Sanctuary Care Limited

Carlton Dene Residential Care 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?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Carlton Dene Residential Care Home on 12 and 13 June 2017, the inspection was unannounced on the first day and we informed the registered manager we would be returning the following day to complete the inspection. Our last inspection took place on 26 and 27 September 2016 where we found three breaches of regulations relating to safe care and treatment, person centred care and good governance. The provider sent us an action plan following the inspection telling us what they were going to do to improve the service.

Carlton Dene Residential Care Home provides accommodation and respite care for up to 42 older people. There are two floors in the building divided into four units which provide a mixture of respite and permanent placements. The home had communal lounges, dining areas, activity rooms and an open courtyard. At the time of our inspection there were 40 people living at the home.

The service had a registered manager who was present on both days of the inspection. 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.

Safeguarding concerns were reported and the provider took preventative action to minimise further concerns. People told us they felt safe and the registered manager was aware of her responsibility to report allegations of abuse to keep people safe from harm. Risk assessments were in place and updated to show how risks could be managed and reduced, however records were not always fully completed or up to date.

Areas of the home were clean but more detailed checks were needed to monitor the upkeep of this. Health and safety checks of the building took place and emergency evacuation plans were in place.

Incidents and accidents were reported and documented, but further learning was needed from the outcome of these to mitigate the risk of people receiving unsafe care.

The application of topical creams was not managed safely. Medicines had been administered as prescribed and disposed of safely but monitoring of fridge temperatures for the storage of medicines required further improvements. Staff had received regular medicines training and their competency to manage medicines had been assessed.

The provider completed thorough staff recruitment checks to assess their suitability for the required roles. They were supervised in their roles accordingly and completed an induction and training to keep their practice and skills up to date. However, staff were not suitably deployed in the service at all times.

People had mixed views about the food, their food preferences were recorded, they were provided with

enough food and drink and their nutritional plans were followed. However, the mealtime experience was delayed causing some people to become anxious.

Health care practitioners visited people to ensure they maintained good health. Care records held information about people's nutritional and healthcare needs. Care plans were person centred, but people's end of life wishes were not always being fully explored.

People told us that staff were not always kind and caring and their privacy and dignity was not always respected. Although we observed acts of kindness, we noted that there were times when a kinder and more caring approach was needed. The provider was meeting people's cultural and spiritual needs, and people participated in the interests and hobbies that mattered to them.

People were offered independent and impartial advice from an advocate who regularly visited the home. People's relatives were complimentary about the care their family members received from staff and said they were involved in decisions about their care and any proposed changes in the home.

Staff had completed mental capacity assessments in line with the Mental Capacity Act 2005 (MCA) and these showed where people were able to make specific decisions about their care. Where people had been deprived of their liberty an assessment was undertaken and a Deprivation of Liberty Safeguards (DoLS) authorisation was in place.

People using the service, staff and their relatives spoke favourably about how the home was managed and their feedback was sought about how the service was run.

Systems were in place to manage complaints and these were responded to appropriately. Audits were carried out to check the service was meeting the required standards, however further analysis was needed to detect and address the shortfalls we found during our inspection.

We have made three recommendations about the safe management of topical and liquid medicines and fridge temperature checks, determining the correct staffing levels and people's end of life care needs. We found two breaches of regulations relating to dignity and respect and good governance. You can see what action we have 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.

Staff were not following the guidelines for the safe management of topical and liquid medicines. Oral medicines had been administered as prescribed and disposed of safely. Staff's competency to manage medicines had been checked.

Staff were not always suitably deployed to ensure people's needs were responded to appropriately. Background checks were carried on staff to ensure they were suitable for their roles.

Health and safety checks were routinely carried out, but the cleanliness in certain areas of the home needed to be checked on a more frequent basis.

Risk management plans had been updated to reduce the likelihood of harm, but some plans required further review.

People told us they felt safe. Staff understood how to recognise and report abuse.

Is the service effective?

Good

The service was effective.

Staff received an induction and regular supervision and their work progression was discussed. Training plans were in place for staff to further develop their practice and skills.

People's capacity was assessed in accordance with the Mental Capacity Act (2005) and staff knew how to apply this in practice. Deprivation of Liberty Safeguards (DoLS) applications were made after assessments were undertaken in people's best interests about any required restrictions needed to keep people safe.

People had enough food and drink to meet their nutrition and hydration needs; however, people gave us mixed views about the food and the mealtime was delayed.

Health practitioners visited the home to ensure people's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that some staff were not always caring and their privacy and dignity was not always respected. We observed mixed interactions between staff and people using the service, some of which were caring and some which were not.

People's end of life care needs were considered but not always fully explored to ensure that people's needs were met.

An advocate visited people to offer confidential and impartial advice and to ensure that their views were heard.

Is the service responsive?

Good

The service was responsive.

Care plans had been reviewed to show how care was personalised to meet people's specific needs.

People were involved in leisure pursuits that mattered to them, and had accessed outings and events in the community led by the activities coordinator.

Complaints were acknowledged and acted on in line with the provider's policy and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were carried out in the home but had not identified the shortfalls we found. Incidents and accidents were documented and acted on but further action was needed to ensure that learning took place to help prevent reoccurrences.

The provider had obtained feedback from people to obtain their views, and staff updated relatives in meetings about any proposed changes to the service.

People and their relatives spoke positively about the management of the home and staff were in agreement with this.

Carlton Dene Residential Care 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 12 and 13 June 2017. The first day was unannounced and the second day was announced. The inspection team consisted of two inspectors, two medicines inspectors and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we contacted a representative from the local authority after we received information of concern. In addition to this, we reviewed the information we held about the service including the last inspection report and the provider's action plan.

During the inspection, we spoke with seven people using the service and three relatives, we checked 10 people's care records and 13 people's medicine records. We also reviewed five staff recruitment files and records relating to the management of the home. A number of health and social care professionals visited people during the inspection and we spoke with a district nurse, a social worker, a dietitian and an advocate to ascertain their views about the home. Additionally we spoke with four care workers, the chef, the activity coordinator, five care assistants, three senior care assistants, the regional manager and the registered manager.

After the inspection, we spoke with a General Practitioner who provided a service to people at the home.

Requires Improvement

Is the service safe?

Our findings

We asked people about the medicines they received. They commented, "I don't take medication", "I have pain patches every day." In addition, a relative told us there were no concerns with their family member's medicines.

At our last inspection, we found that medicine administration records (MARs) for people were not signed and stock counts for medicines were not accurate. Prior to this inspection, we had received information of concern about the safe management of people's medicines. At this inspection, we found that the provider had taken steps to address these concerns but aspects of the medicines systems needed to be improved.

Some people were prescribed creams and ointments. We checked the topical medicines administration records (TMARs) which showed the application of creams and ointments. The TMARs were produced by the provider, however, we found these were not completed correctly as the names of the creams and ointments applied were not recorded. The accompanying body maps were not always completed; therefore, it was not always clear where the creams needed to be applied. In addition, many preparations had not been signed as applied for extended periods of time. On discussion with staff, the consensus was that the creams probably had been applied and the TMARs had not been completed to indicate this.

We checked how medicines errors were identified. One person commented, "They do give me my medicines, I know which medicines I'm on, I have it written down every day. Once they run out, they said they changed suppliers, we all make mistakes and it was rectified. I spoke to [the management team] when the medication wasn't going right." Where the management team had identified medicine errors, incident forms had been completed which noted the reasons for the errors and what action had been taken to rectify this and prevent reoccurrence. Staff had received medicines training and their competency had been reassessed. The registered manager explained that staff would be receiving further medicines training as they had recently changed their dispensing pharmacist.

Staff recorded the ambient room temperatures of the medicines rooms daily. We found that both medicines rooms were hotter than the recommended maximum of 25°C, as the readings were 27°C. Staff had taken action by opening windows and turning on fans to keep the rooms cooler. Records showed the minimum and maximum fridge temperatures were monitored daily. We saw that most temperatures were within the required range of 2 and 8°C; however, we noticed a few readings of 9°C recorded in May 2017. We found that staff were not recording current fridge temperatures, and there was no evidence to show that the fridge thermometer was reset each day. This is to ensure that temperature records identify any temperature deviations and give details of corrective actions taken as a result. The impact of the fridge temperatures on people's medicines was minimal because at the time of the inspection, there was one medicine item in the fridge, and this item could be stored at room temperature once in use. We checked the medicines such as liquids and eye drops and found that these medicines did not have the date of opening annotated on the label. We recommend that the provider review their current practice to ensure that the appropriate guidance is followed in relation to the use of topical medicines, the expiry dates for medicines and the fridge thermometer for the safe storage of medicines.

Staff administered medicines and used MAR charts to record this. The MARs provided assurance that people were receiving their medicines safely, consistently and as prescribed. The MARs were computer generated by the pharmacy that supplied the medicines. All the MARs had a photo to ensure staff could identify the people receiving medicines. Information on people's allergy status was also documented.

Staff explained that if people refused their medicines, they would give them time, and ask another member of staff to offer the medicines. If the medicines were still refused after numerous attempts, the dose was placed in a plastic bag for disposal. If this refusal continued, then the GP would be informed. There was a system for medicines disposal and records showed that these were disposed of safely and that staff sought medical assistance from GPs if people were unwell and if this was out of hours, they contacted NHS 111 to ensure that people received prompt and appropriate care and treatment.

One person was taking homely remedies. These are over the counter medicines made available to people. They are for the short-term management of minor ailments, for example, mild pain. Staff regularly checked the medicines stock for the person to ensure there was an accurate stock counts.

Controlled drugs (CDs) were stored in one of the clinical rooms in an appropriate CD cabinet. We found that a senior member of staff checked stock levels for CDs monthly. When CDs were administered, two members of staff signed the CD register. We found that the quantity of CDs in stock matched the quantity recorded in the CD register. All the medicines were stored in locked medicines trolleys within a separate room and we observed that the rooms were clean and tidy, only relevant staff held the keys to access the rooms.

At our last inspection, risk assessments were not reviewed to ensure that they accurately reflected people's needs. At this inspection, we found that action had been taken to update the risk assessments.

Dependency assessments were completed to assess the likelihood of harm occurring, the severity of the risk and the level of support people required to provide staff with guidance on how to best support the person. Records contained details in relation to a number of areas of people's care including their nutrition, mobility and their physical and mental wellbeing. Staff were aware of recent changes in people's needs and responded to this quickly and diligently, for example, referrals were sent to the appropriate health professionals when risks were identified to reassess their health needs and offer treatment and advice.

However, we did find discrepancies in one of the files we viewed that did not contain sufficient guidance to show how risks should be managed. For one person we found that they were refusing wound care, the correct course of action was taken and the person was taken to hospital for treatment but there was no body map and wound treatment plan on file. We also found that the person's medicines risk assessment did not contain information about what staff should do to mitigate the risk when medicines were refused. The registered manager was in the process of sampling care records to audit and some were still in the process of being fully reviewed.

At the last inspection, we found that some areas of the home were unclean and that the monitoring of hot and cold water temperatures was not checked in all of the four units. At this inspection, we checked all of these areas and observed them to be clean apart from the activity room and the adjoining kitchen on the first floor. The registered manager acted on this accordingly and the following day we checked this area again and found these areas had been cleaned. Carpets in the communal areas of the home were scheduled to be cleaned and a contractor had carried out water temperature checks in all four units.

Environmental checks were undertaken, such as the servicing, testing and repair of equipment. Individual fire evacuation plans were on file for people to show how they should leave the premises safely in the event

of fire. Practice fire drills took place in line with the provider's policy and regular testing of the fire alarm and servicing of equipment was completed. Records showed that staff had received fire safety training and that the fire risk assessment had been reviewed.

We asked people if there were enough staff to help them with their needs and requests. Comments included, "For me there is", "I can't tell, I have a key worker, I ask any staff available" and a relative said, "'I think there is, we get things pretty quickly if we ask for them."

Since the last inspection, the provider had restructured the staff team so that the senior staff were overseeing care staff on all four units. We checked the rota and found that there were two members of staff allocated to each of the four units during the day and night and that this included two senior staff members, and we saw these staff were on duty.

The registered manager explained that the two senior workers oversaw the four units and assisted people with their day to day needs. Additionally, the deputy manager and registered manager were available Monday to Friday during the hours of nine to five.

The registered manager also explained they were available during the weekends to support staff with any emergencies. The operations manager further added they no longer used agency staff and the provider's regular bank staff covered any additional shifts to ensure people were supported by staff who knew them well.

In response to a relative's concern about more staff being needed to escort people to the hospital, records showed that the provider had introduced escorts to assist people to health appointments and activities in the community when this was needed. We observed that people attended their planned activities during the inspection and that the schedule of people's daily appointments was recorded on the daily allocation sheet.

However, despite this staff told us at times they felt stretched and there were not enough of them on duty to meet people's needs. They explained there were two staff members on each unit, and when one of them had to help other staff in another unit if there were concerns, this left one member of staff on a unit to support up to 10 people, and this was more prevalent during the weekends.

Call bells were placed in people's rooms and some people were able to mobilise independently without the use of aids or equipment. One person commented, "I don't have a call bell, I have never had a fall." A relative said, "When [the person] arrived there was no call bell but they had this fitted straight away."

The call bell system was set up so that when people rang their bells to request help, this rang through to the main reception on the ground floor to alert staff on reception that people needed support with their care who would in turn phone staff on the relevant unit. The reception area was also staffed to allow visitors in and out of the building, however a relative commented, "I come in every other day, there is not usually anyone around weekends to let you in so I ring [my family member] and [they] tell the staff who come and open the doors." Therefore we could not be assured that there would always be a member of staff available in reception to respond to people's requests for assistance.

During our inspection, we observed that at times care provision seemed hurried and staffing levels varied. For example, during a lunchtime meal in one unit we saw this was rushed and one staff member called across the room to another staff member, "I need someone in here now." On another unit during lunchtime one person said, "'I have never seen so many carers all in one room it's nearly one each." On the second day of the inspection, we saw there were enough staff and a staff member later commented, "There has never

been this amount of staff on shift before." We recommend the provider review their staffing levels to ensure there are enough staff deployed within the home at all times.

We spoke with the management team about this and the operations manager explained the provider was planning a review of the staffing levels in the home to assess if there was an appropriate number of staff on shift during the weekdays and the weekends.

People told us they felt safe. Comments included, "I feel safe because nobody can come through the door", "Nobody can come in unless someone break's in." People's relatives echoed this and told us, "Security on the door is good, the staff are very good with [my family member] who feels very calm, feels secure," and "We think the safety here is really good."

We had received information of concern and we liaised with a representative of the local authority who had held a providers concerns meeting in relation to this. A plan had been put in place by the local authority to address these issues to ensure people were protected. The registered manager had kept the Care Quality Commission (CQC) informed of safeguarding concerns raised in the home. Where safeguarding referrals had been received by the local authority and assessed as not being a safeguarding matter, the provider had implemented measures to ensure staff learned from these incidents. The registered manager said, "I would rather over report [safeguarding] than under report."

Staff members told us they understood what abuse was and how they should report any concerns that they had. There was a clear reporting structure with the management team responsible for safeguarding referrals, which staff members were all aware of. There were written instructions to guide staff and they knew where these were kept. Staff told us they had received training in safeguarding and the records we reviewed confirmed this.

A robust recruitment process was followed to assess the suitability of staff employed. The provider had a central recruitment team who advertised available positions and the registered manager matched potential candidates CVs to the roles and level of experience that were required. Interview notes demonstrated staff were tested on their written and numerical skills as a requirement of the roles. We found that appropriate checks were held in the files of the newly recruited staff. This included thorough reference checks that covered an extensive period of time. Identification and right to work documentation had been verified and up to date criminal record checks were completed.

Disciplinary action was taken by the management team to address staff conduct issues where this was necessary, such as implementing more training for staff and closer supervision of their work practices. This was to ensure staff followed the provider's policies and procedures to make certain poor practice did not have an impact on people receiving safe care.

Good

Is the service effective?

Our findings

At our last inspection, we found staff had not received regular supervision. At this inspection, we checked staff supervision records. These demonstrated that staff attended regular one to one supervision meetings to discuss their practice, skills and development needs and provided an opportunity for both parties to give feedback about their work progress.

Staff had access to essential training. They were required to complete a 12 week planned induction once they began work. Aspects of this included shadowing other more experienced staff, the homes evacuation and emergency procedures and the provider's policy about the use of mobile phones and social networking sites. The induction included a career development plan that demonstrated how staff could progress in the organisation, up to the level of obtaining a professional health qualification with the providers support. A staff member told us about the training courses they had attended and the reasons why this had been effective, and commented, "I have had lots of training, when I attend training I am more confident in my work because when you do something so often you can get complacent if you don't use training."

The provider had a training plan in place to evidence that staff had attended courses on dementia in care, first aid, health and safety, equality and diversity and moving and handling. The training matrix showed the percentage of staff that were compliant with their training, however this required updating as this highlighted that moving and handling training for three members of staff had expired. The registered manager later sent us the training certificates to demonstrate this training was up to date and agreed to revise the training matrix to reflect this.

Mental capacity assessments were available in care records to show staff which decisions people were able and not able to make for themselves. One person commented, "[My family members] don't make decisions for me I make my own decisions." 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Best interests decisions were discussed in collaboration with health professionals and people's representatives to form a balanced view based on people's circumstances to determine how they should be supported with decisions about specific areas of their care. One relative explained, "We are in the process of setting up power of attorney for their health and finances, for [my family member] a care plan approach (CPA) meeting was done." To best support a person who did not have family members or representatives to help them with best interests decisions we observed that an independent mental capacity advocate (IMCA) visited the home to hold discussions about the person's needs to reach a collaborative resolution about specific decisions after consideration.

A staff member provided us with a clear explanation of the MCA and the importance of their role in ensuring that people were able to continue making their own decisions for as long as possible. They commented,

"Always assume capacity, but we test that every day, I try and assess capacity. The person I support can't do banking but I will be able to take [them] to the bank, it gives [the person] a sense of self-worth. Just because yesterday they cannot make a decision about their care, the next day that can change, it doesn't mean they do not have any rights." Records showed that staff had received training in the MCA and we saw examples of the principles of the Act being applied during our inspection, for example, staff were seen supporting people to make decisions and asking for their consent.

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 are called the Deprivation of Liberty Safeguards (DoLS). For some people DoLS applications had been sent to the local authority, and staff were waiting for these to be assessed and authorised. Where DoLS authorisations were in place we found that people had been assessed by a best interests assessor, and any restrictions were imposed in line with the Act using the least restrictive options.

People's opinions about the food provided differed. They commented, "It's good, I enjoy it", "It's fine there is always enough", "What I get is ok" and "Sometimes we get the same thing for breakfast, supper, lunch. I don't have to eat it, [my family member] leaves me money and I get the staff to buy me things to eat, I go to the [club] and eat there."

A relative told us, "[My family member] doesn't like the food and orders from me a regular supply of snacks, grapes, biscuits, [he/she] doesn't say what is wrong with the food, just doesn't eat it. The staff have a better interaction with [them] as they know what's going on."

We observed how people were supported with their nutritional needs. During the morning staff meeting, the chef informed the team that the meal would be delayed by 20 minutes as there were inexperienced agency kitchen staff working at the home that day. This information was not shared with everyone and as a result we saw that this caused some people to become restless and anxious before their food arrived.

People were offered a choice of two dishes that were served up on plates so the options were available for them to view. They were asked by the staff in a calm and respectful manner how they wanted to receive their care. They told people what they were going to do before they acted. A staff member told a person, "I'm going to push your chair in slowly." We also saw that people were encouraged to do things for themselves where possible; one staff member asked a person, "Shall I let you help yourself or shall I pour it?" Most staff when speaking with people leaned down to the person's level.

We found that, one out of two dishes that was served was not what was on the menu, there was chicken and mushroom pie rather than chicken and ham pie. One person made a request for one particular item of food that was not on the menu and we observed that this was given to them. Staff positively encouraged people to eat a sufficient amount of food and to drink plenty. Another person told us the food was "not bad" and explained if they did not want what was on the menu they would be offered an alternative. A relative commented, "Regarding the food they always ask people what they want, even how many sugars they put in their tea."

There were good sized portions of food served and people were offered second helpings. Where people required support to eat specific diets, the records we looked at and observations we made showed that these were being followed. For one person we noted that their eating and drinking care plan was being complied with, they were given a soft food diet and told us they liked their meal. We spoke with the chef who was aware of the person's dietary requirements.

During our inspection, we spoke with a dietitian who was visiting a person in the home. They told us the person's nutrition records were up to date and that the person's nutritional and hydration needs were being met. They further explained that the provider made referrals to them appropriately when they noted that people's weight was above or below the recommended body mass index (BMI). Care records showed people's specific preferences in relation to their foods, if they had any allergies, and if people chose to purchase their own groceries. Some preferred to eat in their rooms and had their own fridges in their rooms to store their food items. A person commented, "I have a fridge in my room where I put my fruits, juices and whatever."

People told us they accessed health care services and that their records held information about their healthcare needs. They commented, "I go to see the opticians" and "I've got records from the GP, my medication record, height and weight." A relative commented, "[My family member] has seen the doctor once or twice not by request, they just came to see [them]."

Records contained input from a range of health practitioners about people's individual health needs and how staff should support them to maintain good health. We spoke with health professionals during and after our inspection that regularly attended the home and contributed to multi-disciplinary meetings to discuss people's treatment plans and offer advice; they spoke positively about the care people received from staff in the home.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us some staff were kind and caring. They commented, "They show me kindness and caring some of them, I just want to see happy faces', "I think they are, they bath you and always say good morning, they know me well'' and "My keyworker is very kind and caring and the night staff, we have a woman here [name of staff] is very good." People's relatives told us that staff were "extremely" caring and "very nice".

Despite this positive feedback, we observed that some staff did not display a caring approach to people. We saw that one care worker did not make eye contact with a person during a mealtime when they spoke and walked away from people whilst they were speaking so they did not know what the person had said. On the second day of our inspection, we observed members of staff congregated in the communal dining area on the ground floor unit in the late morning talking whilst one person was sat at the dining table, with a drink without any interaction from staff. Another person made a complaint about a member of staff during the inspection, the person commented, "They should take seriously that staff need to learn to be caring and kind to the residents." We spoke with the registered manager about this who addressed this immediately with the member of staff.

Some people told us their privacy and dignity was not always respected. They commented, "I told the staff before you come in my room knock the door, not all of them do it they are still learning. When I'm using the toilet some come in and say (their names) I told them don't do that just knock the door", "Some of them do, some of them don't."

We observed during our inspection that most staff knocked on people's doors and called their names before entering. For example, we observed that a staff member knocked and called the person's name even though their door was open and another staff member knocked and called the person's name when the door was closed. However, we saw that some staff did not knock and entered people's rooms without knocking or calling their names. Records showed that staff had received training in dignity in care, but we observed this was not applied and put into practice at all times.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the majority of staff were attentive and showed acts of kindness. People were asked in a calm and respectful manner how they wanted to receive their care. They told people what they were going to do before they supported them. In one communal area where we saw a person sitting on their own, as some people had been taken out on an activity, a staff member asked if they would like to join people on another floor, so they could socialise with more people, which they agreed to. The cleaner was complimentary about the member of staff. Another member of staff attentively listened to a person's conversation, whilst they guided the person to their room when they asked for assistance.

We checked care plans for people's end of life care needs and found that these did not always contain

enough detail to capture their end of life wishes. Where people did not feel confident discussing their end of life needs and wishes this was documented in some people's care plans, but not all. We found care plans had not fully taken into consideration how people's individual wishes should be met and did not always provide enough guidance for staff to follow. For example, we found that one care plan had been recently reviewed to show that the person had previously been assessed as requiring end of life care. Since this review, this person had made a significant recovery. However, there was no information to demonstrate how the provider reassessed the person's needs to reflect what action staff should take if their health needs deteriorated again to support their end of life care preferences and the plan was not signed by the person or their representative.

Care records showed how people's wishes and decisions should be respected and discussions had been held with some people about their end of life care, for example, we saw that a best interests decision was made about a person wishing to remain in the home with the support of health practitioners.

People's care records contained "Do not Attempt Cardio-Pulmonary Resuscitation" forms (DNAR) where this was appropriate. Records showed that the registered manager had held discussions with people's relatives about what the forms were used for. The DNAR forms we looked at included advanced directives for two people that were signed but we found these were not in their rooms and the staff with spoke told us they were not aware who had a DNAR in place. This meant that staff were not aware of people's end of life wishes. We recommend the provider seek guidance form a reputable source in relation to supporting people with end of life care.

People were offered choices about how they would like to receive care. The involvement of families and others identified as important to the person were actively explored, respected and met as far as possible. Relatives told us that staff were knowledgeable about their family members life histories and circumstances, and one relative commented, "They know the family, [their] background and life, 'I've been going to the home a lot when staff have come along I haven't recognised, and they have said, "Oh you are [name of person's] relative." After the inspection the registered manager sent us a local newspaper article where a family member had commented favourably about the good care their family member had received.

People's rights were taken into account and listened to. There were advocacy posters displayed on the wall of the home. During the second day of the inspection, the advocate visited the home and we spoke with them about the service they offered people. They explained they visited the home once a week to provide free, independent and impartial advice that was confidential and aimed at ensuring people's views were heard.

Good

Is the service responsive?

Our findings

At our previous inspection, we found that care records did not always provide sufficient detail to ensure that people received personalised care. At this inspection, we found that people's care records had been updated and that their relatives were involved in this process. There was information in care plans on how best to respond to people's needs anxieties and emotional attachments. Guidance was available for staff on the choices people should be given to promote their independence. People's care was reviewed by social workers and adjustments made to their care plans when this was required.

Care plans contained information based on people's choices and decisions and tailored to meet their individual needs, for example, what they would like to wear and how they would like to be bathed and their nutritional and health needs. They showed what tasks people were able do, independent of staff, where they had refused support and if they chose to provide their own foods. For one person, we saw detailed guidance for staff about how they communicated to ensure that staff were able to understand them and respond effectively to meet this person's needs.

People had contributed to their care plans where this was possible and with the involvement of their relatives or representatives where this was appropriate. However, there was an inconsistent approach in some of the documentation in care records, and some anomalies and discrepancies in files were picked up but these were still being developed, and the registered manager was regularly auditing samples of these records.

At our last inspection, we found that people's individual social, cultural and spiritual needs were not always met. At this inspection, we found that people participated in their chosen pastimes and the hobbies that were important to them.

People told us about the interests and activities they enjoyed doing. They commented, "Reading and watching TV", "Sewing and crotchet knit when they have activities like London Mobility I always join in whatever activity they have" and "I like washing my clothes, I don't get bored. I have my own hoover, I hoover my room, I am busy."

Records showed people's preferences and their favourite hobbies so people could participate in these. For example, the activities coordinator accompanied a person to purchase the newspaper they enjoyed reading daily and we observed staff giving them the newspaper to read during breakfast. A second person's records showed that they enjoyed using the computer to research information and a staff member confirmed this. We visited the person in their room and observed they were on their laptop; the staff member introduced us to the person and asked if they would like to speak with us, but they politely declined for a later time as they were busy on their computer. A relative commented, "They have picked up on [my family member's] interests quite quickly" and "[My family member] has got a good routine."

The provider told us they hoped to obtain their own vehicle to take people out on regular outings. In the interim period the provider had liaised with a local school and reached an agreement to use their vehicle

and driver during school holidays, and we found the appropriate safety checks had been carried out in relation to this. In turn, the provider offered to work with volunteers from the school who were present during the inspection days. During the inspection, the bus arrived to take people to music therapy and a good number of people chose to attend. We spoke with the activities coordinator who held their own records to demonstrate the activities people had engaged in. They showed us photographs of people attending trips and events in the community. One relative spoke positively about the activities coordinator and commented, "[Name of staff] is a very good point of reference for everything, very good at talking with the relatives."

Many people in the home were living with different stages of dementia. Staff had captured people's life histories in sufficient detail to give an overview of their younger, middle and later years, which showed their individual backgrounds, social circumstances and preferences in relation to leisure pursuits. Staff explained how they were able to build good relationships with people because they sat and talked with them to gain a better understanding of their needs.

To better understand and capture people's life experiences the provider had sourced an external service to offer 'WordArt' to people. The facilitator of this activity sat with people during different times of the day over a certain period of weeks. This allowed the facilitator to capture the specific words people referenced and personal anecdotes they expressed during this time. The words were then used to produce a book for people of the words they frequently made reference to which were printed in various formats and colours and people were supported to choose the picture on the front of the book. The books we viewed captured themes in their lives, their experiences, and the people and moments in time that were important to them.

People spoke with us about their religious and spiritual beliefs. They commented, "I could go to church if I wanted to" and "[Name of staff] takes me to church." A relative said, "[My family member] communicates with [their] own priest and the local one came to visit."

During the inspection, we observed a Rosary taking place. The staff explained they also took into account people's diverse places of worship from different faiths and denominations to meet people's religious and spiritual needs if this is what they wanted. The provider had recruited staff that were bilingual to meet people's specific language needs. The staff we spoke with showed an understanding that some people preferred to be cared for by a person of a particular gender and this was acted on. This showed that people's individual cultural, spiritual needs and preferences were met.

People told us if they had any concerns they would address this with staff in the home and knew how to make a complaint. The complaints procedure was visible on noticeboards for people to access if they needed to raise any concerns. One person commented, "The main person I complain about anything to is my keyworker" and people's relatives explained, "If there was any problem with [my family member] I would say" and "There is nothing dramatically worrying or wrong." Records showed where complaints had been raised staff had taken action to resolve these in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, we found that the provided was not completing thorough audits to assess and monitor the quality of the service provided. At this inspection, we found that regular audits were in place but these had not identified the issues we found in relation to topical medicines, determining the correct staffing levels, the training matrix, people's end of life needs and more thorough checks were required in respect of the cleaning in areas of the homes. This meant that auditing systems were not always effectively monitoring or improving the quality and safety of the service.

This was a continuous breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Care records and risk assessments contained some discrepancies; however these were in the process of being audited. The provider had identified that written handovers were not being thoroughly recorded by staff and we noted that one written handover was not completed during a weekend shift. We observed during the inspection that the registered manager was quick to act and resolve concerns but did not necessarily ensure staff always received and acted on the messages that were delivered to them, for example, in relation to people's mealtime experiences.

People spoke positively about the management of the service. Their comments included, "Every time I need to see [the registered manager and deputy manager] and speak with them I feel comfortable when I talk to them, they listen" and "Not necessary I just carry on." People's relatives said, "I have good access to the deputy manager, very accessible" and "I have got access to [the registered manager and deputy manager], never had a problem with chatting with them. It's a very relaxed and calm environment."

Staff also spoke favourably about the registered manager of the home. They said, "The previous manager has left now, we just pop into the office and she takes time to talk with us", "If you tell her about any issues she is on board, worried about a resident? I just call her immediately" and "[The registered manager] is a trier, a fighter, any issues they have to be reported to her."

We observed that where people had fallen, and sustained injuries; there were body maps in place for them. We looked at how incidents and accidents were monitored and managed in the home and if there was any learning from the outcomes of these. Records showed that where people had experienced falls, action was taken, for example, the accident helpline was called, people had been checked by the GP, and checked for health conditions such as urinary tract infections (UTI's) and some people placed on regular observations.

Individual records showed how often people had fallen. One relative told us, "[My family member] had one fall in the middle of the night and shouted and someone came." A separate record showed how the incident was managed, and what was done but these were not collated and evaluated to show how these incidents were mapped to learn from and improve on these.

For example, one person had one fall a month over a period of four months and we visited the person who

was resting in their chair and we saw that their walking aid was placed next to them. However, the provider did not hold information on the monitoring of the call bells to check how often they had used the bells in comparison to how often staff had found the person had fallen or if the person had alerted the staff verbally to indicate when they had fallen. Further monitoring was required to assess if people were always able to reach their call bells, if they required additional aids, and that the provider had exhausted all of the fall prevention measures.

At the time of the inspection, no one in the home was provided with aids, such as pendant alarms or sensor mats in the event that people were not near a call bell. We pointed out our findings to the management team who agreed that incidents needed to be more thoroughly evaluated and action taken to improve upon the prevention measures currently in place.

At our last inspection, relatives were not consulted in a timely way about matters affecting the home. At this inspection, records showed that relatives had attended meetings to discuss any proposed changes to the service. A relative commented, "I haven't needed to attend, [my family member] had a long chat when [they] first came in." Records of these meetings showed conversations were held with relatives about how the provider could improve on communication, their involvement in care plans, activities, and any concerns and suggestions they wanted to raise.

Staff team meetings were regularly held and discussions included people's wellbeing, activities, safeguarding, fire procedures and the importance of offering people choice. A staff member commented, "With Sanctuary taking over they keep pushing it when it comes to transformation there are some things we overlooked with [the previous provider]. They bring in more information about what we need to do."

Annual surveys had been sent to people during 2016; these had been collated and evaluated to show a high level of satisfaction with the service. The most recent annual survey had been sent to people in May 2017 and the results of these were due to be produced between August and September 2017.

The local authority were working closely with the provider and conducted regular monitoring visits to check any actions that needed to be put in place and addressed.
The registered manager had sent the Care Quality Commission (CQC) information about any significant concerns and events that affected people using the service, and we have been notified of these of these events without delay.

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 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: Service users were not always treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17(1)(2) (a)(b)(c)