Alliance Care (Dales Homes) Limited

Westbury Court

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Westbury Court is a care home providing personal and nursing care to 50 people aged 65 and over at the time of the inspection. The service can support up to 60 people.

Westbury Court is a purpose-built building, which has three floors. The ground floor accommodates people with residential care needs, whilst the first floor accommodates people living with dementia. The second floor supports people with nursing needs. All floors are accessible by a passenger lift and have a dining room with an adjacent kitchenette, communal lounges, and an assisted bathroom.

People's experience of using this service and what we found
Not all risks to people's safety had been identified and considered. There had been altercations between people on the first floor. Some had resulted in harm yet guidance for staff on how to manage such challenges, was not in place. Staff did not always identify situations which could escalate. This did not ensure people were safeguarded from harm.

People, their relatives and staff consistently told us there were not enough staff to care for people.

We made a recommendation to review the numbers of staff available throughout the day and night, by using observation, as well as the home's dependency tool.

Improvements had been made to the management of people's medicines, but further improvement was needed.

Not all people were given appropriate assistance to eat and drink. Some drinks were left on over-bed tables and went cold. Records to monitor people's food and fluid intake were not fully completed. This did not demonstrate people had enough to eat and drink.

People were encouraged to make decisions but where there was doubt about a person's capacity, mental capacity assessments had not always been completed. There were some restrictions such as low beds and pressure mats, which had not been properly authorised.

Staff were happy with the training they received and said they were a good team. Staff felt supported by each other but not necessarily by management.

People were complimentary about the regular staff who supported them. They said they were "caring", "polite" and "respectful". People and their relatives told us they had built relationships with these staff although agency staff were not always so good.

People's privacy, dignity and independence were generally promoted. Systems such as 'resident' meetings were held to encourage people to give their views about the service they received.

Care was not always person centred. Some people did not look well supported, and records did not demonstrate regular nail and oral care had been given. Staff, particularly at night, were not always familiar with people's needs. Each person had a care plan but key areas such as declining care, pain and dementia care needs, were not clearly described. Senior management told us a new person-centred care plan format was in the process of being introduced.

There was a designated activity team, who provided a programme of social opportunities. People engaged with the activities during the inspection and were complimentary about them. People and their relatives knew how to raise a concern.

There was a clear management structure, with designated roles and responsibilities. However, the auditing processes in place were not effective, as shortfalls in the service were not being identified. This meant at this inspection, the service had been rated requires improvement for the third consecutive time.

There was mixed feedback about people's experiences of the service they received. The home worked in partnership with others such as health care and training providers.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 November 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found not enough improvement had been made and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about inadequate staffing and people's care. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. This was because they had not taken sufficient action to mitigate the risks. Please see the safe and responsive key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westbury Court on our website at www.cqc.org.uk.

Enforcement
At this inspection, we have identified breaches in relation to safe care and treatment, need for consent, person centred care and good governance.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Westbury Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by one inspector, an assistant inspector, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The registered manager was working their notice as they were leaving the service. A new manager had been appointed and was planning to start work before the registered manager left. This would ensure a detailed handover.

Notice of inspection
This first day of this inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we had received and held about the service. This included concerns, and statutory notifications sent to us about events and incidents that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used

this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We asked the registered manager to give us contact details of any health and social care professionals, we could contact to give feedback about the service. We did not receive this information.

During the inspection
We spoke with 13 people who used the service and five relatives about their experience of the care provided. We spoke with nine members of staff. This included two senior managers, the registered manager, deputy manager and clinical lead, senior care workers, care workers and activity staff. We spoke to ancillary staff including, catering, housekeeping and maintenance staff.

We reviewed a range of records. This included people's care records and eleven medicine administration records. We checked policies and records for managing medicines and looked at staff files in relation to recruitment and training. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, accidents and incidents and quality assurance records, which the registered manager sent by email.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our inspection in July 2017 and our last inspection in September 2018, the provider had failed to ensure the safe management of people's medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made to the safe management of medicines. However, shortfalls in assessing and managing risk and the prevention and control of infection were identified. This meant the provider was still in breach of regulation.

Assessing risk, safety monitoring and management

- Not all risks to people's safety had been identified or considered. One member of staff tried to assist a person to eat whilst they were asleep. They repeatedly placed cup of juice and a spoon, loaded with food, to the person's mouth, to try to wake them. This increased their risk of choking. Another person required a 'minced and moist' diet, but they were given food of a consistency which looked like thick mashed potato. The staff member gave large spoonfuls of food, without allowing time between mouthfuls. At the end of the meal, the person experienced a short episode of choking, which they cleared by coughing and staff assistance.
- Another person had a pressure relieving mattress, but this had been disconnected from the power. This meant the mattress had deflated, causing a risk of skin damage if led on.
- Information within people's support plans did not show all risks had been satisfactorily considered or addressed. One person had declined to have their wound dressing changed but there was no guidance about how this should be managed, or the impact this could have.
- The format of people's support plans did not always accurately identify the most up to date level of assessed risk. One record showed a person was at medium risk of developing a pressure ulcer but further in the plan, their risk had increased to high. This did not ensure the person was receiving appropriate support.
- One relative was concerned their family member may fall from their chair. They said they had raised this with staff, so their chair and safety could be assessed. This was not completed, and a pressure mat was placed in front of the person. This alerted staff to the person falling but did not manage the risk. The registered manager told us they would investigate this.
- Some aspects of the environment did not ensure safety. This included, a loose toilet seat, the flooring in the lift and a toilet door that did not open easily.

This was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were systems in place to regularly test or service equipment such as the hoists and passenger lift. The temperature of the hot water was monitored to ensure it was safe to use and there were checks for legionella.

Systems and processes to safeguard people from the risk of abuse

● People's safety was not assured. 10 altercations between people had been reported to the Care Quality Commission since August 2018. This included one person who was pushed over, and others being hit with a walking stick or frame.

● Three relatives raised concern about safety and told us about incidents, where their family members had been assaulted. One relative told us insufficient action had been taken to keep their family member safe. Another relative told us, "Luckily, a member of staff saw what was happening, and came in and dealt with the situation, just in time."

● Staff told us at times, they had been subject to people displaying challenging behaviour. This had included being hit, bitten and scratched. Information within people's support plans did not show how they should minimise or manage such challenging behaviour.

● Staff did not always identify situations, which had the possibility of escalating into an altercation. This included, one person who walked into another person's room and drank their drink, in front of them. They were then in another person's personal space within the dining room.

● Staff documented one person's challenging behaviour within a behavioural chart. However, the information was not reviewed to identify if any changes in support were required. Staff had documented terms such as, "Was aggressive", rather than the actual behaviour shown. This did not give a clear picture to enable accurate monitoring.

● Records showed 77% of the staff team had completed safeguarding training. This meant 33% of staff had not received the training.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they would raise concerns about people's safety. One member of staff told us, "I'd raise concerns with [the] manager, inform family and document it. If need be, I could also go to the regional office or we can phone CQC." Another staff member said, "I'd inform a senior carer or a nurse. There is the number we can call. I should have it on paperwork."

● Whilst some relatives were concerned about safety, people did not raise any concerns. One person said, "I feel safe here, as we all get along, and if I was worried about anyone's attitude, I'd report it." Another person said, "I feel safe, there's very few places that anyone from outside can come in. I haven't had any issues with staff."

Staffing and recruitment

● Concerns about inadequate numbers of staff were consistently raised from people, their relatives and staff. One person told us, "The staff are busy, and when I ask for things, like a drink, I can wait quite a long time. It's very frustrating. They say, 'in a minute', but they don't come back." Other comments included, "There aren't enough staff to look after us", "We get very worried at times. There's not always enough staff to keep people safe" and, "There aren't enough staff, they're too busy." A member of staff told us, "We haven't got enough staff. There isn't always time to care. We don't have quality time with people."

● There were concerns about the night time staffing arrangements. One person told us, "The staff are lacking at night. Nobody comes to check on you, they don't come in unless you call them. I worry a bit about what would happen if I was sick and couldn't call them." Another person said, "We have a lot of agency at night. All I can say is that a lot of them are quite bad and have a poor attitude."

● There was a high level of staff vacancies, particularly at night. Agency staff were used to cover these although staff said they also undertook additional shifts. One member of staff said, "There have been times when we have needed to stay on to do a double shift, as cover can't be found." Another member of staff said, "We are short staffed, at night-time definitely and some days. I get messaged most days if I could come and help."
● During the inspection, the home, particularly in the morning, was busy yet calm. Call bells were generally answered quickly although one was ringing for seven minutes.
● The registered manager and senior managers told us the home used a dependency tool to assess the number of staff required on each shift. The registered manager told us they often staffed above these levels and had introduced a 'twilight shift'. They did not feel staffing was inadequate, although recognised more permanent night staff needed to be recruited.
● Robust recruitment checks were undertaken before a new member of staff was appointed to work at the home.

We recommend the numbers of staff available throughout the day and night are fully reviewed by using observation, as well as the home's dependency tool.

Preventing and controlling infection
At our inspection in September 2018, the kitchen was not clean and there was poor hygiene practice. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made to the cleanliness and practice within the kitchen. However, not all areas of the home were clean. This included less visible areas such as the underneath of a bath seat, the wheels and framework of food trollies, and the floor and bin in a kitchenette.
● In addition to the above, there was debris on the floor seals in the toilets and at the back edge of the seats, of the dining room chairs. Light pull chords in communal toilets were stained brown and some of the chairs in the lounges were stained. The chairs were made of fabrics, which could not be wiped easily.
● Records showed 72% of the staff team had completed training in infection prevention. Infection control audits had been undertaken following outbreaks of diarrhoea and vomiting but not all information had been fully completed. Regular audits to assess the prevention and control of infection had not been undertaken.

This was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were responsive when more immediate cleaning was required. When one person spilt their drink, they cleaned the area straight away. Staff told us there were housekeeping vacancies, which had impacted on their work. They said they worked well as a team, so got their day to day work done. However, they were not able to complete more thorough cleaning of people's rooms, as often as they wanted to.
● Staff had access to protective clothing. They washed their hands and wore blue disposable aprons when handling food. People were not however, offered any hand hygiene before they had their meal.
● The laundry room was clean and ordered. Dirty linen was brought through to the side of the room with the washing machines. Clean linen was taken out the other side so there was no cross contamination. Red bags were used for soiled linen, so these could be placed into the washing machine without being handled.
● People and their relatives told us they were satisfied with the standard of cleanliness. Specific comments were, "It's very good cleaning, every day", "Cleanliness is good" and, "The cleaning is pretty good, they're short of staff in the cleaning side but I get regular clean towels, and my bed gets changed weekly."

At the last inspection in September 2018, medicines were not safely managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements to the safety of medicines had been made but further improvement was required.

Using medicines safely

● There had been one error, where staff had not given a person their medicines as prescribed. Their relative told us, "[Family member] has epilepsy medications and missed three doses, then had a seizure. It's being investigated how the mistake happened, and the time of day has been changed." A relative told us, "[Family member] has cream applied to their legs, and this tends to get missed quite often. I think it's probably due to lack of staff."

● The recording of medicines which required extra security had improved. However, daily stock checks were not always done, as directed by the provider's medicines policy. The balance on the day of inspection was correct.

● Temperatures were being recorded daily, to ensure medicines were stored at appropriate temperatures. However, there were gaps in the recording related to one refrigerator, and some temperatures were outside the recommended range. This had also been identified by a recent external audit.

● Some people had non-medicated creams and emollients. Body maps were available to show staff where they should be applied. However, there were gaps in the recording, which did not show the creams were always being applied as directed.

● Information about medicines, which were prescribed to be taken 'when required' was in place. Not all had enough detail regarding the symptoms staff should be aware of for each person, to help them decide when these medicines should be given.

● Opening dates were now being recorded on medicines, which had a reduced shelf life once opened. This ensured they were discarded within an appropriate time frame.

● A new system had been introduced, where staff checked each other's medication administration records (MARs) to ensure they were correctly filled in. There were no missing signatures on those reviewed, which showed people's medicines had been given as prescribed. Any handwritten additions were double signed by a second member of staff to ensure they were correct.

Learning lessons when things go wrong

● The registered manager told us reflective practice took place. However, insufficient action was taken to minimise altercations between people. Monitoring records which showed such behaviours had not been analysed or acted upon to minimise potential incidents.

● Accidents and incidents were recorded and reviewed monthly by senior management.

● A recent investigation following concerns raised, showed some staff had insufficient knowledge about the use of continence products. In response, continence training was being provided, a continence champion was being introduced and people's continence needs were being assessed.

● Staff told us they wanted to provide the best possible care and for the home to succeed. They said they were open to doing things differently, particularly if this further improved care for people. One member of staff told us, "We like to take on board, where we have failed."

● One member of staff told us about the action taken to minimise the risk of people falling. They said, "If there is a risk of falls, people are put on hourly checks, we use [pressure] mats and they have more checks."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- At the last inspection in September 2018, consent to care was not always sought in line with legislation. At this inspection, improvements had not been made and shortfalls remained.
- Mental capacity assessments had not always been completed when there was doubt about a person's capacity. Some people had restrictions to their liberty, such as pressure mats and bed rails but there was no documentation to show they had been properly authorised. One person had a low bed, to minimise the risk of falls, but they were unable to get up from it without assistance. This restriction had not been considered.
- A relative told us their family member had a medicine, in granule form, that was mixed in with their dessert. The person did not have capacity to consent to this, yet the relative had not been involved in the decision to administer the medicine covertly. One person told us they had bed rails, which made it difficult for them to get out of bed. They told us, "I don't need the rails up, they haven't asked me if I want them taken off."
- People told us they were encouraged to make decisions but their ability to do so, sometimes depended on staff availability. One person told us, "I prefer to have a bath at night and then I can get into bed, but there aren't often enough carers to do that." Another person said, "Now and again, they'll ask if you'd like a bath. It's not as often as I'd like because there are quite a lot of people here."

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed consent was requested for appropriately sharing the person's medical records and for using photographs, for purposes such as marketing.
● During the inspection, people were generally offered choices. For example, staff asked one person if they wanted to wear a clothes protector. They clearly explained its use, and said, "Look, I'll show you, it's an apron, would you like to wear it?" Another member of staff asked a person if they could clean their room.
● People told us they were asked to give consent to health care interventions, such as flu and vitamin injections.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always have the required assistance, and their drinks were left untouched. This included hot drinks, which were placed on overbed tables, out of the person's reach. A person confirmed this and said, "I've noticed that sometimes people who need help might be asleep. The staff leave their drinks for them, but they don't come back. It goes cold and the people go without." A relative also raised concerns about inadequate assistance being given.
● People were not always given appropriate assistance to eat. One person was in a low chair and the table was too high for them to easily eat their meal. Another person consistently walked around. Staff encouraged them to return to their meal in the dining room, but this was unsuccessful. The person therefore ate very little. Staff told us finger foods were available, but the person was not offered these. Snacks in prominent positions, for them or others to pick up whilst walking, were not available.
● Two relatives were concerned, as they did not feel staff had enough time to assist their family members to eat. One relative told us, "At mealtimes, I don't feel they're focused enough on the individual. There isn't enough help with meals. It depends who's on duty, how orderly the meals are." Another relative said, "In the back of my mind, there's a concern that they don't have time to make sure that [family member] is eating and drinking."
● Records, for those people at risk of malnutrition or dehydration, had not been fully completed. The person's recommended daily fluid intake was not stated, and the information was not evaluated at the end of the day. Additional snacks, and alternatives when people had declined food, were not documented. This meant, the records did not always show people were being supported to have enough to eat or drink.
● Guidance for hourly observational checks, stated staff should encourage food and fluid intake whilst a person was awake. Monitoring records showed this guidance was not always followed.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was variable feedback about the food. One person told us, "The food? I'm not going to say anything, it's very variable, and I don't want to get into trouble." Another person said, "The food isn't that good, they seem to make it all very bland. I find breakfast and supper alright, but the lunch is less pleasant. I take it or leave it." Other comments were, "The food is satisfactory, there's enough choice and plenty of tea, coffee, water to drink etc" and "The food is very nice so far." Records showed a new head chef position had been filled and it was expected they would concentrate on the consistency of food quality.
● A member of staff told us the provider set the menus, although they were flexible depending on the food available. They said people were offered alternatives if they did not like what was on the menu. After discussion with the chef, one person decided on soup for their evening meal. Another person told us, "The chef has been brilliant. We discuss what I can have. If what's on the menu isn't suitable, they'll make me an omelette."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Records showed people received support with their healthcare. This included support from GPs, community nurses, speech and language therapists and the care liaison team.
● Emergency support was immediately gained, if a person became very unwell or sustained an injury. One person fell from their bed, during the inspection. Staff called for the registered nurse in a timely manner, to check for any injuries.
● People were not always seen quickly, if they had non-urgent healthcare concerns. One person confirmed this. They said, "I've had this problem with my mouth, which is very sore, so I can't eat. Last time, a paramedic came instead of the doctor, and said he didn't know what it was, as it's not really his field. I'm losing such a lot of weight because I can't eat properly. I'm trying to see a doctor." A relative told us, "We're not happy that [family member] waited three weeks to be seen by a doctor for a [condition]. The registered manager told us they were aware there had been problems with GPs visiting, but this was being resolved. They said they would investigate these concerns.
● People and their relatives gave us further feedback about healthcare. One person told us, "I had an eye test here when I first came, I haven't had one lately. I go to my own dentist with my family." A relative said, "The surgery come in every Tuesday and Friday and if [family member] needs to be seen, they will put them on the list."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they were offered a place at the home. One person said, "I came to look round with my family. We saw the room and told them all about my needs and discussed it all with the manager." Another person said, "I came here originally for respite care and after three weeks, I decided to stay."
● There was an assessment of need within the person's support plan. This showed basic information such as the person's medical history, mobility and communication needs. There were details of people's preferences including the time they wished to get up and go to bed.

Staff support: induction, training, skills and experience
● There were four designated in-house trainers and a regional trainer, to keep staff up to date with their knowledge and skills. During the inspection, training on moving people safely and the MCA took place.
● Records showed staff undertook training deemed mandatory by the provider. This included safeguarding, food hygiene, fire safety and dementia. However, not all staff were up to date with their training.
● Staff were happy with the training they received. One member of staff told us, "We have training once a week. Every Wednesday, we go through modules, based on e-learning. We have class room sessions that are obligatory." One member of staff told us they were planning to complete training on venepuncture, to support the registered nurses.
● There were variable views about the knowledge and skills of staff. One person told us, "The staff do work to a fairly good standard, they try hard anyway. I'm not sure that they're all that well trained. It's a bit by guess, and by God, in my opinion." Another person said, "I'm not sure that all the staff are skilled, some seem to have no common sense, but others are more sensible, on the ball, and when they're on duty, you feel more confident about the way things are done."
● There was a schedule, which showed the one to one meetings staff had with their line manager. These sessions enabled staff to talk about their role and any concerns they might have. One member of staff told us the meetings were effective, although not all were completed regularly, in a timely manner.
● Staff told us they supported each other well. Specific comments were, "We're a good team, we all work together" and "They've all been great with me, I can't fault them. They made me feel really welcome and answered any questions I had." Another member of staff told us whilst the staff team was supportive, they did not always feel valued by management.

Adapting service, design, decoration to meet people's needs

● All communal areas and some people's bedrooms had been redecorated. These looked pleasant and homely. One member of staff confirmed this. They told us, "The home has definitely freshened up. It's made the place all homely, earlier it was more blunt. We decorate rooms for people as they want it." The first-floor corridor however, was bland in colour with worn paintwork. Staff and the registered manager told us the area was soon to be decorated.

● One communal lounge had been redecorated but there been a leak, causing damage to the ceiling. There were buckets full of water and a damp odour in the room. Staff told us the room had been, "out of action for ages". A senior manager said the leak was in the process of being resolved.

● On the first floor, doors leading to key rooms, such as toilets, were painted prominent colours and there were some pictorial signs. This helped people with orientation. However, not everyone had their name on their door and there were memory boxes, which were not used. There were limited terms of reference and different textures, to enhance stimulation. Within the ground floor dining room and lounge, there were two clocks, which showed the incorrect times.

● Each person had a spacious, bright room with en-suite shower facilities. All furniture and furnishings were of a good quality and people could personalise the space. There was enough room for any equipment, such as a hoist.

● People told us they liked their room and confirmed they were able to personalise it according to their preferences. One person said, "I like my room, I've got a lovely bay window. You can have whatever you want in your room, and it feels quite private." Another person told us, "They decorated the room for me before I came here, that wallpaper wasn't there when I came to look round. It's a big enough room, and I'm going to have [a television provider] and my telephone put in, they don't mind. I want some photographs put up. They've said the maintenance man will do it for me."

● The entrance area of the home was welcoming, with tea and coffee making facilities. The registered manager told us relatives could help themselves to what they wanted, during their visit. There were various information leaflets, about the home and organisation for reference if needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Whilst most people and their relatives told us they had positive relationships with the 'regular' staff, not all feedback was positive. One person told us, "Some of the staff are great, but some are not as caring as they could be. It's especially lacking at night. Staff don't explain enough what's happening, or what they're doing. They don't speak the way I would. They wouldn't notice if I was feeling down." Another person said, "There aren't as many caring staff as there used to be. One lady from the agency the other night was lovely, she came in and said, 'good evening, my name is … and I've come to look after you tonight'. That's how it should be. The really regular staff are good to me, they're all polite and respectful."
- Other people were more complimentary about the staff. Specific comments were, "They're respectful and call me by my first name, which is what I prefer," and "The staff are caring, they've been understanding about what it's like to leave your home and come here." A relative told us, "The staff are fantastic, they're always willing to listen and are helpful and are polite and respectful to [family member.]"
- There were some good interactions between staff and people who used the service. For example, staff consistently informed a person what was happening as they were being moved in the hoist. Another staff member talked to a person about their rings, as they walked through the dining room together. Other interactions were not so good. Staff often asked people if they were alright but did not always wait for the answer. On the first day of the inspection, some people were given drinks without a choice of what they wanted. One person had to ask for sugar, when they tasted their drink.
- Staff were polite and friendly when talking to people. One member of staff regularly said, "You're welcome", after supporting a person. There were however, some terms of endearment. This included staff referring to people as "mate" and "sweet", and impersonal terminology such as, "I'll do [person's name] quickly."
- Staff told us they enjoyed their job and particularly liked the people they supported. One member of staff said, "I just love it here. The people are great. I just like helping people." Another staff member told us, "I've been here a while. It's the people that make it. I really enjoy what I do, I couldn't think of doing anything else."
- Records showed 84% of the staff team had received equality and diversity training. New roles had been introduced to ensure the provider's values were fully embedded in the home.

Supporting people to express their views and be involved in making decisions about their care

- People were able to give their views through surveys and there were 'resident' and 'relatives' meetings. Records of the last but one 'resident' meeting showed most discussions were about food. The registered manager told us further discussions were being held to address people's preferences.

● People gave us variable views about their involvement in their care plan and its review. One person told us, "We used to always go through my folder, but I had somebody who was my named carer, and now I don't." Another person said, "I haven't seen my care plan. We talked about my needs before I came here and I'm sure it got recorded somewhere, but I haven't had a review with anyone." A relative told us, "I have seen [family member's] care plan. I've checked it and there's also a copy in the bedroom. I'm happy that it reflects my [family member's] needs."
● People and their relatives were being encouraged to give their views about the planned redecoration of the first-floor corridor. Samples of paint and wallpaper had been placed on the wall, so people could select their favourite.
● People were able to eat with their relatives within the home or go out freely. One person told us, "I often go out with my family, there's no restrictions. You just tell them as you go, and you sign out". A relative told us, "You can come in at any time, there's no restrictions. The staff are pleasant and usually I'm offered a drink."

Respecting and promoting people's privacy, dignity and independence
● People's rights were generally promoted. However, metal trollies were used to serve drinks to people and transport crockery. The trollies were very loud when being pushed, particularly on hard flooring within the dining room and over ridges. The noise was very intrusive and did not show empathy for people's needs or privacy.
● People were generally supported in private and staff knocked on doors before entering. However, one person's continence aid was visible, as they were trying to get out of bed. Staff supported the person once it was brought to their attention.
● Staff were knowledgeable when talking about people's rights to privacy and dignity. This included keeping curtains drawn and making sure people were covered when receiving personal care. Ancillary staff told us they always worked around people and did not intrude on their privacy. One staff member said, "If a person isn't very well, we'll pop back later, or we do what is absolutely necessary. If they don't want their room cleaned, that's fine. We'll do it another day."
● People were positive when talking about their rights to privacy, dignity and respect. Specific comments were, "You can be completely private and do your own thing. The staff won't bother you if your door is shut. You're left to your own devices" and "The staff are very good about privacy when they're helping you with a shower or bath. Usually it's the same person, and they make sure the door is closed so you'll be private."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care was not always person centred. For example, on the second day of the inspection at 08.00, staff were walking around the home, waking people. They knocked on the person's door, drew their curtains, asked if they were alright and if they needed a drink. The member of staff then left the room and repeated the same routine with the next person. This did not consider people's personal needs and preferences.
● Not all staff were fully aware of people's needs and choices. One person told us, "Two [night] staff came in at 5 or 6am in the morning and started taking off my bedclothes. They said, 'We've come to change your pad'. I told them I don't wear a pad, so they said 'Well, you must be wet then' and I said, no because I use the commode. One of them said, 'Well you must be a genius then.'" This was totally disrespectful and showed the staff were clearly not aware of the person's needs. Another person told us, "The night staff came in to 'pull me' out at 6am. They'd probably got the wrong room number, as the lady next door is 'done' early."
● During the inspection, one member of staff assisted a person to eat by placing a fork, filled with food, to their mouth. The person turned their face away and they held their hand over their mouth. The staff member carried on and was insistent, until another staff member suggested the person might be able to eat independently, if given support to hold the fork. They did this, and the person ate well.
● Most people looked well supported but some had brown debris under their nails and unclean hair. One relative confirmed this. They told us, "[Family member] often has very dirty fingernails, I don't know what he does, but they are very soiled, and I often have to clean them when I come in." Records showed some people had not always received regular oral care. One relative told us, "[family member's] teeth are in a terrible state. We went to the dentist before coming here and they were prescribed some special toothpaste because of decay. I'm not sure if the staff try to clean [family member's] teeth, but the toothpaste is still there six months later."
● Each person had a care plan, but the information was limited in detail and not person centred. There was little information about how the person wished to live their life, or their earlier years. There was no guidance to help staff support people with resistance to care, sundowning, pain, vision loss or the management of behaviour that challenged. Sundowning is a symptom of Alzheimer's disease and other forms of dementia, whereby confusion and agitation may get worse in the late afternoon or evening. Whilst the care plans had been regularly reviewed, any amendments to people's support had not been made. This included any further action needed to address weight loss. A senior manager told us they had recognised improvements needed to be made to people's support plans A new person-centred format was in the process of being introduced.
● Daily records were task orientated. Staff had written for example, "[Person] in bed at the start of shift. Personal care and repositions where required. No concerns" and "Regular pad changes during the night.

Checked regularly. Appeared to have slept well." Staff had not always documented how they had managed specific incidents such as anxiety. One record stated, "[Person] has been setting her pressure mat off most of the night, trying to get out of bed." There was no information about why this was or what staff had done to support the person.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives were generally happy with the service they received. Specific comments were, "I'm happy here, the girls are good, I'm quite settled" and "It's very nice, I'm happy here. They do alright and they're hardworking, doing their best." One person told us, "I like it here, they try hard. Overall, it's a pretty good place. It just needs some tweaks, and more staff."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff told us they were familiar with people's communication needs. One member of staff told us, "We have non-verbal people. We talk to them and assist and watch facial features. If they can write, they write, and we have white boards for them." Staff supported one person in this way during the inspection. Another member of staff said, "We have cards with questions for her, seems to really work for her."
● The registered manager told us information could be provided in different formats. However, on the first floor, the menus were written in small text with some complicated names of the meal choices. There were no pictorial formats and people were not shown the meals to help them make informed choices of what to eat. The registered manager told us pictorial formats of food were available, so they were not sure why they had not been used.
● One member of staff had an interpreter to enable them to communicate well with others and to gain information about their role and responsibilities. They said the registered manager often used text messaging to aid communication.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Focus was given to people's social needs and there was a formalised activity programme that was devised by the provider. Two designated activity organisers were employed and a third was in the process of being recruited. The activity programme was displayed on notice boards and copies were given to people in their rooms.
● National and international days were celebrated and there were activities such as baking and singing. Staff told us people were regularly supported to go out. They told us, "Activities are brilliant. I've been going out with people. We took one gentleman to the Armed Forces Day, as a special day out. Once a month there is a minibus we can use. There are coffee mornings and we take people to local gardening centres."
● During the inspection, a staff member spent one to one time with people, suggesting and supporting individual activities, such as knitting, reading magazines, or discussing cooking. Staff also initiated a game of skittles with several people in the lounge. One person who was partially sighted, was given instructions to help them to successfully aim the ball. People were engaged in the activity and seemed to enjoy participating.
● People and their relatives were positive about the social activities undertaken. Specific comments were, "I take part in everything", "I like knitting, there's a 'knit and natter' group and it keeps me busy" and "I had my

nails done yesterday. Sometimes the children come in, I love to see them." They went on to tell us, "[Activity co-ordinator's names] are wonderful, I don't know what we'd do without them, they make this place." A relative told us, "They had an afternoon tea party with a forties theme and it was very good."

● Some people used electronic devices to minimise social isolation. One person said, "I use my iPad to contact family and FaceTime them in New Zealand." Another person told us, "I love the PAT [Pet assisted Therapy dog]. The Activities lady took my photograph with the dog and helped me send it to my daughter with my iPad."

Improving care quality in response to complaints or concerns

● Prior to the inspection, serious concerns had been made about the care of people using the service. This included people being in soiled clothing, continence aids not being regularly changed and inadequate staffing. The concerns were appropriately investigated, through observation, talking to staff and reviewing records.

● People and their relatives knew how to make a complaint although some said they did not like to complain. Of those who had raised a concern, most felt they had been listened to and said action had been taken to resolve the issues.

● People told us they would inform staff, the registered manager or their family if they were not happy about the service. One person said, "I'd tell [activity coordinator's]. They're wonderful and I'd confide in them." Other comments were "If there are problems, they do try to put things right", "They listen if you've got a query" and "We had a long talk about it. I think [the registered manager's] doing something about it." Another person said, "[Manager's name] is approachable and listens if there's a problem. I've only taken small issues to her, but she's done her best to sort them out, she's very good."

● One member of staff and a relative told us they felt concerns were, "brushed under the carpet" and not properly addressed. They said concerns or complaints were often taken from the registered manager and dealt with by senior management, and correspondence was then poor. The registered manager confirmed all concerns were properly addressed although information could not always be shared, due to confidentiality.

● Additional team meetings and meetings with the human resources team had been arranged. This gave staff the opportunity to raise any concerns they might have about poor practice.

End of life care and support

● People were able to receive end of life care at the home, if their needs could be met safely and effectively, At the time of the inspection, no one was receiving this type of care.

● Whilst there was a section within people's support plans about end of life care, the records were not consistently completed. This lack of information did not inform staff of the person's wishes, if their health deteriorated.

● Staff told us they ensured people had a comfortable, pain free death. One member of staff told us, "We always make sure people are comfortable, with regular checks, repositioning and mouth care. We always look after the family as well and see if they need anything." Another staff member said, "Keeping them comfortable, moisturise their mouth." One member of staff said, "We had a lady die recently and you could feel it. It was felt throughout the home."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection in September 2018, the provider had failed to ensure adequate record keeping and action plans were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Leadership and quality assurance systems were not effective as shortfalls in the service were not being identified. Some staff told us they knew the home was not performing well, but staff shortages contributed to this. One member of staff said, "I know we're behind with things, but we try and work really hard. Everyone works flat out but we're pulled in all directions. It's hard."
- The systems in place did not ensure people were safeguarded from harm. The management of behaviour was ineffective and did not minimise the risk of escalation or altercations between people.
- Systems did not ensure everyone had enough to eat or drink and decision making was not undertaken in line with the MCA.
- Risk and care planning were not well managed, and people were being supported by some staff who did not know their basic care needs. These shortfalls had not been identified and no clear action plans were in place.

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

- There was a clear management structure. This included a deputy manager and clinical lead, registered nurses and advanced nurse care practitioners. In addition, the registered manager was supported by senior management including two regional support managers and the regional manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was mixed feedback about people's overall experiences of the home and the care they received. One person said, "Would I recommend it? That's a difficult one." Another person said, "I would recommend

it to other people, it's generally pretty good". A relative told us, "[Family member] is settled here now, but it might not be right for everyone."

● The registered manager told us they promoted a strong culture that was based on the provider's key values. They said they ensured staff had the skills to do their job and said they would not expect them to do anything beyond their limitations.

● There were variable views about the management of the home. Some staff were complimentary with comments such as, "[The registered manager] definitely encourages me. They got me on an NVQ [National Vocational Qualification]. They encourage my confidence and have picked me up when needed. I'd go to [the registered manager] and speak to her and ask for guidance. She's very approachable." Another member of staff told us, "We don't see [the registered manager] enough. She's more office based and doesn't have a presence in the home."

● People were complimentary about the registered manager and their management style. One person told us, "The manager was very good when we came to look round, the way she spoke to us and listened to us, she was very welcoming and informative." Another person said, "I had a long chat with the manager last week and told her about all the things that had happened. She does listen, and I think she's doing something about it.

● The registered manager maintained a record of all compliments received about the service. This included, 'You will never know how much we appreciate the care and love you have given [family member], over the years, much love to you all.'

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Prior to the inspection, a relative had made a formal complaint about the care of their family member, and a lack ongoing discussion about their needs. The relative told us they did not believe management showed empathy and an apology was not given. A senior manager told us they did not agree with this view.

● Another relative told us they did not have an appropriate, timely response to their concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People told us about the meetings, where they could give their views. One person said, "We have resident's meetings where you can complain about things you don't like, I raised some things about the menu. I think they listen, but it doesn't always change as they don't alter the supplier for example." A relative told us, "I attended a resident/ family meeting where you could raise any issues. It was quite well run, and I said that the cutlery isn't always clean or polished looking. For a while it got better, but it's deteriorating again."

● People told us they were generally informed about the meetings in advance, so they could attend. One person said, "The activities staff do come and see me in my room and make sure I know about things like the residents meeting, and then I can have my say." Another person said, "There's one coming up soon, they're pretty good. We're asked what we'd like, things do change." Another person said, "They come to ask me if I want to add anything to the agenda and give me feedback on what was said."

Continuous learning and improving care

● The registered manager told us they used their previous experience and liaised with the staff team, to improve people's quality of life.

● Staff told us team building exercises had been introduced to enhance team work and develop morale. They said the sessions had worked well.

● Staff told us there had recently been improvements to documentation, including care records that were kept in people's rooms.

Working in partnership with others

● Links with the community had been established. Staff told us schools and a local childminder's group, together with their young children, regularly visited the home. They said there was also a summer garden party and a knitting group, where members made items for charity.

● The registered manager told us they had developed links with other services such as health and social care providers and training providers.

● The registered manager told us information was shared between other services within the organisation. This enabled support to be gained, and a consistent approach to be followed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care planning was not always effective, and information did not reflect people's individual needs. Some people did not look well supported and assistance with nail and oral care was not always given. Care was not given in a person-centred way. Regulation 9 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Decision making was not undertaken in line with the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Leadership and quality auditing were not effective as shortfalls in the service were not being identified or addressed. Regulation 17 (1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected from harm and risks were not being appropriately identified or addressed. Less visible areas of the home were not clean. Regulation 12 (1)(2)(a)(b)

The enforcement action we took:

We issued a warning notice to ensure the provider made improvements.