Nellsar Limited

Hengist Field Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on the 9 and 15 May 2017 it was unannounced.

Hengist Field Care Centre is a purpose built service in a rural location with 75 single occupancy rooms, all with en-suite facilities, over a 2 storey building, with a large central courtyard area for people to enjoy. The service provides nursing and personal care, accommodation and support for up to 75 people. There were 67 people at the service at the time of the inspection. People had a variety of complex needs including dementia, mental and physical health needs and mobility difficulties.

There was an acting manager at the service who was waiting to be registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The management of the service had recently changed. The previous registered manager had left and a new acting manager had been recruited two months later. In the interim a new quality and development manager was in charge of the day to day running of the service. The new acting manager had started the day before our inspection. The management structure of the service was that the acting manager was overseen and supervised by the quality and development manager. There were two units in the service and each had a unit manager. The staff team included nurses, care workers, wellbeing staff, activities co-ordinators, administrators, receptionist, a chef, kitchen assistants and housekeeping staff.

People and relatives told us that there were not enough staff deployed at key times. We found some call bells were not answered quickly enough.

We received mixed feedback about the quality of food served. Some people were not supported to eat and drink sufficient amounts. We reviewed people's fluid charts and saw that these had not been completed or people had not been supported to drink enough.

Some people's health needs were not evidenced as being met. We viewed turning charts, food charts, and topical cream charts and found that people's care needs were not being recorded as being delivered.

Activities did not always reflect people's interests and hobbies and some people who were being cared for in their rooms were in danger of social isolation. Some people had received very few structured activities.

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

The registered provider had not fulfilled their responsibility to comply with the CQC registration requirements. They had not notified us of events that had occurred within the service so that we could have

an awareness and oversight of these.

Risks to people were assessed and potential harm was reduced. However for people at risk of choking we found that some improvements could be made. We have made a recommendation about this in our report.

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

Privacy and dignity were not consistently upheld. We saw some people partially exposed in their bedrooms as we walked past their rooms. We have made a recommendation about this in our report.

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

Staff were trained with the right skills and knowledge to provide people with the care and assistance they needed. When staff were recruited they were subject to checks to ensure they were safe to work in the care sector.

We observed some positive interactions between people and their staff and people told us that they liked their staff. People's independence was being encouraged where possible.

People could decorate their rooms to their own tastes and visitors were encouraged and welcomed to the service. There were systems in place to monitor and respond effectively to complaints. And complaint were being used as a tool to improve services.

Quality monitoring systems were in place but were not always being implemented effectively. Some of the shortfalls we highlighted in our inspection had not been identified during audits.

The culture of the service was undergoing a change following a change in the management team. The new management team were providing effective leadership and had a plan to make improvements in the service.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff deployed at key times to answer call bells in a reasonable time.

Risks were being managed safely and potential hazards were minimised where possible.

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

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive sufficient food and drink to meet their needs Some people who required support to eat were not helped and some fluid charts were not completed fully.

People were at risk of not having their assessed healthcare needs met as recording of care was not consistent. For example, turning charts and topical cream charts were not completed.

Staff had access to training to ensure that they were skilled to meet people's needs.

Consent was being sought and the principles of the MCA complied with.

Is the service caring?

Good

The service was not consistently caring.

Care plans contained personal details and information but people's privacy was not always upheld.

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

People were supported to make decisions and staff respected people's choices.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Activities were not person centred and did not reflect people's life histories, interests or hobbies. People cared for in bed were at risk of social isolation.

People were able to personalise their rooms and visitors

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered provider had not notified CQC of all significant events.

Quality auditing systems were in place but had not identified shortfalls highlighted at our inspection.

The culture of the service was undergoing change following recent changes in the management team.

The management team had a plan to make improvements to the service and were starting to implement that plan.

Hengist Field Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 15 May 2017 and was unannounced. The inspection team consisted of three inspectors and two experts 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority quality monitoring and safeguarding teams to gather their feedback.

As part of the inspection we spoke with the quality and development manager, the acting manager, maintenance staff, the cook and kitchen staff, two activities co-ordinators, one staff from the wellbeing team, four registered nurses, six care staff, nine people using the service and 13 visitors including people's relatives. As some people who live at Hengist Field Care Centre were not able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. 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 looked at a range of records about people's care and how the service was managed. We looked at eight people's care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected Hengist Field Care Centre in February 2015 when we had no concerns.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person told us, "They [staff] look after us here. I had a fall at home and now I'm looked after here". Comments received by relatives included, "[The service] telephoned me when my mother had an altercation with another resident who knocked her over. We are quite happy with the way this was dealt with" and "My mother doesn't sleep very well and wanders at night but the staff keep an eye on her and let her doze in a chair in the lounge." Despite these positive comments we found some areas of practice that were not consistently safe.

Some people and relatives told us that sufficient numbers of staff were not consistently deployed to meet people's needs. We saw that one person, who was assessed as requiring support to move, had got out of bed on their own to open their door. We asked them why they didn't use their call bell and they responded, "They [staff] take too long to come in." Another person who uses a call bell told us, "I have to hold my wee ages; they are all so busy that sometimes I wet myself. They need more staff." We saw one person in their bedroom at 11.45am who was in their nightdress. We asked the person if they had a morning routine for breakfast, washing and dressing were told, "Just when they get round to me really, there is a lot of us in here". We checked call bell records from a random sample over three days to check the response times. We found that whilst some calls were answered in less than four minutes, many calls were not answered within an acceptable time frame. One call went unanswered for 30 minutes, another call was unanswered for 25 minutes, one went unanswered for 22 minutes, two calls were unanswered for 20 minutes; nine more calls were unanswered between 10 minutes and 14 minutes and 41 calls took between five and 10 minutes to answer. We spent time observing care in communal areas. We found that in the afternoon people were responded to by attentive staff as they walked past the lounge and were not left alone for long periods of time. We spoke to the management team about staffing levels and were told that a dependency tool was used to determine the number of staff required, but that managers have the authority to put extra staffing in place. The Quality and Development Manager told us, "I did it today: one lady was looking upset so I put in additional one to one for her." However, the registered provider was unable to demonstrate that there were sufficient numbers of staff to ensure that call bells were answered within an acceptable timeframe.

The registered provider did not ensure that there were sufficient staffing levels to answer peoples' call bells in a reasonable time frame. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Individual risk assessments were carried out for people, for example when they may not be able to use their call bell or for falls. Control measures to minimise risks were clear and appropriate. These were implemented by staff, such as ensuring call bells were within people's reach and a 'falls mat' was placed in their room. Each person's file included a completed 'risk assessment checklist' about falls, continence, bed rails, nurse call bells, nutrition, social preferences, well-being, manual handling, and mental capacity. This checklist was updated at each monthly review of people's care plans. However, for people at risk of choking we found improvements could be made. People were assessed by the speech and language therapy team (SALT) where it was deemed there was a risk of choking. SALT guidelines were detailed in people's care

plans but were not contained in the supplementary folders that were used as a day to day recording and monitoring tool. In addition, the handover sheet that was given to staff to alert them to concerns did not consistently have the necessary information. For example, two people's assessments stated they were a "high risk of choking", but the handover sheet did not include this information. The handover sheet did give guidance on how people should be fed, such as, 'Pureed diet, syrup thick fluid and assisted feed' but did not include an explicit reference to the person being at a high risk around food and drink. The service regularly employed a number of agency staff who use the information on the handover sheet to give them the necessary information to keep people safe, by alerting them to potential risks. This means that agency staff may not have access to up to date information about choking risks. Subsequent to our inspection the registered provider informed us that the quality and compliance manager had previously conducted workshops on choking, dysphagia and different diets within group supervisions.

We recommend the registered provider reviews the handover sheet to ensure all information relating to risk is included

The registered provider had ensured that the environment was safe for people. There were up to date safety certificates for gas appliances, electrical installations, portable appliances, lift and hoist maintenance. The acting manager ensured that general risks such as slips, and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date and people had detailed personal evacuation plans to use in the event of a fire. Fire drills were happening and records showed that this included night time drills when staffing levels were lower.

People were protected against the risks of potential abuse. Staff members we spoke with told us they had undertaken adult safeguarding training within the last year. We examined the provider's training records which confirmed this. Staff members were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local adult social services safeguarding team should be made, in line with the provider's policy. There was a safeguarding folder on each floor of the service with documents such as the local authority safeguarding protocol and the provider's policy. We saw evidence of how an ongoing safeguarding incident was being investigated by the service and were shown steps that the new management team had taken to ensure the safety of people.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

People's medicines were managed so that they received them safely. People told us that they received their prescribed medicines when they needed them. One person told us, "I get all my medicines on time like clockwork." The service had a policy for the administration of medicines that was regularly reviewed. We saw nursing staff administering medicines and accurately recording when people had taken these. When nurses found any gaps or mistakes in the medicine charts they logged an incident report that was followed up by the quality and compliance manager. The nurses had their competency last checked regarding medicines administration in November 2016 by the unit manager. Stocks of medicines were counted at each medicine rounds to ensure these were correct. People's medicines were stored appropriately and records of temperature where medicines were stored were monitored. A nurse told us, "We are very organised, and we manage to give the medicines at the right time." There were guidelines in place to tell

staff in which circumstances they should administer medicines prescribed to be given 'as required', and information when these may interact with regular medicines. These guidelines were attached to each medicines administration records and were consulted by staff. They contained sufficient detail to allow staff to identify when the medicines should be given, and the individual ways people may express pain or discomfort when they could not verbalise it. Topical medicines were applied as per the instructions in people's care plans that included body maps. Staff offered the medicine conventionally first before using the covert method when the person refused to take it.

People were receiving a service in an environment that was clean and where risks from infection were being controlled by a robust cleaning schedule and infection control risk assessment. During our inspection we noted that the service was odour free and all surfaces, bathrooms, kitchens, communal areas and people's bedrooms were cleaned to a high standard. We observed several housekeeping staff cleaning people's rooms and good practice was followed in separating soiled linen and clothing and keeping cleaning materials locked away in a trolley. One relative told us, "'X' has bowel accidents and the room is always kept so clean. The home is always so clean and tidy."

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "All the staff seem competent; they seem to know what to do." A relative told us, "Everyone seems very professional and well trained to do their job." Despite these positive comments we found that some areas of practice were not consistently effective.

Some people were not supported to eat and drink sufficient amounts. We reviewed fluid charts which were kept in a supplementary folder in people's rooms. Upon completion they were then filed in the care plan folder. It was evident from our observations that instructions to be actioned from the care plan and the supplementary folder were not being followed. We saw numerous examples of poor recording and in some cases no recording at all. For example: one person's care plan and handover sheet stated "high risk of dehydration" and this was written in red ink on the handover sheet. However, the action next to this comment stated "normal diet, normal fluids". On the first day of our inspection we looked at this person's fluid chart and from 8.00 am to 1.00 pm this person had received 70mls of fluid. Another person had a fluid and food chart as they were being cared for in bed. From 9.20 am until 4.00 pm their fluid intake was 90mls. We looked at their intake on 8/5/17 which totalled 150mls for the day; on 6/5/17 it totalled 450mls. We observed two people who were left with food in front of them without staff support, despite their care plans stating they required help to eat. One of the people's food and fluid chart recorded that they had eaten all of their meal. When we spoke to the person's relative and asked if they could eat independently we were told, "No not really, [X] now needs someone to feed them." We observed one person at 09.15 who was sitting with their breakfast on a table in front of them. The person appeared unable to manage to eat their breakfast or drink their tea. We observed this person again at 10.20, and the meal and drink were still sitting on the table in front of them. We observed eight carers pass by the person's door without entering his room or registering concern. Eventually a senior member of staff went into the room and removed the breakfast, without speaking to the person or offering to get them another breakfast or drink. We checked their care records and saw that this person required assistance to eat. Another person who was assessed as requiring assistance to eat was not being supported at lunch time. Their meal had been in their room for approximately 20 minutes when a carer took the person's lunch away, untouched, saying, "You don't want this do you. Do you want a pudding?" The carer bought a pot of yoghurt to the person without offering any choice or waiting for a reply to their question. We raised these issues with the acting manager who told us that they had recently increased the number of staff available at mealtimes and that they would raise this practice issue immediately with all staff to ensure that all staff members were aware of which people required assistance with mealtimes. Subsequent to our inspection the acting manager sent us confirmation that action had been taken to address this practice.

We received mixed feedback about the quality of food provided at the service. We spoke with the staff and looked at records within the kitchen. The chef had been employed since February 2017 and prior to that had been a senior carer. The chef told us that they knew people's needs well and had received training for food hygiene. Records within the kitchen detailed people that were on specialised diets, diabetic and puree and soft diet. The chef told us they received feedback from residents meetings and had just recently implemented a comments book from 10/2/17. Some people told us that they liked the food; one person

commented, "They make me a jelly for my pudding as I'm watching my weight so I don't have the cake." However, comments from the food comments book were largely critical about running out of food or poor food quality, undercooked and over cooked food. A comment 11/2/17 stated "not enough scrambled egg for soft option, ran out with a few residents still to feed", another comment said "rice in rice pudding was hard and crunchy , not suitable for people on a soft diet" another "tapioca was like wallpaper paste and came cooked in clumps". On the day of our inspection one person told us, "The food used to be much better but lately it's mediocre food dished up." A visitor told us that their relative loved food and was a 'real foodie' but did not like the food at the service. They commented, "My Mum and I come in around food times just to make sure X's eaten, we've started to bring in soup in a flask just in case". There was no subsequent reply, analysis or actions as a result of these comments so we were unsure if these comments helped influence quality of food or any feedback had been acted upon. We raised this issue with the acting manager and were shown an action plan which had focused on peoples dining experiences. The management team showed us evidence of a monthly taster day that was being implemented where people could choose a different variety of one type of food to see if people are happy with products being ordered. The first taster day was scheduled to look at sausages, with other days planned.

The failure to ensure people's nutrition and hydration needs are met is a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had access to a range of healthcare professionals but they were at risk of not having their needs met. We found that people's assessed care needs were not consistently evidenced as being met. For example, positional charts were being operated for those who were cared for in bed to reduce the risk of pressure wounds. We saw directives on supplementary folders for positional changes to be carried out and recorded. However, the recording was inconsistent. We looked at the care records for one person who was bedbound, which stated that they were to have a two or three hourly positional change. We looked at the records for 09/05/17 and there were no entries between 8.00 and 13.00. On 8/5/17 the night record stated on left side at 10.00 pm then right side at 05.00 a.m. On 07/05/17 there was no entry all day and no entry all night. Another person with a positional chart in place was supposed to have a two hourly positional change. Their chart stated entries at 09.20, 10.00 and 11.00, but there was no further record when we checked at 16.30. Another person had a medical condition that required them to receive oral care every four hours. Their records showed that on 06/05/17 they had not received oral care after 15:20; they had not received oral care at all on 07/05/17 and had not received oral care after 11:50 on 08/05/17.

The failure to assess and take action to mitigate the risks to health of people is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
We saw that other care plans accounted for people's health needs. When people had specific medical needs, they had a care plan written about their current health needs that included clear explanations for staff about the medical condition or illness, such as what is atrial fibrillation, hypertension, osteoarthritis or osteoporosis; what to watch out for; and how associated symptoms may affect people in their daily living.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. 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's mental capacity had been assessed in regard to almost each aspect of their care, when they lived with dementia or memory loss. For example, about their ability to use call bells, to decide whether or not having bed rails or a falls mat in their room; to receive help with their personal care and be helped with equipment for moving and transferring. This showed that great attention was paid to people's mental

capacity and their ability to consent.

Staff sought consent from people before they helped them. We observed staff respecting people's refusals, for example to take their medicines or participate in an activity; where this occurred staff used a different approach a short while later, to check whether consent could be obtained. Four people received their medicines covertly and all steps had been taken to assess their relevant mental capacity; a meeting had taken place to decide this least restrictive option was in their best interests. However we noted that in several mental capacity assessments, the outcome of the assessment was not recorded although appropriate steps had been followed to assess the mental capacity. In 'best interest assessments' (a meeting with appropriate parties that followed mental capacity assessments), the decision to be considered was recorded as having already been taken at the top of the document instead of as a conclusion to the meeting.

We recommend that the registered provider reviews the paperwork used to record best interest decisions to ensure that the principles of the MCA are adhered to.

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. Appropriate applications to restrict people's freedom had been submitted to the DoLS office, for people who were unable to come and go out of the premises independently and/or were subject to constant supervision. The least restrictive options had been considered for each individual. When an authorisation had expired, a new application had been lodged with the DoLS office.

People's needs were met by staff who had access to the training they needed. New staff members were supported to complete an induction programme before supporting people on their own. The Care Certificate was being undertaken by all new care staff. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. The registered provider had made standard training available for all staff in areas such as, infection control, health and safety, fire awareness and safeguarding vulnerable adults. In addition to this nursing staff were given additional more specialised training, such as venepuncture or catheterisation training in order to meet the needs of people they were caring for and stay up to date with their learning. People were supported by staff who had supervisions (one to one meeting) with their line manager.

Good

Is the service caring?

Our findings

A person told us, "I like my nurse and I like my carer; they are kind." Another said, "On the whole they are nice people." One relative told us, "[X] is bed ridden but carers work with me to give her the very best we can offer between us all." Another relative commented, "The staff are welcoming and friendly" and a third relative told us, "The staff in the main are great; Mum is happier with the ones she knows, she does get quite upset with the amount of agency staff."

Other staff members addressed people respectfully and with kindness. They appeared to know people well and addressed people by their preferred names. We observed people and staff greet each other warmly using first names: these interactions reflected a mutually respectful relationship that existed between people and their carers. We saw people socialising well in communal areas: referring to each other by first name on several occasions and people appeared to have forged genuine friendships.

People were encouraged, praised and appropriately conversed with during activities; appropriate banter was part of conversations. A person displayed intermittent behaviours that may challenge. Their communication care plan included instructions for staff about how to use simple language, smaller sentences, and good eye contact to avoid the person experiencing frustration and possible distress. Staff used these methods in practice. A care worker told us, "We check on [X] every hour, it is important to be gentle and smiling, without invading her space." Another person experienced a recurrent dream that caused them distress and staff were instructed to wake them gently and with empathy. Their daily logs indicated that staff implemented these instructions. A person who experienced contracture of their limbs was provided with pillows strategically placed to ease their discomfort, as indicated in their mobility care plan.

People's independence was encouraged by staff. In the specialist dementia unit, people had memory boxes by their bedroom doors that included artefacts of their choice. This enabled them to locate their bedroom and provided visitors with topics of conversation about anything that may be particularly significant for the person. Nursing staff took care to explain to people what their medicines were for, before they administered them. One nurse explained to a person, "This one [tablet] is for your blood pressure, afterwards let's test your blood sugar; I see it is a little high, I'll come back shortly with your Insulin, just have a little rest and wait for me I'll be a few minutes."

Staff supported people to make decisions about their care. People's views were reflected in their care plans. For example, one person had a detailed personal care routine but due to illness they were unable to communicate their needs. Staff had ensured that the person's wishes had been included in the care plan, which stated that the person liked to have their hair long and can refuse having it cut for months. The care plan recorded, "'X' used to like to use aftershave and deodorant. Ensure that care staff are using aftershave and deodorant. 'X' used to use talcum powder after personal care and staff are to offer assistance to apply it now."

People's dignity was not consistently upheld. We observed some good practice such as people having their continence needs met quickly and in a discreet manner, as staff helped people use the toilet facilities. Staff

hung a 'care in progress' sign outside people's doors during personal care to protect their privacy. A person told us, "All the staff are very mindful of how I feel." However, we also saw several instances where people were lying in bed with the door open and their bed clothes off and they were partially exposed to passers-by. We discussed this with the management team and it was agreed that a review was required to balance people's choice to have their door open and to be dressed as they wish with their rights to have their dignity and privacy respected.

We recommend that the registered provider reviews practices to ensure that people who wish for their doors to be opened can have their privacy and dignity maintained.

People's wishes regarding resuscitation and end of life care and were prominently recorded in their files. A person who was assessed as approaching the end of their life was provided with half hour checks, repositioning every three hours; checks of their mattress settings to ensure they were correct; and records of their food and fluids intake. People had specific care plans for end of life care and for pain management. Anticipatory drugs were kept to manage any signs of pain if and when they occurred. A nurse was trained in syringe drivers (a portable device that allows medicine to be given over a prolonged period). A care worker told us, "We stay with a resident if we are told the end is near, if there is no family available, so they know they are not alone."

Requires Improvement

Is the service responsive?

Our findings

People did not have access to a programme of activities that was tailored to their individual interests. Care plan and evaluations about how people spent their time did not reflect personal choice and activities did not reflect people's wishes, their previous experiences, hobbies or interests. One activity coordinator told us that they saw their role as, "providing activities and hope and encourage people to join in." Staff had not completed any specialised training in the provision of suitable activities for older people and people living with dementia. The service employed three activity co-ordinators: two of the staff worked for four days per week, and one staff worked two days. Activities staff were employed from 08:00-16:00 but their duties in the morning included helping to get people up and assisting with breakfast and lunch. There was a set activity on each unit in the morning and one in the afternoon. We talked to the activities staff about how they planned their activity programme and they told us that it was mainly "trial and error". The home had information on how people had spent their time prior to admission to the home and with their interests and hobbies. However, there was little evidence that this information was acted upon.

Some people were at risk of social isolation. People being looked after in bed did not have individualised plans to meet their social needs. Some care plans said they had "one to one" but there was no information of what that entailed and no records to show it took place. Care workers who we spoke with had little knowledge of the person's life history and how people preferred to spend their time. Therefore, no provision was being made for people to maintain meaningful interests. Records showed that some of the activities listed by staff included, "Assisted 'X' with breakfast", on another we found four records that stated "I brought 'X' their poll card and asked if she/he wanted to vote , he/she didn't respond", When this activity was refused there was no record of an alternative being offered. We asked staff how often they visited people being cared for in their rooms and we were told, "About two or three times a week." During our inspection, we did not observe any staff visit people being looked after in their rooms. This meant that people being looked after in their rooms could be at risk of social isolation. One person who was cared for in bed had only four activities recorded in a four month period. We spoke to the acting manager about the lack of structured and responsive activities and were told that a new activities manager had been recruited to lead the activities team and direct person centred activities.

The failure to provide personalised responsive care to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Care, treatment and support plans were personalised and people's needs were reviewed regularly and as required. People's needs were assessed before they came into the service to check whether they could be met effectively. The assessment included looking at people's needs in relation to controlling body temperature, working and playing, sleeping, maintaining a safe environment, breathing, mobilising and psychological needs. People's care plans were developed that were person-centred and comprehensively detailed, including people's individual likes, dislikes and preferences about food, routine and communication. Care plans and risk assessments were reviewed monthly or sooner if any events or changes occurred, and updated appropriately. There were care plans about personal care, nutrition, elimination, mobility and communication. A person's nutrition care plan included instructions from a speech and

therapist assessment such as how staff were to ensure a specific diet was provided, how much fluid, which aids to use, which position to encourage while eating. It also included preventative instructions, such as when to refer to a dietician should their appetite reduce and their body mass index reach a certain level. A person's continence care plan indicated the person was at risk of acquiring infections and instructions for staff to ensure adequate hydration; how to 'read' signs of confusion; how to ensure privacy and dignity were maintained; and the need to carry out daily urinalysis (a test to check the appearance, concentration and content of urine). All associated records were appropriately completed.

People were supported by staff who knew them well and understood their needs. Where people had specific areas of need and had made preferences known they had been supported effectively. There was 'at a glance' information in people's files to summarise their needs. This information was personalised, for example, 'Likes to wear cardigan in the lounge; had a fall two years ago and lost confidence; wears glasses; needs to be oriented in time and place; needs bed rails; prefers female carers.' Care and nursing staff told us they were aware of these summaries, and were able to tell us about several people's individual needs and preferences. People had additional care plans that were specific to their needs, such as a care plan for dementia care; for sleep; for recurrent chest infections; skin damage; and for recurrent fungal infections. A care plan on dementia included how the person could be effectively involved in their care, how to communicate with them and interpret any signs of discomfort; stressed their need for quiet places, calm companionship and how to approach them to minimise anxiety. There were individual 'antecedent, behaviour, consequence' (ABC) charts in place for people whose behaviours may challenge. These are direct observation tools that can be used to collect information about triggers and events that are occurring within a person's environment. ABC charts were used to establish how staff could defuse any situation, such as asking a person to go for a walk, or talking with another about a topic that held a special interest for them.

People and their relatives told us that they were able to personalise their room and ask for adaptations or make requests. One relative told us, "The room is nice and overlooks the oast house. The home allowed us to personalise the room and bring our own furniture; 'X's sister cross stitches pictures and they have been put up on the wall." Another relative told us about a landmark birthday where the service had held a party with decorations and a special cake that was made by the chef. Another relative told us, "We visit Nan whenever we like; it's always an open door for visitors." A new resident's relative had mentioned that she would like some pictures put up in her mother's room and a care worker called in to say the handyman will be up shortly to do this. The lady was also a member of the women's institute and several of her friends were resident in the service. The staff said they would assist people to meet up. It was also noted that the person had been knitting which was recorded as one of their hobbies.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service records all complaints in a complaints log and there had been five complaints recorded in 2017. One complaint had been made when night staff had left soiled clothes on a person's bedroom floor. This had been investigated and it was reinforced that all nurses should check the service prior to handing over to the next shift, including a walk around with the next person. The most recent complaint was made around the lack of feedback following a fire bell, the lack of a hot drink available to a person and the delay in answering a call bell. This was also investigated and the complainant was satisfied with the outcome. One relative told us, "My wife has been here five years, we've had a few niggles but they are always dealt with."

Requires Improvement

Is the service well-led?

Our findings

There was a new management team in place consisting of a quality and development manager and an acting manager who had recently applied to be registered with CQC. The new management team had implemented nursing audits for areas such as wound care, incident reports, pressure damage, infection control and medicines. These audits were sent every week by the unit manager and were compiled on a monthly basis. There were also audits for housekeeping, catering and maintenance. Despite these actions the registered provider did not have effective systems in place to monitor the quality of care and support that people received. We saw some good practice such as audits that had led to action being taken to improve the quality of service provided. For example, the quality and development manager told us that they had audited sleeping patterns and outcomes for people who had sleep issues before and after using deep pillow lavender spray. Another person had a wound in their palm as a result of their hand contracting. This was picked up in an audit and the outcome was the wellbeing team soak the person's hand in warm water, massage the person's hand after their personal care and providing people with muscle contractions specialist pillows to lessen any injuries. Despite quality auditing systems being in place some shortfalls that have been highlighted in our inspection had not been identified, such as ensuring sufficient staffing numbers, people's care needs on the units not being checked and audited, fluid charts being incomplete, and an ineffective monitoring of activities provision.

The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service. This is a breach of Regulation 17 of the HSCA Regulations 2014.

The registered provider had not fulfilled their responsibility to comply with the CQC registration requirements. They had not notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Several safeguarding incidents that had been reported to the local authority safeguarding adult's team in the past 12 months had not been notified to CQC. The registered provider has a statutory duty to notify CQC of any safeguarding alerts and this had not happened. This meant that there were incidents that we were not aware of and had only been made aware of subsequent to our site visit. We spoke to the acting manager about this and were told that upon taking up their new role they had identified that some alerts had not been sent as notifications to CQC. We were shown evidence that all safeguarding alerts made since the new management team had been in post had been notified correctly.

The registered provider had not ensured that the Care Quality Commission had been notified of incidents without delay. This is a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We received mixed feedback about the management of the service due to recent changes in the management team. Staff described the quality and development manager, who had ensured the day to day running of the service since the previous registered manager left and the new acting manager started, as, "very approachable" and told us they felt able to voice any concerns with the confidence that they would be heard and valued. One member of staff had requested additional support and felt they were listened to.

However staff told us they looked forward to, "…having a permanent manager so we can get some stability" and, "…a manager who is going to stay and who will give us proper direction on a long term basis." One person commented, "I like all the staff here and really looking forward to them getting a new boss to support them all." Relatives told us, "There seems to be a lack of strong leadership here; we never know who to speak to if we have a problem. We hear there is a new manager which was a long time coming and we hope he or she will introduce herself properly to us." Another relative, speaking about management changes told us, "That really seems to upset the staff, and we've had a hell of a lot of agency lately". The new acting manager told us that they had arranged a meeting with families to introduce themselves formally to relatives and had also moved the manager's office so that it was near the reception and visible for people. The acting manager told us that they will be providing stability to the service working alongside the quality and development manager to drive improvements.

The new management team had a plan to implement improvements to the service. The acting manager told us that they had created an atmosphere where staff were comfortable presenting a problem and were encouraged to think of solutions to problems. For example, two people on the same unit had both requested personal care at 07:00 and previously this was not possible as the night staff were working then and could not support both people. As a solution the acting manager had implemented a change in the rota whereby two staff start their morning shift early to enable both people to be supported. The acting manager described a new handover system that they had put in place where the whole staff team met together. There were three stages to the handover where the housekeeping team attend the first stage, care workers attend the first and second stages and the management and nurses attend all three stages to discuss people's clinical needs in detail. The acting manager informed us that they had started a staff recognition scheme. Staff who celebrated a birthday were given a birthday card and voucher for a massage as thanks for their work. There had been a staff of the month award for each unit. For the first award the managing director of the company presented the certificates and a £50 voucher.

The culture of the service was undergoing change and working towards a positive ethos that is person-centred, open, inclusive and empowering. We were told by the quality and development manager that staff perceived the previous management team as being office based and described a situation where some senior staff had been resistant to change, but were now working with the new management team. The quality and development manager told us, "I've built up a cohesive head of department group so we know what the problem is in each department and there's a greater understanding of each other's issues." The acting manager described a scheme where an emblem is placed on people's doors after they have passed away to indicate the relatives are happy for the room to be cleaned. The acting manager told us, "The housekeeping team had not been a part of the 'group' didn't attend the handovers and did not know who was unwell and whose room needed more attention or privacy." The acting manager told us that they are already noticing more staff members come to the office to talk or discuss an issue.

We recommend that registered provider continues to closely monitor the service to ensure the improved standards of governance are sustained.

The registered provider was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to ensure that the Care Quality Commission had been notified of incidents without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to provide personalised responsive activities and care to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to assess and take action to mitigate the risks to health of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure people's nutrition and hydration needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	governance The registered provider had failed to ensure that quality monitoring was effective in highlighting shortfalls in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure that there were sufficient staffing levels to answer peoples' call bells in a reasonable time frame.