

Priory Rehabilitation Services Limited

The Vines

Inspection report

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Date of inspection visit:
07 February 2017
08 February 2017

Date of publication:
24 April 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We inspected The Vines on 7 and 8 February 2017 and the inspection was unannounced. The Vines is a care home registered to provide accommodation and personal care for a maximum of seventeen people. The Vines specialises in the treatment of acquired brain injury and neuro-rehabilitation for adults. The service aims to promote independence and help each resident back into the community. People required a range of support in relation to their support needs and some people had limited mobility. At the time of the inspection there were thirteen people living in the service.

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

At our last inspection on 1 and 2 June 2016, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities). These breaches were in relation to safe care and treatment, dignity and respect, safeguarding people from abuse, complaints, good governance and staffing. We had requested the provider to take action. The provider sent us an action plan stating that they had addressed the concerns raised. At this inspection we found that improvements had been made and the registered provider was no longer breaching these regulations. However we also found new breaches and made some recommendations. You can see the recommendations in the main body of the report and you can see what action we asked the provider to take at the end of this report. □

The provider had systems in place to protect people against abuse and harm. The provider had effective policies and procedures that gave staff guidance on how to report abuse. Staff were trained to identify the different types of abuse and knew who to report to if they had any concerns. Medicines were managed safely and people had access to their medicines when they needed them.

Food safety checks and some cleaning checks in the kitchen had not been carried out regularly. There was no menu for people to choose food from during the first day of our inspection. People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and staff ensured these needs were met.

The provider had not ensured that there was a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service. We were told that several staff members had recently left the service and had not yet been replaced. There was a high level of agency staff employed to work at the service and occasions where the lack of permanent staff affected people's choices.

There was a lack of meaningful and structured activities on offer to people and there was a lack of therapeutic input to people's activities. The registered manager had recruited people who were yet to start

and had plans to recruit other staff members.

People were not always supported to maintain their independence. The registered manager told us that some staff were reluctant to change their working practice to empower people. The registered manager was working towards a culture change in the service.

Staff were trained with the right skills and knowledge to provide people with the care and assistance they needed. Staff met together regularly and some staff felt supported by the registered manager. Staff were able to meet their line manager on a one to one basis regularly. When staff were recruited they were subject to checks to ensure they were safe to work in the care sector.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

The staff were kind and caring. Good interactions were seen throughout the day of our inspection, such as staff sitting and sharing mealtimes with people as equals. People could have visitors from family and friends whenever they wanted. People spoke positively about the care and support they received from staff members. However, some staff members did not always promote independence.

People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

There were systems in place to monitor and respond effectively to complaints, although verbal complaints were being addressed informally and were not being recorded. Quality monitoring systems were in place but were not always being implemented effectively.

We were told that there were tensions in the service between staff and new management. We were told that this had not affected people living in the service. We found that this was an area for the registered provider to improve.

Support plans ensured people received the support they needed in the way they wanted. People's health needs were well managed by staff so that they received the treatment and medicines they needed to ensure they remained healthy. Staff responded effectively to people's needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The Vines was not consistently safe.

The registered provider had not implement a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and there were not enough permanent staff employed to always ensure people's preferences were met.

Not all necessary safety checks were carried out. For example, food temperature and kitchen cleaning checks were not being evidenced. Risk assessments were in place but did not always fully assess risks and supplementary assessments were not always in place.

Staff members understood their roles and responsibilities around safeguarding and people were kept safe from abuse.

Medicines were being managed, stored and administered safely and people received their medicines when they needed them.

Is the service effective?

Requires Improvement ●

The Vines was not consistently effective.

People had sufficient food and drink to meet their needs. However, there was no menu available for the first day of our inspection.

Staff had access to training to ensure that they were skilled to meet people's needs. However the service needs to recruit to key roles such as deputy manager, assistant psychologist and chef.

People who lived at The Vines had the capacity to consent and the principles of the MCA were being complied with.

People had access to a wide range of health and social care professionals and had their healthcare needs met.

Is the service caring?

Requires Improvement ●

The Vines was not consistently caring.

Care plans contained personal details and information but people's independence was not always encouraged.

Staff developed caring relationships with people and people spoke highly of their staff.

People's privacy was respected and upheld.

Is the service responsive?

The Vines was not consistently responsive.

People did not have access to meaningful activities and there was a lack of therapeutic input in to activities provision.

There was a complaints policy and system for recording and responding to complaints.

Requires Improvement ●

Is the service well-led?

The Vines was not consistently well led.

The culture of the service was in transition and the staff team was fractured. The registered manager was working towards improving this.

The registered manager was providing the service with effective leadership.

The quality monitoring systems were robust but staff were not consistently implementing them in order to identify shortfalls, such as lack of a menu.

Requires Improvement ●

The Vines

Detailed findings

Background to this inspection

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

The inspection took place on the 7 and 8 February 2017 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service. We considered information we held about the service: this included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took the PIR into consideration when we made the judgements in this report. We also contacted the local authority and their quality team to obtain their views about the care provided in the service.

During the inspection we spoke with five people, three of their relatives and two visiting professionals. We spoke with various staff that included the registered manager, the deputy manager, the administration assistant, four permanent care staff, and two agency care staff. Subsequent to our inspection visit we spoke to two members of the senior management team. As some people who live at The Vines were not able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. On this occasion we did not use the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five care plans and associated risk assessments, eleven staff files, medicines administration record (MAR) sheets, incidents and accidents logs, policies and procedures and other records relating to the management of the service. We also 'pathway tracked' people living at the service. This is when we followed the care and support a person received and obtained their views. It was an important part of our inspection,

as it allowed us to capture information about a sample of people receiving care.

We last inspected The Vines on 1 and 2 June 2016 where it was rated 'Requires Improvement.'

Is the service safe?

Our findings

People and their relatives told us that they felt The Vines provided a safe place for people to live. One person told us, "I am safe here because it's lovely and everyone's friendly. If I get fed up they get things to keep me busy. I had a fall and they put extra staff on. I've got an alarm on my wrist in case I fall and I can call for help." Another person told us, "I am safe here because the staff are very, very good. If you speak to them about problems they are eager to help." One relative told us, "Absolutely [person] is safe because they are a very caring bunch of people who look after him." Another relative told us, "Yes he's safe because his key worker is particularly good with him and when I visit I can see he is safe." Despite people's positive comments, we found areas of care that were not consistently safe

At our last inspection on 1 and 2 June 2016 people were not protected from abuse and improper treatment as staff had not had recent relevant training, and social isolation was being used as a behaviour management plan. At this inspection we found that improvements had been made and the breach had been met. Staff members had received training in safeguarding and were knowledgeable about their role and responsibilities in reporting any concerns. One staff told us, "We have training in safeguarding: it's there to protect everyone. If I saw something then there are numbers in the office I can call to report and I can use the whistle blowing procedure as well." We viewed the safeguarding file and saw that two safeguarding referrals had been appropriately made to the local adults safeguarding board in 2017.

Two safeguarding referrals had been made for people who had been found on the floor and one referral had been made following an altercation between two people. One staff member told us, "I've reported a safeguarding concern when a resident pushed another resident over. We did an incident form and contacted the safeguarding team to let them know what happened and it was followed up. Our safeguarding training makes sure we know what to do." We saw that all bedrooms were equipped with a call bell so that people could summon help if they needed it. Subsequent to our inspection we were made aware of an incident that had not been reported correctly. The registered provider had sent confirmation that all staff had been trained, details of training courses and a copy of the organisation's safeguarding policy.

It had been noted in our last inspection that social isolation was used as a tool for managing people's challenging behaviours. In this inspection people with behaviours that challenge, such as shouting, hitting or destroying property had positive behaviour support plans in place. One person had a care plan that detailed their behaviours, their triggers and offered guidelines and positive strategies. The plan took account of the person's history, their medicines and their previous incidents. There was a good knowledge of what caused the person to experience behaviours that challenge, such as decreased mobility. The guidelines offered practical advice for staff members to follow, to ensure that they could keep the person and others safe, such as how to support the person to communicate more effectively with their peers.

At our last inspection on 1 and 2 June 2016 the provider had failed to maintain safe medicine procedures for the storage and recording of medicines. At this inspection we found that improvements had been made and the breach had been met. The medicines room was kept locked and staff administering medicines wore

tabards to let people know they should not be disturbed. Controlled drugs were kept in a separate locked cabinet within the medicines room. Controlled drugs were being checked weekly to ensure the stock was correct. Homely remedies (non-prescription medicines that are available over the counter in community pharmacies) had been agreed and signed off by a GP. Pain relieving medicines to be taken 'as required' were appropriately logged and administered. The medicines file had a front sheet for each person that contained the person's name, room number, any allergies, and a photo of the person with the date it was taken. As required (PRN) medicines were in use and each person prescribed PRNS medicines had a PRN protocol and admin sheet to record when the medicine could be given, how often and to record when it was administered. Medicines had been signed in to the service and the quantities had been recorded.

We checked the medicines administration records (MAR) charts had no gaps in signatures when people had been given their medicines. The medicines trolley had separate locked areas in order to keep people's medicines apart. Boxes and bottles were clearly labelled and dated when opened. For people with conditions that required regular monitoring, such as diabetes, checks had been made and recorded at the timescales requested by the person's GP. We observed good administration practice and people were offered their medicines with a cup of water and were asked if they were ready to take their tablets. One person was offered their medicines but didn't want them as they were eating and the staff member came back later to the person when they were ready. Staff knew what people's medicines were for and one staff who did not know what one tablet was when we asked them found the information in the person's care plan.

At our last inspection we recommended that the service sought advice and guidance from a reputable source on food safety management procedures and food hygiene regulations. At this inspection we found that this area still required improvement. The registered manager told us that the chef was not at work and that other staff had been filling in, in addition to their duties. We checked the fridge and saw that not all food that had been opened had been dated. One packet of ham had been opened with no indication of when this was meaning that there was a risk it could be left opened for an unsafe amount of time and pose a health risk to people. We brought this to the attention of the staff member who was working in the kitchen and were told, "Not everything is getting done and there was nothing in place before. We're trying to get people to label food out of habit but we've recently lost the chef and that affects things."

There was a daily cleaning schedule, for keeping the kitchen clean after it is used, as well as a weekly cleaning schedule. However, the weekly cleaning schedule was not completed for the week prior to our inspection. The Food Standard Agency guidance states that 'Raw materials, ingredients, intermediate products and finished products likely to support the reproduction of pathogenic micro-organisms or the formation of toxins are not to be kept at temperatures that might result in a risk to health.' However we viewed the records for the food temperature checks and saw that these were not completed as often as they should be. For example, from 16 January to 29 January all food temperature checks had been carried out; however, from 30 January to 5 February no temperature checks had been completed.

The failure to comply with safe food practices is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 1 and 2 June 2016 the provider had failed to identify and manage risks relating to the health, safety and welfare of people using the service. At this inspection we found that some improvements had been made and the breach had been met. However, we have also made a recommendation about how risk management can be improved. We saw individual risk assessments for potential hazards to people such as choking or for verbal aggression. One person's verbal aggression risk assessment outlined their typical behaviours, why these behaviours could upset other people and how staff

should support the person, for example, "[X] responds very well to staff offering him a cup of tea or asking if he would like to talk about any issues they may have." However, there was no separate positive behaviour support plan [PBSP]. PBSP's are used to teach a person more effective and more acceptable behaviours than the challenging one in order to reduce the challenging behaviour. This meant that the service was not supporting the person as effectively as possible.

Another person had a risk assessment for choking which stated, "[X] should not be left unsupervised when eating and food should be cut in to manageable pieces. Staff will need to remind [X]...to chew properly." However, there was no separate choking risk assessment and we observed the person eating sandwiches at lunchtime that had not been cut in to manageable pieces. We raised this with the registered manager and were told that the person had never choked so a choking assessment had not been previously completed. The registered manager told us that it is only certain types of food that need to be cut up so sandwiches were safe for the person to eat. By the end of the first day of our inspection the registered manager had implemented a review of the person's choking risk assessment.

We recommend that the registered manager reviews all risk assessments to ensure that these contain full information to help staff keep people safe, and that significant risks are managed with supplementary assessments where necessary.

Environmental risks were being managed effectively through regular monitoring and checks conducted by the registered manager. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. The registered manager ensured that general risks such as slips and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and water safety. Each risk assessment identified the risk and what actions were required of staff to reduce the potential hazard. Fire safety was managed effectively with regular servicing of equipment and weekly alarm tests and regular fire drills which reported the outcome of each drill.

At our last inspection on 1 and 2 June 2016 the provider had failed to implement a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. At this inspection we found that improvements had not been made and there was a continued breach of regulation. The service was staffed by five care workers in the morning and afternoon and two carers who worked a waking night shift. The registered manager had recently increased staffing hours for one person as the result of a fall in December so that the person had one to one staff to keep them safe whilst they regained their mobility skills. The registered manager told us, "We don't use a dependency tool and since I've been here we've not decreased staffing. I know it's the right level because it works: people are safe and there's opportunity for one to one support in the day." The registered manager told us that they have had several staff members leave the service and as such they were using agency staff from one agency and where possible they used regular agency staff.

Several people told us that they felt there were problems with the staff team. A healthcare professional told us that they had no concerns about the quality of care provided to the people at the home, but they felt that there were tensions in the staff group. One member of staff told us, "We've lost quite a few staff and we're down to the bone. In fairness they try to get the same agency staff: I had one issue with an agency staff and [manager] stopped them from coming here." Another staff member told us, "The levels of five and five [carers working in the morning and afternoon] are good as we can get people out but today's the first day in a long time we've had adequate [permanent] staff. Normally there's lots of agency and they don't know how people want their care." Another staff member commented, "The full time staff try their hardest but since last June we've had lots of people leave." We spoke to an agency care worker, who regularly worked at the

service about their induction and were told, "They gave me an induction pack to read which had information about the residents. If there was any information I needed I would just ask and they told me how to do things. My induction helped me to work with the residents." We spoke with the registered manager who told us that they had recently recruited five care staff and were waiting for their employment checks to be completed before they could start working at the service.

We found that staffing of the service was an area that required improvement. There were several key roles that were vacant and the staff team was low on numbers. The registered provider was using an agency to provide staff to the service and the rota showed that staff levels had been consistent. However, we were also later made aware of an issue between agency staff and full time staff that resulted in disciplinary action being taken. We were told that the use of agency staff was affecting people's access to activities in that when there was only one permanent member of staff on shift it was difficult to get people to attend activities. We requested two weeks of rotas subsequent to our on-site visit and saw that there were six shifts where there was only one permanent staff member on shift. This meant that the service was heavily reliant on agency staff and that people's choices and independence may be affected as a result of a lack of staffing.

The failure to implement a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were being followed by the service. We looked at the recruitment records for two people, one of whom had been recruited in the 12 months prior to our inspection. In both cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible. There were detailed and scored records of interviews, using role-specific question formats. Regular one to one supervision and appraisals between staff members and the registered manager were happening and people had the opportunity to raise concerns in structured meetings.

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "The staff will help me if I need them. I don't have any problems but if I did I know they would help me." Another person commented, "I know the staff have enough training because they're really good." One relative told us, "Staff don't leave [X] to sit all day or to lie in bed and they know how to ask and to return to him and be patient: to go back and forth to support him to engage. If he didn't want to go on a walk they would go away and come back again and cajole him into going out." Another relative told us, "We've had regular review meetings with the key worker and we've had phone calls on a regular basis. My brother likes his key worker and they get on well. His [medical condition] is well looked after they make sure he's well fed and cared for." Despite these positive comments we found some areas of care that required improvement.

At our last inspection on 1 and 2 June 2016 we found that staff did not always have the training and knowledge they needed to meet people's needs and ensure their safety. At this inspection we found that improvements had been made and the breach had been met. Every member of staff had completed training in understanding brain injury. The registered manager explained that the provider used an in-house training programme run by the registered provider to supply the standard training courses that staff required. A database automatically alerted management to the imminent expiry date of a training course and automatically re-assigned the course. This system ensured that staff training was kept up to date. We were told that staff were given time within their working day to complete the training. All staff had completed safeguarding training and the registered manager had completed the 'train the trainer' course for safeguarding. Staff competencies were being checked for training courses such as safeguarding and administration of medicines.

Staff received regular one to one supervision sessions from the registered manager. We checked 11 staff files and saw that seven staff members had been supervised in January. The four staff who had not been supervised had received supervision in December 2016. The registered manager explained to us that they aimed for supervision every eight weeks. Staff told us this was an opportunity to discuss their work and any issues that had or training they needed. Annual appraisals had been scheduled. New staff were required to complete the care certificate. The 'Care Certificate' was introduced in April 2015. It is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff were actively working on their Care Certificate. Despite the improvements made to training and supporting staff members, the service being delivered was not always effective due to vacancies to key roles in the staff team. Subsequent to our site visit we were told that there were vacancies to the deputy manager post, the chef's post, the administration post, several care workers posts and two assistant psychologist's posts. This meant that people did not always have access to consistent care workers, or the clinical input from psychology and staff did not have access to a deputy manager.

We recommend that the registered provider recruits to key roles in order to provide an effective service.

At our last inspection on 1 and 2 June 2016 we found that staff did not always have a good understanding of the Mental Capacity Act (MCA) 2005. At this inspection we found that improvements had been made. The

MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had ensured that people's freedom had not been restricted and systems were in place to keep people safe. Records showed that the service had made appropriate referrals for DoLS and were using the principles of the MCA to protect people. For example we checked one person's file and found that four separate mental capacity assessments had been completed appropriately. Where the person was deemed to lack capacity, best interest decisions had been made by a group of professionals who knew the person well. Staff understood the principles of the MCA and spoke confidently about their responsibilities. One staff told us, "MCA and DoLS are separate. The thing about capacity is people have the capacity to make some choices, e.g. if they want a hot or a cold drink, but maybe they don't understand everything about their finances, so they need help." Another staff member commented, "We have multi-disciplinary meetings with the psychologist and we discuss everyone's capacity issues there. All people have a best interest decision in place for certain things but they can still make simple decisions, e.g. what to eat."

People appeared to enjoy mealtimes and had access to the food and drink they liked. People told us that they liked the food and that there was enough food and drink available. One person told us, "The food here is excellent: I've never asked for more food or drink but I'm sure I could," Another person commented, "The food here is lovely and we get enough to eat and drink. I get lots of coffee, the way I like it, and they also gave me fruit tea which was lovely. They cook most things very well and I've never had a bad meal here." One relative told us, "I've had meals there before and it's been fine, they have a cooked meal in the evening and a light lunch." We observed two mealtimes and saw that people were supported to eat their meals in a calm environment. At lunchtime people were offered a choice of crisps and four types of sandwiches. However, the weekly menu that people would choose their meals from was not written for the week of our inspection. We were told that staff would go round to people in the afternoon and offer them the choice of two dishes. If people wanted something different this was accommodated. The staff on duty in the kitchen informed us that one person in particular often refused food in the evenings but if they were encouraged with a lighter option, such as egg on toast they would eat. We raised this issue with the registered manager who told us that they were aware of the problem and that since the chef had left they were, "All hands on deck" to cover the absence and were actively recruiting another chef.

We recommend that the registered manager reviews menu provision for the service to ensure people can access a menu to choose meals from.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. We reviewed one person's care plan to see how the staff were managing diabetes. There was a diabetes management plan on file which was written in the person's own words and gave clear instructions to staff on how to safely support them in the way they wanted. For example, the plan stated, "I have insulin injections twice daily. I am able to give the injections if staff measure out the dose." We observed that this happened in the way set out in the plan. Regular blood sugar levels were recorded and sent to the person's GP at the frequency agreed. There were clear guidelines written for what staff should do if the person's blood sugars were at certain levels in order to keep the person safe. There was a contingency plan for if the blood sugar readings had not improved, including an emergency services response plan.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. One relative told us, "[X] goes to a specialist clinic and he has eyesight checked as he's had problems before; they were trying to get him to see a chiropodist and he can be quite stubborn when it comes to his feet but they got him seen." Another relative told us, "Yes the staff tell [X] and we arrange it together so I can attend appointments with him." We saw that people's care plans contained nationally accepted frameworks to monitor people's health such as the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), for obesity. It also included management guidelines which could be used to develop a care plan. People who were at risk of being under or overweight were assessed accordingly and staff members monitored people's weight effectively.

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "The staff are very caring. Anyone who has a problem can get it solved very quickly." Another person told us, "It's lovely here: everyone is friendly and if they think something is wrong they're very caring." One relative told us, "They are very caring; I've seen them interact with other residents when I've been there and from what I can see they are very caring. There are a couple of smokers in the home and they have to be careful about how many cigarettes they smoke and they handle that really well." Despite people's positive comments, we found areas of practice that were not consistently caring.

At our last inspection on 1 and 2 June 2016 we found that staff did not always protect people's dignity and respect them as individuals living in their own home. At this inspection we found that improvements had been made and the breach had been met. We observed staff interacting with people in a manner that upheld their dignity. For example, one person had returned from a walk and the staff supporting them asked, "Please can you go upstairs and clean your trainers as they're nice and white but there's some mud on them? If you do that, I'll get a cup of tea and some biscuits for us, how's that?" The person agreed to clean their muddy shoes and returned to chat with their staff member about the walk they had been on, talking about the horses they saw. As there was free time before lunch the staff member suggested a card game and other people were invited to sit and play. Three people sat and played card and chatted to the staff member. We observed people being called by their preferred names and when there was an occasion where a staff member used a 'nickname' for someone this was done appropriately and in good humour, with the persons' assent.

People's privacy was respected. Care plans were kept in an office area which was not accessible to people or the public, so that people's confidential information was not available to view. We observed one person who was sitting in the lounge and watching TV with other people and was struggling to remember what they spoke about with a medical professional that morning. A staff member comforted them by saying, "That's OK we're here to help you." When the person continued to ask what they spoke about the staff member reminded them, "It's not the place to talk about it here. Shall I get you a paper to read?" This distraction technique of reading the paper worked for several minutes and staff read the paper with the person and checked several sports results that the person was interested in. However, when the person persisted in asking for confidential details about their medical history they were supported to find a long standing member of staff who brought their care plan to a private room and read through it with them.

Throughout the day of our inspection we observed open and positive relationships between residents and staff. One person was walking in a corridor holding a watch in their hand. A staff member noticed and asked, "Do you want me to help you to put that on?" The person was grateful for the support and indicated which wrist the watch should go on. People were observed saying 'good morning' to each other and their staff team and people were used to speaking to their staff on an equal basis. We observed the registered manager come in to the service and say hello to everyone and chat for a while. One person said, "I want to have a word with you." The registered manager indicated that they were free to talk now if convenient but the person replied, "Not now, I'm watching my programme but I'll come and find you." This was illustrative

of the easy and natural way that people and staff addressed each other during our inspection.

Care plans contained personal information and people could make their views known and be involved in their care and support. There was a personal profile at the front of people's care plans that included details of people's interests and a summary of their personal history. Care plans also contained a good level of detail about how people wanted their care and support to be delivered. For example, one person's file stated clearly how they expected to be supported with their personal care, in the person's own words. It instructed staff, "I like to have a shower in the morning. I would like support from one member of staff. I would like help to wash my back and I can wash my hair myself. I can manage everything else myself but I will ask for help if I need to. I would like the member of staff supporting me to be female."

Despite examples of people being able to have a say in their care, we found that people's independence was not always promoted actively by the staff team. One staff member told us, "We try to promote independence as much as possible. They'll ask me to do something but I'll say 'why don't you give it a go' and help when they're struggling. Some people will not do anything in the home as it's always been that way for them." However, during everyday interactions staff members were quick to intervene and do things for people such as getting drinks throughout the day, or taking plates to the kitchen area after people had finished eating.

We spoke to the registered manager about promoting independence for people in the service and were told, "At the moment there is a very strong 'doing for' culture [instead of helping people to do things for themselves] and staff thinking that residents aren't capable." We spoke to the registered manager about their plans to address this issue. The registered manager demonstrated awareness of the need to embed a culture of promoting independence in the service and the likely challenges they faced in doing so. They outlined plans as to how they were planning to tackle this.

The failure to support people to be as independent as possible is a breach of Regulation 10(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service responsive?

Our findings

People told us they were receiving a person centred service. One person told us, "The staff work out problems for me. I had a problem with the buttons on the remote for the TV and the staff got me a remote with buttons on I can use to watch the TV." A relative told us, "[X] is able bodied and can go out unsupervised. They've provided a card in his wallet and he has a couple of places in the town he goes to and if anything happens they know to call this number." One staff member told us, "All care plans are adapted to people's needs so not one care plan is the same. As we've got to know them over time we know what they like and what they don't like." Despite people's positive comments we found some areas of care that required improvement.

At our last inspection on 1 and 2 June 2016 we found that there was not an effective system for receiving, recording and handling complaints. At this inspection we found that improvements had been made. There was a system in place to record complaints as and when they were received. The registered manager told us that since they had started in the role they had not received any complaints. . There was a suitable policy in place to address complaints appropriately and within a specific time frame. There was a complaints log with a blank complaint form, a blank complaint process checklist and a blank holding letter template all ready to be used when a complaint is received. It was noted that verbal complaints were not being recorded in the formal complaints log and we discussed this with the registered manager.

We recommend that the registered manager reviews the complaints response process so that verbal complaints are recorded on the complaints log.

People were not consistently able to choose what activities they took part in and suggest other activities they would like to complete. On the first day of our inspection we were told that there were no planned activities for the day and that people were doing walks. We were told that one person was due to go out in two days' time to have fish and chips on the beach. There were two vehicles which staff were able to use to take people out. However, there were a high number of staff vacancies meaning that people did not always have staff supporting them that could drive the vehicles. In addition the high number of agency staff on duty meant that people could not always access their structured activities as planned. One person had an activities box which contained word searches and crossword books. However, there was no personalised activity plan. We checked the person's profile and it referenced their fondness of word searches, but it also mentioned, "I like to listen to music, read at bedtime, watch soaps, like animals and wildlife and art groups". None of these other interests were reflected in the items contained in the activities box.

People did not always have a range of activities they could be involved in. We reviewed several care plans and found a lack of access to structured activities. One person told us, "I just go along with most things that are offered. I particularly like days out: it's not very often though." One staff member told us, "Activities are a staffing issue. We used to have two assistant psychologists who came in most days and now they've left we're stuck with board games. People very rarely ask for activities." Another staff member commented, "Weather permitting it would be good to get people out. One or two are more comfortable at home. They used to go ten pin bowling but it doesn't happen as much now. We need more staff to get people out and

about." We raised the concerns around a lack of structured activities with the manager and were told that this was the result of staffing levels and that an experienced activities co-ordinator had been recruited and was waiting for their pre-employment checks to clear before they could start. The registered manager explained that the plan was for the activities co-ordinator to work closely with the psychiatrist and psychologist to develop activities that would complement people's rehabilitation. They told us, "I would like to arrange two outings per week and include more group activities. A local leisure centre is running sessions for people with additional needs and we would like to get more pets in the home. I've put in a change of use request for the small lounge to be changed to a games room and we're going to get a pool table, dart board, chess set, card table, beauty therapy trolley and nail bar. We've also requested a home computer so residents can learn how to use the internet."

People were not receiving a therapeutic service. There was no evidence of structured rehabilitative work during the time of our inspection. One healthcare professional told us, "I'm not concerned about the care of the clients but they are lacking activities and outings, and some of the things we should be doing in a rehabilitative setting. At the moment we have no psychology input therapeutically." When we reviewed activities plans we were not able to see a therapeutic input from professionals. There had been multi-disciplinary team (MDT) meetings but we were told that these had not happened with regularity. One healthcare professional told us, "I was coming weekly but it's harder to instigate (MDT's) now. There's a special format for MDT's but the problem is there is no multi-disciplinary team." We raised this issue with the registered manager and were told, "One psychologist is coming in once a week, we've got a new activities co-ordinator and we will recruit for two new assistant psychologists."

The failure to provide people with a range of meaningful activities is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care, treatment and support plans were personalised. The examples seen were thorough and reflected people's needs and choices. One person's care plan had a goal to remain in contact with their friends and family with staff support. The section of the care plan explained how many family members the person had and how they would like to be supported to stay in contact with them. Another person's care plan had a section on communication and set out how the person wanted to communicate with people such as, "I am able to initiate conversations with other people and like to listen as well as talk. I can usually tell staff if I am unwell or I need support with anything, but I would like staff to ask me if they are concerned." This enabled staff members to communicate effectively with the person. Another person's care plan set out how a medical condition affected their mobility to varying degrees on a daily basis. There was a detailed description of the level of support the person would need on a 'bad day' and how the person wanted the support to be delivered.

People and their relatives spoke highly of the service that they and their loved ones received. One relative told us, "As a family we think it's one of the best places he's been in. It's always very clean and the staff are very helpful and they phone me if there are any issues or problems. Recently a lot of staff have left for various reasons and my brother finds that quite upsetting but I don't think it's affected him massively." Another relative told us, "It's more like a home as it's not big and there aren't many patients and I'm sure they get more attention as opposed to other services." One person told us, "I like it here. I like living here and want to stay."

Is the service well-led?

Our findings

We received mixed feedback about the management of the service. Some people spoke very highly of the registered manager and some people felt that there was a split between the registered manager and management staff they had bought in to the service and long standing staff. One staff member told us, "These are the best managers [registered manager and deputy manager] I've worked with: they work with us and treat all staff the same." Another staff member told us, "We've had a lot of change of late. I'd like to think they're [management] doing a good job. An awful lot of staff have left since they'd joined, but this place wasn't up to scratch." Another staff member told us that staff morale was low, "We've had so many staff leave and there's been no enquiry as to why this has happened. I don't feel [the management team] are supportive or that I can trust them." A second staff member gave us examples of how management changes had affected staff morale. One relative told us, "The management have changed a couple of times and every time it changes there are staff that decide to leave. From what I can tell the house runs smoothly." A visiting health professional, who was regularly involved in the service, informed us that there were tensions between the new management team and established staff members.

We were told by repeatedly that there were tensions in the staff team. The registered manager had been in post since November 2016 and had been joined by a new deputy manager and an administration assistant. The registered manager told us, "There are some issues and the biggest problem is resistance to change. The culture is stuck 10 years ago and there is a huge culture of doing things for and not with people." The registered manager spoke about their plans to implement change within the team whilst supporting care workers. The registered manager informed us that they had given all staff their mobile number as well as their line manager's number so that staff can raise issues with a senior manager directly if they felt it necessary. The registered manager had left a message in the communication book informing staff members that they could ask for any work related training they needed as a way of supporting the staff team, and a staff meal was funded as a thank you. The registered manager informed us, "I work on shift with people and there's a lot of fear about change but staff are more capable: they are ordering medicines where they weren't before. I want to focus on developing staff but we need to get past the 'them and us' mentality."

We spoke with visiting professionals, people, staff and the registered manager and asked how the working culture in the service was affecting people who lived in the service and we were told unanimously that it was not having a negative impact. One relative told us, "I think it [culture of the service] is good. I've been there at Christmas and it's pretty lively. It's not a place where dark clouds come over your head when you enter and they make it as nice as possible. It's a good place and I've never felt uncomfortable." During our two day inspection we could not identify any impact on the care and support that people received. Subsequent to our inspection we were informed of a change in the management structure at the service. We contacted the registered providers' senior management team to seek assurances that the service was being managed effectively following the changes since our inspection.

We recommend that the registered provider seeks guidance about providing staff and management support in order to drive improvements in the culture and cohesion of the service.

At our last inspection on 1 and 2 June 2016 we found there were failures to operate an effective quality monitoring system which recognised areas for improvements and led to action. Along with a failure to maintain accurate, up to date and fit for purpose records relevant to each person and the operation of the service. At this inspection we found that the breaches had been met but there were some improvements to be made. There were quality auditing systems in place but some checks had not been completed. A separate quality audit team had been employed by the registered provider to make unannounced visits and check quality systems such as infection control audits, and check whether the registered manager had completed action points raised in previous audits.

Quality auditing systems were in place and were designed robustly, but some checks had not been recorded. We reviewed a health and safety action plan, monthly housekeeping audits, kitchen audits and infection control audits. The registered manager told us, "There are medicines audits where I count stock and check controlled drugs every week and I also do the water safety and fire checks weekly. I do a monthly falls analysis to try and identify trends: it's not identified any trends yet as only one person is prone to falls and they have an alarm and bed sensor." The registered manager described how they completed falls analysis to try and identify trends, medicines audits, yearly medicines competency checks on all staff, and how they used the observational supervision process to monitor the quality of support delivered. They told us, "I designed the observational supervision forms myself as I thought they would be helpful. My deputy manager and I both work shifts so we can see what happens and what level of service people are receiving." Despite the systems in place some checks had not been identified such as the kitchen cleaning and food temperature checks and the effective monitoring of activities provision. The separate quality audit team had also failed to identify these shortfalls.

We recommend that the registered provider effectively implements the quality auditing systems in place to ensure any missed checks are accounted for.

The registered manager had a vision to drive improvements in the service and relatives were empowered to contribute to improve the service. The registered manager promoted people voicing their views and participating in decisions that were made in the service. There had been satisfaction surveys completed by people. Being able to make choices and going out were consistently identified by people as areas that could improve. The surveys had been recently completed and the registered manager told us that the results would be collated in to an action plan. They told us, "We've approached families about what people enjoy doing, what they used to like as a child etc. This is compiled on to a capture sheet. Each person will have a box and a file with photos, books objects as a means of opening a conversation."

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The registered manager confirmed that no incidents had met the threshold for Duty of Candour.

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 registered provider had failed to provide people with a range of meaningful activities.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure that people were being supported to be as independent as possible.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that safe food practices were followed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to implement a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service