Ashdown Care Limited

Culm Valley Care Centre

Inspection report

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Date of inspection visit:
30 June 2016
01 July 2016
06 July 2016

Date of publication:
12 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 30 June, 1 and 6 July 2016.

Culm Valley Care Centre is registered to provide accommodation for 56 people who require nursing and personal care. There were 47 people using the service on the first day of our inspection. They consisted of 26 people having their nursing needs met by the nurses at the service and 21 people whose nursing needs were met by the local health authority community nursing team. The registered manager made us aware that four people were receiving intermediate care which was where health professionals also supported people to rehabilitate with the aim of returning home.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in May 2015, a breach of a regulation was found. This was because there were concerns about staffing levels, as the provider did not have a systematic approach to determine the number of staff required in order to meet the needs of people using the service and keep them safe at all times. We found some improvements had been made at this inspection. However people were still not having their needs met promptly.

Staffing levels were regularly assessed and dependency levels of people monitored to ensure there were sufficient staff to meet people's individual needs and to keep them safe. The registered manager adjusted the staffing levels to meet those needs. People and visitors expressed concerns about the staff response times to call bells, and as a result felt there were not adequate staff to meet people's needs safely. Following the inspection the provider made us aware that they had increased the volume of the call bell panels. This was because staff had said they could not always hear the bells in all areas of the home. They said they had seen improvements in the response times. We made a recommendation to the provider to monitor call bell response times and staff deployment.

Risks assessments were not always completed correctly to assess people's individual risks. This meant staff might not take the appropriate action to keep people safe. Care plans were developed when people came to the service following a pre admission assessment involving people and their families. However the nurses were not updating people's care plans to reflect their changing needs and were not recording health care professionals' visits and their instructions. Care plans had not always been put into place to reflect people's emotional and mental health needs.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. However these were not fully effective as they had not identified the breaches of regulations found at this inspection. Environmental risks were not always being safely managed, which

could put people at risk in the event of a fire.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. However staff were not following the MCA in regard to people with capacity consenting to their own care at the service. Where a power of attorney (POA) was appointed for a person, there was no clear system to identify whether the POA was authorised for making care and treatment decisions, finances or both. This increased the risk they may make decisions on behalf of a person they were not legally authorised to make.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had received training and had developed knowledge to meet people's needs. Further steps were needed to support staff whose first language was not English to improve their communication skills and check they had the communication skills required to perform their role effectively. Staff relationships with people were caring and supportive.

Medicines were safely managed with the exception of prescribed topical creams which records did not demonstrate had always been applied as prescribed.

People said the registered manager was very visible at the service and undertook an active role, most said she was approachable and available to speak with. Staff said they felt supported by the registered manager and the clinical lead nurses.

People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment required.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service. However one person who required a specialist diet was placed at risk because they received inappropriate food.

Where there were concerns or complaints, these were investigated by the registered manager and action taken and lessons learnt.

We found breaches of the regulations at this inspection. You can see what action we told the provider to take at the back 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 sufficient staff on duty to meet people's needs. People and visitors raised concerns regarding the staff response time to their call bells.

People's safety was not always protected by effective fire and environmental monitoring.

Risk assessment were not always carried out effectively. This put people at risk of not being protected against the associated risks.

Medicines were safely managed although it was not clear from records that people had their topical creams applied as prescribed.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

People were protected by safe recruitment processes.

Accidents and incidents were monitored and any trends identified.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received regular training, supervision and appraisals. However the provider had not supported staff to ensure they had the skills to communicate effectively with people at the service.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). However they had not always ensured people with capacity had formally consented to their own care at the service.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service was caring.

Staff were busy but were caring and kind when interacting with people. They respected people and treated them as individuals and included them in day to day decision making.

Staff recognised the importance of maintaining family contact. Visitors and friends were welcomed.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People's needs were assessed before they came to the service. Care plans were put in place when people arrived at the home. However care plans were not always put in place to reflect people's psychological needs.

Care plans were not updated to reflect people's changing needs and health professional visits and outcomes.

People and their relatives when appropriate had not been involved in reviewing their care needs.

Activities were provided at the home in the main lounge. However there was no provision for people who stayed in their rooms to ensure they did not become socially isolated.

There was an effective complaints procedure in place. People knew how to make a complaint and they had opportunities to offer feedback about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were measures in place to assess the quality and safety of the service people received. However these did not always identify areas of concern.

There was a registered manager at the service. They were working with the nurses at the service to improve their leadership skills.

The views of people, relatives and staff were sought and taken

into account in how the service was run and suggestions for improvement were implemented.

Culm Valley Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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.

The inspection visits took place on 30 June and 1 and 6 July 2016 and were unannounced. The inspection was carried out by two inspectors.

Before our inspection, we reviewed the information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met most of the people who lived at the home and received feedback from 17 people using the service and seven visitors.

We spoke with 16 staff, which included nurses, care and support staff, the cook, housekeeping staff, administrators, the registered manager and a clinical lead nurse. We contacted the local GP practices that supported the service for their views. We also spoke with the district nurse team.

We looked at the care provided to seven people which included looking at their care records and speaking with them about the care they received at the service. We reviewed the medicine records of five people. We looked at four staff records and the provider's training guide. We attended a staff handover meeting and were present at a staff meeting. We looked at a range of records related to the running of the service and quality monitoring information.

Following the inspection we spoke with the provider's representative referred to at the service as, 'The operations manager'. They sent us an action plan setting out the actions they were taking in response to the concerns we identified.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, there was a breach of regulation related to insufficient staffing levels. This was because the provider had not determined the number of staff required in order to meet the needs of people using the service and keep them safe at all times. At this inspection some improvements had been made. People and relatives said there were not always enough staff to meet their needs. However the registered manager said there were enough staff.

Our observations showed during our visits there were sufficient numbers of staff on duty. Staff were busy completing tasks but appeared to have time to meet people's individual needs. The registered manager completed a 'dependency staffing assessment' to ascertain people's level of need. They considered the level of personal care needed, continence needs, manual handling assistance and support with their diet and the amount of staff needed to meet the needs identified. Staffing levels had been adjusted in line with the analysis of assessed need. For example, a care worker had been allocated to start at seven in the morning each day to help night staff with people who chose to get up early and to help with baths and showers.

However people and visitors said call bells were not always being responded to promptly and they were left waiting for bells to be answered. Comments included, "I need someone to help me and can't always get someone"; "They are very slow to answer the bells"; "[Mum] rang the bell and had to wait 12 minutes. That's quite a long time. It can happen quite often. On this occasion we timed it"; "That bell is always ringing. It usually takes about 10 minutes to answer"; "My honest opinion is no, most days there are not enough staff, sometimes Mum is waiting half an hour." One visitor gave an example where they had rung the bell which had taken 31 minutes for staff to respond to. There was no system to undertake formal audits of the call bells to ensure staff responded to bells promptly. We discussed these concerns with the registered manager. They said they had undertaken informal audits by randomly sitting near the call bell panel to check call bells were responded to promptly. They said they were usually responded to within two to three minutes and if they took longer they would ask staff why.

Following the inspection the operations manager sent us an action plan telling us that staff had reported they had difficulty hearing the call bells in some areas of the home. They said they had increased the call bell volume and the registered manager had reported an improvement in response times since this had been actioned.

The majority of staff when asked whether they felt there were enough staff to meet people's needs said they felt when there was a full scheduled team on duty there were enough staff. Comments included, "Today is good as we have a full team. It depends on who is on, things get done…bells are being answered quickly today"; "We do try to answer bells, but there's not enough staff to do everything" and "There's no one in today to do the laundry. There is not enough space for us to do it, but otherwise enough time." Night staff said they felt there were enough staff at night. One member of night staff said, "The days are harder because of visitors, mealtimes and people asking for things." A visiting health professional commented, "I recognise that staffing levels may be low at times." During our inspection call bells were answered promptly.

Staff said there had been a lot of times where staff had rung in absent with short notice. One care worker commented, "We've had a lot of sickness in the last three months. It happens regularly. It depends on the weather. Weekends nobody ever comes in (to cover for sickness)." The staff rota demonstrated for the three months before the inspection there had been only four shifts where the staff levels had been below the assessed level. When there were unexpected staff absences, staff were contacted to see if they had availability to undertake additional duties to cover. The registered manager told us that when staff were unable to cover gaps, she was contacted and she needed to seek approval from the provider for the use of local care agencies to cover gaps. However they said by the time this process had happened the shifts were almost over. There were no examples of agency staff being used on the rotas we looked at. The clinical lead said they could usually cover one unexpected absence but it was harder when there were more.

The registered manager had needed to undertake nurse duties because of a nurse vacancy at the home. They were actively recruiting to fill this position. The registered manager said where she would normally support the nurses to deal with visiting healthcare professionals, making telephone calls and doing additional bits to support the nurses, this was not always possible.

We recommend that the provider and registered manager regularly monitor staff response times to people's call bells and the deployment of staff at the service. This is to ensure staff are available to respond to bells and meet people's care and treatment needs promptly.

People were not always protected because risk assessments for individuals were not always assessed correctly. Care records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's mobility, bed rails, choking, nutrition, pressure damage and falls. In the seven records we looked at, three risk assessments were not completed correctly. They had not identified accurately the risk to the person. These included a person's risk of choking, another's risk of losing weight and a third person's risk assessment of their skin. This meant staff were not aware of the correct assessed level of risk and might not take the appropriate action to keep the person safe. We discussed this with the registered manager and they said they would review the care records and ensure risk assessments were completed correctly.

Since the inspection the provider has informed us that although two of the risk assessments had not been completed accurately this did not change the overall level of risk. Therefore people were not at an increased risk overall.

A person and their relatives spoke to us regarding receiving food of the wrong consistencies. The person required a special consistency diet as they had been assessed as at risk of choking by the Speech and Language Team (SALT). This was clearly evidenced in the person's care plan and the kitchen was aware of their dietary requirement and it was also recorded on the daily menu sheet. However they had received food which was inappropriate. They raised this concern formally with the registered manager on the same day who had tried to address the concerns by putting in place a special individualised menu for the person. However on the third day of our visit the person had again received food which put them at risk of choking. The communication at the home was not always clear to ensure staff were kept informed of people's dietary requirements.

There were not always effective fire risk assessments to ensure the safety of the environment. This was because there were not always effective fire risk assessments undertaken to keep them safe. We found one external fire exit door had rubbish stored outside which was combustible and causing an obstruction. The external fire escape stairs were rusty and the fire door leading out of the home onto it had a push bar and a small bolt in the top left corner. The bolt might not be seen in the event of a fire and could prevent someone

exiting the building safely.

There were fire checks carried out weekly in accordance with fire regulations and a premises audit every three months. The audit or the fire safety checks did not include fire exits and fire escapes. There was no formal system to check fire exits weren't obstructed and that the fire escape staircase was safe for use. This demonstrated that the checks undertaken were not effective in identifying risks.

We discussed these concerns with the registered manager. They had the items blocking the fire exit removed. They arranged for a builder to visit and undertake an assessment of the fire escape staircase. They told us that the fire officer had been aware of the bolt being used on the fire door at their visit in April 2014 as people were at risk of going down the fire escape. We discussed the use of the bolt with a fire officer. They said, "Where an evacuation is managed such as a care home and there is a need to keep vulnerable people inside and away from harm the gold standard would be some kind of lock linked to the fire alarm. Where this is not practical I would accept a bolt providing that all staff have received training and are aware of the security measures to prevent panic in the event of an emergency." However the use of the bolt on an external fire exit had not been considered by the registered manager in the service's fire risk assessment and the potential impact in the event of a fire. Therefore the risk had not been considered.

Following the inspection we contacted the local fire service to share our concerns. They scheduled a visit to the home to undertake a review.

The provider employed a full time maintenance person who oversaw maintenance at the service. They undertook regular checks and maintenance of equipment. These included monthly checks of the emergency lighting, wheelchairs, window restrictors and water temperatures. We identified one room on the first floor with window restrictors in place, which were not effective as they had an opening significantly above the 100 millimetres maximum as recommended by the HSE. This meant vulnerable people had access to a window opening large enough to fall through, and at a height that could cause them harm. The last monthly check of the window restrictors undertaken on 7 June 2016 had recorded the restrictor was in place and effective. This meant staff had not recognised the risk to people, so had not reported the equipment was faulty and needed repair. We discussed this with the registered manager and action was taken immediately to make the window restrictor effective.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

The operations manager sent us an action plan following the inspection telling us what they were going to do to. This included required improvements to the fire escape, reminding staff of their responsibilities, improvements to the risk management of people's dietary requirements and amending the fire check paperwork to include checking fire exits.

External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, gas, electrical and lift maintenance. Fire drills were carried out weekly in accordance with fire regulations.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service. This showed the home had plans and procedures in place to safely deal with emergencies. Accidents and incidents were reported and reviewed by the registered manager to identify ways to reduce risks as much as possible.

There was a safe system in place for ensuring the safe management and review of medicines. Improvements were needed in relation to the administration of topical creams, as this was not always safe. Prescribed creams were recorded on people's medicine administration records (MAR). The information was transferred onto a topical cream chart for care workers to sign when they had administered the topical creams. This guided staff which cream to use, where it should be applied and the frequency of the cream application. There were significant signature gaps on these charts which indicated people may not have had their creams administered as prescribed. The registered manager said she would take action to improve the administration of prescribed topical creams.

People were supported in taking their medicine safely. One person told us they were happy with how they received their medicines but did not have their creams applied consistently. Another said, "My tablets are put in a cup on my bedside table". A nurse demonstrated the new system for storage of medicine being used at the service. The tablets were dispensed in individual packets which were stored in a separate named box for each person living in the home, in a purpose-built trolley. As this trolley is new, there was not yet in place a way to secure it to the wall. However the room in which the trolley was stored was kept permanently locked. When medicines arrived at the home, the MAR showed they had been received safely and only the required amounts were held in stock. Medicines which required stricter control were managed in the required way and the correct amounts held. There was an up to date medicines policy and procedure in place to give guidance. We observed a medicine round where people received their medicines appropriately. There had been an audit completed by the local pharmacist in March 2016 with all action points identified addressed by the service.

Recruitment checks on prospective new staff were completed to ensure only fit and proper staff were employed at the service. Staff files contained police and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions. It prevents unsuitable people from working with people who use care and support services. References for new staff were obtained before they started work. Records of interview notes were kept and gaps in employment history were discussed. However on one care worker's interview form the registered manager had recorded, "She was unable to answer care based questions due to language and lack of experience." The registered manager confirmed the care worker was doing the Care Certificate. However she said they didn't push the staff whose first language wasn't English as it was hard for them to complete.

People were protected from abuse. Policies and procedures were in place to guide staff about the correct action to take which included local authority guidance. Staff were knowledgeable about safeguarding and understood what abuse was. They were aware of what to look for and who to report concerns to.

The nurses completed accident or incident reports when they occurred. These were checked by the registered manager who monitored them to identify any trends or patterns.

Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had access to hand washing facilities and used gloves and aprons appropriately. The laundry room was tidy and soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

Requires Improvement

Is the service effective?

Our findings

People on the whole said they were happy at the home and that the staff were very nice. However, four people and three visitors said there were communication difficulties with some staff, as they had difficulty understanding them and getting them to understand what they wanted. This was because, for those staff, English was not their first language. Comments included, "Some staff can't speak English so Mum doesn't understand them…there is a lack of communication" and "Some of them you have got an awful job to understand. It seems to be getting worse". One care worker said, "There is sometimes a language barrier… it is hard seeing the residents struggle…It is very distressing seeing the residents not being able to understand."

Two health professionals commented about the communication difficulties they had experienced. Their comments included, "I was concerned there was a mix-up of patient names… (A member of staff) not understanding a service user asking for paracetamol" and "I'm trying to promote better communication with the use of charts in the staff area. There have been a few issues of poor communication."

We discussed this concern with the registered manger as we experienced difficulties speaking with some staff whose first language was not English. They recognised there were difficulties and said they relied on having some overseas staff so staffing levels were adequate. For one care worker who we had concerns about, they explained the staff member was always allocated to work on the same floor as a nurse who spoke the same language. That staff member was also undertaking English lessons at the community centre.

Sufficient action had not been taken to support staff, whose first language was not English to improve their communication skills and check they had the communication skills required to perform their role effectively.

People received care and support from staff who received training and support on how to undertake their role. Staff had received supervision on a regular basis. The registered manager confirmed they were undertaking a programme of staff appraisals.

Staff had completed or were scheduled to complete the provider's mandatory training. The registered manager said these consisted of, safeguarding vulnerable adults, MCA 2005, equality and diversity, person centred care, health and safety, diabetes, infection control and food hygiene. They went on to say there were 17 different training subjects staff could complete in the training program they used.

There was a system to ensure staff also remained updated and took refresher training as required. Staff on the whole were positive about the training they had received but not all liked the workbook system used at the service. Comments included, "I felt the training has been really good and taught me a lot that is one area that is good here"; "We have a man come in to train us about fire. He is very good" and "I prefer face to face training the best, I did the workbooks but the questions kept repeating themselves which was confusing."

The nurses at the service had undertaken additional training to ensure they had the knowledge and

competence to undertake their role. This included verification of death training, catheter care and syringe driver training (a small, portable pump that can be used to give a continuous dose of painkillers and other medicines through a syringe). Checks were made to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK.

Induction training for all staff consisted of a period of 'shadowing' experienced staff to help new staff get to know the people using the service. New care workers who had no care qualifications, undertook the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. New nurses as part of their induction also completed an 'induction and orientation for registered nurses'. This was to ensure they had all of the information needed to be in charge of a shift at the home. They had to demonstrate an understanding of what to do if they received a complaint, how to contact professionals and record keeping. All staff completed an assessment regarding the use of equipment at the home as part of their induction.

People were not always having their rights upheld. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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.

Staff were not always aware of people's relative's rights regarding their power of attorneys (POA) and the authorities they had. The registered manager was aware of the different types of power of attorney. This was because people were asked as part of the admission process to the home. However records of these were kept in the main office and not recorded on people care records. Since the inspection the provider has written to us and said they will review people's care records to ensure people's power of attorney information is in the files and that consents have been signed by people whenever possible.

The provider required that staff gained formal consent from people at the service regarding sharing information, having a photograph taken and care plans. However staff had not requested the person give their consent but their family member in six of the files we looked at. Staff had not considered whether the person had the capacity to decide themselves and therefore had not recognised people's rights and followed the MCA. One person said they were in the room when their wife had been asked to sign the consent form by the nurse not them.

The provider's representative sent us an action plan following the inspection telling us what they were going to do to. This stated, "Review of all care records will be undertaken by 29 July to ensure POA information is in the file and that consents have been signed by the resident whenever possible".

The registered manager had considered people's capacity to make particular decisions and knew what they needed to do to ensure decisions were made in people's best interests. Professionals and relatives had been involved in the decision making process where appropriate. For example, a best interest decision had been made regarding where best to have a person's care needs met either at their own home or at Culm Valley Care Centre. The registered manager and clinical lead had a good understanding of MCA and were working with the nurses at the home to have a better understanding.

Staff had received training about the MCA and they demonstrated an understanding of people's right to make day to day decisions. When asked about their understanding of the MCA, one care worker knew about

DoLS and said "if they want to go out they can, we see what we can do."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager confirmed DoLS applications had been submitted for people living at the home who were awaiting assessment. The Supreme Court judgement on 19 March 2014 widened and clarified the definition of deprivation of liberty. It confirmed that if a person lacking capacity to consent to arrangements is subject to continuous supervision and control and not free to leave, they are deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and in a person's own best interests.

People had access to healthcare services for ongoing healthcare support. One person said, "If they thought I needed the doctor I would get him. The nurses here are very good. The majority of (care staff) are very good." People were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. People's medical history and health needs were recorded when they were admitted to the home. The care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. Staff worked with health professionals such as the community nurses, occupational therapists and physiotherapists. One health care professional said they were contacted but not always promptly. They said staff were not recognising that people's conditions were changing and being proactive in their response. For example, identifying that a person required additional pain relief medicines. Other health professional's comments included, " The staff and management are all very friendly. They listen to, and put into action advice that is offered when in the best interests of residents."

Where staff had identified people as at an increased risk of skin damage, pressure relieving equipment had been put into place to protect them from developing sores. This included pressure relieving mattresses on their beds and cushions in their chairs. When people came into the home staff undertook an assessment of their skin to ascertain any sore areas of concern. Care workers undertook daily checks of people's skin and reported any concerns to the nurses.

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu with two meal choices and other options people could choose. The cook said when a new person came into the home, the staff completed a nutritional profile about their likes, dislikes and meal requirements which was given to kitchen staff. There was also a white board in the kitchen where staff recorded people's changing wishes and needs, so all staff would be aware of changes. People who required a pureed option had their meals formed in specialist moulds to make it look more appetising. People were asked the previous day for their meal choices which were recorded on a sheet populated with people's names and dietary requirements, for example, diabetic or puree. The cook said that people assessed as at risk of weight loss had additional fortified mousse each day.

People were mainly positive about the food at the home. Comments included, "The food here is very nice"; "I have no complaints about the food"; "not too bad" and "sometimes the portions could be bigger…I have asked for extra potato and I have had more."

People had jugs of water and juice in their rooms and staff offered regular refreshments. Meals were served in the main lounge and on the first and second floor. Staff served up people's meals using the menu sheet from the day before, and ticked the list to confirm each person had received their meal. However, some people and their visitors gave us examples regarding the food they had received. For example, one visitor

gave an example where their relative had not received a meal. They had raised it with the staff and an alternative had been found

Good

Is the service caring?

Our findings

People were supported by caring staff who treated them with kindness. We spent time talking with people and observing the interactions between them and staff. Staff were always busy and were mostly interacting with people when they were providing support. Staff were pleasant in their manner and helpful towards people and were talking to people and at times happy banter was heard. People seemed to know the staff well and were seen positively interacting with some.

Staff treated people with kindness and compassion. Throughout our visits staff were respectful in their manner. They greeted people with a smile and people responded positively. The atmosphere at the home was busy. Staff supported people eating their lunch when required. They were discreet and not rushed in their approach and retained eye contact with people throughout to give them reassurance.

Staff treated people with dignity and respect when helping them with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on people's bedroom doors before entering and gained consent before providing care. However one visitor said "It is not dignified how they put tea in a plastic glass when (the person) prefers a cup."

Staff involved people in their care and supported them to make daily choices while they were undertaking their care. For example, people chose the clothes they wore and where they wanted to spend the day. One person commented, "Not too bad here…I get up on time." Staff said they knew people's preferred routines, such as who liked to get up early and who liked to stay in bed. We heard staff discussing that two people had chosen to stay in bed and therefore they had left them.

People's relatives and friends were able to visit without being unnecessarily restricted. People said their visitors were made to feel welcome when they visited the home. One visitor said, "Always made to feel welcome when I come." The majority of people's rooms were personalised with their personal possessions, photographs and furniture.

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse. One person was receiving end of life care at the home at the time of our visit. The staff worked closely with the person's family and GP to ensure they were informed. A health professional commented, ""End of life care is usually provided well… turning, repositioning and tender loving care is nicely handled." The registered manager told us in their PIR how they were working to improve their end of life care further. They recorded, "We are introducing a bereavement guide to give to families after the death of a loved one to support them with what they need to do, and to offer after death support, especially if death was sudden."

The registered manager had received numerous thank you cards from families whose family member had passed away at the home. Comments included, "staff were always kind and patient"; "thank you for all the care and compassion given and shown to my Mum and Dad who saw their lives out in your care… I am

happy in the knowledge that their final days were made as comfortable as possible" and "You made Mum's last few days as comfortable as you could, she enjoyed her time with you and a lot of you became her friends."

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs because people's care and support was not well planned when their needs changed. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the pre admission process and were asked their views and how they wanted to be supported. An activity of daily living assessment was completed on admission and this information was used to develop care plans where it was assessed people required support.

Care plans were written to reflect the assessed needs of people when they arrived at the service. However they were not always updated with people's changing needs. This meant staff may not be consistently guided how to meet people's needs safely.

For example, one person had developed a chest infection and the GP had visited. However there was no care plan to guide staff on how to support this person to be comfortable. This person was very anxious and was heard calling out and becoming distressed. Staff did not have a consistent approach to relieve the person's distress. There was no care plan regarding the person's anxiety and measures staff should take to relieve their unease. We discussed with the nurse on duty the distress the person was displaying. They confirmed they had been visited the previous day by a specialist doctor (they were unable to tell us who) and antidepressant tablets had been prescribed. However this was not recorded in the person's care records.

We discussed this with the registered manager and by the second day of our visit a care plan had been written regarding the person's anxiety and how to approach and calm them. The doctor's visit and the outcome had been retrospectively added but the doctor was not identified.

Another person who had complex health needs stayed in bed for the majority of the time. Staff explained that the person experienced a lot of pain and anxiety when they were repositioning them. One senior care worker said, "(Person) is very insecure being moved, we have to explain first, have to do it slowly talk to her she can understand. Can be anxious so speak calmly and explain to her." There was no care plan in place regarding the person's pain or anxiety and guidance for staff to have a consistent approach. There was also no care plan regarding the person's social and emotional needs.

The family of this person expressed concern that their relative did not have the physical ability to use the call bell. Their comments included, "There's one thing I am concerned about. Mum can't press the bell. She is utterly dependent on others. How would she get help? It's fixed in front of her but her hands are too stiff to press it now…I came in after work one day and Mum was calling out "help me, help me!". She wanted help to remove her quilt because she was too hot. She can't do it and she can't call for help." The person's care plan clearly guided staff that they must ensure the person's call bell was in reach at all times. We discussed this with the manager and two care workers who said they felt the person could ring their call bell. Staff were completing checks on this person every three hours to reposition them and support them with meals. However there was nothing recorded in the person's care records to assess and monitor the person.

Care files included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. Care records showed that staff had involved other health and social care professionals. Referrals were made to the Speech and Language Therapy (SALT), physiotherapist and occupational therapist. The registered manager recorded in their PIR, "We have started writing care plans on the computer so they are legible, easily read, and can be quickly updated in response to changes in a resident's care needs."

People and their families had not been regularly given the opportunity to be involved in reviewing their care plans. One visitor said, "I am happy staff know Mum's needs… I know she is alright they always ring me if there is a problem…any problem they call a doctor. I haven't had a care plan review. It would be nice to know the progress Mum is making and discuss any problems." The registered manager explained that they had sent letters to family and friends last year inviting them to review the care provided for their family member. They confirmed a number of reviews had been carried out last year with a few at the beginning of 2016. They said they needed to remind the nurses to include people and their families when appropriate in reviews.

At weekends a care worker was allocated to work in the lounge to ensure people's safety and undertake activities. This was because the ground floor has no bedrooms and there was no activity person, administration or reception staff. People were not very positive about the activities at the weekends, saying there were very few. We discussed this with the registered manager who said they tried to delegate care workers at weekends who had an enthusiasm for activities. However, these arrangements were not always ensuring activities were being carried out. The provider made us aware after the inspection that people did have access to crafts and social conversation with other people living at the home.

Up to 20 people who used the lounge during our visits were supported and had the opportunity to partake in the activities on offer. However, there was no system to ensure people who had chosen or needed to stay in their rooms for health reasons were not being socially isolated. People in their rooms only had staff engagement when staff were undertaking tasks, as they were too busy to spend meaningful time with people. A personal social profile had been completed for people who came to the lounge regularly. This included information about what people enjoyed, birthdays, occupation, hobbies and interests. However, these had not been completed for the majority of people at the service. Therefore staff were not aware of people's past and interests so they could not provide meaningful social support.

A relative heard we were undertaking an inspection and shared their experiences with us through the CQC website. Their comments reflected two people and three visitors and included, "My relative …report being very bored much of the time in spite of best efforts of staff… The service do put on some excellent events during the course of the year and have someone there every weekday to do 'activities'. However, there is not enough variety and innovation to help residents feel as if they have a purpose to their lives or can still contribute in any way…"

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

The provider employed an activity person who worked five days a week. They were based in the main ground floor lounge where they supported people with their meals and to participate in a range of activities. These had recently included the celebration of the Queen's 90th birthday with a garden party and a virtual cruise around the British Isles. Outside in the garden stood a model of the Queen and a flower feature in the shape of a crown with bunting, following the celebration. On display in the lounge were numerous crafts and a special display of caricature models of people dressed up in their best clothes attending a garden party.

The monthly newsletter for July 2016 had activities scheduled which included, bingo, board games, cooking and arm chair exercises. On the last day of our visit the local vicar was giving people communion in the lounge and visiting two people in their rooms, as requested by their families.

People spoke highly of the activities person and the registered manager said they had nominated them for an award with the National Association for Providers of Activities for Older People (NAPA). This is an organisation dedicated to increasing the profile and understanding of the activity needs for older people.

The registered manager said they tried to encourage people to go to the lounge and that they all had a copy of the monthly newsletter advising them what was on offer. However a lot of people still chose not to attend. They went on to say they encourage staff to do people's nails and hand massages and maybe they had not recorded when they had. They went on to say that they had been working to get volunteers to come and meet with people at the home, but this had been unsuccessful.

Relevant assessments were completed and up to date. Risk assessments included an assessment of nutritional needs, mobility, falls and skin integrity. Nurses completed monthly reviews of people's risk assessments and care plan reviews of designated individual people's needs.

The provider had a complaints procedure which made people aware of how they could make a complaint. It also identified outside agencies people could contact. People were also made aware of the complaints policy as part of the home's admissions checklist. The registered manager had received one complaint in the last twelve months. They had followed the provider's policy regarding responding to the complainant and undertook an investigation. When the complainant was still not satisfied with their response, a further meeting was held and an agreement reached and lessons learnt as an outcome. During the inspection the registered manager received a complaint which they were in the process of responding to.

Requires Improvement

Is the service well-led?

Our findings

Leadership within the home was not ensuring staff had the information they needed and that records were maintained as they should be. The service had a registered manager in post as required by their registration with the CQC. The registered manager was experienced and suitably qualified. People and relatives, were, on the whole, positive about the registered manager. They said she was friendly, approachable and available if they wanted to talk with her.

The registered manager was supported by two clinical lead nurses, with one on maternity leave at the time of the inspection. This meant there was no clinical lead working during the day as the second clinical lead worked at night. Nursing staff were not experienced in making day to day clinical leadership decisions and managing the staff team. This meant the registered manager had been working with the nurses to take the lead and direct the care staff. However the registered manager said they were having difficulties making the transition as they were used to being guided by the clinical lead. Following the inspection the provider said that this would facilitate development of their skills and was an opportunity to assess their performance.

The registered manager recorded in their PIR, "Handovers at the start of each shift ensure changes in a resident's condition or choices are given to staff in a timely manner, so they are kept up to date." We attended a morning handover between the night and day staff along with the registered manager. Information was passed to the nurses regarding people's clinical needs and areas of concern. However care workers were not engaged with the handover with two arriving over half way through. There was no clear direction given by the nurses as to what was expected of them. Therefore care staff were not aware of care they needed to deliver. For example, one person required a specialist splint be put on their hand twice a day. This was recorded in their care plan. However, the person said it had not been put on by staff since they arrived at the home more than a week ago.

A nurse meeting was held in January 2016 where all nurses attended. At the meeting they discussed the importance of ensuring care plans and daily evaluation charts reflected what was happening with every resident at any time and not wait until the end of the month to make changes". Following the meeting the registered manager wrote a letter to the nurses regarding records not being completed promptly.

The operations manager had identified poor documentation of visiting health professionals and had recorded on their action plan from their April 2016 visit, "Identified evidence in care records of health care professional colleagues being involved in a resident's care but the information from the visits is not always integrated into care plans." However it was clear from the evidence found at our inspection that the nurses had not improved their record keeping.

The quality assurance systems used at the home did not always identify areas of concern. The provider had a number of quality monitoring systems in use which were used to review and improve the service. The registered manager had a schedule of required audits and reviews to be carried out each month. These included catering reviews, care records, audits, medicine audits, falls analysis, activity reviews, infection control and premises checks. However these audits had not always been effective and had not identified all

of the breaches of regulations found during the inspection. For example, in relation to safety risks, communication issues, responding to changes in people's care needs and accuracy of care records. This showed the quality monitoring systems in use at the home were not fully effective.

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

The operations manager undertook regular visits to the service to support the registered manager and undertook quality monitoring checks. This included speaking with people, visitors and staff to ask them about their experiences and views. They also audited a random sample of people's care records, staff files and service management records.

Senior care workers were clear about their role and responsibilities. One senior care worker explained how as part of their duty they checked charts were being completed. These included fluid, diet and repositioning charts. One care worker said, "They (the nurses) do the tablets and deal with the doctors and emergencies." The registered manager told us in their PIR changes they were putting in place, "Develop Senior Carers' roles to be more involved with residential residents care plans and develop their skills (for example) taking observations. Develop RNs (registered nurses) to carry out more supervision sessions with care staff, on the job and one to one."

The provider encouraged open communication with people who used the service, those that mattered to them and staff. People using the service and their relatives were encouraged to complete an annual satisfaction questionnaire. The provider had been trialling the use of comments cards for the first six months of 2016. These were located in the main lower ground floor entrance away from where people spent their time. However the registered manger had checked regularly and nobody had completed a comment card during the six month period. People had also been asked to complete an activity and catering review in February 2016. The service had given out 48 questionnaires and received 19 responses. People said they were happy with the food and activities at the home.

Meetings had been held for people and relatives to be informed about changes and give their views. Ten people and one family member attended the last meeting in the main lounge. Menus were discussed; laundry and that unidentified clothing remained an issue. People were asked if they were happy with the cleaning and everyone was content with the activities. A meeting was held following this meeting with the kitchen staff about menu planning. The four week menu was discussed and feedback given by people. As a result they agreed to change the tuna and pasta bake and add egg mayonnaise salad and sausage plait. This showed positive action was taken in response to people's feedback.

The registered manager said they walked around daily and spoke with people and any visitors they saw to ask their views and discuss concerns and undertook a general environment check. Each month a newsletter was produced and given to everybody at the home to keep people informed. The newsletter contained information about activities, external entertainers coming to the home, people's birthday celebrations and requested items that people and visitors may have for arranged activities.

Staff were actively involved in developing the service. We were present at a staff meeting; although it was not very well attended. There was an open discussion with staff adding their views. The registered manager said they would write up the minutes of the meeting and they would be put out for all staff to read.

The registered manager monitored and acted appropriately regarding untoward incidents. They looked at trends and patterns in accidents to ensure appropriate actions were taken to reduce risks.

In September 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored the highest rating of five, which confirmed good standards and record keeping in relation to food hygiene had been maintained.

The provider had displayed the previous Care Quality Commission (CQC) rating of the service in the main entrance and on the provider's website. The registered manager and provider were meeting their legal obligations. They notified the CQC as required, providing additional information promptly when requested and working in line with their registration.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people had care and treatment which was appropriate and met their needs. (1)(a)(b) (3)(b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring people received safe care and treatment. Risks were not being managed safely. Reg 12 (1)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems had not identified areas of concern. (1)(2)(a)(b)