Larchwood Care Homes (South) Limited

Highfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 2 & 3 June 2016. The service is a nursing home for up 34 older people some of whom may have dementia type illnesses, physical and or sensory impairments. The home is located in a rural setting outside the village of Bekesbourne. In order to afford everyone single person accommodation the home usually accommodates only 32 people but two rooms can be used as shared accommodation if a need for this arises. Twenty eight people were in residence at the time of inspection. People have their own bedrooms some with ensuites the majority of accommodation is located on the ground floor with three bedrooms located on the first floor accessed by shaft lift.

This service was last inspected on 19 May 2014 when we found the provider was meeting all the regulations. There was a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were treated with kindness and respect by staff but shortfalls in some areas of practice meant that people could be placed at risk. Observations and discussion with staff and relatives showed that there was not enough staff to meet the needs of people living in the home. The lack of flexibility within the staff team led to isolation for those people who stayed in their rooms either by choice or because there were not enough staff, space or appropriate equipment available to enable them to transfer to specialist seating and sit out in communal areas.

Medicines were mostly managed well but improvement was needed with protocols for administration of some medicines. How people were supported with their hydration and nutrition needs was not always well documented to show the action was taken.

Care plans to show how people's health needs for everyday support and end of life care was supported by staff practice. The Care Quality Commission (CQC) were not notified as required regarding the death of a service user still registered as a resident of the service,

The provider had identified a need for investment in the premises and plans were in hand for some upgrading to take place. We considered however, that some repairs and maintenance needed to be progressed sooner as they posed a risk to people in the home and or their visitors. We asked the provider to ensure that immediate action was taken to address sunken flooring outside the dining room which posed a tripping hazard, and also wear and tear on some wooden handrails which left people at risk from splinters in their hands.

Staff had received fire training, they understood fire procedures and how to evacuate the building and they attended fire drills. We have made a recommendation that the provider seek further advice from the fire service in regard to some of these arrangements.

Quality assurance audits were undertaken, to monitor service quality and address any issues highlighted from, we have recommended that timescales for addressing shortfalls be reviewed to ensure those that impact on the quality of support and experience of care people receive are dealt with as soon as possible.

Staff were working to the principles of the Mental Capacity Act 2005 (The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for themselves), but decisions made in the best interest of people were not always well documented in care plans and we have made a recommendation around this.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had referred a number of people for assessment for DoLS authorisations but these were still to be processed. The registered manager understood when an application should be made and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

People were provided with a wide range of activities but not everyone was able to access these, some people nursed in their rooms were at risk of isolation and we have made a recommendation for improved recording in this area to judge the level of interactions with other people they have.

People and their relatives felt able to raise concerns and felt these would be addressed but improvements were needed in the way complaints were recorded and managed and we have made a recommendation for this.

People told us they felt safe and liked the registered manager and staff that supported them. Relatives told us they had no concerns about the service and were satisfied with the overall standard of support provided. They felt confident in the quality of care and said they were kept fully informed by the service and that communication was good.

Recruitment processes ensured only suitable staff were employed. Staff received induction and a range of training to give them the knowledge and skills they needed. Staff felt listened to and supported staff received regular formal supervision and met regularly with their registered manager, records of these discussions were made available to view.

Staff were able to demonstrate they could recognise, respond and report concerns about potential abuse. The premises were clean. All necessary checks tests and routine servicing of equipment and installations were carried out.

People ate a varied diet that took account of their personal food preferences. Their health and wellbeing was monitored by staff that supported them to access regular health appointments when needed.

People said their needs were attended to by staff when and if they required it. People respected each other's privacy. People were supported to maintain links with the important people in their lives and relatives told us they were always consulted and kept informed of important changes.

We have made five recommendations:

We recommend that the provider seeks support and training for the management team to be able to review the current development plan for the service and prioritise shortfalls to ensure those that currently and directly impact on the quality of support and experience of care people receive are dealt with as soon as possible.

We recommend that the provider seeks advice and guidance from a reputable source, about the management of isolation and provision of activity and stimulation to people nursed in their rooms.

We recommend that the provider seeks guidance in respect of recording best interest decisions in keeping with current best practice.

We recommend that the provider consider current fire legislation and guidance in relation to the frequency of fire drills for day and night staff and the content of evacuation plans for people and take action to update their practice accordingly.

We would recommend that the provider seek guidance form a competent source suggestions for best practice around meaningful effective signage and décor for people with dementia.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

There were not enough care staff to provide people with adequate interaction and stimulation. Medicines were managed well but some protocols for as required medicines needed improvement.

The premises needed investment and there was a lack of adequate space and appropriate seating for people. Fire procedures were understood by staff, improvement was needed around fire drills for staff and a review of evacuation plans with the fire service.

Safe recruitment processes ensured only suitable staff were employed. Servicing checks and tests of fire, gas and electrical installations carried out regularly. Staff understood how to recognise and respond to abuse. Accidents and incidents were monitored for emerging issues

Is the service effective?

Requires Improvement

The service was not always effective

People's nutrition and hydration needs were not always well documented or the actions taken to ensure shortfalls were addressed. People were supported in accordance with the principles of the Mental capacity Act 2005 but recording of when best interest decisions were made needed improvement.

Staff said they felt supported and received regular supervision. Staff meetings were in place. Staff training gave them the right knowledge and skills to understand people's needs and support them safely.

People ate a varied diet that took account of their preferences. Peoples health needs were monitored and they were supported to access healthcare appointments.

Is the service caring?

Good

The service was caring

People were treated with kindness, patience and respect. People were given opportunities to express their views.

People's privacy was respected. People were provided with information in formats to suit their needs. They were supported to personalise their own space to help them settle.

Staff supported people to maintain links with their relatives and representatives and to form friendships with other people in the service. Relatives felt they were kept informed and always made welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were individualised but improvement was needed to record end of life care preferences, staff knowledge of people did not always match care plans, important health information or changes were not always made known to care staff.

People were provided with a programme of weekly activities but not everyone could access these and were at risk of isolation. People and relatives told us they felt comfortable raising issues with staff and were confident these would be addressed, but recording of complaints and complaint outcomes needed improvement

People referred to the service had their needs assessed to ensure these could be met.

Is the service well-led?

Requires Improvement

The service was not consistently well led

The Care Quality Commission was not always notified appropriately of the deaths of service users. People, their relatives, and staff commented positively about the leadership of the registered manager, and the quality of care people received.

Quality assurance audits were undertaken and were effective but their findings were not fully implemented yet, and timescales for achieving improvement needed review.

Relatives and people were encouraged to give their views about the service. Policies and procedures were kept updated to inform staff. Staff said they felt listened to and were given opportunities

to express their views in regular staff meetings.

Highfield

Detailed findings

Background to this inspection

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

This inspection took place on 2 & 3 June 2016 and was unannounced. The inspection team comprised of one inspector a specialist advisor and an expert by experience on the first day of inspection. A specialist advisor is someone who has clinical experience and knowledge of working with people who are living with dementia and have nursing needs. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

At inspection we met and spoke with fourteen people who lived in the service and observed interactions between people and staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. Not everyone we met was able to speak with us so we used the strategic Short Observational Framework for Inspection (SOFI); SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, Area manager, deputy manager, two senior care staff and three care assistants in addition to members of the domestic staff team. After the inspection we contacted a further seven relatives and five health and social care professionals. We received feedback from four relatives who spoke positively about the service and raised no concerns.

We looked at seven people's care and health plans and risk assessments, medicine records, three staff recruitment training and supervision records, staff rotas, accident and incident reports, servicing and

maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt completely safe at Highfield. Comments included "I know there is always someone to come and help me day and night when I ring my call bell." "I feel safe here, they are kind", another said "They are kind to me, that's what I need". Relatives said "I can be confident that my mother is in safe hands when I leave the home" another said "they are as safe here as they would be anywhere". Relatives told us that call bells were within reach of those in bed and those in danger of falling had "alarm mats" situated at the side of their beds, we sometimes heard these ringing for some time before they were switched off and several relatives commented on the need for more staff particularly when the home was at full capacity. Staff commented "I like working here; I think people are safe and well cared for. The nurses tell us if there are changes to a person's care needs or if they have lost weight and need extra support".

The staff rota showed that during the morning there were six carers on duty and one registered nurse, this reduced to five carers and a registered nurse in the afternoon, and one nurse and two carers in the night-time, agency staff were used to fill gaps in shifts but they preferred where possible to cover shifts from within the existing staff team. There were several carer vacancies at the time of our inspection. Feedback from staff and relatives showed staffing to be the main area for improvement.

On the first day of inspection we highlighted concern as to how few people left their room. Our observations showed that a high proportion of people in the home were nursed in bed or kept to their bedrooms, for some this was a personal choice or a result of their frailty, but for others there was no apparent reason why they should remain in bed all day. The registered manager used a dependency tool to help inform her how many staff were needed to meet the needs of the people currently in the service, most people were high dependency; requiring support from staff around all their personal care needs, 11 people required assistance to eat, a few people required two staff to help transfer them. The morning personal care routine was not completed on the first day of inspection until 11:30 am leaving little time between then and lunch for any meaningful interaction, lunch for some people did not finish until 2:30 pm.

Observations showed that although staff were constantly busy they provided individual support to people in an unhurried way, where possible spending a little time with people when they had time. There remained long periods of the day however, when people were at risk of social isolation because staff were engaged with personal care tasks around the service. The lack of adequate care staff coupled with shortfalls in availability of accessible communal space for people with specialist seating needs caused a culture that did not encourage people to stay mentally active for as long as they could, in spite of their complex health and physical needs.

This is a breach of Regulation 18 (1) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Cleaners worked each day to regular cleaning schedules and had daily weekly and monthly tasks to complete to maintain a standard of cleanliness. Staff were provided with protective clothing when supporting people with personal care. There was a sluice which was clean and tidy and staff used this to

manage commodes hygienically, but this was not routinely locked and we found it open at inspection and a hazardous chemical within easy reach of anyone who entered the room.

Some areas of the service such as communal bathrooms/shower rooms were in need of updating and with breaks in floor seals that could impact on infection control measures because they could not be cleaned thoroughly.

There was signage on some toilets but as nearly 50% of the people supported had some level of dementia more could be done to make this a more dementia friendly environment.

We would recommend that the provider seek guidance form a competent source suggestions for best practice around meaningful effective signage and décor for people with dementia.

Although the new provider has identified the need for investment in the home to attend to much needed upgrading; this did not cover the lack of adequate facilities for more than eight people to sit in the lounge at the same time or twelve people to eat together in the dining room. People who required specialist chairs to help transfer them from their room to make use of communal space were restricted as to where they could eat their meals and could not attend entertainment in the main lounge.

People were placed at risk because staff did not adhere to security measures for the sluice, the premises was in need of upgrade to provide people with the necessary space and equipment they needed to improve their quality of life.

This is a breach of Regulation 15 (1) (b) (c) (e) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014. Medicines were administered by qualified nursing staff, who received updated training and competency checks. Observations of systems for ordering, receipt, storage, administration, recording and disposal were mostly managed well; some improvements however, were needed as not all prescribed medicines that people took now and again, for example for occasional pain relief had person specific guidance in place for when these should be administered which would help ensure they were administered in a consistent manner by staff.

A system was in place for the assessment of pain and the administration of pain relief but this assessment tool was not used; nurses felt confident of knowing people well enough to know when they needed pain relief. Our observations showed the expression of pain through nonverbal means could be overlooked and put down to the person's dementia when it could be an indicator of pain.

There was a failure to ensure that protocols for use of as required medicines were in use for all those used, or that the system for the assessment of pain and administration of pain relief was used. This is a breach of Regulation 12 (g) of the Health and Social Carer Act 2008 (Regulated Activities) Regulations 2014.

General servicing and testing of equipment was undertaken with a regular programme of updates in place. General maintenance and repairs were also undertaken as and when required by a maintenance person with larger projects undertaken by a company maintenance team. Weekly and monthly checks and tests of fire alarm, extinguisher and emergency lighting equipment were being maintained. A fire risk assessment that included an assessment of how staff would evacuate the home was last completed in 2014 and was due an update.

Personal emergency evacuation procedures (PEEPS) were completed for everyone but relied on people being left in situ behind fire doors in the event of a fire; there is a responsibility for staff to take responsibility

for evacuating people where possible and the current personal evacuation plans lacked information about how staff would evacuate people using what equipment many of whom were nursed in bed.

Fire drills were held at least monthly, and some longer serving staff said they had been trained using evacuation equipment. Staff confirmed they had attended at least two and records were maintained of all attenders, but we noted that night staff attendance was limited and there was a need to ensure that all staff including night staff attend a minimum of two drills annually and in accordance with guidance contained within fire regulations.

We recommend that the provider consider current fire legislation and guidance in relation to the frequency of fire drills for day and night staff and the content of evacuation plans for people and take action to update their practice accordingly.

Risk prevention measures that people may be subject to from their environment or as a result of their own care or treatment were implemented and staff were provided with guidance on how to support people safely. Environment risk information was kept updated through regular health and safety checks of the premises. Risks that individuals were subject to as a result of their health and condition for example falls, nutrition, pressure ulcers were reviewed with care plans on a monthly basis, when a re-evaluation of risk reduction measures was undertaken and this determined whether further amendments and changes were needed to reduce risk levels further. Staff were aware of where emergency procedure information was kept and a business continuity plan had been developed in the event that an incident occurred that stopped the service. The registered manager had made links with several local care homes where people could be taken if the building needed to be evacuated for some hours.

People were protected against the risks of receiving support from unsuitable staff, because recruitment checks undertaken ensured staff selected were safe and had suitable qualities and experience to support people safely. Checks had been undertaken with regard to criminal records, proof of identity and previous conduct in employment and character references.

Staff demonstrated an understanding of safeguarding, could recognise abuse and their roles and responsibilities in protecting people from harm. They received safeguarding training with regular updates. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to the registered manager and provider or to outside agencies where necessary.

Accidents were appropriately reported and sent to the area manager for analysis of any patterns or for example whether there was a correlation between medicine times, or location and times of falls, and whether some individual needs could continue to be met within this service safely.

Requires Improvement

Is the service effective?

Our findings

One person said they has had help in accessing a dentist for treatment and others confirmed they had access to a chiropodist and saw the GPs when they visited.
A relative told us "Staff are excellent, they know her moods, whether she wants to get up or stay in bed. I come to visit every day and I have never had any concerns about the staff, when my relative came here she was very poorly having been in hospital for some weeks. She wasn't eating at all but after two days and perseverance by a member of staff, she is eating well." Relatives said that the staff were always encouraging people to take fluids. Another relative said that staff supported their relative appropriately with a very specialised diet and ensured that they received the right type of food.

People were weighed regularly and we noted where a loss of more than 2kg occurred for someone not on a weight reducing diet, appropriate referrals were made to the dietician service. In the interim or following dietician assessment where advice had been provided care plans were not always amended to provide guidance to staff about increasing the frequency of high calorie snacks, drinks and meals. Where we did find an example of written guidance from the dietician that had been included in the file we found this was not being implemented. For example in the persons file a notice had been added of dietician advice this made clear that under no circumstances should the person be given a cup with a lid and a spout. Staff told us any such changes in need would be cascaded to them at handover; we checked handover sheets for the day of the recommended change and two subsequent days but found no record of this information being relayed to staff. We checked the person's room and found they had been provided with a cup with a lid and a spout clearly against the professional advice.

Food and nutrition charts were kept and a target guide for the amount of fluid that should be taken was recorded, these were checked each day by the nurse in charge but there was no evidence of the actions they took when they highlighted insufficient intake. For example one person had a target of 2000mls per day, by mid-afternoon the person had only taken 260 mls of fluid and 500mls catheter output, this represented a high risk of dehydration but no additional actions were recorded for staff to follow. A note from a dietician in March 2016 gave a clear dietary plan but there was no evidence this had been shared widely with the staff team, the record stated the person was at risk of dehydration and malnutrition but did not link this to the dietician's advice.

The failure to ensure that people's nutritional and hydration needs were appropriately monitored and arising issues acted upon is a breach of Regulation 9 (3) (i) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of actions to take when best interest meetings needed to be held for example, necessary health interventions. A number of people had already been referred to the DoLS office. Restraint was not used and staff were not trained in the use of physical interventions but best interest decisions taken to keep people safe were not always recorded within care plans, for example a person at risk of falls had been provided with an alarm mat to alert staff when they stood up from bed, this represented constant care and supervision but was not included in their care plan as to how the team supported them in

the least restrictive way and in their best interests.

We recommend that the provider seeks guidance in respect of recording best interest decisions in keeping with current best practice.

Staff refresher training in the Mental Capacity Act 2005 (MCA) was overdue but they demonstrated a good understanding of what this meant on a day to day basis for people. MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff sought people's consent to provide them with support for their everyday care and treatment tasks, one care plan viewed stated that 'consent established using a picture board and x pointing to the word "yes"; this is good practice. Staff understood that when more complex decisions needed to be made that people who lacked capacity to decide for themselves, relatives, representatives and staff would help make this decision for them in their best interest. Many people's relatives were authorised representatives to help make decisions on their behalf.

We spoke with the cook who had an understanding of people's individual dietary preferences and any specialist diets that needed to be catered for. Most people's health was fragile with complex health needs, although not nutritionally at risk the cook reinforced the food people received with cream, milk and milk powder to ensure they received the nutrients they required. Dietary needs and nutritional assessments were undertaken to highlight anyone at risk from poor nutrition. Menus were developed from an understanding of people's likes and dislikes gathered when they were admitted to the service and from changes requested by them at resident meetings. People were given a choice for their main meal and for their supper. Fresh fruit was available in the fridge and the cook advised that usually melon or soft fruits were sent round sometimes in the afternoon for people to have with their afternoon tea.

We observed the lunch period. A small number of people sat at table in the dining area supported by one staff member. Other people ate their meals in their bedrooms and 11 people required full assistance from staff. A range of pureed, soft and normal meals were provided dependent on individual needs, lunchtime took a long time and we met someone on the first day who was just about to have their meal at 2:30 pm. Staff said although this was unusually late the person may well not have had their breakfast until later so this was not a problem, and they were not unduly worried by the lateness. We observed staff assisting people with their meals and for the most part this was unrushed and done well, with good eye contact and interaction from staff, we saw only two examples where improvement could have been made through lack of appropriate seating for staff and the distraction of a television; we discussed these issues with the registered manager at the time.

The registered nurses had been in post for some time and knew people's health needs well. The nurse in charge told us that the GP practice for the service provided a routine fortnightly visit and reviewed everyone in the service; they said this was conducted very much as a ward round and they needed to be aware of everyone's current state of health. People's medicines were reviewed as part of these visits. Staff supported people with their other health appointments and made referrals to health professionals as and when needed. Staff were vigilant in checking people's wellbeing and whether there was an emerging health related need.

Adaptations such as the installation of an overhead track hoist had been made in one bathroom to help people access the bath. People at risk of falls, and pressure ulcers were assessed and procedures and equipment implemented to reduce the risk of harm occurring. Room checks ensured that people's air mattresses were kept at the correct setting; alarm mats were in use for people at risk of falls or who may wander at night. Relatives said they felt happy that their family members health needs were attended to.

New staff underwent a period of induction and were initially supernumerary on shifts for the first two weeks of their employment, this was so that they could familiarise themselves with the routines and people's individual care regimes and their competency assessed. The new starter induction was linked to the new Care Certificate. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

New staff were expected to complete a probationary period before they were made permanent in their role, they met with the registered manager during this period on several occasions, and this ensured that the registered manager was confident that they had the right competencies and had learned and put into practice the skills they needed to support people safely.

All staff were provided with a computer login to enable them to access training modules the required pass mark for staff in completing these was 100%. The Registered manager said she could see from looking at the training record system which staff had completed what training and the number of tries it took them, where this showed the staff member was struggling to achieve the required level this would be addressed with them within supervision, to see if they required additional support around this. The company has a training team to deliver in house training as and when required. Care staff spoken with told us that they were up to date with their online training programme although we noted that some of the nursing staff were still to update all their mandatory training. Staff said there were opportunities for them to take qualification courses and that the registered manager was supportive of their career aspirations and their desire to further their careers; she encouraged staff to undertake qualification training and 17 out of 21 care staff had achieved NVQ level 2 or above.

Staff said they experienced regular supervisions with a supervisor and also assessment of their competency in some areas of their work. Some supervisions were undertaken in groups but not well documented, observations of practice and competency were undertaken and also some face to face meetings. Staff said they found supervision helpful not only to discuss training and development but to highlight areas they needed to improve on and also to receive praise where they were doing well. A system of staff appraisal was in place for staff in post for more than one year, but with recent organisational changes completion of these had slipped, but the registered manager was aware of this and was taking action to address this.

Good

Is the service caring?

Our findings

People told us that they were well cared for by kind and caring staff. One commented "I cannot complain about anything. The staff are all very kind, caring and helpful. They are very good with the hoist and I have no worries when they are moving me. They take me to the lounge in a wheelchair whenever I want. Personal care is excellent and I was given a choice whether to have male or female carers."

Relatives told us how they felt about the care provided at the service. "It was the best thing I have done bringing Mum to Highfield. When I first visited the Home I felt it was right for us. It doesn't feel like a Care Home, it feels just like Home." Another said "I work in the care sector and this is one of the best homes I have seen." Others said "Mum cannot speak but I know from her expression that she is happy here." "If I am not visiting and phone to see how my relative is, whoever answers the phone can immediately give me the information I need." "Because I spend so much time at the home, I see and hear what goes on and I can't fault the care given here." Relatives told us that they were made welcome and the kindness of staff was extended to them by the offer of refreshments and meals.

No one at the service was considered to be in need of end of life care at the time of our inspection, but there were a number of people who were considered to be approaching this. The majority of people had a DNACPR (do not resuscitate) order in place and these showed that people had been consulted for their views about this and where people lacked capacity, relatives with relevant authority to make decisions for the person had been spoken with.

Bedroom doors were left open for ease of visual access and people we spoke with were happy with this arrangement wanting to see people passing by; bedroom doors were shut during personal care giving and signs were placed on them that personal care was being delivered to avoid interruption. Staff were responsive to people's individual needs and preferences for example people were given the option of a shower or bath, when they went to bed or got up.

Whilst the provider was aware of the need for upgrading of the premises and tidying up some of the outside areas, the home is set in nice grounds with easy walkways and outside at the front of the building there are places for people to walk with seats for them to sit. A pond at the front of the building provides a feature but is cordoned off for safety.

Although limited for space communal areas were homelike for example at lunchtime people sat down to dining tables that were appropriately laid with tablecloths, flowers in vases, cruet sets, glass ware and cutlery, also condiments that they might want to use with their meal. A choice of drinks was offered. People sat in companionable groups and enjoyed conversations across the dinner table.

People were supported to bring in small items of furniture, photographs and personal items that help people settle and enable them to personalise their room. A good system was in place for the recording and storage of small items of jewellery or cash, and although relatives were encouraged to take some items of value home, others remained in the safekeeping of the home and there were good records of this with

double signatures for any possessions handed over. A small tuck shop operated weekly where people could buy personal toiletries and sweets and other sundries. Regular hairdressing and chiropody visits were also provided.
Religious services by the local Catholic and Church of England representatives were held weekly and fortnightly respectively.

Staff showed themselves to be kind and helpful responding to people's requests for support or expressed need. Staff supported people with their personal care discreetly, and people could retain their privacy by having their room doors open or shut during the day. Some people had lockable facilities in their rooms as they chose to retain responsibility for small amounts of cash.

People's care plans contained information about the important people in their lives and important events they needed to be reminded about. Staff were familiar with their life stories and had built up relationships with them. The service had recently completed a life story project completing the RCN/Alzheimer's "This is Me" documents, these were comprehensively completed.

Bedrooms were of various sizes some with carpeting others with laminate effect vinyl flooring. A programme of upgrading was providing people with rooms that were decorated and furnished to a high standard. People were encouraged with family or staff support to personalise their bedrooms and many seen had personal effects such as photographs, pictures, flowers, small personal possessions, and books. Some people had also brought in items of their own furniture. Not all bedrooms had televisions but this was personal choice.

People were provided with a user guide in their bedrooms, this informed them about the terms and conditions of living in the service, and some of the routines that would make settling in easier to understand and the registered manager understood the need to keep this updated to reflect some changes we had requested and which were made on the first day of inspection in regard to complaints information.

A notice board near to the dining room reminded people of the day, date and weather, this was clear and understandable and helpful to people struggling to retain such information so they did not become confused or lose track of time and the days of the week. People had access to daily newspapers to keep them informed of local national and worldwide events. Their views and those of their relatives were sought through regular meetings and people felt by and large any issues they raised or suggestions were listened to and acted upon where possible.

Requires Improvement

Is the service responsive?

Our findings

A relative said she was very impressed with how staff supported her relative who she commented could be difficult at times, she felt staff remained calm and called her appropriately if they needed about any anxieties they felt she could help her relative.

Care plans contained some good individualised information about what people needed and wanted in the way of support in their everyday life, they were reviewed by the registered nurses monthly. There were some detailed life stories and the deputy and staff were knowledgeable about people's lives although the depth of their knowledge was not always carried into the care plans to aid staff communication and interactions with people. There was limited evidence of people their relatives, or care staff involvement in the development or updating of care plans, although some relatives told us they had been consulted but not regularly.

Staff thought that the communication they received about important changes in people's care and health needs was generally good and passed on through daily handovers. Specific support people required around individual health conditions was recorded within medicine records which care staff did not see as the registered nurses were responsible for medicines. This meant that care staff did not have access to some important information about signs and symptoms that could alert them to a person's deterioration and the need to call a nurse.

Several people were in receipt of anticoagulant medicines that required additional monitoring due to the side effects these can cause. Staff were knowledgeable of the impact of such medicines but there was no cross referencing from medicine records to care records to ensure staff were reminded of the increased risk for people on these medicines of bruising from mobilising with a hoist or blood loss from oral mouth care.

The registered manager told us that they were still working to the Liverpool pathway model for care of people at end of life; this is no longer used and is not deemed to be good practice having been replaced by the '6 Steps end of life care pathway'. The '6 steps pathway' builds on the existing end of life gold standard framework established by Hospices. This strategy applies to all conditions and in all settings to ensure that everyone at the end of their life receives appropriate and individualised care that places them at the centre and takes account of their wishes and preferences.

Whilst this was an area highlighted for improvement on the service development plan the timescale for achieving this was still some way off and the existing care plans seen for end of life care did not give information about the persons preferences in the last few months, weeks and days of life. The registered manager had however, ensured that peoples last wishes in respect of their death and how this was managed had been discussed with them and/or their relatives and this was recorded in their plan of care to ensure their wishes would be fully respected when needed.

There was a failure to ensure that care plans reflected people's needs and wishes to guide care and nursing staff in accordance with current best practice and this is a breach of Regulation 9 (3) (a-c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The Provider Information return (PIR) told us that in the 12 months prior to the inspection a total of 50 compliments and 17 complaints had been received. 7 complaints were made within the same 28 day period but these were not available to view as they had been archived. The PIR stated that ten complaints were resolved. We checked the complaints log and saw that people's individual concerns about other people had been listened to and recorded, however these were not logged and there was no evidence of dating on them or the action taken by staff to address people's individual concerns. Similarly the complaints log contained details of some complaints but not all those received, the log did not always make clear whether the complaint was resolved and where there was learning how this had been disseminated to staff. Improvement to the complaints process had been identified in the service development plan and a timescale for addressing shortfalls set. The management of complaints needed improvement and is a breach of Regulation 16 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was displayed for people to view, this was slightly incorrect and the registered manager changed this during the inspection to ensure people had the right information about how to take complaints forward if they were unhappy with the company's response. Individually people were provided with copies of a 'service user guide' which they kept in their room this was printed in a suitable format and contained a personal copy of the complaints procedure. People and relatives were also provided with opportunities through resident meetings to express any matters of concern which would be reported to the registered manager. A review of some of these meetings showed no particular issues of concern arising. Relatives said they felt confident of raising concerns with the registered manager or other staff if they had them and said they found staff approachable and open.

We observed that activities were on going throughout much of the inspection days, such as quizzes, games and singing. A weekly activity planner had been developed and was displayed on the main information board near the dining area so that people could see what events were happening each week, these included: table top activities, knitting and stitching, singing and music, quizzes, reminiscence, a weekly film show, exercises, people's choice on one afternoon, discussion groups, floor games, gentleman's club, sports and karaoke sessions. People who participated and were able to leave their rooms clearly enjoyed the activities. A recent "This is Me" project could be used to inform further the development of meaningful activity and occupation for people.

The activity organiser also had a remit to visit people nursed in their rooms but these visits could be days apart. A pets as therapy (PAT) dog visited people around the service, and a number of people had visitors but the contacts people at risk of isolation had with other people including staff were not recorded in the records kept in their rooms. It was not possible to know or verify who they had seen and for how long on any given day, to judge whether this was sufficient to mitigate any sense of isolation they may experience

We recommend that the provider seeks advice and guidance from a reputable source, about the management of isolation and provision of activity and stimulation to people nursed in their rooms.

Resident/relative meetings provided people with opportunities to discuss the activities available and whether they wanted to change these or do additional activities.

Relatives told us that they had looked at a number of services before selecting this one for their relative, none were disappointed with their choice and there was a waiting list of people wishing to move in. An assessment of people who were referred was usually undertaken either by the registered manager or one of the registered nurses. The registered manager explained that usually people who were assessed prior to admission were provided with opportunities to visit if they were able, sometimes relatives visited on their behalf. Pre admission information viewed was well completed and had been developed from discussions

with the person and or their relatives about their needs and how they preferred to be supported. From initial pre-admission and discharge information a care plan was developed to inform and guide staff about people's individual needs and how they were to be supported.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff told us that the Registered Manager was always available to speak with and was helpful with any problems. Relatives said they valued the efforts she had made to make the home a good, safe place for people to live. One said "My relative has been in several homes before this one and there is no comparison"; A Senior Carer told us that although she always tried to sort out any problems in her own team she knew that the Registered Manager would be helpful if she needed to speak to her. Another staff member said they had been well supported by the management team and other staff through a recent bout of illness. She said "I love working here, everyone gets on and we are all treated equally whatever our role" She said she also sometimes gets time to spend with people who might just need someone to sit with them and help them manage their anxiety. Relatives said they thought that communication with them was good and that they were kept informed of their individual relative's wellbeing by staff.

We were aware that there was a disparity between the number of deaths that had been reported to the Care Quality Commission (CQC) by the service as required and those that had occurred. This was an oversight as the service was not routinely notifying CQC of the deaths of people in hospital who were still registered as residents of the service. This was discussed at inspection and clarified, but the failure to provide accurate information to the Care Quality Commission of the number of deaths occurring is a breach of Regulation 16 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Staff said they found the registered manager approachable and spoke positively about her leadership style. The registered manager showed that she was familiar with individual people and their support needs, she chatted comfortably with them, their relatives and with staff. They said they felt confident that if they had any concerns these would be addressed. Relatives were happy with the service their family member received.

Staff said they felt supported and listened to. The atmosphere within the service on the days of our inspection was relaxed, open and inclusive, staff was seen to work in accordance to people's preferences and needs and their support was discreet and unobtrusive.

The service staff had experienced a number of ownership and management changes over the past 12 months that had required them to adapt to new ways of working and to new documentation. Staff told us that the new area manager was a visible presence and had spent time at the home working alongside staff, observing and seeing how things worked. Staff said they thought they were kept informed about important changes to operational policy or the support of individuals usually through formal staff meetings which were held regularly. Staff had access to policies and procedures, which were reviewed regularly by the management team to ensure any changes in practice, or guidance was taken account of, staff were made aware of policy updates and reminded to read them.

There was a comprehensive system in place to regularly monitor the quality of the service that was provided through monthly monitoring visits by the area manager in addition to daily, weekly monthly, quarterly and annual audits and monitoring of aspects of the service conducted by the registered manager. The quality

monitoring system was newly introduced following the recent provider and management changes and was still being embedded. It had identified many of the issues we have raised in respect of the condition of the premises, the potential isolation of people, and complaints management. Shortfalls identified were added to a development plan for the service that had timescales in place; progress towards addressing the shortfalls was reviewed at monthly meetings between the registered manager and area manager. At inspection we recommended that some timescales needed to be brought forward to help improve people's experiences of some aspects of care received and is an area for improvement. The registered manager also attended and received support from monthly managers meetings where they discuss and share company best practice.

We recommend that the provider seeks support and training for the management team to be able to review the current development plan for the service and prioritise shortfalls to ensure those that currently and directly impact on the quality of support and experience of care people receive are dealt with as soon as possible.

Surveys for relatives and or people have been introduced recently to enable people and or relatives to post comments anonymously if they wish in a comments box in the main entrance, these were then collected, analysed and actions taken where necessary.

The language used within records reflected a positive and professional attitude towards the people supported. Staff were encouraged to develop their skills and pursue personal development

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The failure to provide accurate information to the Care Quality Commission of the number of deaths occurring.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to ensure that peoples nutritional and hydration needs were appropriately monitored and arising issues acted upon. There was a failure to ensure that care plans reflected people's needs and wishes to guide care and nursing staff in accordance with current best practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure that protocols for use of as required medicines were in use for all those used, or that the system for the assessment of pain and administration of pain relief was used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

People were placed at risk because staff did not adhere to security measures for the sluice, the premises was in need of upgrade to provide people with the necessary space and equipment they needed to improve their quality of life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of adequate staffing placed people at risk of becoming isolated.