Barchester Healthcare Homes Limited

Cherry Trees

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

A comprehensive inspection visit took place on 19 September 2018 which was unannounced. We returned announced on 21 September 2018 so we could review the provider's quality assurance systems and to speak with more staff about what it was like to care for people living at Cherry Trees.

Cherry Trees is a nursing home, which provides care for up to 81 people in three units, located across two floors. At the time of our inspection there were 68 people living at Cherry Trees. The nursing unit was on the ground floor called 'Young at Heart' and residential and respite care was provided on the first floor in 'Cherry Blossom.' People living with dementia were also supported on the first floor referred to as 'Memory Lane'. People had their own bedroom and all the bedrooms had en-suite facilities, plus people had the use of shared communal lounges, a dining room and bathrooms.

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

A requirement of the service's registration is that they have a registered manager. 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 and the associated Regulations about how the service is run. At the time of our inspection visit there was a registered manager in post.

At our last comprehensive inspection in September 2017, we rated the service 'Requires Improvement' overall. We found the provider was in breach of two regulations of the Health and Social Care Act 2008 because insufficient staffing levels had a negative impact in how people received person centred care.

At this inspection we found improvements had been made and the overall rating had changed to 'Good'. The provider had increased staffing levels at the home and people's care and support needs were met, but better deployment of staff was needed at times, especially when shifts remained below the provider's own assessed levels of staffing. We found the provider was no longer in breach of the regulations. However, the challenges of the environment meant some relatives shared continued concerns that staff were not always visible and 'on hand' to offer assistance to their family member when needed. The registered manager said they would consider how they communicated with relatives to assure them there were sufficient numbers of staff on duty to meet needs.

Staff protected people from risks of abuse. All staff understood what actions they needed to take if they had any concerns for people's wellbeing or safety. Staff felt confident to raise concerns with the senior staff, the registered manager and provider.

Staff received refresher training to continue to keep their skills, knowledge and practice updated. People's

care and support was provided by a caring and more consistent staff team, because the provider's reliance on agency staff had reduced since the last inspection. Staff said reducing agency staff had improved communication and improved care delivery.

Staff worked within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff recognised the importance of seeking people's permission before care was provided. Where people's liberties were restricted, necessary approvals had been requested.

Staff were caring in their approach and interactions with people. The investment in keeping the environment safe and risk free showed the provider had considered how their actions impacted on those in their care.

The provider's research and evaluation into their own dementia programme was to enhance the wellbeing of people living with dementia, especially those people living in 'Memory Lane'. The provider's research showed how this had improved people's care across all their homes, such as reducing the number of falls, limiting the use of certain medicines and improving people's wellbeing. This programme had been rolled out to all of their homes and the provider was in the process of accrediting each home over the next two years. Cherry Trees was not yet accredited. On Memory Lane, corridors were themed in colour and interests to help stimulate memories and conversations. However, staff's knowledge needed to be embedded in day to day practice to best utilise the benefits of the provider's dementia programme which looked at key themes and approaches.

There was stimulation for people to be involved in leisure interests to keep them active and to have fulfilling lives. People and staff were working together to help promote social and lifestyle skills.

Staff supported people to ensure they maintained a balanced diet and people had choice of what they wanted to eat and drink, with available drinks and snacks throughout the day for people to enjoy as they wished.

Staff knew people well and care plans suited the care and treatment people required. Nurse and care staff had good knowledge of the people they supported. A regular review of care plans was completed, but this needed to be improved. Some care plan information and risk assessment information did not reflect the person's current situation and some plans would benefit from additional information to ensure consistent care continued.

People received support from other healthcare professionals to ensure their overall mental health and physical wellbeing was met. Regular checks and monitoring ensured medicines were given safely by trained and competent staff. Time critical and patch medicines were given safely in line with their prescription. Some inconsistencies were found in PRN (as and when medicines) protocols although we were satisfied staff knew when to offer these medicines safely.

Health and safety checks through daily walk around ensured the home remained suitable and safe for use. Examples of audits and checks were completed but further improvements to audits and checks when delegated to others, needed improving. Some checks had been completed with limited understanding of what was correct and there remained limited records to show what actions had been taken. The registered manager told us they and their team hard worked hard to drive improvements following the last inspection. The staff team wanted people's experiences to be positive and what they deserved. The registered manager gave us a commitment that actions would be taken following our visit to continually improve the service and outcomes for people and their families.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

At the last inspection we found medicines were not managed safely and given in line with the prescriber's instructions. At this inspection, we found medicines were given safely by trained staff and in accordance with safe administration. Staff understood their responsibilities to keep people protected from unsafe practice. Staffing levels ensured people were supported by experienced staff, but staff deployment needed to be considered when levels dropped below assessed levels. Some individual risk assessments were not always in place to protect people from unnecessary risks but staff knew how to keep people protected and safe.

Is the service effective?

Good

The service was effective.

Staff received training to continue to keep their skills, knowledge and practice updated. Staff worked within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff recognised the importance of seeking people's permission before care was provided. Where people's liberties were restricted, necessary approvals had been requested. Staff supported people to ensure they maintained a balanced diet and people had choice of what they wanted to eat and drink, with available drinks and snacks throughout the day.

Is the service caring?

Good

The service was caring.

At the last inspection we found staff time pressures meant staff did not always protect people's privacy and dignity and were unable to support people where needed to ensure their overall health and welfare was maintained. At this inspection, staff were kind, considerate and caring in their approach to people. Staff were more attentive to people, especially those who needed more support. Staff told us increases in staff had improved how they provided care to people.

Is the service responsive?

Good

The service was responsive.

At the last inspection, people were not always stimulated and able to pursue their hobbies and interests. At this inspection we found people were more involved in pursuing their interests and staff knew more about what interest's people wanted to be involved in. Care plans were improved, but needed stricter quality reviews to ensure they contained the same levels of information that staff had, to provide consistent care.

Is the service well-led?

Requires Improvement

The service was well led.

At the last inspection we found audit systems were not effective and actions were not always taken to drive improvement. We found governance and quality assurance systems had improved, however where checks were delegated to other staff, there needed to be greater scrutiny that actions were taken to improve the delivery of service. People and staff were complimentary of the registered manager and said improvements had been made in the last 12 months. Most relatives recognised improvements had been made and said the registered manager and staff team were approachable, although actions were not always taken when concerns had been raised.

Cherry Trees

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 comprehensive inspection visit took place on 19 September 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector, a bank inspector, an expert by experience and a specialist advisor. The specialist advisor was a nurse and our expert by experience, had experience of people being supported in this type of care setting. Two inspectors returned announced on 21 September 2018 to review quality assurance systems and to speak with more staff. Immediately following our second inspection visit, we received information of concern from two relatives who shared their experiences with us. We shared this information with the registered manager and gave them time to investigate these concerns so they could respond to us with their detailed findings. The relative's experiences and the registered manager's findings were considered as part of our overall judgements in this report.

We reviewed the information we held about the service. Prior to this inspection visit we received information suggesting staff were not always responsive in meeting people's care needs. We looked at this concern during this inspection. We did not send the provider a Provider Information Return which is a form they use to tell us what they do well, and what improvements they plan to make.

We looked at any information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We looked at the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

To help us understand people's experiences of the service, we spent time during the inspection visit talking with people in the communal areas of the home and their own bedrooms, with their consent. This was to see how people spent their time, how staff involved them in making decisions about their care, how staff provided their care and what they thought about the service they received.

We spoke with eight people who lived at Cherry Trees and four visiting relatives during both inspection visits. Following our visits, we spoke with one relative by telephone. We spoke with a senior regional director, a regional dementia specialist, the registered manager, the deputy manager, five nursing staff, seven care staff and one activities staff member.

We looked at specific care plan information in nine people's care plans and other records including individual risk assessments, quality assurance checks, daily notes for people, medicines and health and safety records.

Good

Is the service safe?

Our findings

At our last inspection in September 2017 we rated Safe as 'Requires Improvement'. This was because although people told us they felt safe living at the home, staffing arrangements meant people received their lunches late, were put at risk when staff were not available to observe and support them, and high agency staff use meant staff did not always know people well enough. This meant the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and we asked them to tell us how they would improve. The provider sent us an action plan telling us how they would ensure people were safe. At this inspection, we checked to see if improvements had been made. We found improvements had been made and the rating has changed to 'Good'.

Since the last inspection, the provider had increased staffing levels. The registered manager and staff told us this had made a difference to how they supported people by giving flexibility to cover each floor and to help support people when needed. For people who were more independent, they were pleased with the care and support they received and had no concerns with staffing. One person said, "Everything is here that I need, and there's always somebody about" they added, "I've got a bell which I ring, and in a few minutes, they come."

We continued to receive mixed responses from some relatives about whether there were enough staff. Some relatives whose family member needed more staff assistance were worried help was not always visible or from staff who were, 'unfamiliar faces' (agency staff). Their concerns centred around limited staff visibility at night and weekends. One relative said, "We come almost every day, and there is a relative's meeting on the 10th October and quite a few of us are going to raise this issue of staff."

Overall, we found people were supported by sufficient numbers of staff to ensure their personal care needs were met. We spoke with some of the staff we had spoken with during our previous inspection visit in September 2017 and they were positive about the improvements in staffing levels since our last visit. One staff member told us, "We have more time, people can get up whenever they want to. More staff allows us to give better quality care." Another staff member felt there were enough staff because they could complete their care tasks without rushing. The senior regional director told us they now staffed 140 hours per week over people's assessed needs and the registered manager said over recent months they had recruited more staff and only relied upon agency staff to cover unplanned absences. She was confident that although it was not always possible at short notice to cover when unplanned absence occurred, each shift remained safe to meet people's needs

One staff member said that staffing levels had improved, but said there could still be occasions when due to unexpected staff absence they had to work with less staff on the shift. When we asked staff how this impacted on people, they explained that those people who required personal care from female staff, sometimes had to wait until a female staff member became free. With this, and the relatives who were concerned staff levels fell short, we asked the registered manager to tell us how many shifts in the last two months, had not met identified staffing levels. The provider's records showed 17 twelve-hour shifts had fallen below assessed levels. For example, on 15 August 2018 and 24 August 2018, each floor had one less

care staff member because agency staff were unable to cover at short notice. The registered manager said that because they staffed above needs, one less staff member had minimal impact on care delivery.

Whilst we found staff ensured personal care needs were met, at busy times of the day when people were getting up, dressed or having breakfast, staff spent time with people in their own rooms. This meant the communal areas, especially on the first floor, were left without staff. We did not see that people were placed at risk, although we did see some people were left alone with no interactions or close support if they needed it. When we returned for the second day of our inspection visit, which was announced, we were told some staff had come in two hours before the normal start of their shift to ensure people were up and able to participate in activities. This meant we did not have a true picture of how the home and staff dealt with a 'usual morning'. One staff member told us, "What you have seen on this unit doesn't happen every day." We discussed this with the registered manager and senior regional director whose records showed us seven staff came in at 6.00am. The registered manager told us the staff had agreed this between themselves because they wanted to support each other to improve people's care experiences. The senior regional director felt the lack of visibility of staff, could be down to how staff were deployed and agreed to investigate this and address any emerging issues to ensure staff were proactively deployed based on people's needs. These actions may address relatives' concerns around staffing that are related to individual perceptions of staffing levels because staff are not always visible.

Following our visits, the registered manager told us they now displayed a board with the names of staff on duty on each floor so visitors knew who was on duty and who they could talk to. They also told us staffing would be discussed at the next 'resident's meeting' on 10 October 2018.

People living in the home were supported by staff who knew how to keep them safe when they were known to be at risk. Risks associated with people's care and support had been assessed when they were admitted into the home. For example, we spoke with staff about one person who liked to walk around the corridors but who was at high risks of falls. Staff knew about this particular risk and explained how they supported the person to stay safe without restricting their freedom. "If [name] wants to walk around and they are unsteady, it is almost one to one because we will walk with them." Another staff member explained, "It is teamwork because we all know they are prone to falls. We are always checking where they are and we also ensure they are wearing the proper shoes." This was reflected in the person's care plans and risk assessments.

However, for other people at risk, risk assessment records needed better recording to ensure people received consistent support. For example, we looked at the care plan for a person who had been admitted to the home on 17 September 2018. On 18 September 2018 they had fallen and their daily records stated they could be 'resistant to personal care'. Whilst it was acknowledged that the person had only been in the home for a couple of days, there was no short-term risk management plan to support staff in minimising these immediate risks. Records to monitor when people needed to be repositioned because they were at risk of skin damage needed closer scrutiny to ensure consistency of care. We looked at the daily records for one person who was at risk of skin damage and needed to be regularly repositioned when in bed. We found the daily records sheet did not record when staff had repositioned the person or what position they had been repositioned into. In both cases, we found this had no detrimental impact on the person's health. The registered manager confirmed they had addressed this following our inspection.

People were protected from the risk of abuse. Staff understood the provider's safeguarding policies and procedures for keeping people safe. Staff had safeguarding training and they understood the signs that could indicate a person was at risk of harm or abuse. One staff member told us, "If we see any abuse, it needs to be reported to the nurses." Staff told us they would report any concerns about other staff practice, such as not using the correct equipment to support people to mobilise. One staff member said they would

not hesitate to report poor practice and explained, "If it requires a slide sheet, it requires a slide sheet. If it requires a hoist, it requires a hoist. If equipment is needed, you use it. I would report them straightaway. I am not here to make friends. I'm here to support these vulnerable people." Where a safeguarding concern or incident had been identified, the registered manager had acted to report this to the relevant organisations who have responsibility for investigating safeguarding issues.

The home was clean and tidy and the décor well maintained which made it easier to keep clean. Toilets were well stocked with toilet rolls, hand soap and paper towels. People said staff wore personal protective equipment whenever they supported them. About the cleanliness and personal care received, typical comments were, "We went to lots of homes and compared this to them, this one smells right", "Exceptionally clean - 100% - they clean every day" and "I have to have personal care. They wear gloves all the time and aprons." Staff had received training on infection control and we saw that they followed best practice guidance in how they supported and worked in the home to prevent the risk of infection. Protective personal equipment (PPE) was available and we saw staff removed and disposed of their PPE after they had supported people with personal care.

People received their medicines safely. One person told us, "They (staff) bring medication to me and that's okay as I'd probably forget." Time critical medicines were given when needed and people who required medicines in patch form, received these in line with manufacturers' guidance. Trained and competent staff administered people's medicines and recorded when medicines were given on medicine administration records (MAR). MARs were clearly maintained and when queries arose, staff liaised with GPs or prescribers to clarify instructions that indicated changes. Medication was safely stored in locked trolleys that were kept securely when not in use.

Checks of MARs were completed to ensure medicines were given as prescribed. For medicines given as and when required (PRN), some PRN guidelines were not clear. For example, one person was prescribed PRN Lorazepam 1mg up to twice a day. The protocol in place said, 'To be taken for severe agitation'. When staff were asked what other calming methods would be considered first and what was meant by 'severe agitation', responses were not always consistent. The registered manager said they would review all the protocols to ensure information was available to provide consistency of care and that the protocols corresponded with the care plan.

The registered manager completed an analysis of all the falls that had occurred in the home. However, we found one incident of a person who had fallen was not identified within the overall analysis, however the registered manager agreed to speak with senior staff to ensure all incidents were brought to them without delay, so any analysis would be complete. We were satisfied actions were taken for that individual to help keep them safe. Falls, incidents and accidents were reported monthly to the provider's internal quality teams so the provider understood what incidents happened within each home and to identify any further actions that needed to be taken.

Good

Is the service effective?

Our findings

At the previous inspection, we rated this area as 'Good'. We continued to find staff were trained, supported people without unnecessarily restricting their freedoms and provided people with a balanced and nutritional diet. The rating remains 'Good'.

Staff received training and support to ensure they had the knowledge and understanding to be effective in their role. One staff member told us they had recently had training in cardio-pulmonary resuscitation and was being encouraged to do further training relevant to their role. Another said that the availability of extra training had improved and said, "They are giving the chance to have more training if we want it." One senior staff member told us they were taking further education and the provider had offered to pay for their course. Staff had regular opportunities to discuss their work and development. One staff member told us they found these 'supervision meetings' helpful because, "If anything needs to be improved, I have the chance to speak to the manager face to face."

Newly recruited staff told us about their induction to the home, "My first week included two days training plus I had two shadowing days." Staff said this helped them get to know people and what they required on each visit. The provider invested in their own dementia training programme called 10 60 06, in addition to current dementia training. One staff member told us they had completed level one and two in dementia care and that new staff completed level one as part of their induction. However, when we asked this staff member what the provider's '10 60 06 programme' was, their response showed there were unclear believing it to be about mentorship. Speaking with other staff, further training was required so staff felt more confident to effectively transfer their learning from this programme into their day to day practice.

Staff told us there had been some changes in the environment since our last inspection visit. One staff member told us, "They have changed the colours and made it more homely. They are trying to make it more cosy." A regional dementia specialist said part of the provider's dementia programme was to remove clutter and have subtle themes within the home. On the first floor, corridors were themed as 'travel, beach, gardens and glamour'. Pictures, colours and objects referenced some of those themes. The regional dementia specialist said the 10 60 06 programme was being rolled out but told us staff would be able to tell us what the key criteria were. We asked three staff about the themes in the corridors on the first floor. They explained, "If it is green it is the garden. Where it is blue, it relates to the beach." Another staff member told us the different themes in the corridors included music, fashion, seaside and travel. We saw however, that staff were not always using the environmental themes to their full effectiveness. For example, one person was in the corridor looking at a picture of a train. A staff member asked the person how they were, but did not use the opportunity of '10 60 06' to engage with the person any further. When we approached the person, they started talking about the picture but then said they could not count the carriages because the corridor light was shining on the picture. We told the registered manager about the lighting which can affect people living with dementia and they assured us they would review this.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The

procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager reviewed each person's care needs to assess whether people were being deprived of their liberties, or their care involved any restrictions. We saw appropriate DoLS authorisations were in place to lawfully deprive people of their liberty for their own safety.

The provider understood their obligations and acted in accordance with the MCA. People's understanding and memory had been assessed to check whether they could make their own decisions, or decisions needed to be made in their best interests. The provider had applied to the supervisory body to restrict people's liberty, when it was in their best interests to do so, because the person lacked the capacity to recognise risks for themselves. At the time of our visit, 22 people had an approved DoLS. The registered manager told us these approvals were because people had alarm mats, coded doors to access and straps to keep people safe when transferring to wheelchairs. For people who had capacity, doors to the home were coded, but people were given the code so they could come and go as they wished. For those who could not remember the code, staff supported them to go outside or to access other parts of the home.

Staff understood their roles and responsibilities in ensuring that people's capacity to consent to care and making decisions about day to day issues was sought out before they provided support. Staff had received training in the MCA and DoLS and understood what their responsibilities were.
People were always spoken with and asked by staff when they offered support with care and it was clear that staff considered the individual abilities of people in respect of capacity to make decisions. Questions posed by staff about seeking consent were framed accordingly. When a person declined to be assisted by staff, the staff member tried again a short while later and then another staff member approached the person with the same request which was then agreed to by the person. Staff understood the importance of seeking permission before any intervention of support was provided.

Staff described how they helped people living with dementia to continue making their own day to day decisions. "For the food we have the show plates. For the clothes, we are showing them a choice of clothes. If they can't express themselves verbally, we have to follow their body language." This member of staff went on to describe how they referred to people's care plans so they understood their likes, dislikes and preferences so if necessary they could make decisions in the person's best interests, but said," We will still ask what they want, it is their own choice."

People were supported with their meals at lunchtime by staff and a number of people also had support from their relatives in the dining room or their own room. The mealtime was a busy event with people served by 'hostesses' at one sitting on each floor. Most people were pleased with the food. A typical comment was, "I can get what I want for meals, like today. I enjoy the food." People said they were encouraged to keep hydrated and we saw staff giving people fresh jugs of squash and water. Staff took their time to support people and did not rush anyone. We saw people were presented with plates of two different meals and staff supported people to make a choice. Where people had not clearly expressed a choice, staff repeated the offer and when one person indicated they wanted both selections, a meal was served up that had both alternatives.

People were supported to eat well and when one person, who was known to be nutritionally at risk, repeatedly left the table, staff gently coaxed and encouraged the person to return to the table to eat more of their meal. We saw this person ate more on each occasion they returned to the table. When the person was part way through their pudding, they indicated they would like to try the other option that was available. Staff responded to the person's request and the person continued to enjoy their meal.

Records were maintained of what people had eaten when they were at risk of not eating enough. However,

fluid charts required better oversight because we found it was not always recorded how much fluid intake each person should aim to achieve each day, totals of fluids consumed were inconsistent and it was not clear what action staff should take when targets were not reached. The inconsistent records meant we could not be certain people had enough to drink. A nurse who was responsible for checking these records had not identified these issues. When we reviewed some of these records with the nurse, they said, "It is confusing to know what they have had."

People had access to other healthcare professionals when needed. One person told us, "The doctor comes though the nurses usually ask if they're worried about something, and they would get the doctor if I asked. I have a chiropodist here every three weeks, and another person who does massages of joints comes here." Records showed staff supported people to maintain good health and access health services when required, such as district nurses, occupational therapists, opticians and the GP. The registered manager told us they had established and improved relationships with all healthcare professionals involved in supporting people at the home since the last inspection visit.

Good

Is the service caring?

Our findings

At the previous inspection, we rated Caring as 'Requires Improvement' because we found staff time pressures meant they did not always protect people's privacy and dignity, and staff were not always available to observe people sufficiently to ensure their overall health and welfare was maintained. At this inspection staff said they were able to care for people because they were able to give people the time they needed. Therefore, the rating has now changed to 'Good'.

People were complimentary of the staff. One person said, "Personally, I think it's about how you treat them [staff] too. I have no complaints or concerns. I'm very satisfied and my family is too." Relatives were complimentary of staff, however some relatives continued to share concerns about the numbers of staff and how this showed them that the provider was not always caring, rather than the caring nature of staff.

People were supported by permanent staff who knew them well and it was clear that staff were kind and caring in how they provided such support. Positive exchanges between people and staff were seen and we saw on our first inspection visit, appropriate hugs or handholding were often initiated by people and responded to by staff in a similar manner. Such interactions soothed people who were distressed or confused at times and encouraged them to let staff know what support they wanted. Some people responded by letting staff know they were tired or uncomfortable.

On the second visit we saw occasions when staff had time to sit with people and interact with them on a 'one to one' basis. For example, we saw one member of staff sitting with a person holding their hand. The person was talking about their marriage and a time they had spent in hospital. The staff member was looking at the person, listening carefully to what they said and asking relevant questions that encouraged the person to carry on sharing their memories.

When people became frustrated or anxious, we saw staff handled people's emotions sympathetically. For example, we saw one person became verbally aggressive towards staff when they were supporting them to move in their wheelchair. Staff responded cheerfully and maintained a friendly interaction with the person to give them reassurance. One staff member explained how they managed such situations with, "Reassurance. We can't take it personally and we apologise if they think we have done something wrong."

One relative told us staff were kind and considerate and often shared conversations and feelings with them that showed them staff were caring. This relative told us how a staff member had said how much their relative had missed them when they were not there and how they had recognised this could cause the person upset, which is when they gave them emotional support.

People and relative's comments continued to show how available staffing affected some aspects of a caring service. One person said of staff, "The agency ones can be not so good." Other comments showed people and relatives felt more confident with the provider's own staff to deliver a caring service.

Staff said staffing increases had made a positive impact in how they could care for people. They could

promote people's dignity by spending more time on their personal care. They told us, "We have more time to support people with personal care and ensure their clothes match." Another staff member said, "Now we have time to arrange their hair and paint their nails."

Staff told us they respected people's individuality by treating everyone with the same level of respect and supporting their personal, cultural and religious traditions. One staff member told us how they had previously liaised with a family member to ensure the care they provided one person was in accordance with their faith. Staff understood the importance of people's relationships with their families and friends. When speaking about one person's spouse a staff member said, "They know him better than us because they have been married for so many years."

Records and information about people were managed well and ensured that no information was shared or left accessible to people other than those who were authorised. As part of initial induction staff received guidance about the importance of maintaining privacy in respect of confidential information. Conversations between staff about people were appropriate and respectfully managed by staff sharing essential information between each other.

Visitors met with people in their own private rooms or in the communal areas. Most relatives of people using the service expressed satisfaction with the care and support provided at the home and valued being kept up to date about changes in healthcare needs or any incidents or occurrences. However, following our inspection visit, we received information from two relatives whose experiences were of a service that was not so caring. With both relative's permission, we shared their concerns directly with the registered manager to investigate and respond back to us and those relatives concerned with their findings.

Good

Is the service responsive?

Our findings

At the previous inspection, we rated Responsive as 'Requires improvement' because people were not always stimulated and able to pursue their hobbies and interests. Staff time pressures meant the support from staff was not responsive and their care was not delivered at the right times. This meant the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The provider sent us an action plan telling us how they would improve. At this inspection we found people were more engaged in activities and interests and staff knew more about what interest's people enjoyed. Staffing levels had been increased which helped ensure people's care was more timely. Therefore, the rating has now changed to 'Good'.

People were supported to follow their interests and hobbies. People who were more independent were pleased with the choices of activities, entertainment and how they spent their time. One person said how they looked forward to their visitors. They said, "The actual place is beautiful. The rabbits come out on the lawn and take apples off the tree. I can open my door and sit outside. I've a friend who comes and takes me out." One person told us how they were supported to follow their faith by a visiting priest and friends from the local church community visited. However, some relatives said there was limited stimulation for people who spent time in their room or who did not want to join in group activities.

Most staff spoke about how the increase in staffing levels since our last visit meant they could be more responsive to people's social and emotional needs. One staff member told us, "We have more time to spend with the residents. The quality of care is much better because they are enjoying having activities. We know them better and know what they like and what they dislike." Another told us, "We can spend more time chatting with people on a one to one basis." We spoke with one of the activities co-ordinators. They told us activities included knit and natter, parachute games, manicures and a hairdresser visited regularly. The provider had transport to take people away on organised trips. Some people choose not to participate and for those who spent time in their room due to their health, staff and activities co-ordinators ensured people were included to reduce social isolation.

The registered manager said they had improved how activities were organised within the home by the addition of dedicated activities staff who put together regular planners to inform people what was available and when. These included group and 'one to one' sessions. Outside of planned sessions, we saw care staff showed initiative in helping people to engage with and enjoy sensory items in one lounge. On the afternoon of our unannounced visit we saw that staff organised an unplanned activity in one of the lounges which some people participated in with support from several members of staff. The registered manager had made some recent changes and had started to establish activities of interest for people experiencing memory loss and for those people living with dementia. They told us this was a work in progress. The registered manager said the provider's dementia programme would focus on providing interests and stimulation to people. Part of this included obtaining people's previous interest, hobbies and preferences so they could tailor future interests specifically to meet people's needs which had begun.

Staff knew people well. We spoke with staff about one person whose care we reviewed. Staff were able to tell

us about the person, what they were interested in and their important family relationships. In each person's bedroom was a small 'poster' which gave key and personal information about people. It recorded, "My Favourite Things That Make Me Happy, "Things I like to talk about and listen to" and "Things I don't like". This meant that staff had useful information to engage in meaningful conversations with people. Most care plans we sampled contained sufficient information for staff to provide appropriate care to meet people's individual needs. Overall, where a need was identified, care plans provided staff with the information they needed. If people wanted to be included, their decisions and feedback was considered when care plans were reviewed. When changes in health needs occurred, care plans were updated.

However, two care plan records had been reviewed, but required stronger analysis to ensure the risks and how people had decided they wanted their care, were correctly recorded. This would help ensure staff continued to provide consistent care. We discussed this with the registered manager who assured us all care plans would be reviewed more thoroughly to ensure staff remained responsive to people's needs.

People had a communication care plan which guided staff on what action to take to ensure people understood information. One person's care plan read, 'Can be frustrated if they do not understand so encourage and reassure. Use simple, clear and concise language…. may need to give prompts, repeat or rephrase." For people who were unable to communicate verbally, they used electronic devices to communicate with staff. This meant they could continue to be involved in how they lived their lives and the choices they made. One relative said staff communicated well with their family member by, "Talking nicely, cajole, and tell them what they're doing. They kneel down to their level, and do things at their pace." This approach worked for their relative. Another relative said because of their family member's condition, they had limited understanding. They said, "(Name's) understanding isn't there, but we speak for them and staff use that information." The environment had written and pictorial signs to help guide people around the home. The passenger lift gave verbal information about which floor it was on so people with limited sight would know when to get out.

Complaints were handled in line with the provider's policy. People knew how to complain and would approach management if they felt their concerns needed escalating. Following our inspection visit, we shared the concerns we had with the registered manager about two relative's negative experiences. One relative said they had notified the registered manager by email of their concerns and had not received a response. The registered manager said they had not received an email but told us they had opened two complaints and had contacted those relatives to explain how their concerns would be addressed and the expected timescales. The registered manager investigated the concerns and we found a lack of communication between staff and families had led to concerns escalating. The registered manager provided us with evidence of their investigation findings.

At the time of our inspection visit, no one was receiving end of life care. The registered manager and nurses said they were equipped to provide end of life care and nursing and care staff were trained and skilled to provide the level of care people needed. We looked at a care plan for a person who received end of life care, who had since passed away. The right levels of support and clinical interventions were provided which supported the person's wishes. It was known whether people had a 'do not resuscitate' decision in the event of a cardiac event and end of life plans were agreed with the person and family. Other healthcare professionals were involved where necessary. The registered manager said their purpose was to provide a home for life for those people in their care, if this was their wish.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2017 we found the provider was not meeting all the legal requirements and was rated as 'Requires Improvement' under all the key questions. This was because we found the systems that monitored and managed risk were not entirely effective and staffing levels and staff deployment did not respond safely to people's requests for help. The provider's own audits had failed to identify the issues we found and the culture within the home did not promote good care outcomes. This meant the service was in breach of Regulation 9 and Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The provider submitted an action plan that detailed the improvements required to meet their legal obligations. At this inspection we found some improvements had been made and the provider was not in breach of the regulations. However, whilst we acknowledge the improvements that we saw and were told about, more work was needed to ensure when tasks, checks and responsibilities were delegated to other staff, these were accurately completed. The rating for Well Led remains as 'Requires Improvement'.

People and most relatives were complimentary of the registered manager and the changes and improvements that had been made since our last inspection. One person told us, "We would go straight to (registered manager) if we needed to, she is always available. The (registered manager) was concerned about (relative) not eating when they first came, and they sent her a little snack basket to tempt her with chocolates and biscuits, anything was better than nothing and we liked that."

Some relatives still raised concerns. One relative told us they had raised staffing issues with the registered manager but nothing had changed. For other relatives, they continued to tell us that staffing issues impacted on the care delivered to their relations, mainly due to staff not being around when assistance was needed. The registered manager had arranged a meeting on 10 October 2018 so relatives could discuss their concerns. The registered manager said they wanted to be open, honest and transparent with people and families. One example where this had been done was, following our last inspection, the provider put their CQC report and a copy of their action plan on the provider's website page. This explained what they had done to improve the quality of care, especially around staffing and how it would be monitored. Following our feedback, the registered manager and senior regional director accepted more work was required to better communicate staff arrangements to people and their relatives.

At the last inspection, the registered manager had only been in post a few weeks. We discussed the last inspection with the registered manager, and they agreed the report and rating reflected the home at that time. The registered manager had addressed a lot of issues identified at that inspection and it was clear improvements had taken place and the service had improved overall. The registered manager explained that some staff had not been 'on board' with the changes that needed to be made and no longer worked at the home. As a result, there had been improvements to the team structure with team leaders and senior staff being more accountable. The registered manager told us staff morale had improved and this was confirmed by the staff team. One staff member felt that the quality of care had improved because staff were working as a team now. They said, "We have more support. The nurses are giving a lot of support on the floor. They[provider] are employing more staff so the staff shortages are slowly improving." One staff

member particularly spoke of the support from the deputy manager and said, "They help us as well…..that makes a change to have the support on the floor."

The registered manager had introduced daily 'flash' meetings which we joined during the first day of our inspection visit. This meeting involved heads of departments where any immediate concerns were shared and discussed. People whose health condition needed monitoring were discussed, and then discussed again the following day, to see if any further support or advice was needed. Staff felt the registered manager had made a difference to the home because of their supportive attitude. Comments included: "I really like her. She is really nice and really supportive. She listens to you and she is an open person" and, "It is alright, she is asking if we are okay now and trying to cover the shifts. She is easy to approach."

Staff said they felt supported in their work. Staff had one to one meetings every eight weeks and said they had the opportunity to join in regular staff meetings to share any feedback or concerns. Minutes were taken and staff said they found it useful to be able to read them if they had not been able to attend the meeting. We asked one staff member if they felt their opinions were valued. They responded, "Yes, with colleagues, nurses and the managers. Everyone can say from their department what is going on and what needs to be done."

The registered manager and their senior team completed a range of audits and checks that included health and safety, clinical checks, care plans, medicine records and incident monitoring. Whilst audits and checks were undertaken in respect of risk assessments and people's care plans, some of the issues we found such as the lack of detailed guidance about PRN medication, or the risk encountered by some people who chose not to comply with professional healthcare guidance, had not been recognised and acted on. When care plan reviews were delegated to senior staff, there was limited oversight or accountability to ensure they were completed correctly and we saw examples of risk assessment tools used to indicate people's risk scores were not correct. Food and fluid charts and people's ideal goals did not always correspond to people's care plans. Fluids were not consistently recorded which made it difficult to establish what people had consumed. From reviewing one care record we found a fall on 1 September 2018 had not been recorded which meant the person's increased risk of falling might not be identified at their next care review. In one example, a nurse had changed a catheter at the required interval but because there were no new bags to attach to the catheter, staff had refitted the old bag. This had potential to cause cross contamination and infection. A nurse said this was not good practice and not what was expected from staff.

We found when we raised these issues with the deputy manager and nurses, these issues had not been identified or checked during their clinical audits. From these conversations we found senior staff were not always clear what they needed to check. We told the registered manager who agreed to improve their systems so they had a more informed view of the overall picture and standard of recording and monitoring by other staff when they completed audits.

The registered manager welcomed the inspection and was committed to making the improvements but was pleased with the progress they and their team had made. They told us they were determined to make sure people received a quality of care that they were proud of.

The provider fulfilled their legal obligations. There was a registered manager in post who had been at the service for 12 months and who knew people and staff well. People and relatives said consistent management was welcomed at the home. The registered manager had notified CQC appropriately of specific incidents at the home by submitting statutory notifications. We use this information to monitor the service and ensure they respond appropriately to keep people safe.