

Dr Sunita Nagpal and Partners

# Salisbury Residential Home

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on 21 November 2018 and was unannounced.

We previously inspected this service in April 2018, where we found continued breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, governance, and person centred care. We also found new breaches of Regulations in relation to nutrition and hydration and staffing. The service was rated 'inadequate' overall and was placed in special measures.

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

The service accommodates up to 31 people in one adapted building. At the time of this inspection, there were 20 people living in the service, some of whom were living with dementia.

There was a registered manager in post. Since our last inspection in April 2018, the provider had registered as the 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. In August 2018, a new manager was appointed, and they have made an application to be the registered manager, at which point the provider will step down from this post.

This inspection in November 2018, found improvements had been made in relation to people's safety and care delivery, and the service was no longer in breach of Regulations in relation to safe care and treatment, staffing, person centred care and governance. We did however find a repeated breach in relation to nutrition and hydration. The overall rating for this service is now 'requires improvement'. The service has been removed from special measures.

People's nutritional intake was now being monitored more accurately and we found new systems in place had supported this improvement. However, we found that food was not always served at appropriate temperatures, and the dining experience for people remained poor.

There were systems in place to monitor the quality and safety of the service provided. Some areas of improvement had not been identified through the auditing processes, however, the manager was in the process of updating audits to ensure they were robust.

Staff understood safeguarding procedures and knew how to report any concerns they had.

The provider calculated staffing levels via a dependency tool. Additional staff were brought in at busier periods. However, feedback we received from some people indicated that at times they had to wait for staff. This is therefore an area that will require constant review to ensure people receive care in a timely manner, and we have made a recommendation about this.

There were group and individual activities which people could take part in. However, feedback from people indicated that this was not always meeting their individual and specialist needs. We have made a recommendation about this.

People were protected by the provider's recruitment procedures because checks were carried out on staff before they began work. However, we found some staff who had been employed for a longer period of time did not have robust checks in place.

Staff had an induction when they started work and had access to the training they needed to carry out their roles. The new manager had held supervision sessions with staff and had a schedule in place to ensure this was routinely undertaken.

There were safe systems of medicines administration and recording. Staff who administered medicines were trained and their competence observed before they were authorised to do so. However, when changes were made to medicines and new medicines were prescribed, the guidance sometimes had not been reviewed. However, medication was under review and relevant health professionals were involved.

We observed that staff were kind and caring when interacting with people. However, we did not see that their privacy was always respected. Some feedback from people indicated that the staff approach could vary.

People's care plans were personalised and reflected their individual needs. People and their relatives had opportunities to contribute to the development of their care plan, However, we did not always see that people had signed their care plans; the manager was reviewing this and ensuring people were involved as much as possible.

The provider had addressed previous environmental risks. Risk assessments in relation to people's care had been completed and guidance provided to reduce the risk.

The service worked in partnership with other agencies. Where there had been identified concerns in people's health or wellbeing there were systems in place to contact health and social care professionals to make sure people received appropriate care and treatment. Professionals told us the manager and staff worked co-operatively with other agencies and adopted any guidance they recommended.

The provider had applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted, however, staff were not aware of all people who had such restrictions in place. In some cases relatives had given consent but were not always legally entitled to give consent on people's behalf.

There was a complaints procedure in place and people knew how to voice their concerns if they were unhappy with the care they received.

## 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 consistently safe.

Risks to people had been assessed and suitable steps taken to minimise any risks identified

Medicines were managed safely. However, when changes were made to medicines and new medicines were prescribed, the guidance sometimes had not been reviewed.

Staff understood their role in keeping people safe and their responsibility to report any concerns they had.

People told us they sometimes had to wait for staff to attend to their needs.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

People received adequate nutrition and fluids. However the dining experience was poor, and food was not always served at appropriate temperatures.

Deprivation of Liberty Safeguards had been applied for when people who lacked capacity to consent had their liberty restricted. However, staff were not aware of all people who had these in place. Consent procedures were not always followed in line with the Mental Capacity Act 2005.

Staff had an induction when they started work and the training they needed to carry out their roles.

### Is the service caring?

**Good** ●

The service was caring.

We observed staff to be kind and caring when interacting with people. However, some feedback indicated that the staff approach could vary.

Staff supported people in a way that promoted their

independence.

There were no restrictions on visiting times, ensuring people could spend time with their relatives when they wanted to.

### **Is the service responsive?**

The service was not consistently responsive.

People had opportunities to take part in group and individual activities. However, some feedback from people indicated that this was not always meeting their needs.

People's individual needs and preferences were reflected in their care plans.

There was a complaints procedure in place.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not consistently well-led.

Improvements had been made and were ongoing. However, these need to be fully embedded and sustained within the service to drive continual improvement.

Auditing systems were in place and were being reviewed by the new manager to ensure they were effective and sufficiently robust.

Staff told us they had confidence in the new manager, and were clearer on their responsibilities.

**Requires Improvement** ●

# Salisbury Residential Home

## **Detailed findings**

### Background to this inspection

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

This inspection took place on 21 November 2018 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines, and an expert-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.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding and quality team prior to the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the time of inspection there were 20 people living at the service. To help us assess how people's care needs were being met we reviewed six people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which demonstrated how the provider monitored the safety and quality of the service.

During the inspection we spoke with five people who lived at the service, four relatives, the manager, deputy manager, registered provider, care co-ordinator and three members of care and catering staff. We also spoke with two visiting health professionals.

# Is the service safe?

## Our findings

At our previous inspection in April 2018, we found that people were at risk of harm due to environmental risks. We also found that not all risks in relation to people's care had been assessed fully, and in some cases records were inaccurate. This meant that the provider was in breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and we rated this key question as 'Inadequate'.

At this November 2018 inspection, we found improvements had been made in relation to environmental risks and risks relating to people's care. The provider is no longer in breach of Regulation 12. However, there continue to be some areas still requiring improvement and therefore we have rated this key question as 'requires improvement'.

The provider had addressed environmental risks, such as covering hot water pipes and radiators to prevent the risk of scalding or burns. Furniture, such as wardrobes, were now secured to the walls, minimising the risk of injury to people. The passenger lift was secure and in working order.

People's care records contained assessments of risk to which they were exposed as well as whether they posed a risk to others. There was guidance for staff to follow about reducing these risks. Assessments included the risk of falls, of developing pressure ulcers, from behaviour that might challenge staff and others, and of not eating or drinking enough.

One person could present a significant challenge to staff and a possible risk to others living in the service. The person's care records included guidance for staff about the need to supervise them when they were with others. There was specific guidance about what staff should say so that the person received a consistent response and the action staff should take when the person was in communal areas. We also noted that, to minimise the risk, staff had received professional advice and that this was included in their care records. The person's daily records showed that there was a decline in incidents of concern, suggesting management strategies were effective in reducing them. Staff confirmed that the level of incidents had declined.

There was guidance about how people were to be supported with their mobility and the level of detail about how staff should support people had improved. For example, when a hoist was being used there was detail around the type of sling to be used and how the loops were to be fixed to equipment. This meant staff had clear guidance to ensure people were safe and comfortable when being supported to move.

Where people experienced risks associated with their diabetes, the assessment of risk within their care records stressed the importance of offering a healthy diet and the signs and symptoms staff needed to be aware of if the person's blood sugar levels became too high or too low, and how this would be measured. Further information should be added to include the associated risks in relation to eye and foot care. We did however see that people were seen by opticians and podiatrists.

Choking risk assessments were in place and described how people should eat safely, for example, how they should be positioned, and how food should be prepared.

However, we did find that one person had a health condition, which lacked an associated risk assessment. Their care records showed there was currently a higher risk of them experiencing seizures due to their current health. We brought this to the attention of the manager and provider who agreed to implement a risk assessment the same day.

Systems were in place to reduce the risk of legionella in the water systems, and there was a risk assessment in place outlining responsibilities. One of the ways to reduce the risk of legionella is the effective control of hot and cold water temperatures. We saw this was being done but it was not clear how often these were to be undertaken. Following the inspection the manager sent us an updated risk assessment showing the staff responsible and timescales for work. They also sent us de-scaling records of taps and shower heads. The service arranged for an annual legionella test from an outside company, the most recent showing that no bacteria was detected.

Some people living in the service required a hoist to be supported to move safely, and we saw these had been serviced periodically to ensure they were safe to use. Hoist slings had been serviced by an accredited LOLER (Lifting Operations and Lifting Equipment Regulations) company.

There was a fire risk assessment in place which had been completed this year. Staff carried out fire drills and practiced using the evacuation slide to ensure in an emergency they were confident to evacuate people promptly.

We looked at how the service managed people's medicines and how information in records and care notes supported the safe handling of their medicines. Medicines were stored securely for the protection of people who used the service and at correct temperatures. Staff authorised to handle and give people their medicines had received training and had their competence assessed to ensure they managed people's medicines safely.

Records showed people received their medicines as prescribed. Audits were in place to enable staff to monitor medicine administration and their records. There was personal identification, information about known allergies and medicine sensitivities and written information about how people preferred to have their medicines given to them.

When people were prescribed medicines on a when-required basis, there was written information to assist staff to give people these medicines appropriately and consistently. When people were prescribed medicines for external use such as creams and ointments, there were body charts in use to show staff where on the person's body they should be applied.

For people with limited mental capacity to make decisions about their care or treatment and who would refuse their medicines, the service had consulted with GPs or pharmacists and obtained guidance about how to give people their medicines crushed and hidden in food or drink (covertly). However, we noted that when changes were made to medicines and new medicines were prescribed, the guidance sometimes had not been reviewed and updated specifically for these medicines. In addition, for some people further written clarification was needed about how staff should prepare their medicines in this way. The provider informed us that all residents medicines were being reviewed.

Staff confirmed they had training to recognise and respond to abuse. Staff were clear about the need to



report any concerns and about the kinds of things that could be seen as abusive. They gave us examples of abuse they might come across and a senior member of staff told us that they also reported medicines errors. Staff said that they would report any concerns to the manager and were confident that they would be addressed. They told us that they had also reported concerns directly to the safeguarding team in the past.

At our previous inspection in April 2018, we found the provider was in breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staffing levels were not sufficient to ensure people were safe at all times. At this inspection we found that the provider was no longer in breach of this Regulation, however, some feedback from people suggested that this was an area that would require constant review as the number of people using the service changed. We saw the provider had calculated staffing numbers via a dependency tool, and that this had changed as the number of people using the service reduced. We also saw rotas which showed that additional staff were brought in between 12pm and 2pm to support people at lunchtime.

Staff told us that they felt there were enough staff to meet people's needs safely. They recognised that staffing had been reduced following a reduced number of people using the service but said they were able to meet people's needs properly. One staff member told us, "Staffing levels most days are over on dependency levels. We can spend a bit more time with people." Another recognised that they could not always get to people as quickly as they might like if too many people wanted assistance all at the same time. They said, "We can't get to everyone all at once." However, they went on to explain that they prioritised people needing support and felt that staffing levels were enough at present.

We asked people their views on the staffing levels. One person said, "Sometimes they can take a while coming as they can't be in two places at once. When I ring my bell they can be here in 10 seconds, another time 20 minutes. I think they could do with more staff at times, they are coping, and it could be a hell of a lot worse. I've never had an accident when I've wanted the toilet as I give them quite a bit of warning, I try and work out when I will need to go and how long the wait will be." Another said, "I ring my bell for everything. I never have to wait very long." A relative told us, "They are not that quick at answering the bell, then when they come they say they were busy. I worry that if [relative] does use the buzzer and they take a long time to come there will be a problem. [Relative] doesn't like to put on the staff and knows it will take a long time."

We observed that staff were visible in all areas of the service and monitored people where this was needed. For example, there had to be a staff member present in the dining room during lunchtime, and we observed this to be the case. However, given the feedback from people, this is an area that will require constant review to ensure people receive care in a timely manner.

We recommend that the service routinely asks people using the service for their views and experiences of staffing levels and the availability of staff during the day time and at night. This could also include the views of staff members and visitors to the service.

We found that recruitment checks for staff recently appointed were more robust than was the case for staff who had been in post for a longer period of time. For example, one reference was not received until after the staff member's employment had started. Their Disclosure and Barring Service (DBS) check was completed nine years ago and for a different employer. It had not been renewed in respect of their current employment or during the intervening years to check circumstances had not changed. These checks review whether applicants have a criminal record or other information that might make them unsuitable to work in care, and enable employers to make safer recruitment decisions. We brought this to the attention of the provider who promptly arranged for this to be renewed.

This contrasted with a better process for newer staff. This showed that their interview included discussion about a gap in their employment history not clearly explained on their application form. The enhanced background check with the DBS, was completed before they had started work. The staff member also had references on file to support their conduct, although these were not dated when they were received as an additional check, the manager told us the information had been obtained before their employment started.

There was a system in place to make sure that all incidents and accidents were reviewed regularly. This was to look for and identify any trends and patterns and improve safety as a result if needed. Staff knew to report and recorded any accidents or incidents. Records showed this included what had happened and the immediate action taken.

Infection control procedures were being followed and we observed that the service was clean and fresh on the day of the inspection. There were adequate supplies of personal protective equipment, such as aprons and gloves, and we observed staff used these appropriately. We saw that staff had a cleaning schedule to follow to ensure they maintained standards of hygiene in the kitchen. These were up to date and showed what staff needed to clean and how often.

The service had developed their practice to ensure that lessons were learned and improvements made when things had gone wrong. They had responded to our concerns from the previous inspection and had put improvements in place which supported safer care for people using the service.

## Is the service effective?

### Our findings

At our previous inspection in April 2018, we rated this key question as 'requires improvement'. We had concerns about whether people had enough to eat and drink and the strategies staff used to address this. As a result, the provider was in breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found that although improvements had been made in this area, we also found that the lunchtime experience had not improved and some people's food was not served at an appropriate temperature. The provider therefore remains in breach of this Regulation. The rating for this key question remains, 'requires improvement'.

We found that the, 'quick reference' list for catering staff, showing who needed fortified diets was not up to date. (Fortified diets can include adding cream, butter or milk to increase calorie intake) The list showed that one person needed a fortified diet when there were actually eight. This could have led to people not receiving the appropriate diet. The manager addressed this during our inspection visit, so that catering staff could more easily access the information.

We asked people their views about the food. One person said, "If I get something I don't like I don't eat it and they bring me something else. I require [specialist diet] and they know what I can eat." Another said, "Chicken nuggets are not my cup of tea. The food is reasonable though, good, moderate and bad days. They do the best they can, and I have a choice." A relative told us, "[Relative's] food is always luke warm or cold. The food is very much the same on a weekly basis. As far as the [specialist diet] is concerned they have been very good." Another said, "[Relative] doesn't like chocolate or vegetable soup. The other day they brought vegetable soup and chocolate mousse, the carer obviously didn't know. They took it away, but I tasted it first and it was awful, tasteless. The selection for tea is always soup and sandwiches, they could change it."

We checked the temperature of the food given to two people in their bedrooms, in both cases the food was only warm. Another person was given a bowl of soup that was cold. We informed a staff member who took it away.

At 11am, people were offered biscuits or cold chicken nuggets. We asked the manager about the options and they told us that people had asked for these, and were therefore routinely offering them. However, feedback from some people indicated they did not like what was on offer, and we felt that more choice should be made available for people.

At our previous inspection we made a recommendation that the service explored current guidance to ensure that mealtime experiences were an opportunity to support and promote independence, in addition to creating a positive mealtime experience. Our observations did not reflect that the lunchtime experience had improved for people.

The tables in the dining room had table cloths, placemats and condiments were offered. Only three people

used the dining room, although people were offered a choice of where to eat their meal. There was a large menu board correctly displaying what was on offer that day, and people were offered a choice of soft drinks.

Lunchtime was a practical affair, and not a noticeably enjoyable experience for people. We observed two people being assisted to eat; in both cases staff did not engage with them and did not offer them a choice of what to eat from the plate. The service had staggered lunch times in an effort to ensure people received the support in a timely manner, however, staff were seen to be rushing about, then standing waiting several minutes for more food to be produced.

A staff member explained to us that they felt there were better systems for monitoring how much people had to drink or eat. They said that staff leading shifts were clearer in their roles and that monitoring charts had improved how fluids were added up. They explained that this meant they could hand over to incoming staff whether people were, "On target" to have enough to drink or whether staff arriving for shift needed to ensure they provided additional encouragement to improve fluid intake.

Food charts we reviewed were completed routinely by staff. A new template had been implemented which enabled staff to record people's intake in a more detailed way. Where people declined to eat this was also recorded, which meant staff could demonstrate that they had tried to encourage people to eat.

For one person, we found that there were concerns they were not eating well during the last year, placing them at high risk of malnutrition. The person needed to increase their calorie intake to ensure they achieved and sustained a healthier weight. A staff member told us about this person and how they had identified that they ate a good breakfast, were not normally so keen on lunch, but did like to "snack" during the evening. They explained that this enabled staff to make the most of the time when the person was more willing to eat. The person also needed a fortified diet to increase their calorie intake.

We found that the interventions made were successful in improving how much the person ate, demonstrated by their increasing weight. Their Body Mass Index had increased from low and was now within the average, healthy range. Their weight had increased significantly from 49.95kg to 59.2kg. This showed that intervention was successful in improving the person's nutritional status and showing that they had enough to eat to promote their health.

At our last inspection in April 2018, we found a breach of Regulation 9: Person centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people's records were not always accurate or sufficiently detailed. At this inspection we found improvements had been made, and the provider was no longer in breach of this Regulation.

People's records were accurately detailed and reviewed regularly, or when people's needs changed. We saw during our inspection visit that after visiting professionals had assessed people, that care plans and risk assessments were being updated promptly to reflect professional advice about how people's care should be delivered.

Staff completed assessments of people's needs before they moved into the service. We saw that these involved people themselves where possible and members of their family to gather information about people's needs and preferences.

At our previous inspection we found the provider to be in breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff did not always receive up to date training and there was no management oversight of this. At this inspection we found improvements had

been made and the provider was no longer in breach of this Regulation.

The manager had begun to review staff training needs, and had arranged relevant training where there were gaps, this included training for end of life care. Staff training needs had been discussed with external training assessors, and how staff could enrol to complete the Care Certificate (The Care Certificate is an identified set of standards that health and social care workers adhere to in their work) or attain specific care qualifications. Some staff were already completing care qualifications.

Staff told us that they had access to training so that they could support people effectively. Staff received training relevant to their role such as moving and handling, medicines, and safeguarding. The manager said that some staff training had been out of date at the time they were appointed. They showed us a training matrix which logged when staff had last undertaken training and when it was next due.

We noted that the manager had been able to offer training to staff, for example in moving and handling and infection control, having completed, "Train the Trainer" courses to do this. However, this was time limited and their training to deliver this had recently expired. It needed renewing to help ensure new staff could be trained promptly after their appointment.

A staff member who had been appointed to a coordinator's role to help support the manager, said that, when they were able to, they did check that staff were working as expected and competently. They hoped that the opportunities to do this would improve and increase as the role developed.

Staff confirmed that they received supervision but were not consistent in their awareness of how often it should take place. Supervision is needed so that staff can discuss their performance and any development needs. They told us that the manager had supervised everyone after their appointment so that they had met and discussed work with all staff. One staff member thought this should take place every three months, and one thought it was six monthly. However, they felt well supported by the manager and said that they did not need to wait for formal supervision if they needed to raise anything about their work.

New staff were provided with an induction to ensure they were prepared for the role. We saw induction checklists covering health and safety and care delivery were being signed off to ensure staff were competent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Staff confirmed that they had training in the MCA and in DoLS so that they understood how to support people who were not always able to make decisions for themselves.

Staff described a process of approaching people at different times or involving different colleagues to gain

consent where possible. They recognised that it was most important for staff to know each person and understand how best to approach them. Care plans contained additional guidance about this. For example, one person's care plan showed that they were more likely to accept support with showering if this was done in the morning before they got dressed. The information showed that the person was less likely to become confused and refuse support than if they were already dressed and then staff asked to assist them to get undressed for a shower later in the day.

We noted that the wording on summaries about people's consent could be improved. This was because some of these, for example in relation to medicines management or the use of photographs, indicated that relatives had given consent but were not always legally entitled to give consent on people's behalf.

Records did show when another person was legally authorised to make decisions about their family member's care and welfare. We saw evidence of this authorisation in their care records.

A staff member could explain to us about one person's authorisation to deprive them of their liberty in their best interests and because of concerns about their safety if they left the home. However, they were not aware of similar authorisations in respect of some other people living in the home and which had already been granted.

We reviewed two such authorisations and found that the conditions attached were only in relation to submitting applications for renewals when these fell due, or for review requests if their circumstances changed.

The service had worked with other organisations in order to improve care standards. They had welcomed the support of the local authority quality team who helped them to assess where improvements were needed.

People's records showed that staff did support them to access professionals who could offer advice and treatment to help promote their health and wellbeing. For example, one person's care records showed recent support from the Dementia Intensive Support Team to help address specialist needs. Another person with conditions related to diabetes was supported to access support with both the health of their feet and of their eyes. One person identified as at increasing risk of falls, was referred to the falls prevention team and accessed advice from a physiotherapist. We noted that others had received support from an optician and for hearing aids. A health professional said, "[Manager] is a good advocate for people, she is passionate about people, she will speak up if things are not good for people, they chase referrals, and I have no concerns."

At our previous inspection we made a recommendation that the service explores current guidance to further improve the design and decoration of the service. We found the provider had given some consideration to the premises, though further improvement was needed and the provider told us this work and decoration of the service was on-going.

The service had good navigational signage and people's bedrooms had photographs of them on the door, which would help people to recognise their bedroom. There were several photographs of people doing various activities and wall hangings, some were interactive, others had inspiring slogans in the hallways and communal areas. The service had a well maintained and accessible garden that people could use.

## Is the service caring?

### Our findings

At our previous inspection in April 2018, we rated this key question as 'requires improvement'. This was because we did not always receive positive feedback from people about the staff approach. We were also not assured that people were involved in their care planning, as people had not always signed them to demonstrate that they had been fully involved in creating them and that their views about their care were known. We also found that people's privacy and dignity was not always considered fully.

At this inspection we found that although some further improvements should be made to ensure people's privacy was respected and that the staff approach was consistent, we have rated this key question as 'Good'.

We received mixed feedback from people and their relatives about the staff approach. One person told us, "The care is okay. You get a variety of staff, some are more patient than others, some you get along with better than others, they are all caring. When they do come to me they give me time. I had a good overall wash today and a clean set of clothes." Another said, "I can assure you I am well looked after, there are no problems there. Anything you want they will do for you, they are excellent, helpful, there's not one I don't like. You can have a laugh and a joke which I like. Staff are very friendly and kind. They chat when they have time, they are very busy." A third said, "Staff, well some of them are alright, others, well."

One relative told us, "The care [relative] gets here is excellent. They are always caring, staff are always asking how [relative] is. It's so clean." Another told us, "I've never had any problems regarding [relative's] care, all the staff are lovely, everyone is so helpful. I'm quite satisfied with how they have looked after [relative]. [Relative] is not able to communicate their choices, but they are always clean and tidy, if [relative] wasn't, I'd create."

We observed that staff were kind and caring when interacting with people. However, we did not see that their privacy was always respected. For example, whilst we were talking with one person in their bedroom, several staff members came to say hello to them, and we noted that none had knocked before entering the person's bedroom. We also noted at our last inspection that two toilet doors did not have suitable locking mechanisms in place; we found this had not been rectified. However, the manager informed us following the inspection, that both locks had been replaced. We saw improvement when people were being supported to move in communal areas; on several occasions we observed staff used a privacy screen whilst assisting people from their chairs in the lounge.

We asked people if they were involved in creating their care plans. One person said, "I can't think I have ever been asked any questions about my care." Another said, "I'm not bothered about a care plan, so long as I get a bit of food and drink, I'm happy." A relative told us, "They always contact me if there are any problems, they involve me in everything to do with [relative's] care." Another said, "[Relative] has a care plan, I have seen it and signed it. I attend care planning reviews." We did not always see that people had signed their care plans, however, the manager was reviewing this and ensuring people were involved as much as possible.



A 'resident of the day' system was recently implemented, which involved reviewing the entire care plan with people, and asking them direct questions about their care to ascertain their views. We saw one recently completed, which included offering the person a trip out for the day. The person declined, but this demonstrated that the service was offering ways to enhance people's day to day lives. A key worker system was also in place, which linked a staff member to each person living in the service. This system was helpful for relatives and friends who may have questions which they can direct to the key worker.

Resident and relative meetings had been held, the last one was in August 2018, where the new manager introduced themselves, and spoke about changes they planned to implement to improve care delivery. They also encouraged relatives to give their views on all aspects of their loved one's care. The manager made reference to the previous Care Quality Commission (CQC) report, and the more recent report from the local authority quality team. This was to assure people and their relatives that progress was being made. The next meeting was booked for January 2019.

People's care records reflected what they could do for themselves so that staff could encourage them to maintain their independence, for example, with their hair care or in washing and dressing. Staff were mindful of people's appearance and understood the impact on their well-being. Everyone at the service was dressed smartly, in clean and matching clothes. Personal care was well attended to. We noted that care records showed how staff should approach people who were hard of hearing, to increase their opportunities to understand information clearly.

Staff explained to us how they offered people choices, for example about what to wear, what to eat and where they wanted to spend their time. A staff member gave us additional information about how, despite having a good relationship with a person, they understood that they preferred to receive their personal care from a staff member of the same gender. They told us that staff respected their wishes.

People's relatives and friends were welcome to visit without restrictions. They said they were welcome by staff. One relative told us, "I can come when I want, it's lovely, they always offer me a drink and stuff."



## Is the service responsive?

### Our findings

At our previous inspection in April 2018, we rated this key question as 'requires improvement'. At this inspection feedback from people and relatives indicated that the provision of activity was not meeting all people's individual and specialist needs. Further, people did not always feel that the service was responsive to their needs. This key question therefore remain as 'requires improvement'.

There was an activity co-ordinator who worked in the service Monday to Friday, 10am until 4pm. There was an activity schedule in place, and events were listed on a board in the hallway. There was also a musical entertainer who visited twice a week, and Karaoke which we were told people really enjoyed.

We asked people if they participated in activity. One person told us, "I don't do a lot all day, there is nothing to do, I just sit and watch them [staff] work. I like a sing along sometimes. We occasionally have people come in, it breaks the monotony of just sitting here. I do watch the telly when it's on, there's nothing else to do." Another said, "They give me the option to go down every day, but I prefer my own company. I used to paint but I don't do that now, sometimes I go and watch the singers." A third told us, "I stay in my room as I can't walk. They are very short staffed, that mainly is why I don't go down, they haven't got the time."

A relative told us, "[Relative] sleeps a lot, but they do do activities with them, there are times when [relative] is a bit bored." Another relative said, "[Relative] doesn't go in the lounge anymore as it's the same old music, a bit boring [relative] says. The hardest thing is [relative] is bored. [Relative] would rather be in bed sleeping as they are bored. There is no motivation here".

We recommend the provider seeks best practice guidance about appropriate activities and stimulation to meet people's individual and specialist needs. The provider could also consider routinely asking people living in the service if the activity provision is meeting their needs.

Records were kept of people's participation in activity, however, these did not always show that meaningful activity was taking place. For example, some entries just stated, "Watching TV in room." We discussed this with the manager who told us they would speak with the activity co-ordinator to ensure people's logs were more detailed, and if they declined to take part, that this was also logged.

At our last inspection in April 2018, we found the provider was in breach of Regulation 9: Person centred care of the Health and Social Care Act (Regulated Activities) 2014. This was because key information was missing from people's care plans and the information around people's care was not always current.

At this inspection we found that improvements had been made and the provider was no longer in breach of this Regulation.

Care plans contained information about people's needs and preferences as well as their backgrounds, life histories and what was important to them. In some cases there were gaps in the information incorporated into people's life history documents, but this was included in care plans. Information relating to risks and

associated health conditions were now in place, and these reflected guidance for staff about how people should be supported and what was important to them.

We asked staff about the needs of two people whose records we had checked. They were able to tell us about each person's needs and backgrounds. One staff member gave us detailed information about a person's life history and previous occupation and how this influenced the things they liked to do. The information was consistent with what we saw in the person's care records.

The manager told us how much a particular person enjoyed singing. During our inspection visit, we observed a staff member supporting them along the corridor and joining in with a song they were singing at the time.

The service had developed their practice in supporting people in relation to their end of life care. Although this was still work in progress, we could see that people's views and wishes were now being taken into account when planning for their end of life care. One person whose health had recently deteriorated, had a care plan which took account of their preferences, including a wish to have background music on in their bedroom.

We noted that one person's care records contained information about their wish not to be resuscitated in the event of a heart attack. This clearly showed the involvement of their family member who had legal authority to take decisions about their care and welfare. Their care plan also showed their preferred funeral arrangements, their wish to remain at the service and their fear of being left on their own when they were nearing the end of their life. This helped staff to be aware what was important to the person and their family members when they were nearing the end of their life.

The provider had systems in place for managing complaints. We saw that where complaints had been made the detail of these was logged, as well as the response to the concerns. One person told us, "If there was anything you didn't like I'm sure they would put it right." A relative said, "We had a few little problems, we went to the manager and they sorted them out." Another relative told us, "I have made several complaints. When [relative] first came here they kept leaving the buzzer unplugged. I've complained about the food. Occasionally we get a questionnaire about the home. I got [relative] to help me fill it out. They said they appreciate the feedback, but they didn't change the way the food was served. Over time the other things have improved."

## Is the service well-led?

### Our findings

At our previous inspection in April 2018, we rated this key question as inadequate. This was because we found shortfalls in the service which indicated that the auditing and monitoring systems had failed to identify where people were at risk of harm. We found the provider to be in breach of Regulation 17: Good governance of the Health and Social Care Act (Regulated Activities) 2014.

During this inspection we identified that although improvements had been made and were ongoing, these measures needed to be fully embedded and sustained within the service to drive continual improvement. The Provider had made sufficient improvements to no longer be in breach of Regulation 17, however, we found some areas that required further improvement. Therefore the rating for this key question is 'requires improvement'.

Auditing processes were in place which included care plans, accidents and incidents, medicines, mattress checks, staff training, equipment checks, infection control, record keeping and dining. However, not all audits had identified areas requiring improvement, such as people's dining experience and the preparation of hot food. The last dining audit completed in November 2018 identified no issues with people's dining experience. Where audits were completed, such as infection control, they did not always list a date by which any actions should be completed.

Other areas also required improvement to ensure the service could show more fully how they were mitigating risks. For example, risk assessments had been implemented for bed rails, but they did not specify how often the rails should be checked to ensure they were safely secured. The manager told us this was being done monthly, but there was no documentation to show this was the case. Risks in relation to people's care were now more fully assessed, however, we found one person did not have a suitable risk assessment in place where they were at increased risk of seizures.

Since the last inspection in April 2018, the provider had registered as the registered manager. They had worked full time in the service to address the issues found at the last inspection. In August 2018, a new manager was brought in, and they have now made an application for the registered manager post, at which point the provider will step down from this post.

In August 2018, the provider had also appointed an external consultant to support them to improve the quality assurance processes, and seek advice on other areas of the service, such as care planning. Their review of the service was positive, and reported the new manager to be an effective leader. The local authority quality assurance team had also visited the service to offer advice and guidance to make improvements. The service welcomed input from other organisations.

Following our inspection in August 2017, we imposed conditions on the provider's registration whereby they send us information on a monthly basis in relation to how they were managing risks associated with people's care. Both the manager and care co-ordinator reported that this had been a positive step in making improvements. The care co-ordinator told us, "I've got into a routine of sending the information, it keeps us

on our toes." The manager said, "I think we need to consider keeping this in place longer term as it will help us." We found this view to be positive in helping the service to sustain improvements over time.

Staff recognised that there had been problems in the service and with leadership in the past. They were positive about the changes in management arrangements and the appointment of a new manager in August 2018. They felt there was a lack of support and organised leadership before then. They felt that morale was improving following the change. One told us that they thought this was now, "Eight out of ten."

Staff told us that they felt recording systems had improved so that communication across the staff team was better. They were consistent in their explanations about the changes and how it was now easier to see what people's experiences had been and about any issues or difficulties they needed to be aware of.

One staff member told us, "We've been through a lot of managers. [Current manager] is brilliant. Things have changed for the better. There are new things in place. It's clearer. Communication is much better."

Another staff member said, "It's really nice to have a manager who knows what they're doing. Some staff had gone 'rogue'." They attributed this to a period of poor leadership. Care staff were confident that the manager would address any concerns they raised about poor practice. They felt that the manager would take action if they, 'blew the whistle' about any concerns. They described the new manager as, "Firm but fair." They felt that the manager was supportive and had an 'open door' policy. One explained that the manager always spoke with them during their shift, had built up a good relationship with people living in the service and would provide practical assistance on shift when they needed it.

We asked people their views on the management team. One person said, "I think there can always be improvements, but they seem to know what they are doing." Another said, "They do have meetings where the relatives all attend, I don't go, I'm not a meeting person." A relative told us, "The new manager has done really good, there is definitely a lot more paperwork, and they seem to have an awful lot of meetings." A second said, "The manager has introduced herself to me and she seems to be getting involved in everything. She's making the effort with inspiring slogans on the walls, she seems to work alongside the staff."

Annual questionnaires were sent to people and relatives to gain feedback on the service provided. The last questionnaire was sent June 2018, the majority of which were positive.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs  Food was not always served at appropriate temperatures. People were not provided with a pleasant dining experience.  14 (1) (4) (d)