Sanctuary Care Limited

Hatfield Residential and Nursing 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 12 and 13 July 2016 and was unannounced. When we last inspected the service on 2 and 20 March 2015 we found it was not meeting the required standards. We found breaches of the Regulations in relation to safe care and treatment, staffing and person centred care. At this inspection we found that the provider had made some improvements, however further improvement was needed to meet the required standards.

Hatfield Nursing Home is a nursing and residential care home that provides accommodation and personal care for up to 118 older people, some of whom live with dementia. The home has separate nursing, residential and dementia care units spread over five floors where staff support people with varying needs and levels of dependency. At the time of our inspection there were 110 people living at the home.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

At the previous inspection we found that there were not enough staff to meet people`s needs at all times. At this inspection we found that this was still an area of concern. The registered manager had a permanent recruitment drive to try and build up a permanent staff team and the majority of the agency staff they used were mainly the same to maintain continuity for people. However, people who lived at the home told us staff were not always attending to their needs in a timely way and the care was not always delivered as they preferred due to lack of staff. Staff told us they found the workload to be overwhelming and that the care they delivered at times was adapted around the tasks they had to do and not around people's preferences.

There was a lack of monitoring tools available for the registered manager to effectively monitor people's dependency levels to inform staffing in the home. Call monitoring log reports were not available due to a dated call system used which could not generate reports. The provider was in the process of implementing a new tool to help monitor people's dependency levels and inform staffing ratios. The call system was being changed at the time of the inspection to a more effective one. This allowed the registered manager to monitor the length of time taken for people to have their call bells answered and identify times of the day when staff needed more support in meeting people`s needs effectively.

People had mixed views about the quality of the food provided. Although there were sufficient quantities people told us the quality of the food was not always good. Risks associated with people's daily living were recognised and risk assessments were in place with clear instructions and guidance for staff how to mitigate these risks.

People told us they felt safe at the home. Staff received training in how to safeguard people against the risks of abuse and they were knowledgeable in how to report any concerns internally and externally. Recruitment

processes were safe and helped to ensure staff employed to work at the service were of good character, physically and mentally fit for the roles they performed and able to meet people's needs.

At the last inspection we found that people had not been supported to take their medicines on time or as intended by the prescriber. At this inspection we found that improvements were made and systems were implemented to help ensure people received their medicines safely. The nursing staff were working closely with a local clinical commissioning group (CCG) and GP`s to review and manage people`s medicines effectively.

Staff obtained people's consent before providing the day to day care they required. We found that processes to establish if people had lacked capacity for certain decisions were followed in line with the MCA 2005 and where necessary best interest meetings were organised to develop an effective plan of care for people. The registered manager had submitted Deprivation of Liberty Safeguards (DoLS) applications to the relevant authorities to ensure any restrictions applied to people`s freedom were in line with the current legislation.

People were positive about the skills, experience and abilities of the permanent staff who looked after them. We found that staff had received training and refresher updates relevant to their roles. Although staff felt supported by the management team to develop further, they felt the use of agency staff and their complaints about the heavy workload were not always listened and actioned by managers.

People told us they were looked after in a kind and compassionate way by staff who knew them and their relatives well. Relatives told us they were involved in decisions about the care provided and that staff kept them informed of any proposed changes or developments. We found that personal care was provided in a way that promoted people's dignity and respected their privacy. However, we saw for some people who used incontinence products and these were stored in their bedrooms and visible for visitors when the bedroom doors were opened and this was compromising to people`s dignity.

We found that staff knew people they looked after well and were knowledgeable about their likes, dislikes and personal circumstances. However, we found that the guidance and information provided about people's backgrounds, life histories, cultural and religious beliefs was not always detailed enough for staff to understand people`s needs and therefore they may have not delivered the care and support in a way to meet people`s needs effectively.

People expressed mixed views about the opportunities available to pursue their social interests or take part in meaningful activities relevant to their needs. We found the opportunities provided varied and lacked consistency across different units at the home.

People and their relatives told us that staff listened to them and responded to any concerns they had in a positive way. People, their relatives, staff and healthcare professionals were all positive about the management and leadership arrangements at the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Sufficient numbers of staff were not always available to meet people's needs in a timely and safe way.

People told us they felt safe at the home and were supported by staff who were knowledgeable in how to recognise and report signs of abuse.

Safe and effective recruitment practices were followed.

People were supported to take their medicines by staff who had been trained and had their competency to administer people`s medicines safely assessed.

Potential risks to people's health were identified and effective steps taken to mitigate these.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not always effective.

People were not satisfied of the quality of the meals they were provided with.

People who lacked capacity to consent had best interest decisions made in their favour following a best interest process.

Staff received regular supervision and training to help develop their knowledge and skills to meet people`s needs effectively.

Staff involved other health care professionals in people`s care if it was needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in the planning and reviewing

of their care.

Staff did not always had clear guidance in how to meet people`s different cultural and religious beliefs.

People told us staff were kind and compassionate when offering support to them.

Care was provided in a way that promoted people's dignity and respected their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they did not always receive personalised care that met their needs and took account of their preferences.

Care plans did not always accurately reflect people's involvement in their care reviews or information about what was important to them.

People were not always supported to pursue social interests or take part in activities that met their needs, either in the home or wider local community.

People were confident to raise concerns and felt confident that their concerns would be listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were no effective systems in place to monitor and inform staffing numbers for people to have their needs met effectively.

People's care records were not always updated to reflect people's current needs and give staff clear guidance in how to meet these needs.

Staff told us they understood their roles and responsibilities however they felt overwhelmed on occasions with their work load.

People, their relatives, staff and healthcare professionals were positive about the management and leadership arrangements at the home.

The registered manager sent satisfaction surveys to people and

their relatives to gather their views and improve the service provision.

Hatfield Residential and Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried on 12 and 13 July 2016. The inspection team consisted of two inspectors, a pharmacist, a nurse specialist advisor and an expert by experience. The specialist advisor had the experience in nursing and healthcare, elderly and within the field of palliative care. The expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 21 people who lived at the home, five relatives, 24 staff members, the catering manager, the registered manager and a regional manager. We also spoke with three health care professionals. We reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to nine people who lived at the home, medicine records and six staff files. We also carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People told us staff were not always answering their call bells in a timely way. One person told us that although they never had to use their call bell for themselves they had to call several times for the person in the neighbouring bedroom as they were shouting for help. One person told us, "Sometimes I am pressing my bell and wait and wait and nobody comes. I had to shout this morning until somebody came in to help. I thought I was the only one left in this home."

People told us their needs were not always met by staff especially at night. One person said, "There's only two people on [on one floor during the night] and you can hear the buzzer's going for quite a while." Another person told us, "Day staff are brilliant they are on the ball. A bit slow at night though." Another person from a different unit told us, "This morning a night staff came to offer me personal care and left me in the middle of it to attend to something else. My call bell was far away from me. When I eventually managed to reach the call bell, I pressed on it several times without any response. I was left in an uncomfortable position for a long time."

With the exception of three staff members all the other staff we spoke with expressed their concerns about low staffing levels on the units they worked on and the effect this had on people`s care and staff`s morale. One staff told us, "We are supposed to have one staff in the lounge at all time to observe people, especially those who are likely to fall. We can't always maintain that due to staff shortage." Another staff member said, "This is a high dependency home. We have at least a dozen people [on one unit] that require hoisting, personal care, and management of incontinence. Sometimes personal care can go on until lunch time. It can be very stressful. A number of staff have left as a result of this."

On one of the days of the inspection we observed a person who was confined to bed calling for help on two separate occasions. On one occasion a house-keeper who happen to pass by their bedroom attended to them. On the second time it was lunch time and staff were assisting people to eat. They only responded to the person`s calling for help when they went in to assist the person to eat. We observed there was a call bell nearby however the person who was visually impaired and had not been able to use it. We observed staff working tirelessly to meet people`s needs in a timely way, however there were periods of 15 to 20 minutes when staff were busy in people`s bedrooms or other duties and communal areas and corridors were not monitored.

A healthcare professional told us they felt there were insufficient nurses available to look after and meet the needs of people with the most complex and serious health needs. They told us this had led to poor communication and on occasions had meant that their guidance had not been followed effectively.

We found that this was a continuous breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that there were sufficient numbers of suitable staff deployed to meet people`s need safely.

Staff were knowledgeable about the risks to people`s health and well-being. For example where people

were identified as high risk of falls preventative measures were in place and staff were aware how to mitigate risks by using bed rails, walking aids, assisting people to mobilise. However we found that where people had behaviours which could have been challenging staff had no clear guidance to help them manage these effectively. For example for one person their care plan said, '[Person`s name] has short term memory loss; will enter other people's rooms. Staff to monitor whereabouts to reduce [person] being agitated and challenging behaviour occurring.' There was no guidance for staff to follow in case the person got anxious and agitated and how to manage the situation if the person entered other people`s rooms. We observed this person wandering around the whole of the day and due to their poor eyesight bumped into things. There was no staff linked to them to closely monitor their whereabouts. The team manager had contacted the specialist mental health team and the crisis team but had not put any plan in place to protect the person or the other people on the unit until specialist help commenced. The registered manager told us they had contacted the social work team and they were waiting for a re-assessment of the person`s needs.

People told us they felt safe at the home. One person said, "I feel safe here I'm very happy and the main thing is my family know that I'm safe." Another person said, "I feel absolutely safe, the carer's are lovely lots of people around me, yes I'm very happy." Relatives told us they felt people were safe living in the home. One relative said, "I feel [person] is safe. Staff listens to us and I feel this is a safe place."

Staff had received training in how to safeguard people and were knowledgeable about the potential risks of abuse. They told us they would not hesitate to report any concerns they had to their managers or externally to local safeguarding authorities. Information and advice about the risks of abuse, including contact details for the relevant local authorities, were also displayed at the home. One staff member said, "I would not hesitate to report any concerns I have. We are always asked to report and monitor for any signs of bruising or other signs of abuse." We found that where people had unexplained bruising this had been documented and reported to the nurses and managers. These were investigated and reported to local safeguarding authorities and actions were taken to prevent reoccurrence. This meant that the provider took all necessary steps to help ensure people were adequately protected from avoidable harm.

At the previous inspection we found that people did not always receive their medicines as prescribed or when they needed them. People who were given medicines covertly without their knowledge were not always supported in a safe way. Some people with limited communication abilities who were prescribed pain management tablets to be taken 'as required' (PRN) staff had not been provided adequate guidance about how to recognise when people experienced pain, the potential triggers or when they would benefit from the medicine.

At this inspection we found that significant improvements were made. People received their medicines from trained staff who had their competencies regularly assessed.

We saw evidence of people`s currently prescribed medicines on the Medicines Administration Records (MAR) and copy prescriptions. The allergy status of all people was recorded visibly on their MAR`s to prevent the risk of inappropriate prescribing. People who were prescribed as required medicines (PRN) for their mood, pain relief or for an allergy had individual protocols in place so that staff knew whether the person had cognition or not, the circumstances and the frequency the medicines should be given. When people had variable doses of medicines prescribed to them staff accurately recorded the exact amount they gave to people. This practice enabled the prescriber to determine the effectiveness of the medicine and people were protected from the risk of receiving more than the maximum amount in 24 hours.

We observed medicines rounds on two units. On both the process was professional and accurate but time consuming. This was identified prior to the inspection by the nursing staff and the registered manager.

During the inspection we saw evidence that the GP and a Clinical Commissioning Group (CCG) pharmacists were involved in a review of medicines prescribed to people, reviewing timings of medicines and where it was necessary they made changes to ensure people only had medicines they needed and at a time best suiting them.

Some people had to have their medicines crushed or hidden in food (covertly) and we saw that all health care professionals and families had been consulted before a decision was made to administer medicines this way to ensure this was in the person`s best interest.

We saw that pain charts were in place to regularly assess the level of pain people were in and that medicines were available for people who were nearing the end of their life should they needed these to relieve their anxiety or pain.

Staff enabled people to administer their own medicines. For example, one person was taking their own medicines. Staff carried out a risk assessment and ensured the person was able to understand how to manage their own medicines safely.

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed. The registered manager conducted all the necessary pre-employment and identity checks before staff were offered employment. Staff told us they had been appointed after an interview and started work once references and other checks were completed. One staff member told us they were interviewed by the manager and a person who lived in the home. This demonstrated that people who lived in the home had been given an opportunity to take decisions regarding the employment of staff who were going to support them.

Requires Improvement

Is the service effective?

Our findings

People had mixed views about the standard of food provided at the home. One person said, "The food is average, not great and not bad." Another person commented, "The food has gone downhill I don't know if it's a new chef." One relative told us, "[Person] does have a moan about the food now and again but they [staff] are very kind."

We observed meal times and how staff supported and assisted people to eat their meals. The support people needed varied from some being very able to people who required staff`s full assistance due to their health conditions. Some people required pureed and soft diet. We observed people were served on one unit with a meal which did not look appetising. When we tasted and asked staff to taste the food they agreed with us that it was not at an acceptable quality. One staff member told us, "In hind sight we [staff] should not give food to people if we are not prepared to eat it. We should have sent it back to the kitchen and ask to be replaced." We reported this to the registered manager and by the next day of the inspection they had investigated and found that the trolley used to keep the food hot until served to people was overheating and cooking the food further instead of just keeping it hot.

Staff were required to monitor fluid intake and output for people at risk of dehydration or other health conditions; however this was not always managed appropriately. The fluid charts had all the necessary guidelines to ensure adequate hydration. In a number of cases the instructions on the fluid balance charts were not followed. Records indicated that some people received fluids well below their target levels. One fluid balance record indicated that a person received only 150 ml of fluid in 24 hours. For another person the importance of good fluid intake was mentioned in five separate parts of their care plan yet these omissions had not been picked up consistently by the monthly evaluation done by staff and acted upon. Although we could not find evidence that people suffered from this and they were weekly checked by their GP, there was a risk that people could suffer from dehydration and other health conditions as a consequence.

Nursing staff used the Malnutrition Universal Screening Tool (MUST) to identify people at risk. They also completed an `eating and drinking assessment` to identify where people needed more support with their food intake and weights were recorded and monitored monthly. Following these assessments a care plan for nutrition, eating and drinking was developed and these were reviewed monthly. However, the care-plan had not always used the information from the assessment process accurately. For one person we found that one assessment detailed that they needed a special diet, however the care-plan indicated a normal diet. The weight recorded for one person showed an increase of 9 kg in a month however staff when evaluating the care plan had not queried this. Equally when people lost weight this was not always communicated to the staff from the kitchen to ensure all options were considered to meet people`s nutritional needs.

People who were identified with continuous weight loss were referred to their GP and dietician and they had nutritional supplement drinks prescribed. Staff from the kitchen routinely enriched the food for people and prepared high calorie drinks to promote a good nutrition. However staff could not tell us and records were not detailed to indicate if people who continued to lose weight were drinking the nutritional supplements they were prescribed.

The provider has not ensured they were constantly meeting the nutritional and hydration needs of the people living in the home therefore this was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff told us they had an induction training when they started working at the home. One staff member said they completed a three day induction and also were required to do a lot of courses which included health and safety, moving and handling and infection control. Staff told us they found the training being effective and prepared them for the roles they performed. For example, one staff member said how they always thought they were very good at hand washing but after the infection control training they had realised they needed to do it even more thoroughly. Another staff member said they were going through the work books they were given part of their training and when they were struggling more experienced care staff helped them.

Staff told us they had regular supervisions, however these were often in a group and focused on a topic. For example, completing people's care plans; how to manage people with gluten free diets, serving lunches how to improve or to go through any incident which may have happened where staff felt unsure of what the process was. One staff member told us they had individual supervision as well as group supervision, however they said, "We [staff] reported so many times that we [staff] struggle at times with the work and other things as well. Changes are happening but they are really slow and sometimes we [staff] feel we are not listened."

Staff had completed basic dementia training, however we observed from care practices and staff`s behaviour that they did not have an in-depth knowledge about the principles of good dementia care. For example, staff were not engaging with a person whose behaviour could have been challenging and who walked around all day on the unit. There was no meaningful activity or discussion initiated by staff, they just pointed the person in one direction or another not giving them a purpose. This was not helpful for a person who lived with dementia who may have felt lost. The registered manager identified the need of more qualified staff in different areas such as dementia, falls, nutrition and others to support and mentor staff working on the units. Staff taking on the roles of champions in these subjects were provided with more specialist training to become experts in their chosen area. Their roles and responsibilities included working closely with other care staff to improve care practices. However, this remained an area in need of improvement.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted deprivation of liberty applications to the local authorities for people who had limitations of their freedom in place to keep them safe. Some authorisations were waiting for approval; however staff and the registered manager ensured that these limitations were at least restrictive as possible.

People said that the care staff always asked them before they offered any support. A relative told us the staff always asked before supporting their partner and they felt the staff knew what they were doing.

We found that consent to care had been obtained from people in line with the Mental Capacity Act (MCA) 2005. People's capacity to make decisions had been properly assessed, determined and reviewed where necessary. For example, we saw evidence in one person`s care plan that they had been involved in all the decisions about their care. However, staff identified recently that the person may have lost capacity and the care plan showed that they were assessed as not having capacity to make certain decisions about their care and support. Staff were able to show us records of family member's involvement when a best interest decision was made on behalf of the person. One relative told us, "I have power of attorney and I have been involved in best interest meetings." Staff told us that when people were subject to restrictions to their freedom DoLS application were made to the local authority by the registered manager. This demonstrated that staff had a good knowledge about current legislation and requirements when people lacked capacity to take certain decisions and processes to follow to ensure people were not un-lawfully deprived of their liberty.

People told us that their day to day health needs were met in a timely way and they had access to health care professionals when necessary. They told us the GP visited weekly and they could get appointments with the GP outside normal visiting days. We saw that appropriate referrals were made to health and social care specialists when needed and there was regular contact with and visits from the local mental health team, dieticians, dentists, chiropodists and opticians. A visiting healthcare professional told us, "I review people with complex health needs weekly." This meant that people had been supported to access appropriate healthcare services and maintain good health.

Requires Improvement

Is the service caring?

Our findings

People told us they were looked after in a kind and compassionate way by staff who knew them well and were familiar with their needs and how they wanted to be supported and cared for. One person said, "Staff are very helpful and kind." Another person commented, "I've not regretted it [moving into the home] no place is perfect, not like home, but they [staff] do their best and always listen."

One relative said that the staff were very caring. They told us, "I come here almost every day and at different times and the staff are very receptive." We observed that the nurse administering medicines to people often stopped and had a chat with people. However, we did not observe staff sitting with people throughout the days of inspection to talk to them or spending more time then needed for the tasks they carried out. One staff member told us, "I have always enjoyed caring for people and sometimes I wished that we had more time to talk to them. Most of our time is taken by tasks."

People told us that the permanent staff were knowledgeable about their needs and knew how to support them. However two people mentioned that agency staff were not always as helpful or knew as much as the permanent staff. One person said, "Staff here are very good, they all know how to support me." Another person said, "Staff are good, the problem here is the agency staff. They don't know as much." Staff and the registered manager told us that agency staff were as much as possible allocated to work in pairs with permanent staff to ensure the continuity of the care people received.

In some people`s care plans we saw evidence that their wishes were captured in their own words. For example, one person's plan stated, "I need lots of support and guidance when I am mobilising." We observed staff supporting and encouraging this person while providing reassurance and guidance when they mobilised.
People were not aware they had a care plan and neither if this was reviewed regularly, however they told us staff offered them choices and they decided in what they liked to wear, when to go to bed or have a shower or a bath. One person told us, "It's my choice to have a full body wash although they [staff] are very kind and try to encourage me to shower." Another person told us, "I can go to bed whenever I like, they [staff] pop their head in and ask if I'm okay and say goodnight."

People who were from different cultural backgrounds and religions did not have enough detail in their care plans for staff to understand how to support them effectively. For example, a person`s religion involved keeping a strict dietary regime and specific foods were not permitted. Although the care plan specified the type of food the person was not to have, it had no details for staff about how to handle their food and what specific requirements were to be followed to ensure the person`s needs were met. The person had limited English language communication skills; and although we saw they were able to communicate with their family in their own language, staff made no arrangements to support this person`s communication needs other than a list a few words they had to prompt the person for personal hygiene or toileting needs. We saw this person lying in bed most of the day on both days of the inspection and staff made little effort to motivate and engage with them. When the person`s family visited they became alert, communicated and ate food brought in by their family.

Another person who had moved in the home a month ago had no personal information on their care plan. A staff member told us that they have not seen the family member who was listed as their next of kin to complete the care plan. We asked them if they asked the person`s friend who was visiting daily they told us, "I need to be careful as [visiting friend] is not the [person`s] next of kin." Personal information, likes, dislikes, past events could enable staff to relate to people in their care better. It can help staff understand people`s behaviour and find effective ways to calm people if they were having difficulty settling.

People`s care plans were not effective as a record of how people wished to be supported as they lacked the detail to enable people`s care to be tailored to them individually. They did not reflect how people may wish to spend their day, what contribution they may wish to make to their own care or how they would like their support and care offered. Daily notes were generalised and gave little account of the support people received. For example one daily record entry stated, 'Was in bed [person] at the start of the shift. Spent day in the lounge.'

The provider had not made reasonable adjustments to enable people to receive care and support in a way that supported their cultural and religious backgrounds. Care and support had not always been planned and delivered in a way that met people's individual needs or took full account of their preferences and personal circumstances; therefore this was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that their dignity was upheld and they felt respected by staff. One person said, "The carers are kind, they always treat us [people] with respect." Another person told us, "Staff are very attentive and they respect me."

Staff were seen knocking on peoples doors before entering. Some people chose to close their doors, others left them open. Staff were clear on the need to preserve people's dignity and be respectful all times. One staff member told us, "We always knock on people's door." However, we saw that people had products to support them with their continence (pads) displayed on top of their wardrobe which did not uphold their dignity and privacy. One person had both pads and an old curtain on top of their wardrobe. Also one person had a note on the door of their room which stated, 'Please keep locked during the day' however this door was seen to be open throughout the day and the person was not in the room. This meant that although staff were aware of how to upheld people`s dignity and privacy when they offered personal care and assistance, they did not fully understood or anticipated what impact their actions had on this. This was an area in need of improvement.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found that there were not sufficient opportunities for people to pursue their hobbies and interest. People were not always involved in planning and reviewing their care and support they received.

At this inspection we found that some improvements were made and people`s care plans were more detailed about their needs and the risks to their well-being, however further improvements were needed to ensure the care and support was delivered in an individualised way and people`s needs were met holistically.

People expressed mixed views about the opportunities available for them to pursue their social interests or take part in meaningful activities relevant to their needs. People told us they were bored and was little for them to do all day. One person told us, "I am very bored. The activities when any are not for me. A big chunk of the day we just sit doing nothing." Another person told us, "Activities are practically non-existent. I recently joined in with the baking and iced a cake; I liked that, and I once went on a trip, we should do more trips."

We were talking to a person when a staff member asked them if they would like to play musical bingo. The person said they had never heard of it and would give it a miss. We asked them if they have been going out and what they liked to do. They told us they liked to go out, "A while ago I went to the galleria that was nice look at my shoes. I bought them from there."

The activity organiser said they had recently obtained some sing along records from the local library. They came onto the unit early morning saying, "Shall we have some sing along." They did not ask anyone if they wanted music or if they preferred anything else. There were no overall records of how activities were organised, who covered which unit out of the three activity coordinators working at the home. There were no records of what activities people preferred or who had been on trips. The only information about activities we found was in people`s individual care plans as and when staff recorded if people attended any activities.

Staff made little effort to engage and occupy people who lived with dementia. We observed people sitting for long periods of time and slept most of the day. In one of the units in the lounge there was a TV and people were placed in wheelchairs in front of it. People were not asked if they liked what was on and the same channel was on every time we went into the lounge during the first day of the inspection. There were quite a few bookcases scattered around the home with large selection of books, however people were not encouraged to look at them. One person told us, "I like to read and have read most of the books in here but staff are good they bring some in from home for me."

In another unit we carried out observations, the TV was left on whilst a record of sing along music was put on by an activity organiser who then left the unit after singing two songs. None of the staff went to switch off the TV. Equally none of the staff noticed that the orientation boards on two units which told people the date,

the day of the week and the weather was still set for Saturday 9 July 2016. This was only changed in the afternoon after we mentioned it to staff. This showed that staff were not aware of the impact of the environment on people unable to change the environment themselves and in need of a point of reference to know the date and the days of the week.

None of the people we spoke with had seen their care plans or had any involvement in regular reviews. The involvement people had was mainly in a booklet they were asked to complete with their past history, likes, dislikes and other things they felt it was important for staff to know. Care plans were done by staff when people moved in the home and were comprehensive and contained a lot of information about people`s needs and risks to their well-being. Staff told us they reviewed care plans monthly, however this was not done routinely with people or their relatives. People and where appropriate family members were informed of people`s changing needs and they participated in best interest meetings if there was a need for it. People told us they used the monthly `residents meetings` to express what they liked or disliked about the service they received.

The provider had not ensured that care and support delivered to people had been planned and delivered in a way that met people's individual needs or took full account of their preferences and personal circumstances. This was a continuous breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that they had opportunities in regular meetings to share and raise concerns if they had any. People who were regularly attending the meetings told us that most of the complaints were about not enough staff, food, and lack of activities. One person told us, "I've never complained but you can stand up [in the meeting] and say your peace and a lady writes it down." Another person told us they did attend meetings and brought up issues, "mainly about being bored and not much to do."

People and their relatives were aware of how to make formal complaints and had the confidence that these will be listened, investigated and responded by the registered manager in a timely way. One person told us, "If I have a complaint I wouldn't hold back. They [staff] encourage you to speak." Another person told us, "We can go to the manager she's good, she listens." We saw examples of where complaints had been properly recorded, investigated and resolved by the registered manager and senior staff in a timely way.

Requires Improvement

Is the service well-led?

Our findings

The registered manager completed comprehensive monthly audits in areas such as infection control, health and safety, medicines, accidents and care plans. In the majority of cases the actions to improve on areas identified in audits were followed up and checked in the following month's audits. However, there were areas which were not actioned as promptly. For example, we saw that care plan audits were carried out and accurately identified where the care plans had to improve, however we found that these were not always done by staff. Staff told us this was mainly because they had no time to plan their work effectively. This meant that for some people the care plans were not reflecting accurately their current needs. Staff also omitted to complete care plans to capture people`s cultural and religious needs which could have had an impact on how they received support.

There was a lack of monitoring tools available for the registered manager to accurately establish staffing numbers needed in the home to meet people`s needs effectively at all times. Where people complained that their call bells were not answered in a timely way the registered manager was unable to verify this because the call system the home had was not able to generate accurate reports. At the time of the inspection this was in the process to change to a more up to date system to enable the registered manager to monitor and improve call bell response times.

People had their dependency levels assessed however there were no tools available for the registered manager to use this information and establish staffing based on the dependency levels identified. The provider told us they were in the process of introducing a nationally recognised tool from August 2016 to ensure they were able to accurately monitor and adjust staffing in the home. The registered manager was monitoring staffing levels in their daily walk rounds and regular daily stand up meetings where team leaders from each unit gave feedback about the people, staff and other developments for that day. However, people and staff told us there was not enough staff to meet people`s needs at all times especially in the mornings and when people wanted to go to bed in the evenings.

The provider had not developed sufficiently robust systems to investigate and action long response times to call bells. Care plans were not always reflecting people`s current needs or how their cultural and religious beliefs impacted on the care they received therefore this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

All the people living in the home knew the registered manager and saw them daily when they did their rounds. People who lived in the home and the staff spoke positively about the registered manager. One person in the home said, "[Registered manager] is very nice you see her all the time." A relative also said, "We see the manager every day she is very attentive."

Staff were positive and said that the registered manager was very approachable and wanted to know what was happening. One staff member told us, "We [staff] have a lot of contact; [registered manager] is really good. [Registered manager] wants things done and always wants to improve." Another staff member said,

"[Registered manager's] door is always open she is very approachable."

Staff said they felt supported by the manager. One staff member said, "Really like the manager she is always seen and you can always approach her and speak about any concerns." Another staff member said, "The manager is always around and want`s things done well. They are really supportive and very approachable."

People, staff, visitors and health care professionals told us they felt the registered manager demonstrated visible and strong leadership and had made significant improvements in the relatively short time they had been in post. We saw evidence of the improvements the registered manager brought to the service in just over one year of managing the service.

The registered manager implemented and ensured a robust medication management system was followed by staff at all times. We saw evidence of daily handover checks, daily counts of medicine stocks and weekly medicines audits. We also saw monthly managers audits of medicines management with actions made to resolve issues identified. The clinical manager showed us how they checked that actions had been carried out at the time of the next monthly audit.

The registered manager ensured that for people who were prescribed medicines to help with their anxiety or behaviour issues (antipsychotics) a review was requested from their GP every three months to ensure people were not taking these medicines more than it was necessary because of the side effects. The side effects of these medicines could cause people to be very sleepy and unsteady on their feet and could affect their quality of life.

Accidents and incidents were closely analysed by the registered manager who was monitoring every person who had falls and tried to identify trends and patterns of these falls to try and reduce the numbers. For example, a person whose wish was to remain independent had four falls in one month. The registered manager and staff discussed this in a multi-disciplinary meeting and as a result the person was given a pendant alarm to be able to call for help from any part of the home, an alarm mat to alert staff when they were getting out of bed and may have needed help. They were also referred to the GP for tests to rule out any underlying health condition they may had which contributed to them having falls. Actions agreed in these meetings were re-visited the following month to ensure they were completed and monitored for results.

We also saw records of medicines errors and near misses. These included the details of the error, why and how they had happened and the actions taken to ensure that the error did not occur again. A healthcare professional who gave us feedback about the service told us, "Staff and the manager are very prompt in reporting to us any medication error. They are very open and they will ask for advice to ensure the patients have not been harmed."

We found that the registered manager improved the training staff had. They introduced robust induction training and staff gained the nationally recognised `Care Certificate` qualification at the end of their induction. Although we still identified that some staff needed more guidance and mentoring especially around understanding and caring for people who lived with dementia, the registered manager had also recognised this. They closely collaborated with an accredited training provider and trained staff to the roles of champions in dementia, infection control, falls, wound care and nutrition. At the time of the inspection the champions had just finished their training and had not yet taken on their new roles, this was to commence shortly after their rotas were covered.

The registered manager improved the processes around how best interest decisions were made for people

who were assessed as lacking capacity to make certain decisions. These were fully compliant with the principles of the MCA and where people required restrictions in place to keep them safe DoLS applications were clearly identifying the least restrictive methods in place.

The registered manager and the provider were re-structuring the staffing arrangements in the home. The registered manager identified the need of a senior member of staff on each nursing unit to take over some responsibilities from the nursing staff who were currently managing the unit as well as adhering to their nursing responsibilities. The provider was currently recruiting in these positions.

The registered manager and staff told us that there was a high turnover of staff a few months after the registered manager started at the service. Staff left for various reasons due to personal circumstances or not been able to adapt to the changes brought in by the registered manager. We also saw that staff disciplinary procedures had been used to good effect where appropriate to tackle poor attendance, inappropriate conduct and performance issues. However, this led to a peak in agency use, which unsettled the people living at the home. At the time of the inspection we saw that agency hours used were reducing gradually. This was due to the constant recruitment drive, although recruitment proved to be difficult at times due to the area the home was located in.

The senior management team have linked in with a reputable professional care provider's association to obtain additional support, training and guidance. They have also worked closely with other healthcare specialists and organisations to obtain additional training and development for staff in areas such as pressure and palliative care. The registered manager had also met with people`s GP's and nursing staff from a local hospice to improve both the exchange of information and knowledge about how to improve the overall quality of care. For example, the provider and senior management team had a close working relationship with local authority commissioning and monitoring teams. The registered manager enrolled the home in a complex care premium programme and helped by health and social care professionals aimed to offer better quality care to people living in the home and prevent hospital admissions. This was achieved by offering an intense specialist training programme to staff to up-skill them to meet people`s complex health needs.

The registered manager conducted a service satisfaction survey recently. They asked people living at the home and their relatives to give feedback about the services they received. People were generally positive about the environment, about the kindness of the staff and they felt treated with dignity and respect. However, people commented about the lack of staff, lack of meal choices, activities and laundry service. The registered manager told us they were in the process of analysing the results of the survey and develop an action plan to address the areas where people indicated they were not entirely satisfied with the service they received.

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 9 HSCA RA Regulations 2014 Person-centred care The provider has not made reasonable adjustments to enable people to receive care and support in a way that supported their cultural and religious backgrounds. Care and support had not always been planned and delivered in a way that met people's individual needs or took full account of their preferences and personal circumstances.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider has not ensured they were constantly meeting the nutritional and hydration needs of the people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not developed sufficiently robust systems to investigate and action long response times to call bells. Care plans were not always reflecting people`s current needs or how their cultural and religious beliefs impacted on the care they received.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not ensure that there were sufficient numbers of suitable staff deployed to meet people`s need safely.