granted the lasting Power of Attorney to manage this persons finances, but not whether they were legally able to made decisions about their health and welfare. The manager was not sure if the relative had been granted the power over both aspects of their relative's life and could not find reference to that question being asked or if a copy of the record had been taken for the care file. They checked with the person's relative and were told that they only had control over the person's financial affairs, which meant that they would not be able to make decisions about their relative's health and welfare.

This service did not always protect people's rights under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards, which is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff received training and support to enable them to do their jobs effectively. Staff told us they were provided with training, supervision and support which gave them the skills, knowledge and confidence to carry out their duties and responsibilities. Although, when asked they mentioned that there had been a period without a manager running the service and during that time the levels of training and supervisions had dropped. However, once the new manager had started work they had started to get things in hand. The organisation's training matrix, which was how they tracked staff's training, showed us that the levels of training people had completed had been allowed to drop, but that the percentage of staff that had completed their training had begun to pick up. One staff member told us, "[The deputy manager] had to take a lot on but did a good job, but things slipped. The new manager is beginning to make sure that we get supervision and get the training we need." Another staff said, "Yes, we do training such as dementia care, moving and handling and health and safety."

This service had a dedicated dementia unit. Staff told us that they were only offered a half days training in understanding dementia. One staff member told us, "I think that there is better dementia training out there, the session we do is pretty basic." Another said, "If we are going to do the best we can, we should get better training. There are so many people here who have dementia we must understand how to work with them to feel more relaxed and happy." One social service professional told us that they felt the staff would benefit from advanced dementia training, "It would improve their understanding of the needs of people with dementia."

We discussed with the manager the necessity for staff to receiving more in depth dementia training and improvements that could be made in the range of activities offered to the people using the service that were living with dementia and the valuable advice that is available on line in this area. The manager acknowledged the need for the staff to receive further dementia training and told us that there were plans to improve training in several areas.

People told us that they enjoyed their meals, one person told us, "I eat well, maybe too well I get to choose what I want. I told the manager I liked Haddock and she bought some in for me, good it was too." Another person said, "It's mainly well cooked, I like the puddings." We observed people's mealtime experience on both of the units, several times over the three days of the inspection. The food looked appetising and well cooked. People told us that they enjoyed the food offered to them, had enough to eat and that they were able to make choices from the two meals on offer. We were told, "They [staff] show me two different plates of food and I chose one, which makes it easy to decide." Another person told us, "I can't eat chewy food, I manage OK." A relative said, "My [relative] enjoys [their] food here, and never complain about [their] food.

There was a difference in people's mealtime experience depending on which dining room they ate in. The Willow had a larger dining room, with smaller dining tables and more staff were based in that unit. This meant that they were able to interact with people and pass the time of day while they waited for their meal, the main meal was planned to be served at 1pm and people were sitting in the dining room well before that time but staff did not begin to service the meal until after 1.20pm. People told us that the meal time had changed recently and that although it was planned for 1pm more often than not it was served later, one person told us, "It's getting later and later before we get our food." However, there was enough staff available to serve the meal and clear the tables while other staff sat and supported people to eat in an unrushed and dignified way. We observed positive interaction between staff and the people they helped to eat their dinner. Staff sat with the person they supported, while chatting and encouraging them to eat.

As previously mentioned in relation to staffing levels, the experience on Chestnut unit was not as positive, while staff were still kind and supportive towards people, they did not have enough staff on that unit to properly support people to eat because they had to move between tables going from person to person helping them to one forkful of food before moving onto the next person. When this was discussed with the regional manager they ensured us that action would be taken to improve these people's mealtime experience. We have since been informed that extra staffing hours have been added to the rota, which should improve the situation so that people would be able to enjoy their meal with staff spending time to help them individually and encourage them to eat their meal before it gets too cold to enjoy.

Plate guards and specialist utensils were available for those who found it easier to eat with these aids. This helped to promote independence, meaning that people could manage to help themselves to eat without the need of staff support.

The home had responded to specialist feedback given to them in regard to people's dietary needs and had taken action to meet them. For example, by introducing food that was fortified with cream and extra calories to enable people to maintain a healthy weight. Staff were found to be knowledgeable about supporting people to eat healthily and meeting their individually assessed dietary needs.

The manager and staff told us that meal times could be flexible and that people could chose to eat when they wanted to. A staff member told us, "People can have their breakfast when they like. Some wake up early and the night staff do their breakfast and some get up later."

However, people told us that if they were up early they had to wait until the main breakfast was served before they could eat. One person said, "I'm an early bird, up early and ready for my breakfast straight away, but I have to sit around and wait for it to be cooked with everyone else, mind you they do 'do' a good breakfast, I enjoy it when it comes." Others told us that even if they preferred to eat in bed before they got up and dressed, they were encouraged to get up and have breakfast in the dining rooms. One relative told us, "[My relative] used to enjoy having [their] breakfast in [their] room before having to get up, now [they] get rushed up in the morning so they can all have breakfast together in the dining room. This upsets [them] and me."

On the day that we arrived at the home at 7am we saw people that were up early being given a hot drink and a couple of biscuits while they waited for breakfast to be served. The senior on duty asked one staff member to prepare some toast for one person who was expecting transport to take them to hospital for an appointment. During the main meal we saw that most of the people living in the home ate their meals in the dining areas. The care plans we saw did not record if people had a preference where they ate their meals. We recommend that the service asked people where they would like to eat their meals, record that preference in people's care plans and to honour that wish.

Recognised professional assessment tools, such as the Malnutrition Universal Screening Tool, were used to identify people at risk nutritionally and care plans reflected the support people needed. Care staff, had received training to enable them to understand and use these tools. People's weights were monitored so that action could be taken if needed. For example, they would increase the calorific content in food and drinks for those people losing weight or seek specialist advice.

People's care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs. The service had regular contact with a GP surgery that provided support and assisted staff in the delivery of people's healthcare. People were supported to attend hospital and has assess to other healthcare professionals. The healthcare professionals that we talked with were mainly positive about the service. One told us, "We work well together, the staff are confident and will always ask if they aren't sure of something or need to check something with me" Another said, "[The deputy manager] is very knowledgably, she makes sure people get what they need."

Good

Is the service caring?

Our findings

People felt that staff treated them well and that they were kind and caring. One person said, "The staff are very caring, but are so busy they do not have time to chat for a long time." Another said, "They [the staff] are very kind, and will always help you." A relative told us, "The staff appear caring and know what my [relative] needs."

When staff spoke with people they were polite and courteous. Relatives were complimentary about how staff treated their family members. One relative said, "The staff here are very kind to my [relative] and will often come in to have a chat with [my relative]."

Throughout our inspection we saw staff knocking on door before they entered people's bedrooms and closed doors when offering personal care. When staff approached people to offer personal care they were tactful in their approach. One person said, "The staff will always ask what I want before they complete any task."

People were treated with dignity and respect and staff were discreet when asking people if they needed support with personal care. Any personal care was provided promptly and in private to maintain the person's dignity. One person, who had spilt food onto their clothing, was taken to be changed. The staff gently assisted them out of the room saying, "You always like to look pretty, let's go and find something smart to change into."

We saw interactions between people and members of staff that were caring and supportive. When people spoke, staff inclined their head to indicate they were listening, let them finish what they were saying and responded, if it was a request for a drink for example it was given. This demonstrated that staff listened to people. In less busy times of the day the staff sat in the lounge chatting and being sociable. They spoke with people in a thoughtful manner and asked if they were all right or if they wanted anything. People were offered alternatives drinks or milk shakes if they were unable to voice a preference. We saw genial banter and laughs between people and staff. Staff were able to tell us about people's needs and specifically how they liked to be supported and their experiences in life which were important to them. This helped staff communicate effectively with them.

For example, we saw a staff member talk to a person who was worried about an upcoming hospital appointment, they were worried about getting their breakfast before the transport came and a little later they were concerned that the transport was late in coming and were worried whether they would get there on time. The staff member was skilled at communicating with them; they sat next to the person and explained that if arranged hospital transport was late picking people up, their appointment time was left open so that they could still attend their appointment. Each time this was done the person was more relaxed and waited calmly. We saw that staff had built up a good relationship with the people they were supporting and there was an open and friendly atmosphere.

One relative told us, "My [relative] is hard of hearing but the staff stand nearby and speak slowing and clearly

to [them] so [they] hear what they say." Another relative told us that, "The staff are very kind and caring, and make time to come in and have a chat." The manager told us that people were encouraged to be involved in planning their care where they were able and that relatives were consulted about their family member's care. One relative said, "The staff keep me informed of things about my relative, such as when they had a fall or if they have a chest infection." Another told us, "The staff and manager will always come and let me know how my [relative] is when [they are] not well, and they let me know what [they] have had to drink and eat."

A visiting professional said, "The staff work hard to look after the residents, and have been through a few changes." and "When I come they know what is needed to be done and get on well with the residents, that makes my job easier as it helps relax the patient."

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were happy with the standard of care their family members received and it met their individual needs. One relative said, "They [staff] have worked tirelessly to keep my [relative] comfortable, they are good people." Another told us, "I couldn't manage anymore, but since my [relative] moved here [they] have been so much better, I'm thankful for that."

Relatives told us that they had been provided with the information they needed during the assessment process before their family member moved in. Care plans were developed from the assessments and recorded information about the person's likes, dislikes and their care needs. However, we found that the care plans did not always reflect the person's needs and they were not always reviewed and updated if people's needs changed.

The new care company had implemented their own corporate style care plan, which meant that the service was in the process of transferring people's information from one to the other. This meant that the majority of care plans were new and the ones that had not been transferred showed evidence that they had been reviewed regularly.

However, three of the five care plans that we looked at did not reflect the current needs of the person they involved. One in particular talked about the person being mobile with the use of a walking frame, liking to have a rest in bed in the afternoon and eating well. In reality this person was being cared for in bed as they had become frail and was not expected to be up and about again. Family members had been made aware of the person's frailty and the doctor had made preparations so that they could be kept comfortable and pain free.

The care plan had not been updated since before the start of the person being cared for in bed. Meaning there was no detailed care plan about them being cared for in this way with regards the extra care and support they would need while being cared for in bed, their eating preferences and how their food should be prepared and what records should be kept. This person had frail skin that had broken down and the resulting pressure areas were being dressed by the district nurse. This meant that it was essential that good detailed records needed to be kept to ensure that they were repositioned regularly and often so as to try to stop further pressure areas developing. The records we saw were poorly done. What the person drank was written on their positional sheet with no proper detail so that it was impossible to properly check that they were getting enough to drink. There were gaps in the recording, which could mean that they were not repositioned for over five hours on some occasions, and neither was it being recorded if they were being offered a drink. This way of recording the person's fluid intake did not allow for the daily amount to be calculated so there was no oversight of whether or not they were getting enough to drink to keep them comfortable.

There was fluid thickener on their bedside table and some had been added to a glass of orange squash with a straw in it. Thickening agents are used in people's drinks if they have difficulty swallowing, this helps them to drink without choking. There was also an open fruit juice carton on the table that had not been thickened.

This showed that the staff were unclear as to whether the person had problems with their swallowing or whether they had their drinks thickened or not. Neither the care plan or doctors/nurse visit sheets recorded when this was prescribed nor any instructions for its use. This meant that it was possible that the person could be at risk of choking because there was no clear guidance for staff to follow in regards of supporting them to drink.
Another example of a care plan that did not fully reflect the person it was written for, failed to mention that the person had a safety mat in front of their chair. A safety mat is an aid to alert staff to when the person got up out of their chair so they could immediately check that they were steady on their feet and not in danger of falling. The use of this equipment indicated that the person's mobility was not as stable as indicated in their care plan and staff may not know that they were at more risk of falling than their care plan indicated.

Staff we spoke with were knowledgeable about the care people needed to stay safe, so people did receive care that met their needs. However, it is important that people's care plans reflected their current needs so that staff returning to work after time away and new staff, including new managers and senior staff, would be able to quickly get to know the person, how they should receive care and whether there had been any recent changes to their needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had two full time activities coordinators; they worked together and told us that they supported people in activities of their choice, some individually as well as in groups. People had mixed views about their experiences of accessing activities. Some people did not think that they were supported to maintain their hobbies and past interests. One person told us, "We are not really asked what our hobbies are, so we just do what is going on." Another person told us that they enjoyed the activities they were offered, "We do things like bingo and quizzes, I like to join in. We used to get out, but that has been stopped apparently. I enjoyed my trips to the pub."

Formally two different activity programmes were run in the two units aimed at the different needs of the people in those units. The manager told us that since taking up their post they encouraged people from both units to take part in activities together. But we were told that some people did not like their activity being disturbed by those who were not fully involved coming and going and some said they did not bother to join in if the activity was not being done on their unit.

A relative told us, "My [relative] used to enjoy trips out to the shops or a pub trip, but that seems to have stopped now. A staff member also talked about how they used to take some people to the pub, which they really enjoyed it but that has now been stopped. We discussed this issue with the manager who told us that the service had a minibus and that they hoped to get more outings organised.

During our inspection preparations were in place to transform one of the lesser used rooms into a replica pub bar. The fixtures included a mock up bar with beer pump handles, hand painted plaques depicting old beer logos on the walls, pub table and chairs around the room and a pool table ready for a game. At the end of one of our inspection days a party was just starting to celebrate the opening of this area. It was intended as a place people could sit in during the day and to spend time with their visitors to soak up the ambiance, reminiscing about past social events. People told us they thought it was a good area to spend time in and that they had enjoyed the party. The manager talked about setting up regular pub evenings.

The manager also had other plans to make improvements to some of the areas of the service that were little used, one area was going to be developed into a pets room, with small petting animals. That room would overlook a planned sensory garden that could be safely accessed from another room. There were also plans to invite the local community to build up a relationship with the service. There was a lot of unused land

belonging to the service, it was hoped to develop it into allotments for local people to use. Children from local schools already visited the service to help celebrate special occasions; the children gave the people who live in the service a carol concert at Christmas for example.

During our last inspection on 14 November 2015 we found that people could not be confident that their complaints would be listened to, taken seriously and acted upon. During this inspection we found that improvements had been made to the way that complaints were recorded and responded to. We saw that there was a policy and procedure in place that was followed, and it was posted within the service for people to see. Several people told us that they had not needed to make a complaint, others made comments such as, "I did have a bit of trouble getting the manager to understand my views at first but we came up with a solution." And, "If I have a problem I talk to the carers, they help me and I'm usually happy in the end." A relative told us, "No, I have no complaints. I would go straight to the manager if I did." Another said, "I haven't had any complaints since [my relative] moved in."

Requires Improvement

Is the service well-led?

Our findings

As noted during our last inspection on 14 November 2014, the service did not have a registered manager in post at the time of the inspection. There was a new manager who had been in post three weeks and plans to make their application to register with the Commission in the near future. There has not been a registered manager in post since 1 April 2014 and there have been three changes to management since that date. The lack of an effective manager in post has meant that the people lived at this service did not receive a consistently good quality of care and the service has not been well led.

Arrangements were in place to regularly assess and monitor the quality of the service provided. When the new management company came into place in January 2016 they undertook a quality monitoring audit and drew up an action plan that was assessed monthly and updates added. This was a live document and new actions were added after each of the regional manager's monthly quality monitoring audits. Progress had been slow in the first instance because the manager in post at the time was absent for a long period and resigned their post in April 2016.

However, the concerns and breaches to regulation that we have highlighted during our inspection were not identified or dealt with. This indicated that the service did not have an effective quality assurance monitoring process in place.

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

People's confidentiality was not always protected. Their care plans were not kept private, they were either stored in a cupboard with the doors open in an office that was often open and left unlocked or they were left on a table in one of the units while being worked on and occasionally left unattended. This means that people not authorised to read the care plans could have access to them and possibly damage them without understanding their importance.

Because of the recent changes in care provider and manager at the service it was not possible for us to form an opinion as to whether the culture of the service was positive, open or empowering. Nor had the new manager's leadership skills been tested long enough for us to make a judgement on their leadership skills. There had been so many changed and people told us that they felt unsettled but hoped for the best and had seen some improvement since the new manager had arrived.

Although it was not possible for us to assess the new manager's capabilities as an effective manager, they showed enthusiasm and told us of their plans to improve the service and had recognised some areas that needed improvement and has started to take action. They were being closely supported by the regional manager who also supported the manager during our inspection. The regional manager told us that with the new manager now in place, they were confident that the quality of service offered to people would now improve.

Staff told us that they had had a lot of changes recently and said they had not been supported during this period of change. We were told that the staff had rallied round and the team had, "Muddled through." and that the assistant manager had, "Held things together." One staff member said the staff had felt, "Abandoned by the Organisation." However, with the appointment and arrival of the new manager staff felt more confident and hoped things would improve. One staff member said, "[The manager] has lots of good ideas and looks as if she will make a difference."

We asked people who used the service and their relatives about the quality of the service provided. We also asked people to comment on the senior management team's leadership and management approach. The comments were mainly positive and one person told us, "I'm happy here, I get what I need. There have been a lot of changes though, that was unsettling." Two relatives spoken with told us, "The new manager seems to have some good ideas." Another relative told us, "Things are improving and we have the new manager to thank."

The manager told us that the views of people and those acting on their behalf were important and that the new management company had plans in place to ask people for their opinion of the quality of care they received at regular intervals by asking people to complete questionnaires. The information will be analysed and an action plan would be drawn up to cover areas that were found to be in need of improvement. Resident and family meetings were planned and one was held to introduce the new manager.

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 Care plans did not always reflect people's current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The practice of getting people up before they are ready is an example of the service not respecting people's right of choice or their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This service does not always protect people's rights under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no risk assessments in place for the use of dangerously hot equipment in the unsupervised proximity of the people who used the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were risks to people's wellbeing in regards to the fabric of the building and no understanding of the resulting fire risk posed to the safety of people in the service. There was no up to date fire risk assessment for the building Nor were there hand or grab rails in the service to enable people to move safely along the corridors.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have an effective quality assurance monitoring process in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff on duty to care for people when they wanted or needed it or to help keep people safe. Nor had a needs assessment been carried out to calculate the necessary staffing levels