

Portsmouth City Council

Shearwater

Inspection report

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Date of inspection visit:

09 May 2018

14 May 2018

Date of publication:

28 June 2018

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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Shearwater is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide accommodation for up to 60 people some of whom live with dementia. Accommodation is arranged over three floors with stair and lift access to all areas. There was a good choice of communal spaces where people were able to socialise and all bedrooms had en-suite facilities. At the time of our inspection there were 34 people living at the home.

The inspection was conducted on 9 and 14 May 2018 and was unannounced.

At the time of the inspection there was not a registered manager in post at the service, there was a manager who had taken over the overall running of the service and was planning to apply to become registered to manage the home.

At our last inspection, in September 2017, we identified breaches of Regulation 12; Safe Care and Treatment, Regulation 18; Staffing, Regulation 17; Good Governance and Regulation 9; Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This resulted in the service receiving an overall rating of 'Inadequate' and being placed in special measures.

At this inspection the service received an overall 'Requires Improvement' rating and was removed from special measures. We recorded one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the Need for Consent. You can see what action we told the provider to take at the back of the full version of this report.

Improvements had been made in the quality assurance processes within the home and we saw robust audits were completed for most areas. However, we found further work was still required in some areas including working within the principles of the MCA and ensuring that all medicine was managed safely.

We found that in the main improvements had been made that had resulted in people receiving safer, more effective, person centred care. A range of processes and procedures had been put in place and were followed to help ensure staff followed best practice guidance when providing care and support to people.

People told us that they received their medicines safely and on time. However, medicines were not always stored safely and where people were prescribed topical creams there was not clear and robust systems in place to ensure these were given appropriately.

Risks to people were assessed and managed effectively. Staff were provided with clear guidance on how risks should be managed and demonstrated an understanding of specific risks to people.

Where accidents and incidents had occurred, these were clearly logged, reviewed and analysed to see if there were any common themes and if there could be any learning from these events.

There was enough staff deployed to meet people's needs and keep them safe. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner.

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff had received training in safeguarding, which helped them to identify, report and prevent abuse.

Appropriate recruitment procedures were in place to help ensure only suitable staff were employed. People's needs were met by staff who were competent, trained and supported appropriately in their role.

People were supported to have enough to eat and drink and had access to health professionals and other specialists if they needed them. Staff worked in partnership with healthcare professionals to support people at the end of their lives to have a comfortable, dignified and pain-free death.

Staff showed care, compassion and respect to the people. There was a relaxed and calm atmosphere within the home. People were cared for with dignity and respect and their privacy was respected.

People were encouraged to be independent and the staff supported people to meet their cultural and spiritual needs.

The service was responsive to people's needs. Care files were person centred and contained consistent and relevant information about people. Staff demonstrated that they know people well, understood their needs and had knowledge of their likes and dislikes.

People had access to a range of varied activities they enjoyed. People were listened to by staff and their views and wishes were respected.

People, their families and staff had the opportunity to become involved in developing the service.

There was an open and transparent culture within the home and people and families confirmed they felt able to approach the manager at any time.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

We found action had been taken to ensure people were safe. However, there was now a need to further embed and sustain the improvements into practice.

People told us that they received their medicines safely and on time. However, medicines were not always stored safely and where people were prescribed topical creams there was not clear and robust systems in place to ensure these were given appropriately.

Individual and environmental risks to people were managed effectively.

People felt safe at the home and staff knew how to identify, prevent and report abuse.

There were enough staff to meet people's needs and recruiting practices helped ensure that all appropriate checks had been completed.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Best interest decisions had not always been made in accordance with The Mental Capacity Act 2005. This meant that staff could be providing care and support to people without lawful consent.

People received effective care from staff who were competent, suitably trained and supported in their roles.

People were supported to have enough to eat and drink.

People had access to health professionals and other specialists if they needed them.

Procedures were in place to help ensure that people received consistent support if they were admitted to hospital.

Adaptations had been made to the environment to meet the needs of people living in the home.

Staff made appropriate use of technology to support people.

Is the service caring?

Good 

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

People's specific communication needs were understood by staff.

Staff understood the importance of respecting people's privacy.

Staff respected people's independence and encouraged people to do things for themselves.

People were supported to maintain friendships and important relationships.

Is the service responsive?

Good 

The service was responsive.

People received personal care in line with their personal preferences. Care files contained detailed information to enable staff to provide care and support in a personalised way.

Care and support was planned in partnership with people, their families and healthcare professionals where appropriate.

Staff responded promptly when people's needs or preferences changed. Staff were kept up to date on people's changing needs.

People received appropriate mental and physical stimulation and had access to activities they enjoyed.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People knew how to raise a complaint and the manager had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement 

The service was not always well led.

Improvements had been made in the auditing process within the home and robust audits were completed for most areas. However, these audits had failed to identify that the service was not always working within the principles of the MCA and ensuring that all medicine were managed safely.

People were happy living at Shearwater and felt the service was well-led.

Staff were organised, motivated and worked well as a team. They felt supported and valued by their managers.

People, their families and staff had the opportunity to become involved in developing the service.

There was an open and transparent culture within the home and people and families confirmed they felt able to approach the manager at any time.

Shearwater

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 14 May 2018 and was unannounced. It was completed by three inspectors 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.

Before the inspection we reviewed information, we had received about the service, including previous inspection reports, the provider's action plan for improvement and notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection, we spoke with nine people who use the service and four family members. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the service manager, the provider's representative; who was also the nominated individual, the manager, the deputy manager, six care staff, two domestic staff, the cook and the activities coordinator. We also received feedback from three health care professionals who had contact with the service.

We looked at care files and associated records for 17 people and records relating to the management of the service, including duty rosters, staff recruitment files, accident and incident records, maintenance records and quality assurance records.

Is the service safe?

Our findings

At the previous inspection in September 2017 we found that the service was not safe. Risks to people had been assessed, however, information within people's risk assessments and care records was inconsistent and conflicting, placing people at risk of harm or injury. Care delivery was not carried out in accordance with assessed risks. There were not enough regular staff deployed to meet people's essential care needs and to ensure people's safety. We told the provider they must make improvements and must keep us informed about the actions they were taking to keep people safe. At this inspection we found action had been taken to ensure people were safe. There was now a need to further embed and sustain the improvements into practice.

The management team had assessed the risks associated with providing care to each individual and specific risks to people were recorded within their care files. The information within the care files highlighted the potential risks and provided information for staff to help them avoid or reduce the risks of harm. For example, where people were at risk of choking and required their food at a soft or pureed consistency or a thickening agent added to their drinks, care files now specified consistently how the person should be supported and the stage of thickness food and fluids should be provided at. This was further supported with best practice guidance and information to staff of how to ensure people could be fed safely.

Where people were at risk of developing pressure sores records demonstrated that risks were mitigated and guidance was followed as highlighted in the care file. For example, for one person who was cared for in bed, their care file stated that they required their position changing every two hours and they were not to be placed on their right side. The turning monitoring chart showed that this person's position had been changed in accordance with their care file. Other preventative measures to mitigate the risk of people developing pressure sores were in place. For example, some people who were at risk of developing pressure sores had been provided with pressure relieving mattresses. We found that these mattresses had been set correctly in accordance to the person's weight and there was a process in place to ensure the mattresses remained at the appropriate setting. Additionally, people were provided with pressure relieving cushions as required.

Where people were at risk of falls action had been taken to help prevent future falls from occurring. For example, the home's fall audit had highlighted that one person was experiencing falls during a certain period of the day. This had resulted in an additional staff member being provided during the hours that the person's fall risk increased. This helped to monitor the person's movements more closely to prevent future falls.

Other risks were monitored and managed and risk assessments in place included moving and positioning, nutrition, medicines, challenging behaviour and safe use of equipment such as electric beds and bed rails.

There were now enough staff deployed to meet people's needs and keep them safe. People's and their family members' comments included, "Yes, I think there is enough staff. They are all very nice and helpful" and "At the moment there are [enough staff] as there are not so many residents." People also confirmed that they didn't have to wait for support from staff when they required it. One person told us, "No, you don't

have to wait" and another person said, "I've pressed it by accident and they've come quite quickly."

During the inspection staff were visible and responded quickly to people's needs. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff we spoke with confirmed there were enough staff to provide appropriate care without being rushed in their duties. One staff member said, "It can be busy first thing in the morning but then we have time to do activities with people, speak to them and do puzzles and board games." Another staff member told us, "There is enough staff now and we have lots more time to spend with people."

Staffing levels were determined by the manager or deputy manager who used a dependency tool to assess the level of support people required. This tool was reviewed weekly or more frequently if required. The deputy manager also told us that when determining staffing levels, they listened to feedback from people and staff and observing care and response times. There was a duty roster system which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed using overtime and agency staff.

At the previous inspection in September 2017 we found that where people were prescribed 'as required' (PRN) medicine to help with anxieties there was not clear and robust systems in place to ensure these were given appropriately. At this inspection we found that some action had been taken to address this concern for some people, however, protocols regarding the administration of PRN medicines were not in place for all people. This meant that people may not be receiving this type of medicine in a consistent way or as the prescriber intended. This was particularly in relation to the use of topical creams. We found that where people were prescribed topical creams there was not individual guidance available to staff as to when, where and how these creams should be applied. Systems were in place to ensure that people's prescribed topical creams contained labels with opening and expiry dates. This meant staff were aware of the expiration date of the item when the cream would no longer be safe to use.

Additional concerns in relation to the safe storage of medicines were also identified. We found that the provider's policy stated that the temperature of the medicines cupboard should be checked twice each day. Over the last eight days prior to the inspection we found that the temperature of this cupboard had not been checked on two occasions. Records were also completed to monitor the temperature of the fridge that contained medicines which needed to be stored at a cooler temperature. However, since the beginning of the May 2018, two gaps were evident on this record. This indicated that medicines were not always stored in line with national guidelines. This was discussed with the manager who agreed to review the current practices.

Medicines must be stored at specific temperatures to ensure their effectiveness. However, we found that where the temperature of the medicine cupboard had been recorded temperatures had reached 26 Degree Celsius, 27 Degree Celsius and 29 Degree Celsius which is above the recommended guidelines as stated on the medicines packaging. This was discussed with the management team who were aware of this issue. The management team were able to provide us with evidence that this had been discussed with a pharmacist for guidance in relation to the safety and effectiveness of these medicines. Additionally, actions had been taken to rectify the issue which included, hiring a portable air-conditioning unit and the use of fans and ice cubes until a ceiling fixed air-conditioning unit could be installed. We saw evidence that this was currently being arranged.

When people and their family members were asked if people got their medicines on time their comments included, "Yes", "[person] does, they [staff] have to gently persuade" and "Yes, I take tablets in the morning and at lunchtime." Medicines were administered by staff who had received appropriate training and had

their competency checked yearly to ensure that their practice was safe. Staff supporting people to take their medicines did so in a gentle and unhurried way. They explained information about the medicines they were giving in a way the person could understand and sought people's consent. Staff remained with people until they were sure all medicines had been taken. We also heard people being asked if they needed any additional medicines such as pain relief and people confirmed that could access pain relief if they needed it.

A medicines profile had been completed for each person. This showed any allergies to medicines, the person's preference in taking their medication and any special requirements such as taking before food or avoiding grapefruit products. However, we found that one person had been prescribed a medicine that should be administered 30 minutes before food. Records showed that this medicine had been given to a person after and with food at times. This was discussed with the manager who contacted the GP and agreed to review these practices.

There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely. Stock checks of medicines were completed monthly to help ensure they were always available to people. This included controlled drugs which were stored in accordance with legal requirements. Daily and weekly audits of controlled drugs were undertaken by two members of staff.

Some people were having their medicines administered covertly. This is when essential medicines are "disguised" in food or drink. When medicines are administered this way to people who are unable to consent, mental capacity assessments and best interest meetings should take place in accordance with legislation. We looked at the documentation in place for one person who was having their medicines crushed and mixed with food or liquids. There were clear records in place to show that the GP had authorised such and that the decision to administer medicines this way was in the person's best interests.

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff had received training in safeguarding, which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse. A staff member said that if they had any safeguarding concerns they would, "Report it to the manager." Records showed the manager had worked effectively with the local safeguarding team to undertake investigations and appropriate action had been taken to protect people from the risk of abuse.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or people made vulnerable by their circumstances. Staff files included application forms, records of interview and references.

The home was clean and systems were in place to ensure that all areas and equipment were cleaned on a regular basis. Domestic staff told us they felt they had sufficient time to complete their daily cleaning routines and staff had attended infection control training. A family member said, "It's very clean. The toilets and bathrooms are excellent." Staff had access to personal protective equipment (PPE) and wore these when appropriate. The staff described how they processed soiled linen, using special bags that could be put straight into the washing machine to avoid the risk of cross contamination. A clear system was in place in the laundry room to help prevent cross contamination between soiled linen entering the laundry and clean linen leaving the laundry.

Equipment such as hoists and lifts were serviced and checked regularly. Environmental risk assessments and general audit checks of the building were done weekly and a monthly health and safety audit was completed. On reviewing these they were robust and included weekly window restrictor checks, sprinkler system checks, air conditioning unit checks, fire escape checks and general maintenance checks. The audits showed a clear action trail and when issues had been identified they were acted upon immediately and the relevant people contacted to make repairs if the maintenance person was unable to complete this work. There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly. Personal evacuation and escape plans had been completed for each person, detailing action needed to support people to evacuate the building in the event of an emergency.

Is the service effective?

Our findings

At our last inspection, in September 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that contemporaneous records were kept for each person. At this inspection, we found action had been taken and there was no longer a breach of this regulation. For example, care monitoring records such as repositioning charts, food and fluid charts and body maps were now in place where appropriate and demonstrated that care had been provided as per guidance in the care files.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who 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 capacity to make particular decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible. Best interest decisions were not recorded for five people who had been assessed as lacking capacity. Within these people's care files there was no evidence that showed what decisions had been made for these people, why they had been made or who had been consulted in the decision-making process. In one person's care file we saw a comment about gaining the person's consent, it read, 'If no consent is given we must implement what is in their best interest.' However, there was no best interest decision recorded to back up this statement. This meant that staff could be providing care and support unlawfully.

The failure to ensure that best interest decisions were made in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

When people and their families were asked if staff sought verbal consent before providing care or support their comments included, "Oh yes; they say, can we do that for you", "They will always ask first" and "They say 'Is that OK for you?' They are very good." We observed staff seeking consent from people using simple questions and giving them time to respond. Staff told us how they offered people choices and sought consent before providing care. One staff member said, "I would always ask the residents first before I do something." However, for two people who lacked the capacity to make specific decisions we found that their family members had made decisions on their behalf. The manager was unable to clarify if these family members had the legal authority to make decisions for the person.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. Staff were aware of the people that these restrictions applied to and the support they needed as a consequence.

The lack of understanding around the MCA was discussed with the management team who acknowledged that this was an area needed reviewing and agreed to look into this.

People, their families and a healthcare professional told us they felt the service was effective. A family member told us, "I think it's a million times better than when [person] was in independent living, it's fantastic. [Person] is comfortable, not hungry or in pain. What more could you want?" Another family member said, "I love it, I can't fault it. The staff are so lovely. The staff are so good with the residents, so patient. There's loads of interaction, they're not just left in a chair." People told us, "The service is good" and "What I like is that if you want privacy, you can go to your room. The staff look after you well."

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training which included the completion of a workbook that followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Staff confirmed that they had received induction when they started work at the service.

People and their families described the staff as being well trained. When one person was asked if they felt the staff were well trained they responded with, "Fairly well" and another person told us that, "Some are very skilled." Staff told us they received effective and appropriate training. A staff member said, "I have done all the training and it is all up to date."

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. There were clear records confirming that staff were up to date with the provider's essential training. This included safeguarding, moving and handling, infection control, food hygiene, mental capacity act and fire safety. In addition, some staff had completed other training relevant to their role, including dementia awareness, skin care awareness and end of life care. Staff training was both completed face-to-face with a facilitator and through e-learning. Staff demonstrated an understanding of the training they had received and how to apply it. For example, they used moving and positioning equipment in line with best practice guidance.

Staff were appropriately supported in their role. They received one-to-one sessions of supervision from a member of the management team on a three monthly basis. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. In addition staff received group supervisions and the management team regularly observed staff's practice and fed back to them about their performance. Staff told us they felt supported in their role and felt able to approach a member of the management team if they had any concerns or suggestions for the improvement of the service. A staff member said, "The management are very approachable, there is always someone you can go to."

People told us they had enough to eat and drink and that fluids and snacks were offered throughout the day, evening and night if required. People told us that they enjoyed the food and were given a choice about what they ate and drank. One person said, "It's very good. There's generally a choice of two." Another person told us, "I'm fed sensible food. I get my five a day." A third person confirmed that, "If I wanted something else, they would get it." Family members also confirmed people were given choices about what to eat and had enough food and drink at the appropriate consistency to meet their needs.

We saw people were supported to make informed decisions about food choices through the use of verbal

descriptions and photos. Alternatives were offered if people did not like the menu options of the day. During mealtimes, people were encouraged to move to dining tables although if they chose not to, this was respected. This helped make the mealtime a pleasant and sociable experience. We observed lunch and saw that people had different meals according to their choice. Staff were supportive to people during meal times. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. When assistance was required, this was provided by staff in a relaxed and unhurried way.

People's nutritional needs were assessed to help identify if they were at risk of malnutrition and if a referral was needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). Care records showed referrals were made where people had nutritional or swallowing needs and the advice of the SALT was recorded. Staff were aware of which people needed soft or pureed food. Food and fluid intake and weight was monitored where needed so any action could be taken regarding weight loss or gain.

People were supported to access healthcare services when needed. One person told us, "I haven't had to [access healthcare support], but I've seen other people get a doctor." A family member said, "They call the doctor in. They ask if I'm happy with that or whether they should take them off to hospital, but I say; whatever you think." Care records confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. Information in relation to people's health needs and how these should be managed was clearly documented within people's care files. Staff knew people's health needs well and could describe the action they would take in medical emergency.

The home was taking part in a care home pilot scheme which involved conducting multi-disciplinary team meetings twice weekly. These meetings included participation from GPs, a community matron, a representative from the local mental health team, a pharmacist, an occupational therapist and a physiotherapist and gave the staff at the home the opportunity to discuss any concerns they had in relation to the people they were supporting. We attended one of these meetings and found that specific people were discussed in detail. Where concerns were raised about people's physical, emotional or social wellbeing there was a team approach to help ensure that effective and appropriate support and care could be provided quickly. This also demonstrated that the service worked in partnership with healthcare professionals.

There were clear procedures in place to ensure that people received consistent support when they moved between services. The home used the 'Red Bag Pathway' to enable a smoother transition when people move between hospital and community settings. The Red Bag Pathway helps ensure that all standardised paperwork, medication and personal belongings are kept together throughout the person's hospital episode and is returned home with them. The standardised paperwork ensured that everyone involved in the care for the person had the necessary information about their general health, current concerns, social information, abilities and level of assistance required. This allowed person-centred care to be provided.

The environment was well maintained and appropriate for the people who lived there with passenger lifts to all floors. Decoration supported people living with dementia or poor vision which included picture signs on toilet, bathroom and bedroom doors and hand rails of contrasting colours to walls. Throughout the home there were notice boards and displays for people to view. These included old pictures of famous people, a display in relation to the upcoming royal wedding and information about upcoming events at the home. These gave people the opportunity to reminisce about past events and provided them with information about the home and activities. People's bedrooms had been decorated to their tastes, together with some of their furniture and important possessions. People had access to a variety of different communal areas in the home which meant they could choose whether they spent time with others or alone. People had access to the gardens which were safe, fully enclosed and provided various seating options. At the time of the

inspection people were involved in choosing a new water feature for the garden from photos.

Staff made appropriate use of technology to support people. For example, pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries and an electronic call bell system allowed people to call for assistance when needed. Following feedback from people and family's computer tablets had been purchased to help people maintain important relationships via the internet.

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People and family members agreed that staff were caring. One person said, "They're very good, especially [name of staff member]. You can ask them anything and if they can do it, they would." Another person described how a particular staff member made them laugh. A third person described the staff as being, "all very nice and helpful." The home had received several written compliments since the last inspection, Comments included, 'Thank you for the superb care you gave [person's name] from the minute they moved into Shearwater House; words cannot express how amazing your care is!' and 'Thank you to each and every one of you who looked after [person's name] with such compassion, dedication and hard work.'

People were cared for with dignity and respect and all interactions we observed between people and staff were positive and supportive. Staff were heard speaking to people in a kind and caring way and would interact with people in a positive, friendly and cheerful manner. We saw staff kneeling to people's eye level to communicate with them. We heard good-natured interactions between people and staff, showing they knew people well. We saw that staff responded to people quickly when they showed signs of emotional distress. For example, during lunch a person became agitated with a staff member for not providing them with their meal quickly. This staff member reassured this person gently and when they gave this person their meal the person thanked them. The staff members responded with, "You're very welcome." There was no evidence of irritation about the person's demands and the staff member was kind and respectful throughout. On another occasion a person was heard to sneeze, a staff member said, "Oh bless you [person's name], would you like a tissue?"

People were listened to by staff who gave them the time they needed to communicate their views and wishes. Where people had specific communication needs, these were recorded in their care files and known by staff. One care file provided information to staff about how to best communicate with a person who has a speech impairment. For example, information in this person's care file read that, '[person] can say 'walk' and this usually indicates that they are unhappy' and '[person] can say 'yes or yeah' and 'no' which indicates accurately their preferences'. Another care file advised staff to 'use closed questions' and 'keep background noise to a minimum during conversations' to aid communication.

People were encouraged to be as independent as possible. At meal times we saw that staff would encourage people to feed themselves and people had access to appropriate specialist equipment where required. We saw people being encouraged to stand and walk on their own using walking aids, such as frames and sticks. Staff did not rush them and allowed people to go at their pace. For example, we saw one staff member supporting a person to walk. The staff member gave clear and gentle instructions to the person throughout making comments such as "Step slightly to your left" and "That's brilliant, you're doing really well." Comments in care files highlighted to staff what people could do for themselves and when support may be needed. For example, one care file stated, '[Person] is usually able to wash their hands and face independently if the flannel is passed to them.' Staff understood the importance of maintaining people's independence and a staff member said, "The people here are all individuals, they don't all like or need the same thing."

People's privacy was respected when they were supported with personal care. During the inspection we saw staff knocked on people's doors and ask permission before entering their rooms. Staff could describe the practical steps they took to preserve people's dignity and privacy when providing personal care.

Information regarding confidentiality, dignity and respect formed a key part of the induction training for all care staff. Confidential information, such as care records, were kept in secure cupboards and offices and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who were important to the person. All the families we spoke with confirmed that the manager and staff supported their loved ones to maintain their relationships and that they could visit at any time. When we asked one family member if they could visit at any time and if they were made welcome they responded with, "Of course, they always offer tea and biscuits. They know us, it's like seeing friends. It's like visiting her at her home, not in a home." Another family member told us, "I've been made very welcome and they [staff] have said I can come anytime." A written thank you read, 'Thank you for making us all so welcome we came to visit, nothing was too much trouble.'

Is the service responsive?

Our findings

At our last inspection, in September 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that each service user had a person-centred care plan in place. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

Care files were now person centred and contained consistent and relevant information about people. Information within these care files included people's specific needs, detailed guidance for staff as to how best to support people; people's personal history; likes and dislikes and hobbies and interests. These records helped to ensure that people received the care that they required in line with their needs, wishes and preferences. During the inspection we saw that care was provided in line with this information. For example, one person's care file highlighted that a person who was unable to communicate liked their window slightly open during warmer weather and we saw that this had been respected. People's care files were reviewed every month by a member of the management team or more frequently if required to ensure that information remained relevant and correct. There was a system in place which required senior management to review these files to ensure consistency and we saw that this was being completed and any concerns noted were acted upon.

Staff told us they found the information within the care files useful and that it helped them understand the person and their needs. They demonstrated a good awareness of the individual support needs of each person living at the home, including those living with dementia. Staff knew how each person preferred to receive care and support for example, those people who needed to be encouraged to drink, the support each person needed with their continence and where people liked to spend their day.

Care and support was planned in partnership with people, their families and healthcare professionals where appropriate. A member of the management team completed assessments of the people before they moved to the home to ensure their needs could be appropriately met. The deputy manager told us that when assessing people, they would also consider any additional equipment that may be required to meet the persons needs appropriately and if needed, this would be arranged before admission. People and their family members told us that they were involved in their or their relatives care. One person said that they weren't involved in their care plan, however confirmed that they were spoken to regularly by the staff about their needs to see if anything had changed. A family member told us, "I have been involved [with care planning]." Another family member said, "I'm supposed to be talking about it this week." Family members also confirmed that they were kept informed of any changes in their loved one's needs both face to face or via telephone or email contact.

Staff were kept up to date on people's changing needs through verbal handover meetings which were held in between the day shifts and they were also provided with daily handover sheets. These meetings and handover sheets provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. On viewing the handover sheets, it was noted that staff were provided with appropriate and up to date information about peoples

care needs. During the inspection agency and bank staff also told us that they felt they were provided with enough information to give appropriate care to people. One of these staff members confirmed that they were shown where people's care plans were when they started and are given a detailed handover each time they work at the home.

The service was responsive to people's changing needs. Records showed that when people's health deteriorated, the service referred people to appropriate health care professionals.

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. We heard people being offered choices throughout the inspection. For example, one person was supported to move to the garden as staff knew they enjoyed being outside and staff were heard asking people what they wished to watch on the television. Within people's care files there was information about people's abilities to make informed choices. For example, within one care file we read, '[Person] is able to choose their own clothes but can get overwhelmed. Staff are to provide a choice of two or three options.'

People had access to a range of activities. The service employed a full-time activities coordinator who told us that the activities were adapted according to the likes and preferences of people on a day to day basis. Activities were provided both in groups and individually and there was a designated activities room available to people. Group activities provided included crafts, flower arranging, planting seeds, music, games, reminiscence and armchair exercises. Throughout the inspection we saw people participating in the activities provided. A volunteer played scrabble with a person, a staff member was seen supporting a person to colour a picture and another staff member was painting a person's nails. One person was seen reading to a group of pre-school children who were visiting the home. These children then went on to sing to people in one of the communal areas. In another communal area we heard a staff member asking people if they would like to watch a film; people were involved in picking the choice of film before it was put on. Staff members were often seen sitting with people, initiating conversations and encouraging them to be involved.

The activities coordinator told us that when people were admitted to the home they would meet with them and their families where appropriate to discuss their interests to help activities to be tailored to their likes and interests. People's care plans highlighted their social interests and past hobbies. Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. On viewing the minutes from the recent 'resident and relatives meeting', we saw that discussions had taken place which involved people in making decisions about future activities.

Links had been developed with the local church, day nursery, volunteer organisations and a local music school. These links had resulted in people having the opportunity to attend weekly 'in house' church services, fortnightly visits from pre-school children who take part in activities with the people living at the home and visits from some pupils from the local music school. Additionally, the activities coordinator told us that there were now 11 volunteers who visited the home over the week. They explained that was a new initiative and the volunteers were encouraged to agree to befriend at least three of the residents, so that they can interact with someone else if the person they were planning to visit did not feel like interacting with them on a particular occasion.

The activities coordinator also arranged seasonal or specific events at the home including picnics and celebrations for important events, such as the upcoming royal wedding which families and friends were invited to attend. People and their families were kept informed of up and coming events and daily activities directly from the staff, posters displayed throughout the home and the resident newsletters.

At the time of the inspection no one living at the home was receiving end of life care. However, the manager and deputy manager were able to provide us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Staff had received training in end of life care. Comments on thank you cards also demonstrated that effective end of life care was provided. These comments included, 'You made the last few months of [relative's] life seem worthwhile' and 'Thank you for allowing us to stay all night before [relative] died. It meant so much to us to be with [relative] right until the very end.'

There was a complaints procedure in place which was clearly displayed in the entrance hall and throughout other areas of the home. People and family members said they knew how to complain about the service but had not had cause to. One formal complaint had been recorded since the previous inspection. The manager and deputy manager were able to demonstrate that they had a clear understanding of the complaints procedure and we found that this had been followed. Clear records of complaints were kept and these showed that any concerns that were brought to their attention were thoroughly investigated and the people involved were updated promptly with the outcome. In addition, a complaints log was kept allowing any themes or trends to be identified which helped ensure that any concerns raised about the service could be learnt from and mitigated.

Is the service well-led?

Our findings

At our last inspection in September 2017 we found there were a lack of systems and processes in the home to assess, monitor and mitigate the risks associated with people's care and ensure the safety of the services provided. We therefore identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that significant improvements had been made which resulted in people receiving safer, more effective, person centred care. A range of processes and procedures had been put in place to help ensure staff followed best practice guidance when providing care and support to people. For example, the service had implemented a 'turnaround' team. This team consisted of the provider's representative, the manager, the deputy manager, the service manager, a social worker and an occupational therapist. This team meet weekly to look at the care practices and paperwork used in the home to help ensure that care was provided effectively, consistently and in line with best practice guidance.

Improvements had been made in the auditing process within the home and we saw robust audits were completed for most areas. These audits included the environment, infection control, food safety, fire safety and care planning and demonstrated that action was taken where concerns were noted in a timely manner. We also saw that where incidents and accidents were logged and these were analysed to see if there were any common themes and if there could be any learning from these events. However, we found that the provider's audits of the delivery of care and support had not identified that people did not have best interest decisions recorded when required or that copies of all relevant legal documentation was in place in relation to who could legally make decisions about people's care and welfare. Additionally medicines were not always stored and managed safely.

Although we found improvements had been made further work was still required in some areas, as highlighted above and time was also needed to ensure that the new practices that had been implemented were embedded to ensure that improvements made were sustained particularly when occupancy of the home increased.

At the time of the inspection there was not a registered manager in place. The previous registered manager had left the service in April 2018. At this inspection there was a manager in place who had taken over the overall running of the service, with support from the provider's representative. The manager had commenced the registration process with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Although there was no registered manager in place, there was still a clear management structure in place. This structure consisted of a service manager, the provider's representative, the manager, the deputy manager, assistant managers and care staff. Each had clear roles and responsibilities which were understood by all staff.

People were happy living at Shearwater and felt the service was well-led and when asked all said that they would recommend the home to others. Comments from people and their family members included, "It seems to be run fairly well" and "It's quite good for the number of people here." A healthcare professional said, "This is one of the better homes, it's very good and really improved."

Staff told us that they felt that the management team were supportive. One staff member said, "The deputy [manager] is lovely and always helpful." Another staff member told us, "The new manager seems very approachable and we can go to the assistant managers or deputy if we have a problem, it's not an issue as they will always listen." Staff also told us that they felt that there had been an improvement in the service since the last inspection. Their comments included, "There has been a lot of stress and changes but things are getting better", "Although there have been a lot of changes it is positive", "There is enough staff now and we have lots more time to spend with people" and "There have definitely been improvements."

Although staff felt supported some commented on the new arrangements that had been put in place which had resulted in putting the assistant managers in one office and not directly on the floors of the home that they were assigned to. One staff member said, "Care staff need back up; when the assistant managers were on the floor they used to help with care and be available when staff needed them. Now they are only here when they are doing medicines, staff have to ring them and try to find them now." Another staff member said, "It worked better when there were assistant managers on the floor as you could find them straight away if you had an issue, now we can't find them." A third staff member also commented on this new arrangement and said, "I'm hoping that the assistant managers come back on the floors as it was easier to talk to them straight away if we had any concerns." Two family members echoed this issue. Additionally, during the first day of the inspection we saw a visiting healthcare professional waiting for care staff to find a member of the management team before they could provide health support to a person. Another healthcare professional told us, "I have often called Shearwater to enquire about a resident's progress and been asked to call back at a later time in the day as there has been no one available to speak to me." This was discussed with the management team who told us they were reviewing this arrangement.

Staff told us they received regular staff meetings which kept staff updated on the running of the service and enabled them to share ideas they had to help improve the quality of the care and support being provided. These meetings also provided the management team with the opportunity to reinforce the values of the organisation and their application in practice. The management team told us that since the last inspection they were actively encouraging staff to be more involved in the running and development of the service. A staff member confirmed that any ideas they had were listened to and respected by the management team. Staff were also provided with a monthly staff newsletter. On viewing a copy of this newsletter we saw that it provided staff with information about staffing, reinforced the safeguarding responsibilities of the staff and the philosophy of Shearwater and provided staff with information in relation to end of life care and caring for people with specific faiths.

The provider's representative was fully engaged in running the service and played a key role in implementing changes to improve the service. They told us that since the last inspection a governance structure had been implemented to help monitor the quality of the service and care provided. This includes an audit timetable being produced which has helped to ensure that audits are completed regularly and the implementation of new accident and incidents forms. These incident and accidents forms are reviewed by the management team, an action plan developed and actions implemented when themes and trends were identified. This helped to ensure that risks to people were mitigated. These action plans were reviewed monthly by the provider's representative to help ensure that appropriate actions were being taken as required. Quality monitoring visits by the provider's representative were conducted regularly and clear records of these visits were kept. The provider's representative was able to demonstrate that actions were

taken when required.

The provider engaged people in the running of the service and invited feedback through residents' and relative meetings and the use of questionnaires which were sent to people, their families and staff. The last questionnaire was completed in February 2018 and 24 people living at the home had responded to this. We found that feedback was positive and any individual issues were addressed. People and their families had access to a 'Shearwater' newsletter which provided them about changes in staff, upcoming events, plans for the service as well as information about the managers 'open door policy' and how to complain. People and their families felt able to approach the manager and staff at any time and were confident that actions would be taken when required. In the foyer, we saw a board entitled: "You said, we did." This was used to publish comments from people, together with action staff had taken in response. For example, following feedback from family members and the people living at the home, computer tablets had been purchased to allow people maintain their relationships with their loved ones.

There was an open and transparent culture within the home and people and families confirmed they felt able to approach the manager at any time. Duty of candour requirements were being followed; these required staff to act in an open and transparent way when accidents occurred. The manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed prominently in the home.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider failed to ensure that best interest decisions were made in accordance with the Mental Capacity Act 2005.</p>