Methodist Homes

Richmond

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Richmond is located in Bexhill-on-Sea and provides accommodation and personal care for up to 58 older people who live with dementia, and live with long term healthcare needs such as Parkinson's. The home is set out over two floors, Richmond and Heatherbank. Heatherbank was on the ground floor and supported people who lived specifically with dementia and who had additional health problems such as decreased mobility. Richmond supported people with health needs and general frailty. There is lift access between the ground floor and upper level. At the time of our inspection there were 36 people living at the home.

People's experience of using this service and what we found:
At the last comprehensive inspection in November 2018, we told the provider they needed to improve the oversight and governance of the service and to ensure people received safe care and treatment. The manager and provider had made significant improvements to the governance and oversight arrangements, implementation of systems and processes to safely assess and manage risks to people, including their medicines. However, there were some areas of documentation that needed to be further developed to ensure people received safe and consistent care. There were also improvements needed to ensure people consistently received care that met their individual needs. Activities reflected people's preferences and interests. However, the activity programme has been impacted on by staff sickness. One person told us, "I enjoy the activities, but they are in a bit of a doldrums now." There were plans to allocate care staff to cover the programme so that people received the social interaction they needed and wished for. At the time of the inspection, it was clear that there was some instability within the staff teams, we received mixed feedback about the management of the service and staff feeling unsupported. The atmosphere of the home was subdued, and if not managed had the potential to impact on the people who lived there.

People received safe care and support from staff who had been appropriately recruited, trained to recognise signs of abuse or risk, and understood what to do to safely support people. People said, "I do feel safe, I am happy here, I like the food and I don't need more," and "I like it here genuinely, I'm very safe, I feel this is my home." People were supported to take positive risks, to ensure they had as much choice and control of their lives as possible. Medicines were given safely to people by competent and knowledgeable staff, who had received appropriate training. There were enough staff to meet people's needs. The provider used a dependency tool to determine staffing levels. Staffing levels were reviewed following falls or changes in a person's health condition. Staff were deployed in a planned way, with the correct training, skills and experience to meet people's needs. Agency staff used, received an induction to the service and worked alongside regular staff.

Staff told us that they had received the training they needed to meet people's needs safely and effectively. The training matrix tracked staff training and this had ensured all staff received the training and updates needed to provide safe consistent care. A plan of supervision to support staff was available and this also included competency sessions on training received. One staff member said, "Supervision is every couple of months, but we are encouraged to speak up if we need support." People's nutritional and health needs were

consistently met with involvement from health and social care professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Everyone we spoke to was consistent in their views that staff were kind, caring and supportive. People were relaxed and comfortable in the company of staff and were treated with respect. People's independence was considered important by all staff and their privacy and dignity was also promoted.

People were encouraged to go out and meet family and friends. Technology was used to keep families in contact by skype and email. Staff knew people's communication needs well and staff communicated with people in an effective way.

Care delivery was based on people's preferences and wishes. People were involved in their care planning as much as they could be. One person said, "I am very involved in my care plan because I know what I want." End of life care planning and documentation guided staff in providing care at this important stage of people's lives.

People, their relatives and health care professionals had the opportunity to share their views about the service. Complaints made by people or their relatives were taken seriously and thoroughly investigated. One visitor said, "I speak to the manager if I have any concerns." The provider and manager were committed to continuously improve, and had developed structures and plans to develop and consistently drive improvement within the service to deliver sustainable good care.

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 13 December 2018)

The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

Why we inspected:
This was a planned inspection based on the previous rating.

Follow up:
We will continue to monitor information we receive about the service until we 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?

The service was safe.

Details are in our safe findings below.

Good

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good

Is the service caring?

The service was caring.

Details are in our safe findings below.

Good

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below

Requires Improvement

Richmond

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance services for older people and those who live with a dementia type illness.

The service is required to have a manager. The service had a manager who had been in post for three months and had just had their interview to be registered with the CQC. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

The service type:
Richmond 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.

Notice of inspection:
This inspection was unannounced.

What we did before the inspection:
We reviewed the information we held about the service and the service provider, including the previous inspection report. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.
We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection:
We looked around the service and met with the people who lived there. As some people were unable to fully communicate with us, we spent time observing the interactions with people and staff. We spoke with 18 people in more detail to understand their views and experiences of the service and we observed how staff supported people. We spoke with the manager, area managers and 12 members of staff, including the maintenance person, two house keepers, and two members of the kitchen team.
We reviewed the care records of seven people who were using the service and a range of other documents. For example, medicine records, four staff recruitment files; staff training records and records relating to the management of the service.

After the inspection:
We continued to seek clarification from the provider to validate evidence found. We looked at resident and staff meeting minutes, accident and incident records over a period of four months, training and supervision data. We spoke with three professionals who regularly visit the service.

Good

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 has now improved to Good. This meant people were safe and protected from avoidable harm.

Using medicines safely
At our last inspection the provider was asked to make improvements to the management of medicines and to peoples' health related risk assessments.

At this inspection we found improvements had been made and the management of medicines and risk assessments had ensured people's safety.

- Arrangements had been made to ensure the proper and safe use of medicines. Medicines were stored, administered and disposed of safely. Medicines were ordered in a timely way.
- We asked people if they had any concerns regarding their medicines. One person said, "No concerns at all, very good." A second person told us, "It's a relief to leave them to someone else, if the doctor changes anything, staff will talk me through what's changed." We were also told, "I assume I get my medication on time, I do query them on the odd occasion, I look to the staff to know, and they are the experts."
- All staff who administered medicines had the relevant training and competency checks that ensured medicines were handled safely. We observed staff administering medicines safely to people ensuring that they were offered the medicines, given time to take them in the way that they preferred and signed for once they were taken.
- Protocols for 'as required' (PRN) medicines such as pain relief medicines were available and described the circumstances and symptoms when the person needed this medicine.
- Medication audits were completed on a daily and monthly basis. The registered manager reviewed and analysed the findings of the audits to ensure they took action that may be required to safeguard people.

Assessing risk, safety monitoring and management
- The care plans had individual risk assessments which guided staff in providing safe care. Risk assessments for health-related needs, such as skin integrity, weight management and nutrition, falls and dependency levels had been undertaken.
- Care plans and risk assessments identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. For example, people with mobility problems had clear guidance of how about how staff should move them safely. People with fragile skin had guidance on how to prevent pressure damage using air flow mattresses, regular movement, continence promotion and monitoring. Daily record checks for air flow mattresses and continence care were up to date.
- Risks associated with the safety of the environment and equipment were identified and managed appropriately. Environmental risk assessments had been expanded and developed to reflect the current refurbishment of the premises. This had ensured that the environment was safe for all the people who lived there.

● Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP).
● Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Learning lessons when things go wrong
● Accidents and incidents were documented and recorded. We saw incidents/accidents were responded to by updating people's risk assessments. Any serious incidents resulting in harm to people were escalated to other organisations such as the Local Authority and CQC.
● Staff took appropriate action following accidents and incidents that ensured people's safety with restricting their mobility and this was clearly recorded. For example, one person had an unwitnessed fall in their bedroom. Staff looked at the circumstances and ensured that risks such as footwear and trip hazards were explored. A sensor mat had been placed in their room which meant staff could support the person safely, whilst not restricting them from walking independently.
●Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff were aware of the signs of abuse and how to report safeguarding concerns. They were confident the management team would address any concerns regarding people's safety and well-being and make the required referrals to the local authority.
● A staff member said, "The safeguarding training is necessary, we get really good training and we discuss safeguarding procedures at team meetings, the manager updates us of any changes to the procedures." Another staff member said, "We report anything that is poor practice or abuse, the residents are all very vulnerable." People told us they felt safe. Comments included, "We are taken care of, we are looked after well." "The security makes me feel safe, the staff understand our problems," and ""I think we are looked after very well, I feel very safe here." A visitor said, "The staff are very good so I feel confident about her safety here."
● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training. We did receive negative feedback about the processes staff used to raise staffing issues and this has been reflected in the Well-Led Question as the impact on people's safety was minimal.
● Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. The Provider had an equalities statement, which recognised their commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age.

Staffing and recruitment
● People continued to receive care and support in an unrushed way. We were made aware by people, staff and visitors that there had been a high usage of agency staff over the past five months. The management team had ensured that as far as possible it was the same agency staff used to provide continuity of care and

informed us that "Agency usage has decreased, and we are actively recruiting."
● There had been concerns raised about the standard of care delivered by agency staff at night. To mitigate risk and ensure that care delivery at night was safe, the deputy manager was working alongside the night staff.
● Comments from people about staffing included, "Not bad at answering the bell, it depends on staffing, not as many regular carers as there used to be," and "I think there are enough staff on the whole, there seems to be an awful lot." Visitors said, "The staffing levels seem okay," and "Better recently, has been poor, some aspects of care like showers and oral hygiene was being missed, but seems to be improving, I have to say it depends who is on duty."
● Rota's confirmed staffing levels were consistent, and the skill mix appropriate. Staff shortfalls had been planned for and regular agency staff booked. There was always a senior on duty who took the lead on the floor. Staff told us "It has been difficult with working with a lot of agency, but we have regulars now and not using as much," and "There have been trouble with agency staff at night, but that has been dealt with."
● There was a robust recruitment programme. All potential staff were required to complete an application form and attend an interview, so their knowledge, skills and values could be assessed.
● New staff were safely recruited. All staff files included key documents such as a full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service.

Preventing and controlling infection
● The service was clean and without odours. Domestic staff completed a daily cleaning schedule. People and visitors were complimentary about the cleanliness. Comments included, "They keep my room really clean, despite the builders being in the home," and "Everywhere is clean, there is a lot of work going on to replace carpets and ceilings."
● Staff used personal protective equipment (PPE) when assisting people with personal care. PPE such as hand wash, gloves and aprons were available in all bathrooms (with visual reminders about washing hands) and at the entrance of the building, to help protect people from risks relating to cross infection.

Good

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 Good. At this inspection this key question has remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they enjoyed the food. Comments included, "The food is acceptable, I get enough, we get a menu each day, sometimes it is a bit haphazard, snacks in-between, a lovely big biscuit tin," and "In my opinion the food is very acceptable, I sit at a table with three ladies, we get a menu, there is a choice, and we get plenty of drinks with nice biscuits."
- People on both floors were offered and shown choices of food and drink. Vegetables were served separately on the first floor enabling people to choose what they wanted and how much. One person said, "Yes, they offer me choice at all meal times, we help ourselves and there's always something I like."
- On the first day of the inspection the meal time experience on Heatherbank (dementia floor) was subdued with people not being appropriately supported to enjoy their meal. On the second day it was an improved experience for people. Staff were more engaged and responded to people's individual needs. This has been more reflected in the responsive question. The meal service on the first floor was social with lots of chatter and people chose to sit with friends
- Staff knew people's preferences, which were recorded in care plans. Discussion with the kitchen team confirmed they were knowledgeable about people's personal preferences and dietetic requirements. They confirmed that they had received training in the preparation of textured foods and received regular updates when dietary guidance was changed. The food prepared was presented well and met people's individual needs. Pureed food was presented in a way that people could see the differing colours and textures.
- Staff offered people drinks throughout the day and staff supported them appropriately. People who had been identified as at risk from dehydration had their fluids recorded, monitored and drinks encouraged by staff. All staff were informed at handover of those who had not been drinking very much. We saw one person being encouraged to drink little and often during the day. This approach meant that the person received sufficient fluids to maintain their health.
- Food offered and taken by people was recorded in their care records and an overview of peoples' weights were kept by the manager. The system highlighted those at risk from weight loss and weight gain. Actions were taken if concerns arose. Such as referral to the GP or dietician. Evidence in care records supported this.
- Staff were knowledgeable when asked of who needed fortified food and close monitoring because of weight loss. One staff member said, "We discuss residents every day at hand over and if someone is not eating or has lost weight we discuss how to prompt and improve their intake. The chef adds double cream, butter and evaporated milk to food and sauces to add calories."
- Fresh fruit was available in the kitchenettes on each floor. Homemade cakes and pastries were prepared daily for afternoon tea. People said, "Nice cakes, freshly cooked."

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).

● Staff had received training in the principles of the MCA and understood their role and responsibility in upholding those principles.
● People were asked for their consent and were involved in day to day choices and decisions. Staff interaction with people demonstrated that people's choice and involvement was central to how care was provided. We saw people making choices about who supported them, how they spent their time, and meals and drinks.
●There was a file kept by the manager of all the DoLS submitted and their status. The documentation supported that each DolS application was decision specific for that person. For example, regarding restricted practices such as locked doors, sensor mats and bed rails. We saw that the conditions of the DoLS had been met. For example, each person's care plan reflected how the decision had been made and what actions staff needed to take.
● The manager had made DoLS applications to the local authority when necessary and kept them under review until a response had been received.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they started to receive support from staff. Records showed consideration had been taken to establish what practical assistance each person needed before they had moved into the service. This had been done to make sure the service had the necessary facilities and resources to meet people's needs.
● Nationally recognised risk assessment tools were used to assess risks, for example, those associated with nutrition and skin integrity. Care plans and assessment tools reflected NICE guidance.
● Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practices, which contributed to good outcomes for people. The staff team worked closely with the community diabetic team to ensure people received the care they needed.
● Peoples needs were consistently reviewed and when peoples' needs changed, a review was held to ensure that Richmond was still able to meet their needs safely. If the person required nursing care, or specialist care, the appropriate referrals were made.
● People's protected characteristics under the Equalities Act 2010 were identified. For example, around people's heritage, cultural requirements and gender preferences of their staff. One person said, "I was asked if I wanted a male or female care to do my personal care, they have always ensured that I get a female carer."

Staff support: induction, training, skills and experience
● On-going training was completed by staff in a variety of subjects such as food safety, infection control and moving and handling. One staff member said, "The training is both face to face and on-line." The provider sourced face to face training from various external agencies, for example, the local authority.
● Staff had recently attended a dementia course which staff said , "Really good, I learnt a lot," and "Really good training, lots of new ideas."

● Our observations during the inspection confirmed that staff had received training, for example, people were moved safely with lifting equipment and medicines were handled safely.
●New staff completed an induction aligned with the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Staff spoke positively about their induction experience. One staff member said, "The induction was good, I had time to read care plans, get to know people before working on the floor."
● Staff received regular supervisions with their line manager. One staff member said they valued their supervision as it was a chance to discuss their professional development and an opportunity to discuss training.

Adapting service, design, decoration to meet people's needs
● Richmond was a purpose-built building and provided a welcoming and comfortable environment for people. The home was being extensively refurbished with specific attention to ensuite facilities and communal areas.
● Richmond offered a cinema room, hairdressing salon, training/ spiritual/church service room, activity room and well-maintained garden /patio areas. The garden area was well kept, safe and suitable for people who used talking aids or wheelchairs. There were areas to sit and enjoy the pleasant garden.
● Notice boards contained information about the service, activities, staff names and roles, religious services and complaint procedures.
● Appropriate signage was displayed to support people living with dementia/memory loss to recognise and access toilets and other key areas. Planned refurbishment includes the introduction of memory boxes and new signage that will be placed appropriately to support wheelchair users.
● People's bedrooms were personalised and individually decorated to their preferences. People and relatives said they were encouraged to bring in their own possessions, such as pictures, photos and small bits of furniture. Bedrooms reflected people's personal interests.
● The first floor was accessible, by stairs or a lift which ensured that people who were unable to walk independently had full use of the communal areas and gardens.

Good

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 remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- Feedback from people and visitors described staff as kind and caring. Comments included, "Staff are very kind, very good at dignity and respect." "The staff are wonderful, we all get on very nicely, and they have a good sense of humour and can't do enough for us," and "Great deal of respect, absolutely a caring environment here, I can't fault it." Visitors said, "There are some wonderful staff here, there have been issues but mainly to do with the amount of changes to staff," "Yes she is very much treated with dignity and respect; some of the staff are very special," and "Can't fault staff kindness."
- The kindness of the staff team was commented on by a visiting health care professional who told us, "Always polite and welcoming." Another health professional said, "I have no concerns, always helpful and treat people respectfully."
- People were treated with kindness and care by staff. Staff spoke respectfully to people and showed a good awareness of people's individual needs and preferences. People were relaxed and cheerful in the presence of staff. Birthdays and special events were celebrated. During the inspection the chef had prepared a Remembrance celebration tea which visitors were also invited to.
- Equality and diversity was embedded in the principles of the service and the provider had an equality and diversity policy in place to protect people and staff against discrimination. Staff understood the importance of people's diversity, culture and sexuality to them as a person and to managing their care needs in a person-centred manner. The manager used team meetings to share information by national organisations to promote discussion and reflection around this area.

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

- People and their families confirmed they were involved in day to day decisions and care records showed they participated in reviews of their care. Comments included, "I think we discussed care plans and my wishes when I am poorly, we have discussed whether I want to go to hospital," and "I'm sure I have been involved, I know they ask me if I'm happy with the care." A visitor said, "We are really please at the level of involvement, they inform us of changes." "We were involved in her care plan and have Power of Attorney."
- People's views were reflected in their care records. Where people needed support with decision making, family members, or other representatives were involved in their reviews.
- Care records included guidance for staff about how to help people make as many decisions for themselves as possible.
- Staff supported people to keep in touch with their family. Visitors were always made welcome and offered a drink, and some privacy to talk. One visitor said, "The new manager here is excellent, she lets me Skype Mum when I am away with a screen and headphones." Another visitor said, "I am involved in decisions about my mother, they contact me and keep me updated."

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was respected. Staff explained how important it was to listen to people, respecting their choices and upholding people's dignity when providing personal care. They were able to give examples of how they ensured people's clothing was clean and their dignity was maintained during meal times.

● We observed staff knocking on people's doors to seek consent before entering. Discussions about people's needs were discreet, personal care was delivered in private and staff understood people's right to privacy.

● People were supported by staff to take pride in their appearance. People were supported to maintain their personal hygiene through baths and showers when they wanted them. People were assisted with make-up, jewellery and nail care. We were told that personal care had been an issue some months ago but had improved.

● Staff told us they always promoted people's independence when they were supporting them. We saw staff prompt and encourage people to walk independently, with the appropriate aid. Staff also said they encouraged people to go and visit friends or just for a walk. For example, one person told us they liked to go out in the community and told us, "I wear a tracker when I go out for a walk and fresh air, I can do what I want, get up and go to bed, I am encouraged to be independent."

● People's care plans recorded details about which personal care tasks people were able to do and noted that staff should be encouraging them to do these themselves, such as cleaning their teeth.

● Confidential information was held securely in locked cupboards. People had received an updated privacy policy and policy statements following changes to data protection legislation in May 2018.

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 Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's individual needs were not always met.

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

- Before coming to live at Richmond, senior staff visited the person, either at home, in hospital/care home and completed a pre-admission assessment. This ensured that the person's needs' and expectations could be met by the service. For example, ensuring specialised equipment, such as pressure relieving mattresses were in place before they arrived.
- Care plans were not all personalised and not all contained up to date information to guide staff on how best to support them with their assessed needs. For example, one person who lived with diabetes managed with staff support to self-test their blood sugars and self-administer their insulin. However, there was no guidance in the care plan about the management of the diabetes, signs of high and low blood sugars and documenting the rotation of injection sites. When discussed with staff, they were not fully aware of the persons normal blood sugars and not confident in recognising the symptoms of low and high blood sugars and of what action to take. This was immediately rectified, and risk mitigated should the person become unwell and be unable to manage their insulin.
- Other examples where specific health problems had not been considered and had the potential to impact on people's well-being were identified to the manager during the inspection. These included nutritional guidance for people who had kidney disease and non-diabetic hyperglycaemia and of preventing progression to developing diabetes. These were also amended by the second day of the inspection. The manager had identified prior to the inspection that there was work to do on the care plans and had started to review and rewrite all care plans.
- The manager had introduced a handover sheet that highlighted people's specific needs which was important due to the amount of agency staff used. However, it was missing important information such as who was a diabetic and who needed a soft diet. This was immediately updated by the manager.
- Some people required assistance with their meals and on the first day of the inspection did not get the specific support they required. For example, one person who could eat independently had been left tilted back in their chair and unable to reach their plate. They did not have the right cutlery and so began to eat with their fingers. This was identified to staff who adjusted the position of the chair and changed the cutlery. Once this had been done, the person was able to eat their meal. On the second day of the inspection we saw that this person had a lipped plate and angled cutlery and ate their meal independently.

Ensuring people received care to meet their identified needs therefore was an area that required improvement.

Care plans were reviewed monthly and amended more frequently when needs changed. There was clear guidance for staff on people's mobility needs and the care required to manage their personal care, for example, people had oral hygiene care plans that described how staff should support people with their

teeth or dentures.
● People who lived with behaviours that challenge had detailed care plans and risk assessments that identified triggers and how staff should manage these so as to provide a consistent approach.
● People's records reflected their beliefs, values and preferences and included specific details like favourite clothes, whether they liked to wear makeup and how they liked to wear their hair.
● Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in.

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
● People were supported to maintain relationships that were important to them. Visitors were made welcome at the service at any time. Visitors told us, "We always feel welcomed, tea and coffee offered all the time." One visitor told us they visited regularly to have lunch with their relative which was lovely for both of them.
● Care plans recorded information about people's interests and hobbies. People confirmed they were usually happy with the activities on offer. However, this had changed recently as both the activity people were off sick.
● People told us, "Usually a lot to do, but everyone seems to be off, we have a new minibus and that will get us out and about," and "I am a bit of a loner, so don't do some of the activities, I sit and watch on the sidelines, we have a quiz today." We were also told, " We do some activities, I take the minutes for the residents committee and do the flowers on the balcony," and "No we don't have an activity programme now, so we don't know what's going on, no trips lately as minibus is changing."
●The planned activity programme was varied and included skittles, exercise classes, art and crafts, pet therapy and one to ones for people in their rooms. The programme was not being followed at this time due to the team being sick. Plans to provide cover for sickness for activities were being discussed with the provider. At present care staff were doing pampering sessions, exercises and ball games.
● The support people required from staff to engage and interact with them to reduce the risk of social isolation was set out in their care records. One person said, "I enjoy reading and I go to the library and choose my own books." People and visitors told us staff had time to chat with them. One visitor said, "The staff make time for chatting, they talk to us as well, nothing is too much for some of the 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 were knowledgeable about people's communication needs and there were detailed assessments highlighting support needs within their care plans. This included specific information on how the person communicated, and any aids they might use, such as glasses and hearing aids.
● People's communication and sensory needs were assessed regularly, recorded and shared with relevant others.
●Technology was available in the home for people to communicate internally with staff using the call bell system and externally using landlines or mobiles to talk to and receive calls from relatives and friends. There was a broadband system in place and people used this to contact relatives using skype and emails.
● Notice boards and walls were used to display information about up and coming events or something interesting and attractive to look at. There was some pictorial signage around the home to help orientate people.

Improving care quality in response to complaints or concerns

● There was a copy of the complaints policy readily available for people and visitors to the service. People and their relatives knew how to make a complaint and felt comfortable to do so. They described how the management and staff team were receptive to feedback and shared examples of their views being acted on.

● We reviewed complaints that had been received by the service since the last inspection. All complaints were investigated, an outcome and lessons learned were recorded. For example, comments about the food had been taken forward and the menus were under discussion and changes would be made with the newly appointed chef.

End of life care and support

● Staff attended palliative/end of life care training and there was a provider policy and procedure containing relevant information about end of life care. Staff told us that they felt prepared and understood how to support people at the end of their life. One staff member said, "We know how important it is to make sure people are comfortable and pain free. The district nurse and GP are really supportive."

● Care plans identified people's preferences at the end of their life and the service co-ordinated palliative care in the care home where this was the person's wish. Care plans also contained information and guidance in respect of peoples' religious wishes and their resuscitation status. Do Not Attempt Resuscitation forms (DNAR) had been discussed with the person if possible, family, GP and had been reviewed regularly.

● Staff demonstrated compassion towards people at the end of their life. They told of how they supported them health and comfort wise. This included regular mouth care and position moving. We were also told that families were supported and that they could stay and be with their loved ones at this time.

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.

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

At the last two inspections the provider had needed to improve the systems to assess the quality of the service and mitigate risks to people. Improvements were seen in how the service was assessing the quality however, the systems were not fully implemented and embedded into practice. It is acknowledged that there was a new manager in post who was in their third month and who had identified shortfalls and was addressing them.

- The provider had made improvements to the quality assurance system to protect people's safety. This included reviewing and updating audits in relation to how medicines were being managed. The audits measured all aspects of the service and there was evidence that they were effective in driving improvement. Audits were carried out by the management team in relation to care plans, medicines, activities, kitchen, mealtime experiences, call bells and infection control.
- Actions were recorded that had arisen out of any issues found. Actions were clearly documented and followed-up. For example, some people's care plans on Heatherbank floor had been reviewed along with supporting documentation to ensure they were current and more personalised. However, some care plans on Richmond floor needed urgent review to ensure they reflected people's specific needs. For example, one person had swollen lower legs and this had not been mentioned within the care documentation. There was also misinformation in respect of peoples consent forms. The manager addressed the shortfalls identified during the inspection process and was in the process of reviewing all care plans. The improvements made, needed more time to be sustained, maintained and fully embedded into the culture of the service.
- It is part of the registration condition for a service to have a registered manager. The manager had just had their interview to be registered with the CQC.
- At the time of the inspection, it was clear that there was some instability within the staff teams, we received mixed feedback about the management of the service and staff feeling unsupported. The atmosphere of the home was subdued, and this if not managed had the potential to impact on the people who lived there.
- It was evident during the inspection that the management of the staff team needed to be improved and this was something that the management was aware of and was addressing through supervision, family/resident meetings and staff meetings.
- People, relatives and staff told us they felt the quality of care had not been impacted by the changes but

were concerned if not managed effectively, staff would leave and that would impact on people care and well-being. The manager said, "It's been challenging because of the use of agency, but things are improving everyday."

● Improvements were needed to how information was being communicated around the management changes. There were missed opportunities between the provider, people and relatives regarding what was happening and why there had been changes. One of those was of how the change of managers was managed and this was acknowledged by the area manager. The management team gave assurances this would be followed up through staff meetings and 'resident and relatives' meetings, and for those who were unable to attend, through a letter. We will not be able to confirm if sufficient action has been taken until we next inspect the service.

● Concerns were raised about confidentiality of concerns raised. This was referred to the management team to discuss with those involved. These were areas requiring improvement. 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

●The manager was open and knowledgeable about the service, the needs of the people living there and where improvements were required.

● The manager understood their role and responsibilities to notify CQC about certain events and incidents.

● Notifications were submitted to the CQC, as required. The previous CQC rating was prominently displayed in the home and on the provider's website.

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

● People felt confident to talk with the manager if they needed to. One person said, "(name) is the manager, she is very approachable and I have spoken to her," and "There is a new manager, there is a list up with who is in charge, haven't needed to see them."

● People and relatives told us they found all staff to be approachable, from care staff to management. Interactions between people, relatives and staff, were warm and positive and they clearly knew each other well.

● The manager and provider collected and analysed information about the service, for example falls, and used this information to create an action plan to reduce or mitigate identified risks.

● Staff, people and relatives told us they were given opportunities to share ideas and make suggestions to improve the service as and when they wanted to. There was a residents' committee that people 'owned' and staff were invited to. One person said, "It's good to be able to speak up, we do moan but we also talk about what is good, fun and put ideas forward."

● There were two monthly resident and relative meetings that were well attended. Families were very involved in these meetings and felt it gave them the opportunity to discuss the service, such as plans for the new mini bus and trips out, colour schemes for the on-going refurbishment. Comments included, "We have resident's meetings, I have been but not on a regular basis, more for curiosity," and "Really enjoy the meetings, a sense of community."

● The provider issued satisfaction surveys annually to gain people's feedback. We reviewed the outcome of surveys and saw that people had expressed a good level of satisfaction with all aspects of the service. The provider had acted in response to any negative comments, including changing carpets and planning a refurbishment. Relatives' feedback indicated that staff were always friendly, helpful and supportive. Staff meetings were held monthly, and minutes taken. There was opportunity to discuss training and accident prevention. At the last staff meeting, staff were reminded of the importance of good recording of fluids. This had improved recording and monitoring.

Working in partnership with others

● Staff worked closely with local healthcare providers such as the GP surgery, district nurses and the local pharmacy. The manager and provider worked in partnership with the local authority commissioners to share information and learning around local issues and best practice in care delivery.