Four Seasons (No 9) Limited

Bon Accord

Inspection report

79-81 Church Road
Hove
East Sussex
BN3 4BB

Tel: 01273721120
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 27 November 2017 and was unannounced. Bon Accord is a nursing home providing accommodation for people who are living with dementia and who may require support with their nursing and personal care needs. Many of the people, due to their cognitive abilities, had difficulty communicating their needs. This meant that they were vulnerable as they were not able to raise concerns or make basic decisions about their care and welfare needs. Bon Accord is registered to accommodate 41 people. Some of the rooms were designed as shared rooms; however, rooms had been converted and were now single occupancy. This meant that the home could accommodate a maximum of 33 people. There were 23 people living at the home at the time of the inspection. The home is a large detached property situated in Hove, East Sussex. It has three communal lounges, two dining rooms and communal gardens.

The home is owned by Four Seasons (No9) Limited, which is part of a large, national corporate provider called Four Seasons. Four Seasons (No9) Limited own a further three care homes in England. At the previous inspection on 31 May and 7 June 2017, a manager and a deputy manager from one of the providers' other services had been in day-to-day management of the home. The manager was going to apply to become the registered manager. However, at this inspection, the manager had left employment and the deputy manager was in day-to-day management of the home. In addition, the regional manager and a member of the providers' quality team visited the home twice a week to ensure that there was appropriate support and governance in place until a new registered manager was found. The provider was in the process of trying to recruit to the post of registered manager. However, the home had been without a registered manager for nine months. A registered manager is a '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 home is run.

At the previous inspection on 31 May and 7 June 2017 the home received a rating of 'Inadequate'. This home has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this home is now out of Special Measures.

At this inspection the provider was found to have met the previous breaches of regulations, however, continued improvements were needed to sustain and embed the improvements that had been made. Although the management of risk had improved and people were receiving appropriate support to maintain their health and well-being, further improvements need to be made to ensure that all risks, specific to peoples' lifestyles, are managed effectively. People were asked their consent and were able to make decisions about their care. When people had a condition that affected their ability to give their consent, mental capacity assessments had been completed and Deprivation of Liberty Safeguards (DoLS) applications had been made. Conditions associated to peoples' DoLS had mostly been met. One person had a condition associated to their DoLS which informed staff that they needed to support the person to regularly access the community. Records showed that the person had been supported to access the

community and had enjoyed car rides and visits to local cafes and shops. However, this had not happened frequently as outlined within the DoLS. These are areas of practice in need of improvement.

Records demonstrated that people had received appropriate support from staff and external healthcare professionals at the end of their lives. However, records did not always plan for or document peoples' preferences and wishes for their end of life care. We recommend that the home consider current guidance on advanced care planning so that conversations with people about their preferences at the end of their life can take place.

People told us that staff were available to assist them when required and our observations demonstrated that staff were available to support people according to their needs. One person told us, "There seem to be staff on duty". The home was not at full occupancy; however, the provider had made the decision to keep staffing levels the same as if the home was fully occupied. Although the consensus was that there was sufficient staff, one relative told us, "They have lots of empty bedrooms at present and they will need extra staff if they fill them". We were unable at this inspection to determine whether the current service provision could be sustained over time, should the number of people living at the home increase.

People, relatives and a visitor told us that people were safe. One person told us, "I feel safe because I can always see staff around". A relative told us they had "peace of mind" knowing their loved one was safe and protected from harm. Risks to peoples' safety, in relation to their physical and healthcare needs, were regularly assessed and appropriate care was provided to ensure that people received safe care. One person told us, "I can go into the garden when I want and I still feel safe, there are no restrictions placed on me". People were protected from the risk of harm and abuse as they were cared for by staff who had undertaken the relevant training and who knew what to do if they were concerned about a person's welfare. The provider had a good approach to ensuring that lessons were learned when incidents had occurred. There had been health and safety incidents that had occurred at the providers' other homes and they had ensured that these were discussed at a health and safety meeting to minimise the chances of the incidents occurring again. People had access to external healthcare services if they were unwell; there was good communication between different healthcare services to ensure people received coordinated and consistent care.

People had access to medicines when they needed them. The management team had worked hard to improve the management of medicines and there were good systems in place to ensure that people received their medicines when they needed them. The home was clean, there were good practices in place to minimise the spread of infection and cross-contamination. One person told us, "My room is cleaned every day". Another person told us, "There are never any odours".

People, relatives and a visitor told us that people were happy with the food that was provided, that they enjoyed the meals and were provided with choice. Comments included, "Food is quite good" and "I have a choice of food". People had access to sufficient quantities of food and drink. Appropriate measures were taken when people had lost weight; they were regularly weighed and had access to food that was fortified to increase their calorie intake.

People were able to live in an environment that had been adapted to acknowledge their cognitive abilities. Pictorial signs informed people of where bathrooms were and equipment such as grab rails and toilet seats were in brighter colours to support people who were living with dementia to use facilities independently or with minimal assistance. Peoples' bedroom doors resembled front doors and had been painted bright colours, displaying numbers to aid peoples' orientation. Communal spaces enabled people to socialise with others if they wished and smaller, quieter spaces were available for people to use if they preferred to spend

time on their own. People were able to access the communal gardens and some were supported to access the local community.

People were cared for by kind and caring staff. One person told us, "Kind people who treat you with dignity and respect". A visitor told us, "They think about the person, not just the task, they always chat to everyone in the lounges and make sure they are comfortable". Peoples' privacy was respected and they were treated in a dignified and respectful manner. People and their relatives were involved in decisions that affected their care. Regular meetings and newly introduced care plan reviews enabled people to share their views and express their wishes. People were able to raise any concerns or complaints and these were listened to and acted upon.

Peoples' needs were documented in care plans that informed staffs' practice. These were regularly reviewed and updated to ensure they reflected peoples' current level of need. People had access to activities and meaningful occupation to occupy their time. One-to-one time was offered to people who chose to spend time in their rooms and others had access to a varied range of activities such as arts and crafts and external entertainers. Local nurseries had been invited to regularly visit the home and observations showed people enjoying playing games with the children and listening to them sing. It was evident that this lifted peoples' spirits as people were observed smiling and laughing.

The provider, management team and staff had worked hard to improve the experiences of people. People, relatives staff and healthcare professionals told us that the home was managed well. People, relatives and visitors had confidence in the deputy manager's skills and abilities and were complimentary about the changes they had implemented within the home. Quality assurance processes audited and monitored the systems and processes to ensure that they were meeting peoples' needs. Shortfalls had been recognised and the provider and management team had undertaken a systematic approach and had concentrated their efforts on specific areas of practice to ensure that improvements were made. The management team worked with external agencies to ensure that practice continued to improve and develop and to ensure that staff learnt from other sources of expertise.

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 home was not consistently safe.

People were protected from the spread of infection. Most risks were identified and monitored and there were assessments in place to ensure peoples' safety. However, not all risks, particularly in relation to peoples' lifestyles and social needs, had been considered. There were sufficient numbers of skilled and experienced staff to ensure current numbers of people living at the home were safe and cared for. However, the home was not at full occupancy and the provider needs to demonstrate that sufficient staffing levels can be sustained should occupancy levels increase.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety. The provider demonstrated a reflective approach and implemented changes when lessons had been learned from incidents.

People had access to medicines when they required them. There were safe systems in place to order, manage, store, administer and dispose of medicines.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who might lack capacity but had not consistently worked in accordance with them.

People were cared for by staff that had received training and had the skills to meet their needs. Staff worked with external healthcare professionals to ensure that people received appropriate and coordinated care.

People had access to healthcare services to maintain their health and well-being. People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

Is the service caring?

Good

The home was caring.

People were supported by kind and caring staff who knew peoples' preferences and needs well and who could offer both practical and emotional support.

People were treated with dignity and respect. They were able to make their feelings and needs known and were involved and enabled to make decisions about their care and treatment.

Peoples' privacy and dignity were maintained and their independence promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People were supported to have a pain-free and comfortable death. However, records advising staff of peoples' wishes for their end of life care were not always in place.

People had access to a varied range of activities and entertainment. People were supported to engage in meaningful activities and were not at risk of social isolation. People were involved in the development and on-going review of care plans. Care plans were detailed and provided staff with personalised information about peoples' care.

People and their relatives were made aware of their right to complain. People were encouraged to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

People, relatives and staff were complimentary about the leadership and management of the home and told us that this had improved. However, the home had been without a registered manager for nine months.

There was a positive culture and staff morale was good. Mechanism were in place to involve people and their relatives in decisions that affected their lives.

Quality assurance processes ensured the delivery of care and drove improvement. The management team maintained links

with other external organisations to share good practice and maintain their knowledge and skills.

Bon Accord

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 27 November 2017 and was unannounced. The inspection team consisted of two inspectors, an assistant inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert-by-experience had experience of older peoples' services.

Prior to this inspection, on 27 November 2017, we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. Prior to the inspection we asked the provider to complete a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. We used all of this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 12 people, four relatives, one visitor, 12 members of staff and three members of the management team. Prior to the inspection we contacted one external healthcare professional as well as the local authority for their feedback. We reviewed a range of records about peoples' care and how the service was managed. These included the individual care records for nine people, medicine administration records (MAR), six staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounges and in peoples' own bedrooms. We also spent time observing the lunchtime experience people had, the administration of medicines and activities that were taking place.

The home was last inspected on 31 May and 7 June 2017, the home was rated as 'Inadequate' and we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 31 May and 7 June 2017, the provider was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the administration of medicines and the continued lack of effective risk management for some people. Following the inspection, the provider wrote to us to inform us of how they were going to address the shortfalls and ensure improvements were made. At this inspection it was apparent that improvements had been made and the provider was no longer in breach of the regulation, however, further improvements were needed to the management of risk.

At the previous inspection on 31 May and 7 June 2017, there were concerns with regards to the management of risk, particularly for people who had specific health conditions. Some people were living with diabetes and there was insufficient guidance to inform staffs' practice of peoples' condition and the measures that needed to be taken to maintain their health. Some people required their blood glucose levels to be monitored on a weekly basis; however, there was no evidence to demonstrate that this had been undertaken. At this inspection improvements had been made and people who were living with diabetes had clear care plans that informed staff of peoples' healthcare needs and provided guidance on the signs and symptoms to look for if a person's blood glucose levels were too high or too low.

At the previous inspection on 31 May and 7 June 2017, there were concerns with regards to wound care. Although people who had wounds had received support from external tissue viability nurses (TVN) the guidance that they had provided had not been documented in peoples' care plans to inform staffs' practice so that they knew how to care for peoples' wounds appropriately. This meant that people had not always received the appropriate support to maintain their skin integrity. At this inspection improvements had been made. There had been a reduction in the amount of people requiring wound care. Those that had wounds had received appropriate treatment from TVNs and care plans were detailed and provided staff with guidance to inform their practice and to ensure people received appropriate care.

Risk assessments for peoples' healthcare needs were in place and regularly reviewed. People were involved in the development and on-going review of care plans and risk assessments. Risk assessments identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. Staff were made aware of risks to peoples' safety through verbal handovers and meetings as well as having access to risk assessments, which were stored securely to maintain confidentiality; this meant that staff were aware of how to support people and were aware of the measures to take to assure peoples' safety.

However, although risk assessments in relation to peoples' healthcare had improved and people were receiving appropriate care for their health needs, there was a lack of risk assessments for people's social needs. One person sometimes displayed behaviours that challenged others. Observations showed the person enjoying a visit from local pre-school children. However, the persons' mood and behaviour rapidly changed and they demonstrated signs of apparent anxiety. Staff effectively supported the person and used techniques to diffuse the potentially challenging situation and divert the person's attention. However staff had not considered the risks for the person and others when undertaking certain activities and had not

agreed techniques and strategies to manage potentially challenging situations to ensure that staffs' practice and approach was consistent. Records showed that the person was sometimes supported by staff to access the local shops. However, there were no formal risk assessments that considered the potential risks this could pose and strategies that staff could use to support the person effectively. Although the management of risk had improved and people were receiving appropriate support to maintain their health and well-being, further improvements need to be made to ensure that all risks, specific to peoples' lifestyle, are managed effectively.

People, relatives, a visitor and staff told us that there were sufficient staff to meet peoples' needs and our observations confirmed this. The provider used a dependency tool and peoples' needs were assessed on an on-going basis and this was used to ensure that the levels of staff aligned with peoples' assessed level of need. People told us that staff were available to assist them when required and our observations demonstrated that staff were available to support people according to their needs. One person told us, "There seem to be staff on duty". The home was not at full occupancy; however, the provider had made the decision to keep staffing levels the same as if the home was fully occupied. Although the consensus was that there was sufficient staff, one relative told us, "They have lots of empty bedrooms at present and they will need extra staff if they fill them". We were unable at this inspection to determine whether the current service provision could be sustained over time, should the number of people living at the home increase. When the provider was asked how they would ensure that staffing levels continued to remain sufficient to meet peoples' needs if the occupancy levels increased, they explained that they would introduce a phased approach to increasing numbers to enable them to have time to identify peoples' needs and devise and implement their care plans. They also explained that they would be more realistic when assessing peoples' needs prior to them moving into the home, that when doing this they looked at this alongside the needs of existing people who lived at the home to ensure that staffing levels could meet peoples' assessed level of need. Whilst it is acknowledged that the current staffing levels improved the safety of people, we cannot at this stage determine an accurate representation of the care delivery if occupancy levels increased. The provider would need to demonstrate appropriate staffing arrangements over a period of time, to ensure that the sustainability of good care could be achieved for people. We have therefore identified this as an area of practice that needs improvement.

At the previous inspection on 31 May and 7 June 2017, although medicines management had improved since the previous inspection, there were continued concerns with regards to the administration of medicines. Staff did not always record the time of the medicines being administered to ensure that there was a safe and appropriate timeframe in-between each dose. Observations showed that staff did not always witness people taking their medicines and sometimes signed medicine administration records (MAR) before observing that people had taken their medicines. Staff who were administering medicines were not always familiar with the people they were administering medicines to. Despite photographs being in peoples' MAR, checks were not always made to ensure that staff were administering medicines to the correct person. Medicines were stored in locked medicine cabinets, however, during the administration of medicines staff left the medicines cabinet unlocked and therefore there was a potential risk that people could access medicines that were not prescribed for them. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example, covertly hidden in their food or drink. Some people received their medicines covertly. Reviews of the need to administer medicines covertly had not always taken place. Medicines that were in-use and stored within the medicines fridge were not always labelled to inform staff of the opening date, this meant that it was not always possible to establish if the medicines remained effective, was within its expiry date and was safe to use. There were inconsistent records when prescribed medicines had changed.

At this inspection, improvements had been made. The management team had worked hard to ensure that

medicines management had improved and that people had access to medicines when they needed them. People were assisted to take their medicines by trained staff that had their competence regularly assessed. Observations demonstrated that safe procedures were followed when medicines were being dispensed and administered and peoples' consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines and appropriate guidance for staff. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People, who were able, were encouraged to self-administer their own medicines and risk assessments were in place to ensure that there were safe mechanisms in place to enable this. People told us that they were happy with the support received. Regular medicines reviews ensured that medicines to support people to manage their behaviour were monitored and their excessive use minimised. Appropriate documentation was in place so that information about peoples' medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital.

Accidents and incidents that had occurred had been recorded and monitored to identify patterns and trends and relevant action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in peoples' needs or support requirements. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency. Equipment was also regularly checked and maintained to ensure that people were supported to use equipment that was safe.

People, relatives, a visitor and healthcare professionals told us that the home was safe and our observations confirmed this. When asked why they felt safe, one person told us, "I feel safe because I can always see staff around", One relative told us they had, "peace of mind" knowing that their loved one was safe and protected from harm. Comments from other relatives included, "My relative has to be hoisted and they do it well. They always have two carers and use the correct slings. The hoists they use are modern and they do not cause my relative any pain" and "My relative is very safe here".

People were cared for by staff that the provider had deemed safe to work with them. Prior to staffs' employment commencing, identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

People were treated fairly and equally and were protected from discrimination and harm. Observations showed that people appeared comfortable in the presence of staff. Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. Mechanisms were in place to raise peoples' awareness of their own personal safety and to enable them to raise concerns. Regular residents' and relatives' meetings as well as reviews of peoples' care provided an opportunity for people to raise issues and discuss any concerns they had. Historic safeguarding enquiries had been closed by the local authority and the provider had demonstrated a reflective approach to ensure that they learned from the outcomes of the enquiries to ensure peoples'

safety. Further reflective practice had occurred as a result of the findings within previous CQC inspections and the management team explained that they had a better understanding of the importance of documentation to confirm their actions as well as staff being more accountable and responsible for their actions. Records showed that the provider had been proactive and had raised safeguarding alerts to the local authority when they were concerned about peoples' well-being.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People were supported with their continence needs, when appropriate and had access to hand-washing facilities. Personal protective equipment was available for staff to use to ensure that infection control was maintained and cross-contamination was minimised. One person told us, "My room is cleaned every day". A visitor told us, "There are never any odours".

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 31 May and 7 June 2017, the provider was in continued breach of Regulations 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to an inconsistent approach to ensuring that peoples' rights were protected. Peoples' capacity to give their consent had not always been assessed and relevant people were not always involved in the decision making process when people did lack capacity to give their consent. In addition, conditions associated to peoples' Deprivation of Liberty Safeguards (DoLS) had not always been met. Further concerns related to timely access to healthcare interventions to ensure peoples' health and well-being. Following the inspection, the provider wrote to us to inform us of how they were going to address the shortfalls and ensure that improvements were made. At this inspection it was apparent that improvements had been made and the provider was no longer in breach of the regulations, however, further minor improvements were needed to ensure that improvements made were embedded in practice.

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 make 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 manager and staff had a good understanding of MCA and DoLS. Observations showed that staff explained their actions and asked peoples' consent before offering assistance to them. People were provided with choice and able to make decisions with regards to their day-to-day care. One person told us, "I can make my own decisions and plan my day". To ensure that peoples' cognitive abilities were not discriminated against, when people lacked understanding to make specific decisions mental capacity assessments had assessed peoples' capacity and best interests decision meetings had taken place to involve relevant people in the decision making process. Some people had Lasting Powers of Attorneys (LPA) who were legally able to make decisions on peoples' behalves when they lacked capacity in specific areas. The provider had demonstrated good practice by obtaining copies of the documentation for this to assure themselves that people making decisions on peoples' behalves had the legal right to do so. Staff were aware of peoples' changing needs and people were monitored to enable staff to identify any changes in their needs, this took into consideration peoples' mental health and any deterioration in their cognitive abilities. As a result mental capacity assessments were reviewed or renewed if changes had occurred. Staff had undertaken distress reaction training which provided them with the skills and confidence to support people when they displayed behaviours that could challenge. Staff ensured that practices that restricted peoples' freedom were minimised, when people demonstrated signs of apparent anxiety or distress, staff supported them appropriately, using distraction techniques and engagement as opposed to physical restraint to manage potentially challenging situations.

At the previous inspection on 31 May and 7 June 2017, DoLS applications had been submitted to the local

authority when staff had recognised that peoples' freedom was being restricted. Some DoLS had been authorised and were subject to conditions which were imposed by the local authority. This meant that the provider needed to ensure that the conditions associated with peoples' DoLS authorisations were met. At this inspection, conditions associated to peoples' DoLS had mostly been met. One person had a condition associated to their DoLS which informed staff that they needed to support the person to regularly access the community. Records showed that the person had been supported to access the community and had enjoyed car rides and visits to local cafes and shops. However, this had not happened frequently as outlined within the DoLS. Staff told us that they tried to support the person to access the community as regularly as they good, however, external influences, such as staff sickness had an impact on their ability to maintain regular trips into the community. Efforts had been made to involve staff that were responsible for activities and the management team told us that additional activity staff had been employed which would ensure that the person was supported to go out of the home regularly. Although efforts had already been made to ensure that external factors did not affect the person's freedom, this needed to be further embedded in practice and therefore this is an area in need of continued improvement.

Peoples' physical and mental health, as well as their social needs, were assessed prior to, as well as when they moved into the home. Assessments took into account peoples' abilities and skills as well as their needs and care was centred on these. Peoples' risk of malnutrition was assessed, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed regularly, to ensure that they were not unintentionally losing weight. Records for some people showed that they had been assessed as being at a higher risk of malnutrition and staff had ensured that changes were made to the frequency in which the person was weighed so that they were monitored more closely. In addition, peoples' food had been fortified to increase their calorie intake. Food and fluid intake was recorded if people's intake of food needed to be monitored. Peoples' skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had wounds, regular monitoring took place and appropriate treatment provided. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses as well as regular support from staff to frequently reposition.

At the previous inspection on 31 May and 7 June 2017, there were concerns with regards to untimely intervention when a person, who was living with diabetes, showed continued signs of high blood glucose levels. The person had been admitted to hospital on two occasions as a result of these. At this inspection, improvements had been made. Records for people living with diabetes were detailed and comprehensive. Staff were provided with detailed information as to what signs and symptoms to look for to enable them to seek timely healthcare advice and support for people. Therefore the provider was no longer in breach of this regulation.

Peoples' healthcare needs were met. There had been some historic incidences of when people had not always received timely intervention when their healthcare needs had deteriorated, however, this had improved. People and their relatives were involved in explanations and decisions about their healthcare needs. People and relatives told us that they were confident in staffs' abilities to recognise when they were not well and to seek medical assistance when required and our observations and records confirmed that people received timely intervention from healthcare professionals when required. Comments from relatives included, "The physiotherapist used to come and she got my relative their new wheelchair, it is much more comfortable" and "I asked the nurse if my relative had had the flu injection, I was pleased they said yes". Peoples' healthcare needs were monitored and reviewed on an on-going basis to ensure that the care that

was being provided was meeting their needs.

People, relatives and visitors told us that staff were competent and that they had faith in staffs' abilities and skills. A visitor told us, "In the olden days when things were going wrong, I did not think the staff were skilful – too many strange faces. It is different now; all the staff are good and kind. One person and their relative told us, "Staff are well trained now and more skilful than before, I have seen them having training in the lounge".

The provider had acknowledged that staff had not received appropriate support and development to enable them to fulfil their roles and support people effectively. They had made changes to the training that was available to staff and had shown a commitment to learning and development. Staff that were new to the home were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures as well as an orientation of the home, an awareness of the expectations of their role and the completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. All staff had access to on-going learning and development to equip them with the necessary skills to support people effectively. In addition to completing the provider's core training, staff undertook courses that were specific to the needs and experiences of people that lived at the home and who used the services. For example, the dementia care framework had been launched within the home that provided staff with specialised training and development to enhance their understanding and to support people who were living with dementia. The training included staff wearing eye masks and gloves and being exposed to background noises so that they could experience first-hand what it might be like to live with dementia. In addition, the provider had made a short film about people and their relatives' journey when moving into a care home. There were plans for all staff to watch the film to provide them with a better insight into peoples' experiences when moving into a care setting. Links with external healthcare professionals were maintained to provide additional learning and development for staff. Some care staff held diplomas in Health and Social Care, whilst others were encouraged to develop within their roles. Registered nurses were provided with appropriate courses to maintain their competence. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss peoples' needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive.

Peoples' diversity was respected and people were treated fairly and equally. Person-centred care was promoted throughout the staff team. People were supported by staff that knew them, their needs and wishes, well. People were supported to independently mobilise around the home and technology, such as call bells, were available for people to use if they required assistance from staff. One person had access to another form of technology to aid their independence and encourage stimulation as they had an I-pad and an I-phone. There was good inter-departmental working and effective communication took place to ensure a holistic approach to meeting peoples' care and support needs. Regular inter-departmental meetings took place to share information on each person to ensure people were provided with appropriate care that was consistent. The sharing of information extended to external services and records showed that there had been good communication with external services to ensure people received coordinated care.

Staff had encouraged links with the community and people from the Princes Trust had worked at the home, painting all of the bedroom doors bright and different colours to reflect peoples' choices. Door knockers and numbers were also in place that aided peoples' orientation of the home as they were able to distinguish which bedroom was theirs. Further adaptations to the environment had taken place such as different

coloured toilet seats or handrails that would be more noticeable to a person living with dementia. The home was designed in such a way that provided adequate space for people to enjoy time with one another as well as smaller rooms if people wanted to have their own space. People could choose to socialise with other people, enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather.

People told us that they enjoyed the food that was provided and had access to drinks and snacks throughout the day and our observations confirmed this. When asked about the food, comments from people included, "It is quite good", "I have a choice of food" and "I like to eat in my room, I don't use the dining room". There were two adjoining dining rooms where people could eat their meals. Observations showed that some people chose to eat their meals in the dining rooms whilst others preferred to eat in their rooms or at small tables in the communal lounges. People had a pleasant dining experience and were able to socialise with others. Staff were respectful and supported people appropriately when they required assistance to eat and drink. There was a range of food options for people to choose from and people told us that they could choose what they had to eat and drink. Observations demonstrated that when people disliked the menu option that their right to change their mind was respected and they were able to choose alternatives. Aids and adaptions were made available for people to use to enable them to remain independent and to take into consideration their cognitive and physical abilities. For example, there were beakers with lids and handles that people could use if required.

Good

Is the service caring?

Our findings

At the previous inspection on 31 May and 7 June 2017, the provider was in continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to staffs' consistent approach to maintaining peoples' dignity and providing a caring service. Following the inspection the provider wrote to us to inform us of what they would do to ensure that improvements were made. At this inspection it was evident that improvements had been made and staff were observed demonstrating caring and warm interactions with people. Therefore the provider is no longer in breach of this regulation.

People were treated with kindness and compassion from staff that knew them well. Warm and personable interactions were observed. Comments from people, relatives and a visitor praised staffs' caring attitudes. When speaking about staff, one person told us, "They are kind people who treat you with dignity and respect". A visitor told us, "They think about the person, not just the task, they always chat to everyone in the lounges and make sure they are comfortable".

The providers' aims stated, 'Work together to bring a little joy to everyday experiences'. They had a set of values which included respect, caring, trust and making a difference. It was evident that the management team and staff were working hard to ensure that this was implemented in practice. The atmosphere was calm and people were cared for by staff that were understanding and patient. People were happy in the presence of staff and willingly accepted support from staff who were happy and able to offer assistance. Caring interactions such as holding hands and sharing conversation and jokes with people were observed. For example, a hairdresser was visiting the home and one person was asked if they were ready to go to the hairdresser's room. When staff asked the person how they were going to have their hair styled they said, "blue", this raised smiles and laughs amongst people and staff. Staff were observed engaging in conversations with people, dependent on their interests, for example, on two separate occasions, two staff spoke to one person about their favourite football team and what the latest scores were. This demonstrated that staff knew peoples' interests and made attempts to engage with people based on their likes and hobbies.

Outside of peak times, staff took time to listen and talk with people. At times, some people showed signs of apparent anxiety and distress. Staff were on hand and responded promptly, ensuring that people were reassured. Observations showed that when staff responded to peoples' needs this had a positive impact on the person's well-being and they were observed to be calm. When possible, staff had collated information about peoples' lives, backgrounds, interests, employment and preferences. These were regularly reviewed and added to, so that when staff became more familiar with people and relationships developed further, the records could be updated to further inform other staff and ultimately enrich the positive relationships between people and staff. The provider had acknowledged that this could become a more meaningful exercise and to ensure that information was adapted to meet peoples' differing communication needs, as well as their understanding, had introduced new booklets that could capture this type of information but in a much more interactive way for people. For example, a scrapbook documenting peoples' lives which could include photographs so that people and staff could use these as a communication tool and encourage

people to reminisce were being introduced. These mechanisms provided staff with an insight into peoples' lives before they had moved into the home.

Peoples' independence was promoted and encouraged. People could choose how they spent their time, some spending time in the communal areas of the home, whilst others preferred their own space in their rooms or quieter areas of the home. Some people independently accessed the local community. One person told us, "I can go into the garden when I want. There are no restrictions placed on me. There is a ramp and I can sit on the grass in my wheelchair". People were treated with respect and dignity and afforded privacy by staff who took time to explain their actions and involve people in the care that was being provided. Staff were mindful of the impact receiving support, particularly with aspects of peoples' personal care needs, could have on a persons' dignity. Observations showed staff knocking on peoples' doors and waiting for a reply before entering peoples' rooms and asking peoples' consent before supporting them with tasks. Staff attended to peoples' needs in a sensitive and discreet manner and people told us that staff always promoted their privacy and dignity. Peoples' wishes, with regards to their preferences of male or female care staff, was ascertained and respected. Staffing allocation ensured that there were staff of different genders so that peoples' wishes could be respected and accommodated. Comments from visitors included, "They knock on doors and ask for permission to do things" and "They are treated with dignity and respect, they pull the curtains and ask me to leave whilst they attend to personal care".

Information held about people was kept confidential. Records were stored in locked offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. Peoples' diversity was respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Guidance produced by Skills for Care advises on the importance of promoting equality, diversity and human rights within the care planning and decision making processes. Care plans considered peoples' religious and spiritual needs and people could receive regular visits from a local priest.

The provider demonstrated that they cared, not only for peoples' well-being, but also for staffs. At previous CQC inspections staff had felt unsupported and devalued due to the changes in management and the implications of these on their work. The provider had acknowledged staffs' feelings and had organised for listening sessions with their human resources team. This had enabled staff to share their concerns and receive support. Staff told us that the morale within the home had improved and that they were happy in their work and this was apparent during our observations of staffs' interactions with people. Positive relationships were encouraged and people were able to receive visits from visitors and relatives, who were made to feel welcome and were encouraged to join people for meals. People, and their relatives if appropriate, were involved in peoples' care, as well as matters relating to the running of the home. Regular residents' and relatives' meetings took place to enable people and their relatives to share their ideas and be kept informed of changes at the home. The provider acknowledged that people and relatives may prefer to share their views and concerns in a different way. An I-pad was stationed in the foyer of the home and could be taken to people and their visitors. This captured feedback from people and fed into the providers' quality assurance processes. Additional support to enable people to share their views could be provided through advocacy services or peoples' paid representatives which had been appointed as part of their DoLS authorisations. An advocate and paid representatives are people who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. Posters were displayed that informed people, visitors and staff, of who they could contact outside of the home to make their views and concerns known.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 31 May and 7 June 2017, the provider was in continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the lack of meaningful activities and stimulation for people as well as care records not being updated. Following the inspection the provider wrote to us to inform us of what improvements they would make. At this inspection it was evident that improvements had been made. People's care records were detailed and had been regularly reviewed and updated and they had access to meaningful occupation and stimulation. Therefore the provider was no longer in breach of the regulation. However, despite this we found an area of practice, in relation to planning for peoples' end of life care, which is in need of improvement.

Staff received support and advice from external healthcare professionals to ensure people experienced a comfortable and pain-free death. The provider took precautions to ensure that they were prepared for peoples' conditions deteriorating. Advice had been sought from external healthcare professionals, equipment hired and anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. Relatives were welcome and able to spend time with people at the end of their lives. According to the Social Care Institute for Excellence (SCIE), people who are living with dementia should to be supported to make an advanced care plan, this means discussing and recording their wishes and decisions for future care, it is about planning for a time when they may not be able to make decisions for themselves. SCIE advises that providers of homes also need to ensure that they are prepared for situations and do their best to ensure that they know, document and meet the person's wishes at the end of their life. Advanced care plans were not always in place for people. Records showed that these were often only devised when people were nearing the end of their life. For example, records for one person, who had recently passed away, showed that an end of life care plan had only been devised five days prior to the persons' death. Records demonstrated the appropriate support that the person had received from staff and their GP, however, did not plan for and document the persons' preferences and wishes. When this was raised with staff they informed us that there were several parts to the end of life care plan and on that occasion only the last part had been completed. However, records for other people also showed that end of life care was not always planned for. Not having an advanced care plan in place could potentially mean that a person is cared for in a way that is against their wishes if they do not have the capacity to make their feelings known at the time. We recommend that the home consider current guidance on advanced care planning so that conversations with people about their preferences at the end of their life can take place.

At the previous inspection on 31 May and 7 June 2017, there were continued concerns with regards to the lack of stimulation and meaningful occupation for people. At this inspection, peoples' experiences had improved and they had access to both one-to-one interaction and group activities and entertainment. People had access to a variety of activities, such as external entertainers, arts and crafts and PAT dogs, (Pets as Therapy). In addition, staff had recognised the positive impact interacting with younger people could

have on older people, particularly those living within care homes. They had contacted local nurseries and had asked if they would like to undertake regular visits to the home to interact with people. One of these planned visits was taking place and we observed this to be a positive and enriching experience for people. People were smiling, laughing and playing games with the children, enjoying puzzles and listening to the children sing. Observations showed one person, who spent most of their day walking from one area of the home to another, not wishing to engage or interact with other people or staff, smiling whilst watching the children play and patting one of the children on the head. People told us how much they enjoyed the visits from the children and it was apparent that this lifted peoples' spirits.

People could choose where they spent their time, some spending time in the communal areas of the home, whilst others chose to spend their time in their own rooms. The management team had made improvements to ensure that people were not isolated in their rooms. People no longer had bedrooms on the third floor, which was infrequently accessed by staff; instead they now resided on the first and second floors of the home, this meant that staff carried out regular checks to ensure peoples' well-being. People were provided with a call bell so that they could call from assistance from staff and had timely access to assistance and told us that when they used their call bells staff responded promptly. For people who were unable to use a call bell, due to their capacity and understanding, pressure mats were used so that when people mobilised staff were alerted and could go to the person to offer assistance.

Records showed that dedicated activities staff had spent time with people, undertaking one-to-one activities to meet their social and emotional needs. There were plans to take down a dividing wall from one area of the lounge into the dining room, the plan was to create a larger environment so that more people could sit together to enjoy the activities and entertainment that was provided. People were encouraged to maintain contact with those that were important to them. Observations showed people enjoying visits from relatives and friends, who told us that they were welcome in the home.

People had detailed and person-centred care plans that reflected their needs, abilities and preferences. The management team had worked hard to improve the care records for people to ensure that staff were provided with relevant and up-to-date information to guide their practice and to ensure that people were supported according to their needs and preferences. Prior to moving into the home, as well as when people first arrived, their needs were assessed and numerous care plans were devised, dependent on their needs and these were included within their care records. These care plans contained specific information about peoples' abilities and needs in relation to their physical, mental, emotional and social well-being. People and their relatives were involved in the development of care plans. The provider had introduced a system known as 'Resident of the day', this meant that each day one person's care records and their care, would be reviewed to ensure that the care they were receiving was current and continued to meet their needs. In addition to this, the provider had started to introduce and had sent invitations to relatives and those that were involved in the person's care, to a care plan review. These reviews helped to ensure that care plans were person-centred and reflected peoples' wishes. Care plans provided staff with detailed information to guide their practice. For example, care plan records for one person who used a catheter stated that the catheter bag should be changed weekly and the catheter itself every 12 weeks, records showed that this had been implemented in practice. Further advice to staff stated that when emptying the catheter bag that they should not attempt to do this until it was two-thirds full as frequent draining could increase the risk of infection. Care plans also recognised peoples' social needs. Records for one person stated that they used to have an office-based employment in their younger life. Advice within the records advised staff that the person liked 'tinkering' and working with pieces of paper. It suggested that the person could be invited into the office to do 'office work'. In addition, a box of different bolts and locks had been placed in the hallway for people to touch and interact with. The level of person-centred detail, in relation to peoples' healthcare conditions as well as their social needs, meant that staff were provided with sufficient guidance to ensure

that people were supported in accordance with their needs and in the way that they preferred.

People were informed of their right to make a complaint when they first moved into the home. Posters were displayed that informed people of the complaints procedure and comments boxes and feedback systems on I-Pads were available for people, relatives and visitors to use to make their comments and concerns known. People told us that they knew how to make a complaint and would feel comfortable doing so, without the worry of any repercussions to their care. Regular meetings as well as newly introduced care plan review meetings provided additional forums for people to make their feelings known. People told us and records confirmed, that people were able to speak freely and air their views and concerns. One person told us, "I am fairly treated and have nothing to complain about". Complaints that had been made had been dealt with in accordance with the providers' policy and demonstrated that the provider was transparent and open with people who used the service. The management team and staff demonstrated a reflective approach to their practice and were constantly reviewing how they worked and learned from instances. For example, there had been health and safety incidents that had occurred within the providers' other homes. These had been discussed within a health and safety meeting to ensure that any lessons were learned to minimise the chances of the incidents happening again.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 31 May and 7 June 2017, the provider was in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the lack of effective governance systems. Following the inspection the provider wrote to us to inform us of what improvements they would make. At this inspection it was evident that improvements had been made and the provider was no longer in breach of the regulation. However, there were further improvements that were needed to ensure that systems that had been introduced were sustained and embedded in practice.

At the previous inspection a manager and a deputy manager from one of the providers' other services had been in day-to-day management of the home. The manager was going to apply to become the registered manager. However, at this inspection, the manager had left employment and the deputy manager was in day-to-day management of the home. In addition, the regional manager and a member of the providers' quality team visited the home twice a week to ensure that there was appropriate support in place until a new registered manager was found. The provider was in the process of trying to recruit to the post of registered manager. However, the home had been without a registered manager for nine months. A registered manager is a '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 home is run.

At the previous inspection the provider had devised an action plan to address some of the shortfalls that were found at the previous inspection on 6, 7 and 15 February 2017. However, they had not addressed all of the concerns that were found and although attention had been focussed on improving some key areas of practice, clear management plans were not in place to address other breaches of regulations. Although improvements had been made since the previous inspection on 6, 7 and 15 February 2017, it was found that there were continued concerns with regards to the systems in place and the sustainability of the ordering of medicines. The deputy manager and manager were the only staff trained to order medicines. There were concerns that if they were not at work that there would be no one else to order medicines and there was a potential risk that peoples' medicines might not always be available when they needed them. At this inspection, although the deputy manager was the person responsible for ordering medicines, other trained nurses also knew how to do this should the deputy manager be absent from work.

At the previous inspection, quality monitoring, such as surveys and audits had taken place to enable the provider to have an oversight of the systems and processes at the home. However, when issues had been identified through the audits there were no clear action plans to demonstrate how the provider planned to rectify the shortfalls to ensure improvements were made. Other shortfalls related to a lack of detail in care plans as well as a lack of plans to address the risk of social isolation for people. At this inspection it was evident that improvements had been made. The provider and management team had worked systematically to ensure that efforts were concentrated on each area at a time. Medicines management had been a focus as had care planning and access to stimulation for people. The provider had recognised that there were still some inconsistencies in recording to demonstrate staff's practice and was working with staff and reminding them of the importance of recording their actions.

People, relatives, a visitor and healthcare professionals told us that the management of the home had improved and that they felt confident in the skills and abilities of the deputy manager and felt satisfied with the current management arrangement. Comments from people and relatives included, "He knows everyone and is pleased to chat with them" and "He is very approachable I can talk to him any time".

The management team were competent and held appropriate management or nursing qualifications. They ensured that staff felt supported and equipped to support people effectively. Staff told us and observations showed, that management had a visible presence in the home to ensure that both people and staff knew who to approach if they had any queries or concerns. Staff told us that they were involved and kept informed of any changes within the organisation. Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through a range of regular meetings. Staff had access to regular one-to-one meetings with the management team and told us that they could approach management at any time if they had any concerns or needed further support. Staff were provided with regular feedback on their practice to enable them to reflect on and develop their knowledge and skills to improve the support that people received.

The provider demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. Records showed that the provider had been open and transparent, recognising and explaining the shortfalls that had been found at the previous two CQC inspections and the implications this had had with regards to new people not being able to move into the home. The provider had explained to people and relatives what they were doing to ensure that the home improved. People and relatives were involved in planning and contributing to any changes that were going to occur. Other records showed that people and their relatives or representatives, if appropriate, were informed if peoples' health needs or condition had changed. The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The provider was proactive in recognising when requirements changed; the CQC had recently introduced and implemented new Key Lines of Enquiry (KLOE). The provider had already notified their services to ensure that management teams were aware of the changes and could work towards ensuring that they were working in accordance with these.

Peoples' right to privacy was respected and information held about people, within both manual and electronic records, were stored and passed to other professionals appropriately. Both manual and electronic quality management systems were in place that ensured that regular audits of the service, which included surveys that were sent to people, relatives and professionals, were conducted and monitored by the management team. People told us that they were asked for the feedback, one person told us, "We discuss any changes taking place, and we can bring up anything that worries us". Staff were encouraged to identify areas that could be improved upon and discussions had taken place in regular staff meetings. A whistleblowing policy informed staff of their responsibilities to raise any concerns. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace. There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting peoples' needs.

The provider and management team had developed good links with the local community such as local nurseries and religious leaders. Relationships with external healthcare professionals and local authorities had been developed to ensure that people received a coordinated approach and service.