Caring Homes Healthcare Group Limited

Laverstock Care Centre

Inspection report

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Date of inspection visit: 28, 29 April and 1 May 2015
Date of publication: 15/07/2015

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**

Overall summary

We carried out this inspection over three days on the 28, 29 April and 1 May 2015. The first day of the inspection was unannounced. Our last inspection to the service was on 20 May and 11 June 2014. During the visit in May/June 2014, there were shortfalls in care provision and people's dignity was not being promoted. There were also shortfalls in cleanliness and infection control. We issued four compliance actions to ensure the provider made improvements. The provider sent us an action plan, which described how the shortfalls would be addressed. During this inspection, we saw that improvements had been made to each area.

Laverstock Care Centre provides accommodation to people who require nursing and personal care. The home is arranged over three floors, with en-suite bedrooms and communal rooms on each floor. A section of each floor is run separately for people living with dementia type conditions.

The home is registered to accommodate up to 80 people. On the day of our inspection, there were 74 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

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. The registered manager was available throughout the inspection. A senior manager was also present at the end of the inspection to receive feedback about our findings.

Not all risks to people's safety had been identified and addressed. People's care plans did not consistently provide staff with information about the risk, potential triggers or the action required to minimise the risk. Not all incidents between people were reported using local safeguarding procedures or appropriately investigated by the registered manager. This did not enhance people's safety.

There were a range of systems to monitor the quality and safety of the service. Audits were undertaken at varying frequencies depending on the subject. However, hot water from two hand washbasins and the cleanliness of some armchairs and toilet seats had not been identified and addressed.

Whilst care plans were in place, not all were person centred and easy to follow. Not all contained clear details of people's needs and the support they required. Whilst staff and the registered manager had a clear understanding of the Mental Capacity Act 2015, documentation did not demonstrate this.

Since the last inspection, improvements had been made to the service. People looked well supported and the quality of staff's interactions with people had improved. Staff spent time with people and were responsive to their needs. They assisted people to eat in a focused but sensitive manner and regular drinks were offered.

Staff told us they felt well supported and they undertook a range of training to help develop their knowledge and skills. There were varying views as to whether there were enough staff on duty to meet people's needs effectively. Staff sickness and high dependency of people compromised some satisfaction. During the inspection there were sufficient numbers of staff available and the home was calm. However, staff were not consistently aware of some people's whereabouts.

People told us they felt safe at the home. They were happy with the care they received and the way staff treated them. There were varying views about the food although people had enough to eat and drink. People were aware of how to raise a concern or make a complaint.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Not all risks to people's safety had been identified or addressed. Records did not clearly identify individual risk, potential triggers or how staff were to manage particular issues.

Not all incidents between people had been appropriately reported to safeguarding or investigated by the registered manager to minimise further occurrence.

There were sufficient staff on duty to meet people's needs although staff were not fully aware of some individual's whereabouts at all times. Views about staffing levels varied with staff sickness and dependency levels compromising satisfaction.

Appropriate systems were in place to manage people's medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager and staff demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA). However, an assessment of the person's capacity to make the specific decision in question was not recorded.

Staff felt supported in their role and morale had increased. Staff were offered a range of training to help them to do their job more effectively.

People's health care needs were appropriately assessed and staff supported people to stay healthy.

People had enough to eat and drink although their views about the food provided varied. People's risk of malnutrition had been assessed and appropriate measures were in place to enhance calorie intake.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and the way staff treated them. Relatives were equally positive about the staff and the care provided.

There were positive interactions between staff and people who used the service. Staff promoted people's rights to privacy and dignity and spoke to people in a caring, friendly and respectful manner.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst care plans were in place, not all information was easy to follow. The plans were not person centred and did not clearly identify the support required.

Improvements had been made to the care people received. People looked well supported and were more relaxed and less agitated.

Staff interacted with people well and responded to people's needs in a timely manner.

People told us they knew how to raise any concerns or complaints and were confident that they would be taken seriously.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager was experienced and kept themselves up to date through meetings, reading and researching topics.

Improvements had been made to the service since the last inspection. Further plans were in place in response to the recently adopted dementia care initiative.

There were a range of systems in place to monitor the quality and safety of the service. However, some shortfalls had not been identified and addressed.

People and their visitors were encouraged to give their views about the service provided. Systems to gain people's views were being reviewed to ensure maximum effectiveness.

Laverstock 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 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 was unannounced on the 28 April 2015 and continued on 29 April and 1 May 2015. The inspection was carried out by two inspectors, a bank inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with twenty people living at Laverstock Care Centre and six visitors about their views on the quality of the care and support being provided. We spoke with the registered manager and eleven staff. We looked at people's care records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures. We looked around the premises and observed interactions between staff and people who use the service.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before our inspection, the registered manager was asked 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. The registered manager returned the PIR in a timely manner.

Requires Improvement

Is the service safe?

Our findings

Not all risks to people's safety had been identified or addressed. One care plan identified that a person was at risk of leaving the home unaccompanied. There was no information to indicate why this was a risk nor how it should be managed. Records showed that another person was at high risk of falling. A member of staff told us that this risk was most prominent after a meal, when the person tried to get up without waiting for staff assistance. This was not detailed within the person's care plan and there was no information about the support they needed with their walking. Another person received regular observations as they entered other people's rooms, presenting risks to their safety and that of others. They were also at risk of falling. Some measures to minimise these risks were recorded in various sections of the person's care plan but they were not immediately obvious to the reader. This gave the likelihood that some measures to enhance the person's safety would be missed. Staff were aware of the risks associated with this person going into other people's rooms but not of the risk of falling. The person's whereabouts was being monitored by staff. However, on the first day of our inspection, staff had not identified that they were in another room of someone being cared for in bed. This presented risk of harm which had not been sufficiently identified or addressed.

Records showed that one person had struck another when entering their room. This person then retaliated. Staff intervened but the assault was not reported in relation to local safeguarding protocols. A member of staff told us that this was because no injury had been sustained, and the people involved were unable to give an account of what had happened. This was a mistaken view and did not enable further risk to be minimised. We asked what actions the provider had taken to review the risks and risk management process in relation to the incident. The member of staff told us "probably none because this is a dementia unit and you can't stop these things from happening." This view did not promote people's safety.

This was a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received safeguarding training. They were knowledgeable about recognising possible signs of abuse. Staff told us they would immediately report any suspicion or allegation of abuse to the registered manager or the most senior member of staff on duty. If they felt their concerns were not being taken seriously or if the issues were about the registered manager, staff told us they would speak to a senior manager or other agencies such as CQC. Staff were aware of the policies and procedures in place to keep people safe.

Throughout the inspection, the home was relaxed and people were supported appropriately without having to wait. There were minimal call bells ringing and those which did ring, were answered without delay. Staff spent time talking to people and were not rushed in their manner. These factors indicated there were enough staff on duty. However, we found two people in the bedrooms of others and another person had walked along the corridor in a state of undress. Staff had not identified this, which indicated staff were insufficiently deployed to supervise people effectively.

People gave us varying views about whether there were enough staff on duty to support them effectively. Some people were positive and told us they did not have to wait for staff to answer their call bell. One person told us "they always come quickly. It's not a problem". Another person said "I can't complain. They're there if you need them. You just need to call and they'll help you". Other people told us staff response times could vary. One person told us "the carers are lovely, but short staffed. They work very hard". Another person said "there are not enough staff sometimes. This is noticeable in the mornings, when people are getting up and during the evening when they are going to bed".

There were varying views from staff as to whether there were enough staff on duty to meet people's needs. One member of staff told us that staffing levels were not unsafe but staff had to work hard to get everything done. They told us "staff are committed to people and they want to do a good job, so they'll miss their break, if it gets busy". Another member of staff told us that staff supported each other and worked well as a team, to make sure people received what they needed. They said "there's always 'a floater' [an extra member of staff who assists where needed] which helps if we're struggling. Other staff from different floors or seniors will also help if there's a problem". One member of staff told us the atmosphere was now much calmer. They said this was because there were vacancies and those people with

Is the service safe?

high dependency needs, were no longer living at the home. A senior member of staff told us they disagreed with this view. They said "staff are now much better at managing situations so the atmosphere is much calmer".

Other staff felt there were not always enough staff available. They said they found it particularly challenging if a staff member called in sick at short notice and their shift could not be covered. Staff told us that working with a member of staff less, during the day or night was difficult. On the second floor dementia unit, one member of staff told us "we usually have four staff which isn't too bad but if someone goes sick, it's really difficult with only three staff". They told us that one member of staff always remained in the lounge to supervise people. This meant that if there were three staff on duty, there would only be two staff to assist people. They said this was not enough, especially as some people required the assistance of two staff to help them with their personal care or manual handling needs. Another member of staff told us that sometimes they felt inadequate staffing levels increased people's anxiety and associated behaviours. They said this was particularly apparent during the late afternoon when some people became increasingly unsettled.

People told us they received their medicines as required. One person told us "the nurses give me my medicine at the same time every day". Another person told us "they always give me my medicines and a glass of water to take them with". One person asked staff for some pain killers as they said their leg was "giving them gip". Staff respected this request.

People's medicines were managed and administered in a safe and ordered manner. Medicines were dispensed into a monitored dosage system by the local pharmacy. This minimised the risk of error. Staff had satisfactorily signed the medication administration records (MAR) to show people had taken their medicines, as prescribed. When a person had refused or had not received a medicine, the appropriate code had been recorded on the MAR. People's photographs were attached to their MAR sheets to aid identification and any medicine allergies were recorded. Individual protocols for the use of 'as required' medicines were kept with people's MAR sheets. The protocols directed staff as to the medicine's correct administration to ensure maximum effect. However, within three cases, the protocols had been signed by the nurse who compiled them, but lacked an approver's signature and a review date. Some people had been prescribed their medicines to be taken covertly if required. One covert medication assessment form had been signed by a GP and a nurse, but not the person's next of kin. This was addressed during the inspection. Another person's covert medication assessment form had not been reviewed since 2012. A senior member of staff told us they would address this without delay.

People told us they felt safe within the home. One person told us "I do feel safe living here. The carers make me feel safe". Another person told us "I feel safe here. I am well looked after and the staff are very good. I never want for anything". Another person told us they felt safe as there were "no abusive characters". Relatives told us they had no concerns about their family member's safety. One relative told us "I am happy with my wife's care and I know she is safe here, I can go home and not worry". Another relative said "I've never seen anything which would worry me, the carers are very kind. I've seen other people being helped and staff always seem patient".

Organised recruitment procedures were in place, to ensure people were supported by staff with the appropriate experience and character. All applicants provided evidence of his or her identify and their right, if applicable to work in the United Kingdom. Disclosure and Barring Service (DBS) checks were undertaken. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. Applicants were subject to a formal interview and their previous employers were contacted to provide details about their past performance and behaviour. Some employers gave clarification of the date of employment rather than further detail, which limited the information available. Records showed that one applicant had limited experience, so their step father had given them a reference. This did not give an objective opinion regarding their suitability for the post.

Requires Improvement

Is the service effective?

Our findings

Staff demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) worked. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

One member of staff told us that people lacked capacity when they were unable "to make the best judgement for themselves at the time". They said "we have to help them with that judgement and still try to give choices". Another member of staff said that they assume the person has capacity, and ensure any decision made on their behalf is made in their best interests. Another member of staff spoke about intervening in people's lives as little as possible. They gave an example of balancing people's skin integrity needs against their unwillingness to have personal care. They concluded that personal care would be given only in as much as it was necessary, to preserve the person's skin integrity and dignity.

Applications to authorise restrictions for some people had been made by the service and were being processed by Wiltshire Council, the supervisory body. However, not all care plans had a clear statement relating to the person's mental capacity. The registered manager used "best interest care plans" for some, but not all of the care plans on which people lacked capacity to decide. From the best interest decisions in place, the provider's MCA processes did not record an assessment of the person's capacity to make the specific decision in question. In addition the MCA processes did not meet the required standards set out in 5.15 of the MCA Code of practice on best interest decision making.

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

People told us staff understood their needs and provided the care they needed. They said staff were competent in their role. Visitors also shared this view. One visitor told us "the girls here are very good. I have no concerns about the care". Another visitor told us "the staff get a lot of training but there are some which have such empathy. They've just got it and are so natural. That can't be taught. It's with them, which is a real skill. I watch them sometimes and I must say I'm impressed".

Staff told us they received a range of training to assist them to do their job more effectively. One member of staff told us about a new training initiative, which the home had recently adopted. The training known as 'Living in My World' was aimed at developing care provision, provided to people with dementia. The member of staff was passionate about this training and explained how they were cascading its ethos to the staff team. They showed us developments to the environment which had been made as a result of the training. This included wall art in the bathrooms and items of familiarity on people's bedroom doors and in the corridors.

One member of staff told us they had recently completed training in relation to mental capacity, the deprivation of liberty safeguards (DoLS) and safeguarding. Another member of staff told us they had recently obtained level 3 diploma in health and social studies. One member of staff, who had recently started employment at the home, told us they had received appropriate induction training. They said this was a mixture of practical and 'on line' sessions in subjects such as safeguarding, moving and handling, food safety, fire safety, mental capacity and DoLS.

On the first day of our inspection, the registered manager facilitated a training session for staff on our inspection methodology. The registered manager told us they felt it was important for all staff to know about regulation and their responsibility of providing safe care. Once informed, they believed staff would understand why shortfalls were identified rather than thinking managers were 'just moaning or picking fault'.

The electronic system used to record staff training, showed that staff had undertaken training in a range of mandatory subjects. The system produced alerts when refresher training was required. This ensured all staff were up to date with their knowledge. However, certificates to evidence the training staff had undertaken were not consistently placed

Is the service effective?

in their personnel files. The registered manager told us that this was because the home was using two systems for documenting staff training. They said training records would soon be held electronically to ensure clarity.

Staff told us they felt well supported in their role. They said they gained support from each other and/or their line manager. Some staff said they felt work had been given to team building which had improved the overall atmosphere of the home and general staff practice. They said morale was better and they felt valued. Staff told us there were staff meetings and formal staff supervision sessions or appraisals, where they could discuss their performance, training needs and general wellbeing. One member of staff told us that staff meetings were held three to six monthly and everyone was encouraged to give their views. Another member of staff said that staff meetings took place "quite a lot" and staff were encouraged to raise any issues they had.

There was a supervision matrix in place, which ensured supervision sessions occurred when required. Paper records of the meetings were maintained and stored securely. However, not all issues discussed were documented. For example, before our inspection, we received information of concern about two members of staff and their practice. The registered manager had investigated the concerns but there was no record of this within the staff member's personnel files.

People gave us varying views about the food although said they had plenty to eat. Some people said the food was good. One person patted their stomach and said "oh yes. It's liver and bacon today, my favourite". Another person told us "lunch is ok, but supper's not so good." They elaborated this view by saying they did not like things like cauliflower cheese. Another person told us "You get a lot of food but it gets a bit monotonous." Other views were "the food is a bit indifferent. Sometimes I eat in my room. There are no snacks or fruit to be had" and "the food is mediocre". Another person told us "the food is average. We get two choices for the lunch time meal, no snacks, so I keep chocolate in my room". People told us they could ask for an alternative if they did not like the main meal.

The lunch time meal in all areas of the home was calm and unrushed. Staff provided good support for people who needed assistance to eat. They said at breakfast, people had a choice of cereals, porridge, toast or a cooked breakfast. At lunch there was a choice of two dishes and at tea time there were sandwiches and/or a hot snack. People were offered a range of homemade cakes for afternoon tea. People were offered regular drinks and had drinks beside them. These were regularly replenished when they became low. Some fluid charts however demonstrated that the core times for having drinks were between 9am and 5pm. There were minimal entries recorded after 5pm.

Those people at risk of malnutrition were regularly assessed and monitored. They were weighed at intervals which related to the level of risk or weight loss. One member of staff told us "if people are losing weight, we let the kitchen know and they make shakes etc". Staff told us that when new people were admitted to the home, they were able to meet the chef. This gave people or their relatives the opportunity to discuss dietary requirements and personal preferences. Staff told us the kitchen staff had a list of people's dietary requirements so they were fully aware of what foods were required. There was a four weekly rotational menu which was based on variety and good nutritional content.

People told us they were able to see health professionals where necessary, such as their GP. One visitor told us that their relative was currently being seen by their GP, and at a memory clinic. When asked if staff contacted the GP if the person was unwell, the visitor stated "Yes, they are very good at that."

Staff told us people received good support from a number of GP surgeries in the area. They said all but one GP visited weekly, as a matter of routine and were available for advice and to visit as required. One GP visited on a fortnightly basis. Staff told us that registered nurses took action if a person was not well. They said they were able to request a visit from specialised services such as a diabetic nurse or a speech and language therapist, when required. Clear records were maintained of appointments with health care professionals. Records showed any intervention, advice and follow up action. On the day of the inspection, two faxes had been sent to the local surgery to request advice about the treatment of two people living in the home.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated well and staff were caring. Comments included "everyone's very kind. Super-duper", "the carer's are lovely, they work very hard" and "oh, the carers are very good, they're all kind. I get all the help I need. They come in and chatter. I'm very happy here".

Visitors were equally positive about the care their relative received and the qualities of the staff. One visitor told us "the carers here are very good, kindly, especially the older girls". Another visitor told us "the carers take the time to help my nan put makeup on. My nan was always very particular about putting her makeup on every day". In addition to makeup, the person had been supported to have well-manicured and neatly polished finger nails. Another visitor told us "the carers are like angels. They go above the call of duty".

People and their relatives told us that the home welcomed visitors at any time. One person told us "my family can't get here until late at night due to work but the staff don't mind". One visitor said "I come here every day and they look after me as well. I can eat here and they always check that I'm well and managing ok. They don't have to but it makes me feel welcome and so that I'm not a bother". Another visitor told us that staff enabled them to be involved in their relative's care. All visitors told us staff kept them up to date with any issues related to their family member.

Staff asked people about their wellbeing and called people by their Christian names. They spoke to people as they went about their work. Staff were respectful in their interactions, gave each person individualised focus and time to express their needs or wishes. Staff bent down to people to gain eye contact and to be on their level. One member of staff talked to a person about the football and where they had worked when they were younger. Another person became upset and agitated. Staff sat down with the person, held their hand and gave quiet reassurance. Staff smiled at people and spoke in a warm and pleasant manner. One member of staff identified a person looked tired. They asked the person if they were alright or if they wanted a lie down. Another person was agitated and looking for their bedroom. A member of staff accompanied them and selected items such as photographs that the person would recognise. This enabled the person to settle and relax and they said "home, sweet home". Staff enabled people to make decisions. This included where to sit and what to eat and drink. Staff asked one person if they wanted a bath or a shower. They then asked "now or later?"

Staff showed a caring and courteous approach towards people. People were fully informed and involved in interactions such as using the hoist. One member of staff pushed a person in their wheelchair to the dining room table for lunch. They informed the person they would be going over a slight ridge on the floor which would cause them to feel a small bump. Another staff member supported a person to sit down in their chair. They gave clear instructions in a sensitive manner. At lunchtime, staff supported some people to eat. They gave the person their meal and informed them of what it was. They asked the person if they wanted support and offered them a clothes protector. People's views were respected and the clothes protectors were removed after people had finished their meal. Staff ensured people were well positioned so that they ate safely. They sat with them at the same height to maintain good eye contact. Staff offered a mouthful of food and waited for the person to finish before offering more. They offered encouragement and asked what food they wanted next. The interaction was focused, relaxed and unrushed. Staff noted another person was not eating. They offered assistance in a caring manner.

People told us staff promoted their privacy and dignity. They said staff knocked on their bedroom door before entering and always closed the door and the curtains, before providing personal care. Important aspects of people's lives were recorded in their care plan. This included important relationships, plans for the future and daily preferences. Staff demonstrated a good understanding of what was important to people and how they liked their care to be provided. They confidently told us how they maintained people's privacy and dignity. This included covering people during the provision of personal care, leaving people alone to use the toilet and ensuring clean, coordinated clothing in accordance with personal preference. One member of staff told us promoting dignity was all about getting to know each person. They said this ensured care was delivered in the right way and conversation could be used to relax the person and to build their confidence.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not always demonstrate a person centred approach. The plans due to their format were not easy to follow. There were many sections to the care plan but people's immediate care needs were not always clear. Entries had been made in the evaluation section of the care plan, which over time presented a risk that the information would be lost. Not all plans were sufficiently detailed to identify the support people required. The registered manager told us they were planning to develop a "pen profile" which would address these issues. They told us they would be discussing this with senior managers of the organisation.

One care plan contained a hospital discharge letter. The letter stated that the person had poor swallowing and had probable recurrent aspirations. A member of staff confirmed this and said they were having a thickening agent added to their drinks. There was no specific care plan relating to the risk of aspiration in place. Records showed that the person had lost weight but up to date nutritional assessments had not been completed. They had not been weighed since the weight loss was identified, a period of two months. A record of the person's dietary intake indicated that the person was receiving regular meals but the portion sizes were not always recorded. This did not enable accurate monitoring. On the second day of the inspection, the person's fluid chart indicated that they had not been assisted to have any drinks. Staff completed the chart retrospectively later in the day, which increased the risk of error. Records showed that the person was repositioned at regular intervals to minimise their risk of pressure ulceration. However, their care chart to demonstrate these interventions was not always specific and terms such as "repositioned" were stated. The person's care plan indicated that they required the use of a specific hoist and sling when being moved, and that two staff were required. Staff confirmed this was accurate however, in the person's room, records showed that they used a standing hoist. These records also stated the person ate and drank independently and had a normal diet. This gave conflicting information to what was recorded in the care plan. A member of staff removed these records as they said they were not up to date.

Not all care plans had been clearly updated as people's needs changed. One care plan stated that the person could eat independently but later in the evaluation section it stated they required "prompting and encouraging with assistance as required". Another care plan stated the person was independent with drinks but throughout our inspection, staff gave full assistance. Records showed the person was fully mobile which reduced their risk of pressure ulceration. They were supported to the table for lunch with the assistance of two members of staff. Staff told us and records showed that the person was at risk of urinary tract infections. There was no care plan in place regarding effective hydration.

This was a breach of Regulation 9 (1) (b) and (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, staff were not responsive to people's needs. Some people were not supported to change their position to minimise their risk of pressure ulceration. Other people were not effectively supported to eat or to manage their agitation. Staff did not respond effectively to those people who called out. At this inspection, improvements had been made to the care people received. People looked well supported with clean, clothing, freshly brushed hair and clean finger nails. People were settled, less agitated and received better support from staff in a timely manner. Staff were responsive to people's needs and undertook any requests raised. Staff spent time talking to people and responded appropriately to any requests. They responded well to a person who wanted to go out on their own. They tried to divert the person's attention by conversation, offering a cup of tea and looking at photographs.

Staff demonstrated a good understanding of person centred care. One member of staff described personalised care as "each of us are unique. We have different views and needs, different standards depending on mood, culture, experiences". They said person centred care required them "to identify the needs on an individual basis and continually assess." Another member of staff told us that person centred care was "all about each individual". They said they talked to people to find what they wanted in their care plans and always ensured information was centred on the individual. The member of staff told us that it was important to be able to empathise with people and not to make assumptions. Staff told us they were able to apply person centred care in practice.

Whilst staff were aware of person centred care, some of the language they used was not appropriate and did not

Requires Improvement

Is the service responsive?

promote such values. This included a person being described as "randy" and another member of staff saying "Right, I'm going to go and do Vera". One member of staff asked "She's a beaker now?" in relation to finding out which type of cup a person used. These comments did not demonstrate a person centred approach. In addition, some entries within care plans were not appropriate. This included "I am commoded. I am got up in the morning and put to bed at night".

People's views about the social activities available to them varied. Some people told us they enjoyed the activities on offer. One person told us "the activities co-ordinator is very good and there are lots of things to do. They [carers] come and ask me if I want to go down to join in. They play music and last week, they took us out into the garden and we had tea out there, we all sat around chatting". Another person said "they keep us active and our minds going". More negatively, one person told us they did not join in any of the activities because they did not interest them. The person said they preferred to read their newspapers and do crosswords instead. They said they wished there were other people who were able to hold a 'proper conversation'. Two people told us that they would like to reminisce more about their past experiences.

There was an activities programme displayed on notice boards around the home. These activities took place in varying parts of the home and people were able to participate as they wished. Whilst activities took place during the inspection, people who did not participate were generally unoccupied. One member of staff told us they had purchased a selection of things to promote activity provision. This included items with texture, movement and light. Staff were enthusiastic about these items yet they did not assist people to utilise them during the inspection.

People were clear about how to raise a concern or make a formal complaint. People told us they would raise small issues with a member of staff. If their concern was more serious or about a particular member of staff, they said they would speak to the manager. People were confident their concerns would be addressed appropriately. The complaints procedure formed part of the welcome pack which was given to people when they first moved to the home. Details about making a complaint were displayed in some areas on notice boards. The registered manager regularly monitored complaints, to assess whether there were any particular themes or emerging trends. Details of complaints were forwarded to senior managers for monitoring purposes. The registered manager told us they aimed to ensure any issues were addressed quickly so they did not escalate.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, whilst the home was generally clean, less visible areas were not. This included debris on the base and framework of the hoists and people's wheelchairs. Improvements had been made to these areas although some armchairs were stained on the arms and on the underside of the cushions. The underneath of toilet seats were discoloured and some had lost their stoppers which caused them to be unstable and difficult to keep clean. These issues had not been identified despite there being a range of systems in place to monitor the quality and safety of the service.

Audits were undertaken at varying frequencies dependent on the nature of the subject. This included monthly audits of key areas such as medicine management, infection control and the environment. There were environmental checks such as regular testing of the fire alarm systems and small portable electrical appliances. Staff told us the maintenance staff regularly checked the temperature of the hot water to ensure it was within safe parameters. However, the water from two hand wash basins was hot to touch. We asked staff for a thermometer to monitor the temperature of the water. A thermometer could not be located. Two staff told us the temperature of bath water was automatically controlled by a device on the bath. They did not monitor the temperature to ensure the device was working effectively. This placed people at risk of scalding. At the end of the inspection, the registered manager told us they had purchased some thermometers and these were in situ.

Monthly analysis took place in relation to accidents, incidents, pressure ulceration, falls and complaints. This enabled further occurrences to be minimised. A senior manager told us they regularly visited the home and audited particular areas. This included talking to people and staff, observing practice and assessing documentation such as care planning.

The registered manager told us that following the last inspection, the staff team had worked really hard to address identified shortfalls and to improve the service. They said a great deal of progress had been made and further plans, particularly around the development of the environment, were in place. The registered manager told us they now had a core staff team which provided consistency and stability. They said in addition, staff had a passion for their role and were trying hard to learn and develop their skills.

Staff told us that following the last inspection, the atmosphere of the home and the overall service had improved. They said they now felt listened to and were not so rushed, which meant they could give people more time and better care. Staff told us they now felt able to raise concerns and were confident matters would be appropriately addressed. The registered manager confirmed that they had an 'open door' policy and welcomed people's views. Staff confirmed this yet two members of staff told us they would like to see the registered manager 'on the floor' more often. They said a better management presence and greater leadership would enable greater monitoring which in turn, would increase standards further. Some people also agreed with this view, stating they did not really know who the registered manager was. The registered manager told us they were not surprised with this view. They said they tried to see people as much as possible but due to the size of the home, this could sometimes be a challenge. They said they relied on the team to give them feedback and visitors regularly came to the office to share their views.

Staff told us there were regular meetings to ensure information was shared as required. They said there were meetings for the heads of departments, as well as for teams such as the registered nurses. Records of the meetings were maintained but there was no evidence of recent care staff meetings. The registered manager confirmed that these had not taken place as often as they should have done. They said this was because they had concentrated on the registered nurses so they could disseminate the information. The registered manager said they would address this and would schedule additional time for care staff.

The registered manager was experienced and had a clear vision for the future of the home They said they kept themselves up to date by various meetings, reading care journals and researching topics on the internet. The registered manager told us they were well supported by senior managers, the staff team and other departments

Requires Improvement

Is the service well-led?

within the organisation. This included human resources, estates management and finance, which enabled the registered manager to focus specifically on the day to day management of the home.

The registered manager told us people's views about the service were gained on an informal and formal basis. They said there were resident and relative meetings although these were not always well attended. In order to address this, the registered manager said they had arranged for a dementia care specialist, to give a talk at the next meeting. Posters advertising the meeting were displayed around the home. One visitor told us they found the meetings useful and informative but felt they would be more productive, if more people attended. The visitor told us they had in the past been asked to give their views via a survey. They said they were readily able to give their views at any time and were confident any issues would be addressed appropriately.

The registered manager confirmed that annual surveys were sent out to people and their relatives. However, they said they were looking to develop other ways of gaining feedback, as the surveys were not conducive to everyone's needs. The feedback received from surveys had been collated and showed that people were happy with the service received. There were no action plans to show how any issues raised, had been addressed. This did not enable the service to show how people were being supported to direct and develop service provision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not ensured risks to people using the service were assessed and action taken to mitigate those risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **An assessment of the person's capacity to make the specific decision in question was not recorded. In addition the MCA processes did not meet the required standards set out in 5.15 of the MCA Code of practice on best interest decision making.**

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 **Planning of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare.**