Minster Care Management Limited

Sovereign House

Inspection report

Daimler Drive
Chelmarsh
Coventry
West Midlands
CV6 3LB

Tel: 02084227365

Date of inspection visit:
14 June 2018

Date of publication:
09 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 June 2018. The inspection was unannounced.

Sovereign house is a care home registered to provide nursing care and accommodation for a maximum of 60 people. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation is provided over three floors. The ground floor provides residential accommodation for both younger adults and older people (including those people living with dementia). This floor also has 19 beds known as "pathway 2" beds which are used for short term placements from hospital to help rehabilitate people prior to going back home. The first floor provides accommodation for people requiring nursing care who may also be living with dementia. The second floor has 21 beds to accommodate older people. Seven beds on this floor are referred to as "discharge to assess" beds where people from hospital are again supported with a view to going home once they are well enough.

Sovereign House was previously registered under a different provider. This is the first inspection of Sovereign House under the new provider. However, many of the staff who were at the home prior to the new provider taking over, continued to work at the home.

The service has a registered manager. This is a requirement of the provider's registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home was managed by an experienced management team who aimed to provide good standards. The provider and registered manager completed a range of quality monitoring checks to ensure the care and services provided were in accordance with the standards people should expect. However, our inspection process identified some areas needing improvement, this included a breach in the regulation related to person centred care and we also found staffing arrangements were sometimes not effective to ensure people's needs were met. . This suggested the audit check process was not always effective.

Staff were recruited following a number of checks to ensure they were suitable to work with people. They received appropriate training and support, understood their roles and responsibilities and had confidence in the management team.

People felt safe and at ease with staff, and staff understood their responsibilities to protect people from the risk of harm and discrimination. We saw staff were caring in their approach to people, but they did not always have time to spend with people or listen to what they had to say. People said sometimes they had to wait for support. People had some opportunities to engage in, and experience, stimulating activities

within the home to help support their mental, physical and emotional wellbeing.

Risks related to people's health were identified in their care plans to help minimise those risks.
People were able to access healthcare professionals when needed to support their healthcare needs. Staff who administered medicines understood what was required to manage these safely, although some medicine records were not accurate.

People's ability to make decisions was assessed in line with the Mental Capacity Act 2005. Staff offered people choice and respected the decisions they made. Where restrictions on people had been identified, Deprivation of Liberty Safeguards authorisations were in place to lawfully deprive people of their liberty for their own safety.

People were encouraged and supported to eat and drink and were mostly positive about the quality and choice of their meals.

The design of the premises meant there was sufficient space for people to move around easily to access the communal areas of the home. The home was clean and tidy and staff followed the provider's policies and procedures to ensure people were protected from the risks of infection. Health and safety checks were completed to protect people from environmental risks within the home.

People knew the registered manager and spoke positively of them. We saw where concerns had been raised, these had been taken seriously, investigated and responded to within a timely manner. Where accidents and incidents had occurred, action had been taken to minimise the risk of them happening again. The registered manager worked closely with the provider and understood their regulatory responsibilities such as those related to the submission of statutory notifications and the completion of a provider information return.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected from the risk of abuse because staff had been trained and understood the actions required to keep people safe. Risks to people's health were identified in care plans and staff knew how to manage them. Staffing arrangements were not always effective to meet people's needs. People received their medicines when needed and were protected from the risks of infection. Accidents and incidents were recorded, reviewed and acted upon to help identify any actions to prevent them from happening again.

Is the service effective?

Good

The service was effective.

Staff received appropriate training, guidance and support to ensure they had the required skills and experience to meet people's needs effectively. Staff worked within the principles of the Mental Capacity Act 2005. We saw staff asked for consent before delivering care. People were offered a nutritionally balanced diet and were supported to eat when needed. People had access to healthcare professionals to maintain their health.

Is the service caring?

Good

The service was caring.

Staff were supportive and kind in their approach to people and aimed to support people in ways they preferred. Staff understood the importance of enabling people to be independent where possible and to respect people's privacy and dignity. People were supported to maintain relationships important to them and were involved in decisions about their care where possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans provided staff with information about how to respond

to people's individual needs in a way they preferred but people did not always experience person centred care. People were offered opportunities to engage in some stimulating activities to help maintain their wellbeing. People were involved in planning their care and changes in people's health were monitored to identify any changes in staff support required. People were aware of how to raise concerns and these were responded to in line with the provider's complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were various systems in place to monitor and improve the quality of the service but we found people did not always experience the quality of care and support they should expect to meet their needs. There was a clear management structure in place to support staff. Staff told us their managers were very supportive and they felt able to have open discussions with them.

Sovereign House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 14 June 2018 and was unannounced. The inspection was undertaken by two inspectors, an assistant inspector and a specialist advisor. A specialist advisor is a qualified health professional.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications we had received from the registered manager. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. They did not share any information with us that we were not aware of.

We spoke with five people who lived at Sovereign House and three relatives about their experience of the service. We spoke with the registered manager, two nurses, two activity co-ordinators, seven care staff, a catering assistant and two visiting health professionals about their experiences of the home. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We looked at five people's care plans to see how their care and treatment was planned and delivered, and looked at other records related to people's care such as food and fluid charts and medicine records. We checked whether staff had been recruited safely and whether they were trained to deliver care and support appropriate to each person's needs. We looked at quality monitoring information and health and safety records to see what actions were identified and taken to improve the ongoing quality and safety of the service.

The registered manager had attempted to complete a provider information return (PIR) but due to technical

difficulties, this was not available prior to our inspection. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The registered manager shared information they would have provided in this document with us during our visit.

Requires Improvement

Is the service safe?

Our findings

We checked if there were enough staff to support people safely and appropriately, and found some people felt there were not enough staff at times to meet their needs effectively. A visitor told us, they felt the home was, "Often quite short of staff." They gave an example of their family member needing assistance to use the toilet and having to wait 20 minutes by which time it was too late. They explained how anxious this had made their family member feel. One person told us, "It is okay (living at the home), they are overworked and understaffed but I am quite happy."

Two people told us they wanted to have a shower but were not always able to have one. One told us, "I have a shower but not very often. In the other home I was in I could have a shower whenever I wanted. Some staff wash me in bed, but some don't. They stand giggling and talk in their own language and then say, 'Oh leave them, there's no time, leave them' then maybe they will give me a quick rub on the face." A staff member told us it was usually the night staff that supported people with showers because the day staff were "very busy". A second staff member told us there was a limited amount of showers they could complete each day because some people needed to be hoisted which took a "long time".

We received conflicting comments from staff regarding there being enough of them to support people's needs effectively. One said, "It is busy but between us we get things done. I would say… yes… there is enough….It's hard at times but we provide the care people need." Another staff member told us, "There is not enough staff. In the mornings there is so much more to do than in the afternoons." They went on to tell us that following the handover meeting with staff there were a number of people that needed to be washed and dressed and supported to eat their breakfast, they said it was a challenge to do this for all those needing support before 12.30pm (when lunch was served). They stated, "We are never on time. Sometimes we get the food trolleys at 1pm." On the day of our visit we saw lunch was late in all dining rooms and people were kept waiting.

We saw on the first floor staff were task orientated with minimal time to spend interacting with people. There was one person in bed who looked unkempt with a beard and long dirty nails. We established this person was usually clean shaven. We were not assured this persons' personal care was managed effectively. The nurse told us the person often resisted care but assured us they would assist them in the afternoon to have a wash and trim their nails. We discussed staffing arrangements with the registered manager who told us they would review them to see if any changes were needed.

We found some risks associated with people's care were not managed consistently. For example, during our walk around the home with the registered manager we saw a person in bed anxious and calling out. We saw the person was positioned horizontally across their bed with their head between the pillow and the bed rails and their legs were hanging over the bed rail. The registered manager raised the alarm via the call bell and staff repositioned the person in bed. Staff told us the person had a health condition which resulted in involuntary movements which meant they moved into different positions when in bed. Whilst they advised the person had been seen by a doctor and their medicine reviewed, we could not be assured the current monitoring arrangements were sufficient to keep this person safe. The registered manager advised staff to

increase checks to every 15 minutes.

Specialist mattresses were available for those people at risk of skin damage because of the amount of time they spent in bed. The mattresses had been regularly checked to ensure they operated correctly. Records confirmed when nurses identified concerns with wounds they had sought specialist advice on managing them.

Risk assessments were reviewed monthly and updated as required to ensure the information they contained was accurate to support staff in keeping people safe.

People said they felt safe living at Sovereign House because the staff that supported them were kind and they felt at ease with them. A relative told us they felt their family member was safe at the home and spoke positively of the staff.

Procedures were in place to assist staff in protecting people from the risk of harm. The provider had a clear safeguarding reporting procedure which was displayed in the communal areas of the home to inform people how to report concerns if they felt unsafe.

Staff had received training in safeguarding people from abuse and understood their responsibilities to keep people safe. They described the signs which might indicate someone was at risk of harm. For example, a person being withdrawn or showing signs of distress. Staff told us they would report any concerns to their managers. One said, "If I thought someone was being abused I would document it and then tell the nurse. The nurses would make a referral to social services to investigate." Another told us, "I would go straight to the nurse, I have raised a concern before and action was taken to investigate which was really good."

People told us they received their medicines when needed. One told us, "My tablets are on time and have never been forgotten." A visitor told us their family member required their medicines to be crushed as this was how they had been given them in hospital, but had recently found this did not always happen at the home. They advised this had been reported to staff at the time and this now happened. Where medicines were prescribed "as required" there were usually clear guidelines around when they should be given to make sure they were given consistently and people were not given too much medicine. We found in two cases there were no guidelines, but the registered manager confirmed following our visit that action had been taken to address this.

We saw staff counted the amount of tablets in boxes following administration each day to make sure all tablets could be accounted for. Where we had found some of the counts were incorrect, the registered manager investigated these and provided explanations following our visit. For example, in one case, a tablet had been dropped and disposed of but not recorded. The registered manager told us they would ensure staff went through retraining, supervision and a competency assessment to reduce the risk of this happening again.

During our walk around the home we identified some environmental risks such as a hot plate on the food trolley in the dining room was left unattended for a short time which could have presented a burn risk to people. As we were about to bring this to the attention of staff, a staff member came into the dining area, identified the risk, and removed it. We noticed there were two portable heaters in people's rooms that were plugged in and were concerned these also could present a burn risk to people. The registered manager subsequently advised these had been removed and individual risk assessments would be completed if their use was needed.

People had personal evacuation plans which informed staff of the assistance people would need if the building needed to be evacuated quickly and safely. This information had been collated and was displayed at the nurse's station so it would be readily available to the emergency services. A nurse said, "The information is available quickly so in the event of an emergency I can grab the sheet quickly."

We found the home was clean and well maintained. Our discussions with staff members assured us they understood their responsibilities in relation to good hygiene and infection control. For example, one explained the importance of always wearing personal protective equipment when they assisted people with personal care to reduce the risk of cross infection in line with best practice. They said, "We know to wear gloves and aprons. We always do here, it's to protect people." We saw this happened.

The provider's recruitment procedures minimised, as far as possible, the risks to people's safety. Staff confirmed their references had been requested and checked and they had not started working at the home, until their disclosure and baring (DBS) clearance had been assessed by the provider. One said, "After I got the job I had to wait for my last employer to give me a reference." Another said, "Once my DBS came through it was checked and then I could start work." The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.

Accidents and incidents were recorded and reviewed by management staff and where appropriate, actions taken to minimise the risks of a re-occurrence.

Good

Is the service effective?

Our findings

Staff told us they were provided with effective support when they first started work at the home. One said, "When I started I did my training and then shadowed another care assistant. They showed me the ropes, things like daily routines and what people liked. It was a good induction and gave me confidence to do my job."

Staff spoke positively about their training and were confident this had provided them with the knowledge and skills they needed to meet people's needs. They demonstrated an in-depth knowledge of each person's individual needs and were skilled and confident in their practice. One told us, "I work with a lot of people who have dementia. I've had the training I need which included a test to make sure I understood the condition." Another told us they used a hoist to move people and they confirmed they had received training to complete this task safely. They said, "I did hoist training, I had a go in the hoist to experience what it was like for people, it helped me to understand why at times people can become anxious when they are moved." We saw during our visit the staff member put their training into practice. They moved two people safely and offered a person reassurance when they became anxious.

Staff felt supported by the management team and told us they received regular supervision of their work. One said, "Yes, I get supervision every couple of months with the nurse. It's a time to talk about how things are going and if there is anything that I could be doing better." Another said, "Yes, supervisions happen but I wouldn't wait for supervision if there was something I wanted to discuss, I can talk to the manager at any time here."

Staff told us communication at the home was good. A nurse said, "Carers are really good, they listen and follow my guidance." We saw this happened during our visit. For example, we heard a nurse and care assistants discussing when to take their breaks so no more than one of them was on a break at any time. A diary was used where staff shared important messages such as people's planned appointments and any new planned admissions.

People had communication care plans which helped the staff to understand how people preferred to communicate. For example, one person had a hearing impairment and the person's care plan advised staff to use short sentences, speak loudly and give the person plenty of time to answer their questions. We saw staff had a good understanding of the way people preferred to communicate. Some people were unable to use speech and we saw staff watched the person's body language to understand what they wanted. For example, one person pointed at a cup which staff knew indicated they felt thirsty.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked and found the provider was working within the principles of the MCA and conditions on authorisations to deprive a person of their liberty were being met. Records showed people who lived in the home had been assessed to determine whether they had capacity to make their own decisions. Where people did not have capacity to make specific decisions, appropriate discussions had taken place with those closest to them or their advocates to ensure decisions were made in their best interests. The outcome of these were clearly recorded.

Staff told us they had received MCA training and our discussions with them confirmed they had some knowledge of the Act. One said, "People have the right to refuse help, I respect that." However, they were unable to give examples of when a person might be deprived of their liberty. Comments included, "I'm not sure," and, "The nurse would deal with that kind of thing." Despite this, we saw examples of staff applying the principles of the Act to protect people's rights, which including asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. For example, they asked people for permission for completing tasks such as, moving them from their wheelchair into an armchair. The registered manager told us following our visit, action had been taken to refresh staff training on MCA and DoLS. They told us, "One to one supervisions have commenced to discuss further and to identify staffs individual training needs and preferred ways of learning." They stated "Easy Read Guides for MCA and DoLS had been placed on all units for staff to reference and that competency assessments would take place following one to one supervisions, to check staff understanding of MCA and DoLS.

We observed lunchtime on each floor to check if this was a positive experience for people. Lunch was served later than planned and therefore people had been sitting in the dining room waiting. Staff told us lunch was late on one floor because a meeting had taken place in the dining room. We saw on another floor staff were waiting for all people to come to the dining room before they began to serve meals.

Most people ate their lunch in the dining room but some people had complex health issues and therefore ate their meals in their rooms. We saw people in their rooms who needed assistance to eat by staff were supported sensitively and at a pace suitable for them. There was a choice of meals available to people. Meals were served from a hot trolley in each dining room, and where appropriate, meals were taken to rooms. Choices of cold drinks were available and we saw where some people asked for a different choice of drink, this was provided.

Overall people spoke positively of the food provided. Staff supported people to cut up their food, where needed and in one dining room, a person was provided with an alternative choice to those on the menu which demonstrated their preferences had been taken into consideration.

Where one person was at risk of choking when eating, records showed this risk had been assessed and staff instructed to ensure all liquids were thickened and all of the person's food pureed. Staff knew the amount of thickening agent to use so that it was of the correct consistency for the person to drink safely. One staff member said, "If the spoon stands up in the drink, it's the correct consistency." Another told us, "With meals everything is pureed, we use a tea spoon when we help them to eat because that way we know that there is not too much in their mouth at one time which helps them to swallow."

Some people were at risk of losing weight and were offered fortified foods to increase their calorie intake to maintain their health. We spoke with the kitchen assistant and they explained that foods such as

milkshakes were fortified with evaporated milk, milk powder and double cream. We checked and found these items were available. The kitchen assistant said, "We cook foods with extra spices for some people as that's what they enjoy to eat. Another person is a vegetarian so fish is always available for them."

People's needs were assessed before they came to the home and this information was used to develop their care plans. The provider had an assessment process based on recognised best practice standards to help ensure this effectively identified people's needs and the care planned would therefore result in positive outcomes for people. Some people had regular assessments carried out by visiting health professionals due to their health conditions and changing needs. This was to ensure people's ongoing health and abilities were reviewed and staff were clear on what actions they needed to take to provide ongoing safe and appropriate care to people.

People's records showed how staff worked in partnership and maintained links with health professionals such as GPs to maintain people's health. During our visit a GP visited a person and a nurse explained they had requested the visit as the person had felt unwell. We were aware there was a person in hospital and heard the nurse telephone the hospital to get an update on the person's condition. We also heard the nurse make a telephone call to an optician to request they visited a person and conduct a home visit as the person did not want to leave the home. The nurse said, "It's important they get their eyes checked so I've asked for a home visit."

The design of the premises had been considered to promote people's wellbeing. For example, corridors were spacious and enabled people to move easily around the communal areas. There was some picture signage around the home to support people to find their way around independently. Bedrooms were big enough to accommodate any specialised equipment people may need as well as some of their personal possessions. There was an accessible garden for people and their visitors to use if they wished.

Good

Is the service caring?

Our findings

People were positive about the staff that supported them. One told us, "All of the staff are lovely. If you ask for something, they get it. They are very caring and very attentive. I haven't met one that isn't lovely."

A relative told us, "[Staff member] is really, really lovely. We have said to jolly [person] along and she will go along with that." We saw visitors were welcomed to the home and a notice on display invited them to help themselves to tea and coffee when they wished.

Staff told us they thought the service was caring. One said, "I am really happy here; it's a nice place to work because we all care about the residents. I love spending time with people, having a giggle with them, and seeing a smile on their faces, shows me they are happy too." One staff member explained they gave one person a cuddle whenever they were on duty. They told us, "She responds well to a bit of love, I give her a cuddle so they know I care about them." Another said, "Care is good, I treat people like my own mum and dad."

We saw throughout our visit that when staff were available to people, people were treated with kindness. People approached staff confidently when they wanted something which showed they felt at ease to approach them. For example, a person called out to a staff member to change the television channel and this was done.

Staff knew to encourage people to be independent whilst also considering their safety. We identified examples that this happened. For example, we saw one person walked along a corridor without their walking frame. A staff member noticed this and quickly fetched the person's frame from their bedroom and encouraged the person to use it. Where people declined or refused support staff respected these decisions. For example, we heard a staff member ask a person if they would like to have a shower. The person declined this offer and said, "Maybe tomorrow?" The staff member replied, "Ok, it's up to you."

The home had a 'dignity champion'. They explained the purpose of this role was to gain a greater understanding of how to promote and maintain people's dignity. They discussed best practice recommendations with staff so that they understood how they would benefit people living at the home. We saw the dignity champion had introduced the use of signs across the home for people to use when they wanted private time. The dignity champion said, "I made the signs so staff do not enter bedrooms when people are receiving their personal care. Staff know when the sign is up, not to enter, which means personal care is being provided." A nurse commented, "If the sign is on the door we know not to enter." This demonstrated people's privacy and dignity was taken seriously.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved to the home and information was included in care plans to help staff support their needs. People and their families had opportunities to be involved in the planning and review of people's care and we saw from records this happened.

People felt staff were responsive to some of their needs but staff were sometimes too busy and rushed and had limited time to spend with them. We found that some people were supported more effectively than others. For example, there was one person living with dementia who we saw calling out from their bed and attempting to put their legs over the bed rails. We alerted staff to this and were told the person was at high risk of falls. The person's care plan stated this was the reason the person was cared for in bed. We checked to see if action had been taken to explore if the person could sit out of bed and saw an occupational therapy assessment had been requested in November 2017 to check this. This had not been followed up since then to help support the person's wellbeing. The registered manager told us they would approach the GP as all assessments for occupational therapy had to go via the GP.

One person told us staff did not spend enough time with them to support them out of bed so they could use the toilet safely. Instead they told us they were provided with a bed pan which they did not like to use. We reviewed the person's care plan and it informed us staff were instructed to support the person to transfer out of bed to use the toilet. However, records showed us the person had only been transferred out of bed twice in eight days suggesting staff were restricted in the time they had to spend with them. This meant staff were not following the guidance in the person's care plan to meet the person's needs. A staff member told us they did not know why the person was not being assisted out of bed to do this. Another staff member said "[person] refuses a shower and refuses to use the toilet." We found no evidence within this person's care records to show us they had refused. There were no instructions or guidelines for staff to follow if this person refused despite this person having goals that included ''to progress transfers" and "encourage to increase sitting tolerance in wheelchair". We discussed this with the registered manager who advised an additional assessment of the person's needs would take place and the person's care plan would be updated to ensure the information was correct.

We found two people in bed during our visit who told us they were thirsty and needed a drink. We could not be assured people were checked often enough and that drinks were provided as often as people needed them. One of these people told us they had not been able to alert staff to their needs and said, "I am really thirsty. I don't know when I last had a drink. My time is running out." We found a member of staff who filled the person's water jug and assisted the person to have a drink using a handled beaker and a straw which they knew the person needed to drink independently. We saw the person drank the whole beaker of water. Records showed the person was given regular fluids but visiting family members told us they had on occasions also found the person to be thirsty when they visited. This suggested this person's needs required further review. We asked the person how they usually alerted staff they needed help and they attempted to find their call bell, but this was behind the person's pillow. However, when we handed it to the person they did not have the ability to press it suggesting they needed to be regularly checked by staff. Despite this person's experience, they spoke positively of being at the home and told us, "I like it here. I like the people.

The staff are very good. When you ask them to do something, they do it."

We saw other practices that did not support person centred care and demonstrated improvements were required in staff's understanding of people's individual needs for support. For example, we saw the lounge on the first floor was left unattended for a time and a person walked out of the lounge looking for a staff member to provide them with some sweets. They could not locate a staff member due to staff assisting people in their rooms. Eventually a staff member walked the person back to the lounge and told us the person was not able to have sweets as they were diabetic. Other appropriate sweet options had not been considered for the person. At lunchtime some people were offered a choice and others were not because we were told they had pre-selected their meals. This meant there was an inconsistent approach to managing choice. We also saw gravy was put onto all meals served without asking first if this was what the person wanted.

One person told us that sometimes staff whose first language was not English spoke amongst themselves in a different language when supporting them and would only greet them with "hello" and say "goodbye". This felt this was inappropriate and disrespectful and this had clearly impacted negatively on the person. They told us, "They try their best. It's not right."

We found one person in bed to be anxious and they called out for attention but did not receive any staff interaction and staff did not take time to sit with the person during our visit. Although the television was on, the person did not appear interested in watching it. A staff member told us care staff did not have time to sit with this person. We were told the person enjoyed listening to a particular CD but there was no CD player in the person's room so the person could listen to it. Staff told us this would have to be provided by the person's family.

A family member of another person told us they were concerned their relative did not have enough stimulation at the home. They told us, "I worry that [person] doesn't have enough stimulation …. I just worry because [person's] needs have changed and they don't seem to be aware and think [person] is more able than they are."

There was an activity timetable displayed within the home to inform people what activities were available which included, quizzes and bingo, but on some days, the activities that took place were not accessible to everyone. For example, on Wednesdays the activities available were visiting the hairdresser or 'one to one' activities. Staff said one to one time was only provided to people cared for in bed and when we asked what else people could do on Wednesdays a staff member replied, "Not a lot."

When we looked at what stimulation was provided for people who were living with dementia or who were cared for in bed, we found this was usually only provided in three 15 minute one to one sessions each week. This meant people experienced limited individualised support that was responsive to their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.

As people's experience of stimulating activities varied. We discussed activities with the registered manager. They told us they would discuss the activities programme with the two activities coordinators so that people who were less able to express themselves verbally, or who did not want to join in the group activities, experienced the same quality of engagement or interaction with staff.

There were other people who had a positive experience of the home. For example, from our discussions

with staff it was clear they knew some people very well. They were aware of their abilities, support needs, habits, and preferred daily routines. For example, staff knew one person used to enjoy playing the piano and they told us they put 'piano' music CDs on for them in their bedroom. The staff member said, "Their eyes light up to the music." Another person enjoyed reading the newspaper at weekends and records showed a staff member went to the shop on their way to work to purchase a newspaper for the person to read.

A visitor spoken with described how since their relative had been the home their health had improved. They explained their relative had suffered with swollen ankles but since being at the home they had walked around more and the swelling had gone down. Another person who had a health condition which caused their legs to swell had been encouraged to elevate their legs and was sitting in a recliner chair in the lounge with their legs elevated to help reduce this. A staff member said, "If they don't raise their legs they can swell…that sometimes means they can't walk around as much as they would like to." This demonstrated they knew the importance of ensuring this happened.

People's care plans included a brief life history and information about their preferred routines and lifestyle choices. For example, one person's personal care was provided by female staff because they became anxious when they were in the company of men. Another person liked a quiet environment and we saw their bedroom was located at the end of a corridor which meant they were not disturbed by people walking past.

Staff told us they had received training in equality and diversity and this supported them to recognise and understand the importance of people's different cultures and religions. One person's religion was important to them and we saw staff spent time with the person and read them passages from the bible as they were no longer able to do this for themselves. Another person visited a place of worship each week with their family. Staff knew that it was important to the person to "look smart" and "wear their best clothes" at this time. They explained to us how they supported the person to follow the same routine each week in line with their wishes.

At the time of our visit the home supported people who were moving towards the end of life but we found care plans did not detail people's future wishes for how they wished to be cared for in their final days. This was despite some people having the capacity to share their views. We spoke with a nurse about this and they told us they had tried to hold conversations with people and their families but people had not wanted to discuss it. Information we had received from a member of the public prior to our inspection informed us of a negative experience regarding support provided to them when their family member was at the end of their life. Nurses told us they would make further attempts to gather information regarding people's wishes. They acknowledged that without this information they were unable to ensure peoples wishes and choices would be respected.

People and visitors to the home knew how to raise a concern or complaint if needed. We saw that where complaints had been raised, action had either been taken or there was a date for resolution specified. For example, a complaint had been raised about a broken toilet seat and it was fixed the next day. One person had complained about being washed with a cold flannel in response the registered manager met with person to apologise and staff received supervision.

Requires Improvement

Is the service well-led?

Our findings

We found there were a number of areas where improvements were required and the audit processes and checks used at the home had not identified these. For example, some people did not always receive care that was responsive to their individual needs, and risks were not always managed consistently. People told us they felt sometimes they needed more staff time than staff were able to give, and we identified that the length of time between staff checks was too long for some people. For example, one person told us they needed to use the toilet and had been unable to alert staff to this because their call bell was not working. This faulty call bell had been reported to the maintenance person so this had already been identified, but arrangements to check on the person had not been sufficient. The person told us they wanted support to use the toilet but were often only provided with a bedpan. Some people said they were not able to have a shower when they wanted one and we had to alert staff regarding two people who told us they felt thirsty.

We found prompt action had not been taken to follow up an OT assessment requested in November 2017 to see if a person could have a chair to sit out of bed. This meant the person had been restricted to their bed when potentially they may have been able to sit out of bed to support their wellbeing.

Although we had found areas needing improvement, comments we received from people demonstrated they were satisfied living at Sovereign House and they found the staff kind and approachable. A compliments book located in the reception area confirmed visitor satisfaction with the care and services provided. These compliments received in 2018 stated, "Everyone is so kind, you do a good job," "Thanks' for all of your care and attention," and "We are delighted with the care."

On the day of our visit the provider was in attendance to provide support to the registered manager. They told us they regularly visited the home to check it was running effectively and to ensure any necessary improvements were made. We saw the provider had implemented audit checks such as a kitchen audit to ensure this service ran effectively. This had taken place during May 2018 and showed a score of 92% compliance demonstrating this service overall worked well. The audit had identified that some crockery was chipped and needed replacing. We saw this had been replaced promptly in May 2018.

Health and safety checks regularly took place to keep the environment safe. This included checks of gas, electrical wiring and fire equipment, all of which, we saw had been completed within the recommended timescales.

People and their relatives had opportunities to comment on the quality of care and services provided through regular 'resident' meetings or the completion of annual satisfaction surveys. The registered manager also held open surgery sessions where relatives were invited around every six months to come into the home and speak about the care of their relative, or any other issue they wished, to ensure they remained happy with the care provided. Notes of meetings showed that requests made were acted upon which demonstrated people were listened to.

Staff told us they had opportunities to attend staff meetings and contribute to discussions regarding making

improvements at the home. They also told us they discussed areas where improvements were needed. For example, one staff member told us at a recent meeting the registered manager had reminded them of the importance of taking care of people's clothing as some items had gone missing. They said, "The manager discussed laundry with us and told us we all need to take responsibility for clothing. We were asked to share our ideas and the manager listened to suggestions to make things better."

There was a stable management team at the home and staff received appropriate support, understood their roles and responsibilities and had confidence in the management team. There had been consistent management of the home as the registered manager had worked at the home prior to the new provider taking over. Staff spoke positively of the registered manager and explained how they had been supported. One staff member said, "The manager has supported me to develop my knowledge. She is approachable and is always there if I have any questions." Another staff member explained that English was not their first language and told us how the registered manager had spent time with them to improve their English-speaking skills. They commented, "I am who I am partly because of the help I got when I started working here." Staff told us the registered manager's door "was always open" if they needed to speak with them. One staff member explained how an agreement had been reached with the registered manager for them to work split shifts. This had helped them to manage their work life balance and demonstrated the manager valued staff and worked with them to ensure they could work effectively.

The registered manager worked to the provider's policies and procedures and understood their regulatory responsibilities such as those related to the submission of statutory notifications and the completion of a provider information return. They worked closely with key organisations and agencies to support care provision, service development and effective care. For example, there was close liaison with nursing specialists and health professionals. During our visit we spoke with two visiting health professionals who told us they had seen people's health improve at the home. They told us of the positive outcomes for them. This included one person nearing the end of their life who had significantly improved since being there. The person had put weight on and had participated in activities and seemed like a "different person". They were pleased with the progress the person had made. They told us staff had gone the extra mile to buy the person some chips from the "fish and chip shop" which had helped encourage the person to eat.

The registered manager told us they had been awarded accreditation for the "Say no to infection" campaign running across the city. The aim being to help reduce and prevent infections within the care settings. This demonstrated the provider's commitment to managing infection control in the home and keeping people safe.

The registered manager told us during our visit that care staff had been nominated for 'Skills for Care' awards. Following our visit, they confirmed two awards had been won, one of these being, "Compassion in Care". Skills for Care sets the standards and qualifications to enable care workers to develop the skills and knowledge needed to deliver high quality care to people.

The registered manager told us they aimed to support any new initiatives to improve the effective running of the home. This included being part of the 'React to Red' campaign. This campaign aims to reduce skin damage such as pressure ulcers by increasing staff knowledge on how to prevent them. The registered manager told us following our visit they had been re-accredited for React to Red which demonstrated actions they took to prevent skin damage were effective.

We were also told about the home's participation in a 'Red Bag' pilot to help improve hospital transfers from the home. They explained this was where a red bag was used to transfer people's records, medication and personal belongings in a red bag when taken to hospital. This was to ensure everyone involved in the care

of the person had all the necessary information about them, and upon hospital discharge, this stayed with the person for them to return back to the home. This was to help reduce the amount of time taken for ambulance transfer times, hospital assessment times and aimed to reduce avoidable hospital admissions.

Following our inspection visit, the registered manager told us a meeting had taken place with staff on 18 June 2018 where actions were discussed with staff to improve. This included an agreed time scale of 20 July for refresher training to take place in regards to MCA and DoLS. The provider also told us they would look at staffing arrangements at the home to help ensure people had consistent positive experiences of living or staying at the home. This demonstrated the provider and registered manager took their responsibilities seriously and promptly acted upon areas identified for improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and support people received did not always meet their needs and preferences.