Somerforde Limited

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Inspection report

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Date of inspection visit:
16 January 2018
17 January 2018

Date of publication:
29 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 16 and 17 January 2018.
Somerforde is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Somerforde is a large detached property set within its own grounds and is registered to provide accommodation for up to 24 older people who require nursing or personal care. The home cannot provide nursing care. Accommodation is provided over two floors in one adapted building, a passenger lift provides access between floors. On the day of our inspection 20 people were living at the home.

There was a registered manager in post. 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.

When we completed our previous inspection in November 2015 we awarded an overall rating of 'Good'. During this inspection on 16 and 17 January 2018 we found a number of concerns relating to the key questions safe and well led. Therefore, for this inspection the service has been awarded the overall rating of 'Requires Improvement'. This is the first time the service has been rated 'Requires Improvement'.

People were not always protected from the risk of avoidable harm. Risks to people's health and wellbeing were not always identified in people's care plans, and risk management plans were not always in place to instruct staff on how they should care for people safely. Where risks had been identified, action had been taken to minimise the risk, such as using pressure relieving mattresses. However, there was no guidance in care plans or risk assessments to instruct staff on what pressure the mattresses should be set at and there was no system in place to ensure mattresses were set at the correct setting.

Where risk management plans were in place, such as; repositioning charts and topical medicines application charts, we saw they had not been completed consistently and we could not be sure from the records that people had received the care they needed.

The accident and incident monitoring system was not robust. We found accidents or incidents relating to people had not always been documented by staff. Therefore, the registered manager was not in a position to investigate further to ensure actions were followed through to reduce the risk of incidents occurring. Accidents and incidents had not been audited and no analysis of accidents or incidents had taken place since November 2017 to look for patterns or trends.

Medicine audits were being undertaken; however these were not always effective. We found that whilst medicines were being administered safely, the arrangements in place to manage reordering of medicines

and stock control meant there was a risk that people's medicines might not be available when they needed them. Medicines audits had not identified concerns, such as inaccurate stock, temperature monitoring of medicines storage and medicines not being dated once opened.

The registered manager had quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided at Somerforde. We found the registered manager used a variety of systems to monitor the home. However, governance systems had not identified a number of concerns we found at this inspection.

Following the inspection we received a report from the registered manager describing how they had responded to the concerns and what actions they had taken to address the issues. Medicines administration and stock replenishing systems and the monitoring of risks and falls have been strengthened and any issues dealt with. Robust management oversight is now in place to ensure good practice within the service.

People were consulted about their care to ensure wishes and preferences were met. We saw people's individual needs were assessed and person centred care plans were developed to identify what care and support they required. However, for one person an initial assessment had been completed but a comprehensive care plan, including assessment of risks, had not been completed at the time of the inspection, despite them having been admitted six days before. This meant there was a risk the person would not receive person centred care that was appropriate, met their needs and reflected their personal preferences. We have made a recommendation to the provider about care planning systems.

Care plans contained information about people's specific communication needs, any barriers to communication and how staff could help people communicate. We saw that staff did not always respond to these needs in a timely way. For example, a relative told us their family member lost their hearing aid several weeks ago, they told us, "I've raised it with the deputy manager as the registered manager has been away, but nothing's been done." We spoke to the registered manager about this and they acted immediately.

People told us they felt safe living at Somerforde. One person told us "It feels safe here. I've lived here for some time now and it's improved quite a lot recently." Another said, "I haven't lived here for more than a few months, but they've been very enjoyable months and I feel much safer now than I did living alone in my house" People were protected from the risk of abuse because staff understood how to keep people safe. Safeguarding procedures were in place to help protect people from harm and staff understood their responsibilities to do so and to report any concerns.

People spoke highly of the staff and said that they were caring and kind. People's comments included, "I am very well cared for. Nothing is too much trouble for the staff" and "I like living here, it suits me in every way." The home had a calm and relaxed feel. We observed positive and caring relationships between people and staff. We saw staff treated people with respect and in a kind and compassionate way. People's privacy and dignity was respected by staff. People were able to choose what they wanted to do and were supported to maintain their independence as much as possible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The home worked within the principles of the Mental Capacity Act and the registered manager completed appropriate documentation to evidence this. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

We looked at recruitment processes and found that staff had been recruited safely. Staff told us they were

well supported in their role and received appropriate training and professional development. Staff attended mandatory training in a range of subjects and also had the opportunity to attend other training courses to ensure staff were able to meet the specific care needs of the people who lived in the home.

People were supported by sufficient numbers of staff. During our inspection we observed call bells were answered promptly and staff responded to people in a timely manner. Staff said there were enough staff to care for people and keep them safe.

A variety of activities were arranged for people living at the home which provided stimulation and social interaction. People told us they enjoyed the activities on offer. One person told us, "There's always plenty to keep you occupied here. One lady organises events and trips as well as social gatherings." Another said, "I look forward to the activities, it's history group today and I won't miss that."

People told us they enjoyed the food and were happy with the quality and quantity of food provided. Comments included, "The food here is wonderful. Always plenty of it and a super choice", "The food here is impressive in its quality and variety" and "The food here is consistently good. In fact let me correct that, it's consistently very good." We observed people's lunchtime experience and saw it was a very relaxed sociable experience. People were offered a choice of meals and we observed a staff showing people the different choices that were on offer. People's nutritional needs were assessed and the home responded appropriately to any nutritional concerns.

People were supported to maintain good health and staff ensured they received appropriate and timely healthcare support. Appropriate referrals were made to other care professionals if a need was identified such as dieticians and the Speech and Language Therapy Service.

People were able to enjoy a clean comfortable homely environment. The home was undergoing a full re-decoration and improvement programme inside and out. The provider told us they wanted to create a home to be proud of so that people would feel looked after in a cared for, comfortable home. People were involved in the refurbishment and were encouraged to choose their room decoration. We saw that people had personalised their rooms with pictures and objects that were personal to them.

We found two breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Risks to people health, safety, and well-being were not always being effective assessed, managed or mitigated.

Medicine storage, stock control and reordering systems were not well managed. Medicines were administered safely and people received their medicines as prescribed.

People were protected from the risk of abuse, as staff understood the signs of abuse and how to report concerns.

People were protected because the provider had robust recruitment processes.

There were sufficient numbers of skilled and experienced staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People received care from staff that had the skills and knowledge to meet their needs.

Supervision systems provided staff with on-going support.

People's consent was sought before any care or support was provided. The requirements of the Mental Capacity Act 2005 (MCA) were being met.

People were supported to eat and drink enough to maintain a balanced diet.

Staff worked with external health and social care agencies to provide effective care.

People's needs were met by the adaptation, design and decoration of the premises.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

Staff displayed caring attitudes towards people and spoke about people with affection and respect.

People's privacy and dignity were respected and their independence was promoted wherever possible.

People were involved in the planning of their care and were offered choices in how they wished their needs to be met.

Is the service responsive?

Good

The service was responsive.

People's communicational needs were not always addressed in a timely way.

Care plans we looked at were detailed and person centred. One person's care plan had not been completed fully. We made a recommendation about this.

People were supported to take part in activities they enjoyed.

People had information on how to make complaints.

People were supported to plan and make choices about end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Governance and quality assurance systems in place to assess and monitor the quality and safety of care and services provided were not always effective.

There was an open, transparent culture and staff felt supported by the registered manager.

People were supported by staff who were happy in their work and felt valued.

The provider listened to, and acted on, feedback from people, their relatives and members of the staff team.

Somerforde Limited

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection; it took place on the 16 and 17 January 2018 and the first day was unannounced.

The inspection team consisted of one 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 home.

Before the inspection the registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. Before the inspection we spoke with the local authority Quality Assurance Improvement Team and the Adult Safeguarding Team. We also spoke with the Community Nurses who had been supporting the service.

We spent time in the communal areas of the home to observe how staff supported and responded to people. We spent time carrying out a short observational framework for inspection (SOFI) observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

During the inspection, we spoke with fourteen people who lived at the home and two visiting relatives. We also spoke with a visiting health care professional. In addition, we spoke with the provider, the registered manager, deputy manager, seven care staff and the chef.

We reviewed three staff files, medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records

and surveys undertaken by the home. We also looked at the menus and activity plans. We looked at eight people's individual records, these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in November 2015 the home was rated 'Good' in Safe. At this inspection we have rated the home as 'Requires Improvement' in Safe. This was because we found risks to people were not always managed well to keep people safe. Accidents and incidents that occurred at the home were not always recorded, to ensure future risks to people could be identified and mitigated. Medicines management systems were not managed safely.

Risks to people's health and wellbeing were not always identified in people's care plans, and risk management plans were not always in place to instruct staff on how they should care for people safely. For example, one person had recently been admitted to the home. The person was previous being treated in their own home by the community nurses for pressure ulcer to their skin. The person was at risk of their pressure ulcer deteriorating or developing further skin damage. On admission an initial assessment had been made but no care plan had been developed. There were no risk assessments, risk management plans or body maps in place to advise care staff how they should assist the person to prevent further skin damage.

Although staff did not have written information to refer to, staff liaised with visiting community nurses and used their experience and knowledge to manage the risk. The person was being cared for in bed and staff had arranged for them to have a pressure relieving mattress. However, the person had not been weighed on admission or in the six days prior to the inspection despite being asked to by the community nurse. Pressure relieving mattresses should be set depending on the person's weight. These types of mattresses must be set at the correct pressure in order to reduce the risk of skin damage. There was no guidance in care plans or risk assessments to instruct staff on what pressure the mattress should be set at. This meant that staff had guessed their weight, which put the person at further risk of harm. Staff told us they moved the person frequently and we saw there were repositioning charts in place, however, there was no risk management plan in place guiding staff to how often they needed to reposition the person. The person was being attended by the community nursing team daily to manage their pressure ulcer.

We spoke with the registered manager about this. They told us the person had been admitted when they had been away from the home. They told us when they returned to work the day before inspection, they had identified that this person did not have full care records. The registered manager acted immediately to ensure the person was regularly repositioned and care records were completed along with the appropriate risk mitigation plans.

Another person's records identified that they were at risk of skin damage. Their care plan and risk assessment documented that staff should check their skin integrity and apply a prescribed skin protection cream twice a day. It was not clear from records that the person was receiving the care they needed. Records showed that between 3 and 16 January 2018, skin protection cream was not applied on three days and the person's skin had not been checked on five of days. This meant that the person may not be receiving the treatment prescribed for them and this could put them at risk of pressure damage. We spoke to the person to ask if staff had applied the cream and was told that they hadn't.

Some people were taking a blood thinning medicine. Staff were not aware of the risks associated with this medicine and did not have the required advice to hand to support people when needed, for instance, if the person sustained an injury to their head resulting in excessive bleeding. There was no information available for staff about people's risk of bleeding and bruising and there were no details for staff of what action to take if this happened.

Accidents and incidents were not always being recorded when these occurred. We received information from the community nurse team regarding an incident that occurred with a person's pain infusion pump. The person should have been receiving their medication in a measured amount during the day. Senior staff at the home had been trained to manage the infusion. We saw that in daily records, staff reported on two occasions, 5 December 2017 and 10 January 2018, the pump was 'draining way too fast'. This meant that the person was at risk of an overdose of the medicine. Staff had alerted the GP on these occasions and the specialist nurse attended on 12 January 2018 to ensure the pump could be locked to prevent buttons being accidentally pressed. However, these incidents had not been recorded or documented according to the provider's procedures, to identify whether any actions could have been taken to prevent a reoccurrence. There was no risk assessment in place, care plan or instructions for staff to follow on how to manage the infusion pump. The person's skin integrity care plan and risk assessment did not identify the potential risk and care management of the infusion pump injection site.

Some people were at risk of falling. One person's care records identified they were a high risk of falling and their mobility care plan and falls risk assessment were up dated monthly and when their needs changed. Care plans instructed staff to ensure they mobilised with their frame and an alarm mat was used to alert staff when the person got up from their chair or bed, unaided. Whilst care plans and risk assessments were in place for some people, this was not always the case. During the inspection one person told us they had a fall that morning. We saw from their daily records that this had been their third fall in the preceding three weeks. Their risk assessment from November 2017 stated they were 'low risk of falls'. The risk assessment had not been updated following the falls and there were no accident reports recorded. This meant that staff did not have the information available to mitigate any risk and no monitoring or analysis of the person's falls had taken place to identify any potential causes of the falls.

We spoke to the registered manager about how they analysed and monitored accidents and incidents in the home. They told us staff knew that all accidents and incidents were to be reported on the electronic care planning system that was introduced in November 2017. Records demonstrated that staff had reported some accidents and incidents. However, we saw that not all had been reported appropriately. The registered manager told us that since the electronic system had been in place they had not audited the reports. This meant the home had not used this information to learn from incidents, prevent or reduce re-occurrence and drive improvement.

People received their medicines as prescribed but medicine storage and medicine management systems were not always safe. Prior to the inspection we were alerted by the community nurses and GP surgery about the management of people's medicines. The home ordered and received people's medicines monthly. Their ordering system was chaotic and inaccurate. This resulted in staff having to re-order some medicines throughout the month, as they had miscalculated their stock balance. They also had a large 'overstock' of some medicines. We checked the quantities of a random sample of five medicines against the records and found two of them to be incorrect. One medicine had an overstock of three tablets and another had an under stock of two tablets. Whilst Medicine Administration Record charts (MAR) showed that people received their medicines as prescribed, this was because staff were requesting urgent prescriptions when they realised they had run out of a medicine. This could put people at risk of not receiving their medicines as prescribed and when they needed them.

We observed medicines being administered and saw that this was done in a calm and unrushed manner, ensuring people received the support they required.

Medicines for daily use were stored in a medicine trolley in the dining room. There was a separate medicines room on the first floor. We found creams, eye drops and liquid medicines had not been dated on opening, this meant that people were at risk of receiving medicine that could be out of date. Some people were prescribed 'as required' (PRN) medicines. However, protocols were not always in place to guide staff as to when the medicine may be required.

There was no system in place or equipment available for recording the daily temperature of the medicine trolley. This meant staff would not know if temperatures were outside of recommended guidelines which could pose a risk that some medicines would be unsafe. Temperatures were being recorded daily in the medicines room and medicines fridge.

The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately managed and mitigated. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider took action to address the concerns. A new medicines administration and stock replenishing system was introduced along with regular medicines audits. Falls incident analysis documentation was introduced to ensure falls were recorded and actions were taken. A system was introduced to ensure people requiring pressure relieving equipment, was appropriately assessed and monitored to ensure their mattress was on the correct setting for their weight.

We found that other risks were managed well. For example, people had their needs assessed for areas of risk such as mobility, malnutrition, moving and handling and pressure area care. Records showed if people's health was deteriorating the person was referred to a health care professional such as the community nursing team, occupational therapist or GP. For example, one person was at risk of malnutrition. Their nutrition and hydration care plan identified they were at risk and action was taken to manage the risk. The person was referred to their GP and they were prescribed high calorie drinks and diet. They were having their weight monitored weekly and staff were recording their food and fluid intake. Records showed that their weight had improved.

People told us that they felt safe living at Somerforde. One person told us "It feels safe here. I've lived here for some time now and it's improved quite a lot recently." Another said, "I haven't lived here for more than a few months, they've been very enjoyable months and I feel much safer now than I did living alone in my house"

People were protected from the risk of abuse because staff understood how to identify possible abuse, and were clear in how they would report this. Staff told us that they received safeguarding adults training and were also aware of external organisations they could report their concerns to. Staff told us they were confident the provider would act appropriately to any concerns raised and they would not hesitate to 'whistleblow' if they needed to. Raising concerns at work, often known as whistleblowing, is the act of reporting a concern about a risk, wrongdoing or concerns about the care provided by their employer. There was an up to date adult safeguarding policy in place. Records confirmed that the appropriate safeguarding referrals had been made to the local authority and staff did ensure that all people were protected from the risk of abuse.

People were protected because the provider had robust recruitment procedures. Staff files showed that pre-

employment checks were carried out prior to a member of staff commencing work. The registered manager retained records in relation to each staff member. Records included the interview process for each person, suitable references were obtained prior to an individual commencing work, a full employment history was taken and the person's identification was verified The registered manager also ensured the candidate underwent the appropriate Disclosure and Barring Service (DBS) checks. A DBS check enables the manager to assess employee's suitability to work with adults living in a care setting.

Most people living at the home felt there were sufficient staff on duty to meet their needs. One person told us, "They come when I ring my bell, sometimes I have to wait when they are busy." Another person commented, "There are more carers than previously was the situation, but I think they need more people here at night time." We spoke to the registered manager about this they told us staffing levels were determined according to people's needs and they adjusted the rota accordingly. They felt staffing at night was sufficient to meet the needs of the people living at the home and they constantly kept staffing levels under review.

During our inspection we observed call bells were answered promptly and staff responded to people in a timely manner. On the first day of the inspection, there were four care staff on duty in the morning and three care staff on duty in the afternoon. They were supported by the registered manager, deputy manager, head of care and administrator/activities co-ordinator. Ancillary staff such as housekeepers, chef and a maintenance person were also on duty. During the night two waking carers were on duty to care for people.

The home was clean and odour free. The registered manager had effective systems of infection prevention and control. Staff were provided with hand washing facilities, such as liquid soap and paper towels and antibacterial hand gel was available. Staff were provided with appropriate protective clothing, such as gloves and aprons and we saw these being used appropriately during the visit. We saw staff had access to an infection prevention and control policy and procedure and had completed relevant training.

There were systems in place to ensure the safety of the premises, including regular servicing of equipment. There were up to date service certificates for equipment and services. Up to date certificates were available for electric portable appliance testing, gas safety, fire alarms, fire extinguishers, call bell alarms and safety certificates for the lift and lifting equipment such as hoists. The provider completed a flush of the water system and monitored the water temperatures on a regular basis. The provider had made arrangements to deal with emergencies. People had personal emergency evacuation plans completed for them which gave staff guidance on how they would need supporting in the event of an emergency.

Good

Is the service effective?

Our findings

People told us staff were skilled to meet people's needs and spoke positively about the care and support provided. One person told us "I'm very well looked after by the girls." Another person said, "I can't find fault with anything here. I am very well cared for and in fact sometimes my needs are even anticipated and I get help before I need to ask for it. They're all so caring."

Staff told us they were well supported in their role and received appropriate training and professional development. For example, staff told us they had completed training and updates in areas such as fire safety, moving and transferring people safely, first aid, safeguarding and the Mental Capacity Act (2005). Other training courses were available to ensure staff were able to meet the specific care needs of the people who lived in the home. These included skin care, medicines and medicines pump training, person centred care and end of life care. The registered manager had a training matrix that allowed them to monitor any training updates that were needed.

Newly employed staff members were required to complete an induction programme and were not permitted to work unsupervised until they had completed this training and had been assessed as being competent to work alone. The registered manager told us they ensured all staff were trained to level two Diploma in Health and Social Care. This qualification is designed to equip learners with the skills and knowledge needed to care for others in health or social care settings and is mapped to the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.

Records demonstrated that staff received appropriate supervision and appraisal. These sessions were focused around developing the skills and knowledge of the staff team. In these sessions staff were offered the opportunity to request training and discuss career progression. Staff spoke of good staff moral and how they all worked as a team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs).

People's care plans contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed. For example, one person's care plan described how a decision had been made, with the person and their family, to have an alarm mat placed next to them which would alert

staff to their movements in order to keep them safe and avoid a fall.

The registered manager and staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty. At the time of the inspection no-one was having their liberty restricted.

People confirmed staff always asked permission before providing care and respected people's decisions. We saw people were asked how they wanted to spend their time and where they wanted to sit. Staff understood the principles of the Mental Capacity Act and ensured the people they supported were given choices and supported to make informed decisions of their own. For example one person was asked if they wanted to join in an activity, which they declined, and this decision was respected.

People told us they enjoyed the food and were happy with the quality and quantity of food provided. Comments included, "The food here is wonderful. Always plenty of it and a super choice", "The food here is impressive in its quality and variety" and "The food here is consistently good. In fact let me correct that, it's consistently very good."

The provider told us last year they had received a number of complaints about the quality of the food. They responded to this by changing the menus, sourced food locally and provided more options for people to choose from. People had the opportunity to discuss food with the provider and staff during monthly residents meetings.Staff regularly consulted with people on what type of food they preferred and ensure foods were available to meet peoples' diverse needs.

We observed people's lunchtime experience and saw it was a very relaxed sociable time. We observed staff supporting people with eating where needed and encouraged independence where people were more able. Staff were patient and reassuring and ensured people ate as much of their meal as they were able to. People were offered a choice of meals and we observed staff showing people the different choices that were on offer.

People's nutritional needs were assessed and weights were monitored. Staff regularly monitored food and drink intake to ensure people received enough nutrients in the day. Where people lost weight care plans showed that advice was sought from GP's and dieticians and people were given high calorie foods and supplements. When people had been assessed as having a high risk of choking, advice was sought from SALT (speech and language therapist) and this guidance was documented within the care plans.

We spoke with the cook who had a good knowledge of people's preferences and dietary needs, including providing meals to meet people's nutritional needs. The menus that we saw confirmed that people were offered a varied nutritional diet with vegetables and fruit. The cook told us, "If we have concerns about people losing weight we offer milky drinks, and put more butter with the potatoes. I get feedback from people to make sure they are happy with the food provided."

People were supported to maintain good health and staff ensured they received appropriate and timely healthcare support. People had access to their GP and other healthcare professionals such as the optician, chiropodist and dentist. Appropriate referrals were made to other care professionals if a need was identified such as dieticians and the Speech and Language Therapy Service. A visiting healthcare professional told us they were supporting the home to improve systems and ensure good health outcomes for people living there.

People were able to enjoy a clean comfortable homely environment. The home was undergoing a full re-

decoration and improvement programme inside and out. For example, the home now had a new laundry building with commercial machines and speedy ironing equipment improving the laundry service offered to people. One person told us how happy they were with this, "The laundry has recently been improved. It's bigger now and you get your washed and ironed clothes back ever so quickly." Improvements had also been made to the building façade and the gardens had been landscaped. The provider told us they wanted to create a home to be proud of so that people would feel looked after in a cared for, comfortable home. People were involved in the refurbishment and were encouraged to choose their room decoration. We saw that people had personalised their rooms with pictures and objects that were personal to them. People could also choose to spend their time in two lounge spaces, a spacious dining room and a conservatory that looked out over the gardens.

Good

Is the service caring?

Our findings

People spoke highly of the staff and said that they were caring and kind. People's comments included, "I am very well cared for. Nothing is too much trouble for the staff" and "I like living here, it suits me in every way." Relatives told us, "I am happy that my relative is being well cared for here" and "It's always very warm and welcoming here."

The home had a calm and relaxed feel. We observed positive and caring relationships between people and staff. We saw staff treated people with respect and in a kind and compassionate way. One person told us, "The staff here are wonderful. Let me give you an example. I received flowers from one carer at Christmas, completely out of the blue. It was such a lovely gesture, I was pleased and surprised."

Staff were knowledgeable about people's life histories, preferences, needs and what was important to them, such as family members and any hobbies or interests they had. When we asked about people, staff were able to describe peoples care needs and say how they preferred these to be delivered. We observed that staff knew where people preferred to sit and what objects were important to them. For example, staff made sure that one person had their dolls with them when they sat in the lounge, as it gave them comfort. Staff spoke with us about people in a dignified and professional manner throughout the course of our visit. When able, staff spent time talking with people however; this was limited to times when they were providing direct care and staff appeared somewhat task focussed. We spoke to the registered manager about this and who said they would look into how staff could be freed up to spend more quality time with people. One staff member told us, "I would love to be able to spend more time chatting with people, the more you chat the more you find out about people." Another staff member told us, "We do get time to speak to people, especially when we are helping them."

Mostly we observed staff supporting people well and people received the support they needed at the time they needed it. Staff explained what they were doing when they supported people and gave them time to make choices and decisions. However, we saw some times when this did not always happen. For example, one person was being helped to walk with a frame back to the lounge. When the person reached an armchair they were not helped or guided to sit down. There was no conversation between the staff member and the person, and they just dropped into their chair from a standing position, which could have put them at risk of harm.

People told us staff supported them to maintain as much independence as possible and encouraged people to take part in their care as much as they could manage. For example, by shaving or brushing their teeth or eating without assistance. We saw evidence of this during our visit. For example, staff offered to cut food up for people to make it manageable for them to eat independently.

The home had a calm, relaxing and homely feel. People had been encouraged to personalise their rooms and make them as homely and comfortable as possible with, for example, pictures, ornaments, photographs and house plants. People made choices about where they wished to spend their time. We heard staff asking people if they would like to eat their meal in their room or the dining room. One person

told us, "I sometimes prefer to eat my breakfast in my room. This is always acceptable to the carers and the chef and I think they do such a lot to give us a choice about things like that." There were no locked doors and people could come and go from the home as they wished, though most preferred to stay in.

People were encouraged and supported to maintain relationships with their relatives and others who were important to them. Visiting times were not restricted and relatives told us they were always made to feel welcome and offered a drink. There were quiet areas where people could spend time away from the busier communal areas, other than in their rooms. We saw people enjoyed making use of these areas on their own and with their visitors.

People's privacy and dignity was respected by staff. We saw staff knocked on people's doors and ensured privacy was maintained when personal care was carried out. People were supported to look smart and attention was paid to keeping their hair tidy and gentleman had been shaved.

Records showed people, and their relatives where applicable, were involved in making decisions about care and support. Assessment and care planning documentation showed people were consulted about their wishes when they first came to the home and then on an on-going basis. Resident and relative meetings provided an opportunity for people to make their thoughts known. For example, minutes of one residents meeting showed people had been involved in discussions around the recent improvements, menus and activities.

Good

Is the service responsive?

Our findings

People told us staff were available when they needed them and responded to their needs quickly. One person told us, "I have a bell to use to call for help. I have had the need to use it and help came quite quickly." People felt they received personalised care which met their needs.

Since they were last inspected, Somerforde had introduced an electronic mobile care monitoring system. All care plans were held electronically and staff had individual hand held devices to record all aspects of care. This allowed staff to record care as it was given and alerted the registered manager and staff of any care needs that were required, such as a person requiring their position changing or how much food and fluid they had during that day.

People had a pre-assessment completed prior to arriving at the home. This covered a range of people's needs and helped staff plan their care, making sure they could meet those needs and ensure any specialist equipment was in place prior to the person coming into the home. This basic information was used as the basis for the care plan. However, one person had been admitted to the home on 10 January 2018, an initial assessment had been completed but a comprehensive detailed care plan, including assessment of risks, had not been completed at the time of the inspection. This meant there was a risk the person would not receive person centred care that was appropriate, met their needs and reflected their personal preferences. For example, there was no information about their personal hygiene needs, how they liked to spend their time, daily routines or likes and dislikes. Other care plans we looked at were fully completed, detailed and person centred.

We spoke to the registered manager about this. The registered manager told us the person had been admitted whilst they were absent from the home. Since the new electronic care planning system had been introduced the registered manager was working hard to ensure care plans were detailed and person centred. However, at the time of this person's admission, staff responsible for completing the full care plan in the registered manager's absence, had not done so. The registered manager responded immediately and a full detailed care plan was put in place and they planned to ensure all staff felt comfortable about the electronic care planning system to ensure care plans were completed during their absence.

We recommend the provider review systems in place to ensure care planning and care delivery are robust to ensure person centred care when the registered manager is away from the service.

People's care plans were comprehensive and person centred, providing staff with relevant and appropriate guidance in how to support each person. There was personal information in people's care plans describing how the person wanted to spend their time, their likes and dislikes and other preferences. For example, one person's care plan described how they took their tea, white without sugar and they liked toast and marmalade for breakfast. Another care plan told staff the person preferred to stay in their room listening to opera music. Staff told us they would put the music on for them as they had poor eye sight. We saw the person enjoying their music during the inspection. This told us people received care that was individualised, person centred and based on how they wanted to be treated and looked after.

We found that some improvements could be made to ensure that people received responsive care at all times. The care plans did not always contain people's life histories, past experiences, preferences and goals or how they would be reached. One staff member told us how much they loved to speak with the people they were caring for, "I love to chat with them, they have led such interesting lives." They told us they knew people well because they spent time chatting with them but felt that other staff would benefit from having this information available in care plans, "This detail is not always in the care plan. I think it would be really useful and help staff speak to people about their lives and interests."

People's records included their decisions about the care they wanted to receive at the end of their life. For example, if they wanted to be resuscitated in case of a sudden deterioration in their health and where they wanted to be cared for. The registered manager told us they were supported by local community health professionals when a person was nearing the end of their life. This included appropriate equipment to increase the person's comfort and care and medicines to help with symptom control. People's families were involved as much as possible and as the person wished. Staff received training in caring for people nearing the end of their lives.

People and their relatives were aware of their care plans and told us they participated in review meetings where care staff explained their care plans to them.

All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. CQC have committed to look at the Accessible Information Standard at inspections of all services from November 2017. We looked at how the home shared information with people to support their rights and help them with decisions and choices.

Information about the home was made available to people and staff communicated with people in the way best suited to their needs. Care plans contained information about people's specific communication needs, any barriers to communication and how staff could help people communicate. However, staff did not always ensure people had access to aids designed to facilitate communication. For example, a relative told us their family member lost their hearing aid several weeks ago, they told us, "I've raised it with the deputy manager as the registered manager has been away, but nothing's been done." Another person's relative told us they were still waiting for the large screen television they had purchased to help their relative who has a sight disability, to be put on the wall, "We asked for it to be put in the room for my relative to use, but I see today that's it's still in the box. I think this maybe because the Manager has been off. Usually things get done really quickly when he's present." We spoke to the registered manager about this who responded immediately, installing the person's television that day and arranged for an audiology appointment to replace the hearing aid.

The provider used different ways of gaining the views of people who lived at the home, relatives and staff. For example they held meetings, had a suggestion box, sent questionnaires and a regular newsletter was produced for people, their relatives and friends. People who lived at the home and relatives were aware of the meetings held.

People told us that that they could take part in various social activities which they enjoyed. Some people told us they did not always participate but knew the activities were available if they wished and their choice to not participate was respected. One person told us, "There's always plenty to keep you occupied here. One lady organises events and trips as well as social gatherings." Another said, "I look forward to the activities, it's history group today and I won't miss that."

The home employed an activities co-ordinator to provide support with activities for 20 hours a week. The activities co-coordinator told us when they started their role they spent some time with residents chatting and discovering what their hobbies and interests were and deciding how they could deliver a structured and enjoyable programme of weekly activities. They told us, "All residents and their families are given a monthly newsletter of activities and events. There is also an activities board in the dining room that gives a visual reminder of the activities taking place on any given day. We saw that activities on offer included; history group, music, bingo, exercise to music, quizzes and memory lane sing-alongs. The activities co-ordinator also organised social gatherings to mark calendar events such as; Halloween quiz and buffet, Bonfire night hotdogs and fireworks, residents' Christmas party and the staff pantomime. The provider also hired transport so that people had the opportunity to go out on day trips. Recent trips had included minibus trips to shopping centres and outings to local theatres to see shows. We saw people participating in activities throughout the inspection. Staff encouraged people in the lounge to participate in a group game of bingo. We observed lots of laughing and positive interactions with staff and people.

The activities co-ordinator and staff supported group activities as well as spending time with people one to one, for example, people who were cared for in their room or who chose not to use the communal areas. One staff member told us they would try to sit and chat with people in their rooms when they had time.

The provider had installed Wi-Fi to all areas of the home to enable people to have access to smart TV's, 'Skype' and the internet and to help people maintain relationships that where important to them, helping to prevent social isolation. One person was helped to 'Skype' their daughter who lived in another country. Another person enjoyed using the interactive television to play memory games and sit and watch the interactive scenes, such as a moving fireplace picture. The registered manager also regularly kept in touch with relatives via the email system.

The home was responsive to concerns or complaints raised. The management team had dealt with all complaints received by conducting an investigation and taking disciplinary action if appropriate to do so. The provider told us they had listened to all complaints and concerns and dealt with them in a prompt and professional way. We found the home had responded and learnt from complaints and had changed things within the home as a result of issues raised. For example, previously a common complaint was their was a lack of activity and stimulation for people. The provider responded by appointing an activity co-ordinator and activities were discussed with people individually and during residents meetings.

The provider had a complaints policy and procedure in place and information on how to make a complaint was on display. Complaints were reviewed monthly by the registered manager. We spoke with people to see whether they had ever felt they needed to complain and they told us they would be happy to discuss any issues with staff or the registered manager. One person said, "I asked the Manager to improve my call bell system. He said 'yes' straightaway and I have no doubt he'll see to it. I trust him you see."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2015 we had rated this key question as good. However on this inspection we identified a number of concerns that had not been identified by the home's own quality assurance systems.

We found the quality assurance systems were not always effective as they had not identified the shortfalls we picked up during this inspection. The auditing systems did not recognise that some care plans and risk assessments were not in place and did not always give sufficient guidance for staff to provide consistent and appropriate care. Some people did not always receive the care they needed and as documented in their care plan. For example, one person needed staff to monitor their skin condition and apply creams to maintain their skin health. Their daily records showed they had not always received this care and quality assurance systems in place had not identified this.

People who had been identified as at risk of skin breakdown had equipment such as pressure relieving mattresses. Having the mattress set too firm or too soft could result in pressure damage occurring. We found the home did not have a system for checking pressure relieving mattresses were set to the correct setting for the person in accordance with the manufacturer's instructions. There was also no record of the mattresses being routinely checked to ensure they were in good working order or on the correct setting.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. The provider had a clear procedure for recording accidents and incidents. However, we found accidents or incidents relating to people had not always been documented by staff. Therefore, the registered manager was not in a position to investigate further to ensure actions were followed through to reduce the risk of further incidents occurring. We were informed by the community nurses of an incident where a person's pain infusion pump had delivered their medicines too fast; however, we found no record of this in the provider's accident and incident record book or on the electronic care planning and recording system. There was no evidence of any follow up having been completed. This shows the provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person's care and treatment.

We saw that accidents and incidents had not been audited and no analysis of accidents or incidents had taken place since November 2017 to look for patterns or trends. This showed the accident and incident monitoring system was not robust and the home may not learn from incidents, to protect people from harm.

Medicine audits were being undertaken; however these were not always effective. Before and during the inspection we received information and concerns about the home's management of medicines, in particular, stock discrepancies. During the inspection we found that whilst medicines were being administered safely, the arrangements in place to manage reordering of medicines and stock control, put people at risk of not receiving their medicines when they needed them. The registered manager and provider had recognised the issues around the management of medicines and were taking action to introduce a monitored dosage system and tighter stock control and ordering systems. However, medicines

audits had not identified concerns, such as inaccurate stock, temperature monitoring of medicines storage and medicines not being dated once opened. This meant that the audits were not effective as concerns we found had not all been previously identified and action had not been taken.

The provider did not have sufficiently robust systems and processes in place, such as audits of the service to assess, monitor and improve the quality and safety of the service.

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

Somerforde was under the day to day management of a registered manager and close observation of the provider. Both had a visible presence in the home on a daily basis. During the inspection we discussed our findings with the registered manager and provider and found them to be open and transparent and extremely responsive to any concern we raised. They told us that although disappointed by the concerns we found, they were committed to act on the concerns to ensure the home provided the very best care to the people living at Somerforde.

Following the inspection we received a report from the registered manager describing how they had responded to the concerns and what actions they had taken to address the issues. The management structure had been strengthened with the introduction of a compliance manager. Each member of the management team had defined roles that supported the registered manager to have more oversight of the service. This inspection also prompted the management team to examine and improve other aspects of the service such as working towards a more personalised care plan and ensuring safe, effective care by observation and management supervision. This demonstrates a commitment by the management team to address the issues and provide the best care for people living at Somerforde.

The registered manager and provider had developed relationships with partner organisations including the local authority safeguarding adults team, quality assurance and improvement team and health authorities who commissioned the service. They were very proactive in seeking and accepting support from health professionals and had worked with appropriate partner agencies to ensure that people received the support they required.

The provider information return (PIR) stated, "We provide honest care and aim to meet peoples expectation's, people are treated kindly with their needs and wishes at the forefront of all we do, the staff within the service offer dignified care and respect peoples wishes." The ethos of the home centred on ensuring these aims were met. The homes statement of purpose told people, "We are committed to developing a real sense of passion and compassion for the atmosphere, routine and lives of those in our care." We saw these aims demonstrated by staff during the inspection

People provided positive feedback about the management. One person told us, "The manager's great and the place has improved since he's been here. The staff seem more settled as well." A relative told us, ""I am happy that my relative is being well cared for here and it's well managed. The home is very comfortable and clean."

People or relatives could give feedback about the home to the manager or staff at any time, as they operated an 'open door' policy. We saw the registered manager and provider were available to speak with visitors and relatives throughout the day. People's views and those of their relatives were sought as part of the quality assurance process to make improvements to the home. There were a variety of ways in which they could give feedback. These included annual surveys, residents' and relatives' meetings, care reviews

and through the complaints process. The home also sought external evaluation of their work and had achieved good results from reviews gathered by an independent review website. The review website showed the provider had received a review score of 9.3 (maximum of 10) based on nine reviews over the past twelve months. On line review feedback included; "This place has had a major turnaround for the better. Starting with the owner, he has invested a lot of time and money. The staff are very professional. I have found the manager very helpful and really care about the residents. They are all so obliging and I am happy that my mother is there" , "Very friendly welcoming care home. Lovely staff who are very helpful. Management and staff really look after the residents and care, making sure they are happy. Atmosphere is homely and a pleasure to visit at any times" and "From the moment my mother was welcomed into the home, we felt she was genuinely being cared for and her needs were being addressed. How likely would you be to recommend Somerforde? Extremely Likely."

Staff told us they enjoyed working in the home and felt well supported by the management team. One staff member told us, "I love it here, everyone is so nice and we have a fantastic manager, best I've had. I can't wait to come into work in the morning." Another staff member said, "It's good. We have a good team with good communication. [Manager's name] is a good manager. He will come out and work with us. He's approachable and friendly and he makes sure things are done and observes what is going on." They went on to tell us how supportive the provider was, "He's approachable and you are able to make suggestions to him. The residents have a good old chat with him."

Records showed and staff confirmed that staff meetings were held regularly. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the home and giving them an opportunity to discuss good practice. We saw from staff meeting minutes and staff told us they could raise any issues of concern in staff meetings and that their views were always listened to. We saw staff were valued and recognised for their contribution in the home. The provider had introduced an 'employee of the month' award. People, relatives and staff were able to vote for the staff member who had gone above and beyond. We saw photos of staff receiving their awards and gifts. One staff member told us, "It makes you feel valued."

Staff told us they were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any emergency or concern. There were policies and procedures in place relating to the running of the home. Staff were made aware of the policies at the time of their induction.

Providers of health and social care services are required to notify CQC of significant events that happen in their services such as serious injuries to people and allegations of abuse. The registered manager of the home had made prompt notifications to us of important events, as required. This meant we could check appropriate action had been taken.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately managed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficiently robust systems and processes in place, such as audits of the service to assess, monitor and improve the quality and safety of the service.