Four Seasons 2000 Limited

# Hesslewood House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Hesslewood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation and care for up to 66 people.

The service is divided into three areas; 'Oak' provides nursing care, 'Beech' provides personal care for adults and older people, some of whom may have a physical disability, learning disability or dementia related condition and 'Cherry' provides support to people living with dementia.

The inspection was unannounced and took place over two days on 28 November and 7 December 2017. At the previous inspection in September 2015 the service was rated Good. On the first day of this inspection there were 61 people using the service.

The provider is required to have a registered manager as a condition of their registration and there was a registered manager in post. They had been registered since June 2017. 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.

Most people and relatives we spoke with told us they felt safe living at the service. Care workers received training on safeguarding vulnerable adults and knew how to raise any concerns. Risk assessments were in place and regularly reviewed. Accidents and incidents were recorded and analysed by the registered manager. Systems were in place for the ordering, storage and administration of medicines.

Care workers were recruited following robust recruitment procedures. There were mixed views about staffing levels at the service. We found there were sufficient care workers to meet people's needs safely but have made a recommendation in our report that the provider reviews how staff are deployed in order to maximise people's opportunities for social engagement and emotional well-being.

People were supported to make their own decisions and when they were not able to do so, decisions were made in their best interests. The provider had submitted appropriate Deprivation of Liberty Safeguards (DoLS) authorisation applications, however some improvement was required to the provider's systems to ensure that staff were knowledgeable about any conditions of people's DoLS authorisations.

Care workers received induction, training and supervision. The registered manager took action after our inspection to organise additional training in relation to epilepsy and diabetes.

People's needs were assessed and there were care plans in place to guide care workers on how to support people. Some care files contained personalised information about people's wishes and preferences.

However, there was some inconsistency with this, and some care files lacked clarity about people's healthcare needs. People had access to visiting healthcare professionals where required.

People had a choice of meals and received appropriate support with their nutrition and hydration needs. However, we received mixed feedback about the food available and some improvements were required to the consistency of people's dining experience.

People told us that care workers were kind and caring and we observed positive, friendly interactions between people who used the service and care workers. Care workers ensured people's privacy and dignity were upheld, and supported people to maintain their independence and skills where they were able to.

There were some activities available at the service but the social and leisure opportunities were limited, especially in the nursing area of the home.

There was a quality assurance system in place and the registered manager completed regular audits of practice at the home. Although there was some evidence of action taken in response to issues identified in audits, overall we found that the quality assurance systems in place had not been effective in addressing some of the concerns and inconsistencies we identified in practice across the three areas of the home.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Good**

The service was safe.

Risks in relation to people and the environment were assessed. Accidents and incidents were recorded and analysed by the registered manager.

Robust recruitment procedures were in place. There were mixed views about staffing levels and we have made a recommendation about the deployment of care workers.

Care workers understood how to report any safeguarding concerns. Systems were in place to ensure people received their medicines.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Care workers received an induction, supervision and training, but their knowledge in relation to epilepsy, diabetes and the Mental Capacity Act (2005) could be improved.

People were supported to make informed decisions wherever possible and applications for Deprivation of Liberty Safeguards authorisations were made, but some improvements were required to the systems in place.

People's nutritional needs were monitored. We received mixed feedback about the food and dining experience.

### Is the service caring?

**Good**

The service was caring.

Care workers ensured people's privacy and dignity were upheld.

People and relatives told us that care workers were kind and caring. We observed positive friendly interactions between people and care workers.

Care workers responded to people's diverse needs and received

training in equality and diversity.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans gave care workers information on how to support people, but some lacked detail about people's preferences and clarity about aspects of their care.

There were limited social and leisure activities, especially in the nursing area of the home.

There was a complaints policy and procedure in place, but some relatives raised concerns they felt had not been addressed.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Improvements were required to ensure consistency of practice across the home.

There was a manager in place who was registered with CQC. Care workers received supervision and attended team meetings.

Quality assurance checks were conducted to monitor the service provided but the systems in place had not effectively addressed the concerns we identified in our inspection.

# Hesslewood House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 28 November and 7 December 2017. The first day of the inspection was unannounced and we made arrangements to return on the second day. The inspection team on day one consisted of two adult social care inspectors, a specialist advisor who was a nurse and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience for this inspection had a range of experience, including dementia, older people, physical disabilities and learning disabilities. Day two was carried out by two adult social care inspectors.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the provider and information we had received from the East Riding of Yorkshire Council (ERYC) contracts and safeguarding teams. Some concerns had been raised with us prior to the inspection, which we looked at as part of our inspection. We did not ask the registered provider to submit a provider information return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, deputy manager, resident experience manager and regional manager. We also spoke with seven care workers (including care assistants and nurses), eight people who used the service, seven relatives and a visiting healthcare professional. We looked at the care records for eight people who used the service, the recruitment, induction, training and supervision records for four members of staff and various records relating to the management of the service. We spent time observing the interaction between people and care workers in the communal areas on all three areas of the home and during mealtimes. We also carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves. We spoke to another relative by telephone, after our visits to the home.

Good

# Is the service safe?

## Our findings

We spoke with people who used the service about whether they felt safe at Hesslewood House. Most people told us they did and their comments included, "I feel safe and they (care workers) know how to lift and move me," "I'm well looked after here, I feel safe," and "I'm very happy, it's always warm and safe. I've had a lot of falls but here there's always someone on hand. No one can get in with all the keypads and numbers. It suits my needs." One person was concerned about other people going in to their room and the risk of theft. We spoke to the registered manager about this, who told us that people could have a key to their room if they wished. Two relatives in another area of the home raised concern about someone who used the service going into other people's bedrooms and we spoke with care workers about how they managed this in order to maintain people's safety and privacy.

The provider had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse. Care workers we spoke with were aware of their responsibility to raise any concerns. The registered manager kept a safeguarding log which included information about any incidents or allegations and the actions taken by the provider in response. We saw from this information that there had been safeguarding referrals made in the 12 months prior to our inspection which had been investigated by the local authority, including one concern which was on-going at the time of our inspection. The provider had responded appropriately to these referrals. The registered manager also advised us how they had learned from a complaint which had been upheld approximately 12 months before our inspection. This showed us they took safeguarding concerns seriously and had a system in place to deal with any issues.

The provider had a robust system for the recruitment of staff. We looked at recruitment records for four staff and found that appropriate checks were completed before staff started work. These checks included seeking appropriate references and identification checks. The provider also conducted interviews and completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands, and in addition checks a list of people barred from working with vulnerable adults and children.

We looked at whether there were sufficient care workers to meet people's needs safely. The provider used a staffing dependency tool 'CHESS' (Care Home Equation for Safe Staffing) to indicate the number of care workers required to support people. This tool took into account the assessed needs for each person who used the service. The registered manager reviewed this monthly to determine the staffing hours required. We looked at the rotas for the four weeks prior to the inspection and found that these reflected the assessed hours required. Agency care workers were used where required to maintain staffing levels and there was an appropriate skill mix of nurses, care and ancillary staff. Despite this we received mixed feedback from care workers and some relatives about whether there were sufficient staff, with concerns raised particularly in the Oak area of the home (nursing).

We made observations throughout our inspection in all three areas and found that in the nursing area in particular care workers were engaged in care and administrative tasks for much of the time, and there was limited opportunity for social interaction with people on an individual basis. The layout of the communal

area on Oak meant that when care workers were in the office or the corridor they did not have a clear view of people sitting in the lounge, and we saw examples where this meant care workers were not as responsive as they could have been. We concluded that although the home had sufficient care workers to meet people's basic care needs and people did not have to wait an unreasonable length of time for a response to their call bells, care workers could be deployed more effectively to maximise people's opportunities for social engagement and activities, particularly in the nursing area. One care worker told us, "I would like an extra member of staff ideally. People's basic needs and safety are always met, but it's more about the quality and responsiveness. That's where we would benefit from an additional staff member."

We recommend the provider reviews how care workers are deployed in order to maximise people's opportunities for social engagement, and keeps staffing levels and deployment under continual review.

We found that risk assessments were in place to help minimise risks to people. These included risks in relation to falls and mobility, choking and malnutrition, pressure ulcer development and medication. Risk assessments were reviewed monthly. When a person had been assessed as needing a bedrail in place to prevent them falling from their bed, a risk assessment had been carried out and if a rail was in place, regular checks were made by care workers to ensure the person's safety.

Any accidents or incidents at the service were recorded on the provider's electronic 'datix' system. The registered manager and provider monitored accidents to ensure people were kept safe and any appropriate action was taken to prevent recurrence. We were given access to the records for accidents and incidents and the sample we viewed showed what action had been taken and any investigations completed by the registered manager. The registered manager told us that any lessons learned from incidents were shared with care workers in team meetings or supervisions.

Personal Emergency Evacuation Plans (PEEPs) were in place for everybody who used the service. These described how the person communicated and what help they would need if an evacuation took place. Fire alarms were tested each week and fire drills took place regularly. Fire alarm systems and equipment were serviced regularly. A fire risk assessment was in place for the home and for each bedroom. Care workers described the action they would take in the event of a fire alarm sounding which showed us appropriate systems were in place to help keep people safe in the event of a fire.

The registered provider had a business continuity plan detailing how they would ensure people's safety and comfort in the event of an emergency, such as a fire or flood. Documents we reviewed relating to the maintenance of the environment and servicing of equipment used in the home showed us that equipment was regularly checked and serviced at appropriate intervals. We saw that required actions from an electrical wiring check in March 2017 had been completed. We were also advised that all fire extinguishers that had not passed their routine discharge test in January 2017 had been replaced. These environmental checks helped to ensure the safety of people who used the service.

The provider employed dedicated domestic staff. Care workers and domestic staff completed training in infection prevention and control and had access to personal protective equipment, such as disposable gloves and aprons, in order to prevent the risk of cross infection.

The provider had a medication policy and care workers responsible for supporting people with their medicines had received training in medicines management and were assessed for their competency.

The service had a system in place to order medicines for people. The registered manager explained that they had been working with the pharmacy and care workers at the home to address some issues that had

occurred during the year prior to our inspection in relation to medicines not being received from the pharmacy in a timely manner.

Medicines were stored securely, including controlled drugs (CDs). CDs are subject to strict legal controls in relation to how they are prescribed, stored and administered. We observed people being appropriately supported to take their medicines. Care workers recorded this on medication administration records (MARs). Some people had been prescribed medicines to be taken 'as required' or PRN. We saw each person had a protocol for each PRN medicine which was detailed and person specific. PRN medicines were signed for on the MAR and on a separate sheet with the exact time of administration and the number of remaining tablets. Body maps were used to show care workers where to apply any topical creams or lotions. When people required medication in the form of a patch, a body map was used to record the location where the patch had been placed and this was rotated to ensure effectiveness and prevent side-effects. We noted one example where there was a missing entry on the body map, but we were able to confirm from the person's MAR that they had received the medication patch as prescribed.

Some medicines should be given at precise times to ensure their effectiveness and others should not be given within a specified time period, for example within four or six hours. MARs indicated that medications were given 'early morning', 'morning', 'lunchtime', 'teatime' and 'bedtime'. We discussed with the registered manager how recording the exact time that any time-specific medicines are administered would enable them to more effectively monitor that these medicines are given as prescribed. The registered manager agreed to do this.

Requires Improvement

# Is the service effective?

## Our findings

Care workers received an induction and training when they started in post. Staff new to working in care completed the Care Certificate as part of their induction. The Care Certificate is a set of standards that social care and health workers work to. It is the minimum standards that should be covered as part of induction training of new care workers. The majority of training was completed via e-learning. Topics included first aid, health and safety, safeguarding, control of substances hazardous to health (COSHH), pressure area care, dementia care framework, food safety and information governance. Staff also received face to face training in moving and handling and fire safety. Care workers refreshed their e-learning annually.

Care workers told us the training they received was "Pretty good" and "Generally okay." Three care workers we spoke with commented that they preferred face to face training, but felt the e-learning gave them the basic information they needed. One care worker told us staff were not given training in relation to epilepsy, despite there being four people who used the service that had epilepsy. The care worker told us that this training had been requested in a staff meeting, but as yet had not happened. We also noted that six people who used the service had diabetes, yet care workers did not receive specific training in relation to diabetes. One person who used the service told us that care workers lacked knowledge about diabetes and "Don't understand about insulin dependence." Care workers we spoke with demonstrated a basic level of understanding of diabetes and how to respond in the event of any concerns. However, their knowledge could be improved with further training. We discussed this with the registered manager on the first day of the inspection. When we returned for the second day the registered manager advised us they had responded to our feedback by organising for one of the unit managers (who was an experienced trainer) to develop a diabetes and epilepsy training package to deliver to care workers at the service.

Staff team meetings took place, which gave care workers the opportunity to discuss their work practices. One care worker told us that individual staff supervision meetings only took place, "Once in a blue moon" but others were more satisfied with the frequency of supervision meetings and told us they felt supported. We looked at supervision records which showed us that care workers received supervision approximately every three months.

The provider used recognised assessment tools such as the Waterlow score to assess the risk of people developing pressure sores, the Cornell score for assessment of depression in people living with dementia and MUST (malnutrition universal screening tool) to assess risk in relation to malnutrition. We spoke with the registered manager about other ways in which the provider used evidence based guidance and best practice in the delivery of people's care. They told us the provider's dementia care framework was based on best practice in dementia care, and gave examples of how they had started to make changes to the environment in the Cherry area, to aid people's orientation and assist them to mobilise more freely within the space. Two care workers we spoke with were undertaking the provider's dementia care framework course, consisting of two hour sessions over a period of several months, which they told us they were enjoying.

The design and layout of the home overall was suitable for people's needs, with wide corridors, accessible

bathing facilities and, in some cases, particularly pleasant views of the local countryside from people's bedrooms. However, the décor of the home was tired in places and some areas required repair and maintenance. For instance, the ceiling in one corridor required repair where there had been a leak. We were advised that arrangements had already been made to repair this and decorate a number of areas of the home. We saw during our inspection that the communal area of Cherry was being decorated. The registered manager told us the redecoration in this area of the home would be taking account of dementia friendly design principles and people's personal preferences, including the colour of people's bedroom doors. One person who used the service confirmed to us that they had been asked what colour door they wanted. Once completed, this work would improve the environment and help to aid people's orientation around the home. The environment could also be further improved with more accessible signage and consideration of objects and activities aimed at providing stimulation, such as rummage boxes. In relation to the environment, one relative commented, "There's a lovely patio but it's a disgrace, fag ends all over."

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care files contained an assessment of the person's capacity to make specific decisions. We saw evidence of best interest meetings, for example when a person had required complex dental treatment and had lacked mental capacity to make a decision about this. At the time of our inspection there were people living at the home who were either subject to a DoLS authorisation or for whom a DoLS authorisation application had been submitted to the local authority. The registered manager kept a record of when authorisations were due to expire. We found that not all staff were aware that some people had specific conditions on their DoLS authorisations, which needed to be adhered to, in order for the deprivation of liberty to be lawful. It is important that the registered manager and care workers are aware when people have specific conditions on their DoLS authorisation, so that they can ensure conditions are always adhered to.

The registered manager and one care worker demonstrated a good knowledge of the principles of the MCA, but other care workers we spoke with did not, despite having received training on this topic. They were though aware they needed to get people's consent before providing care and gave us examples to illustrate how they offered people choices and checked people were in agreement with the care they offered.

We looked at the support people received to lead healthier lives, access healthcare services and receive on-going healthcare support. We found there was a record in people's care plans of any contact people had with health care professionals, such as GP's and district nurses. A visiting healthcare professional confirmed to us that care workers at the home referred people promptly when they needed support. They said in the past there had been occasions when they had raised issues in relation to the care people received but these had always been resolved after discussion and staff acted on the advice given to them.

We saw that people had information in their care plans about their health care needs. In some cases this was clear and detailed, but we found some examples where care plans required more detail and clarity to ensure care workers were consistently able to understand and respond to people's healthcare needs. For instance, one person's epilepsy care plan referred to the person's seizures but did not give any detail about

the type or frequency of these, or what specific signs care workers should look for. There was some further information about this in another section of the care file, but having information about the seizures in different sections made it confusing to follow and could have led to information being missed by care workers. The registered manager confirmed the person had not had any seizures whilst living at the home, and they agreed to re-write the care plan with more detail and clarity. When we returned for the second day of our inspection we found this had been actioned. Information about wound care for one person was also not clear, and the provider addressed this following our feedback.

On the first day of our inspection there was an issue with one person's stoma bag in the morning, and the service had no spare stoma bags in stock, until they were delivered at lunchtime. The delivery of stock had been chased by care workers the day before, and on the morning of the incident, because they were aware more stoma bags were needed. However, this should have been identified sooner, as the service should not have reached the point that they had no spare stoma bags available as this could have compromised the person's health and dignity.

We looked at the support people received with their nutrition and hydration. We found care plans contained an assessment of people's nutritional needs and information about any special requirements in relation to their diet or fluid intake. Food and fluid monitoring records were completed where a risk of malnutrition or dehydration was identified. Choking risk assessments were also in place where required. Information about people's dietary needs was available to kitchen staff. A choice of hot and cold drinks were available throughout the day.

There were mixed views from people who used the service about the variety and quality of food available at the home. One person told us, "I don't like the food. There have been a lot of meetings about the food" and another said, "The food is appalling. It's always sloppy meat and sloppy veg. Sometimes I think, that's better, but then it goes back." However, others commented, "It's good food and you get plenty of it," "I get a good choice off the menu" and "The food's not bad." The kitchen was run by an external catering company and care workers we spoke with felt that although people had a choice of two meals from the menu each mealtime, they did not feel people's preferences had been taken into account when preparing the menu and they had little control over this. Care workers were however aware that the menus had been planned to ensure a nutritious and balanced diet. We saw from minutes of a 'relatives and residents meeting' in April 2017, that the chef had attended to get feedback from people, but it was evident from the feedback we received that there were still on-going concerns from some people about the food.

Our observations of mealtimes showed some inconsistency in people's experiences. We saw examples where care workers demonstrated great care and patience in encouraging people to eat, ensuring people's needs were well met. We also observed that when one person did not like the choice of options presented and requested Weetabix instead, care workers accommodated this request. However, care workers did not always pay attention to the presentation of people's meals or to people's preferences regarding the size of the portion the person wanted. We also noted one person requested a napkin, but had to be given paper towels because there were no napkins available.

Overall we concluded that people's nutrition and hydration needs were being met, but some improvements were required to the consistency of people's experience.

We recommend the provider continues to monitor and respond to people's feedback about the food available and the consistency of people's dining experience.

After the inspection concerns were raised with us in relation to one person's care, including their nutrition

and hydration needs. We passed this information to the local authority safeguarding team for their consideration.

Good

# Is the service caring?

## Our findings

People who used the service gave us positive feedback about the care workers who supported them. Their comments included, "I've nothing but praise for the carers, they do a wonderful job," "They're very, very nice to me here" and "The staff understand me. They look after me well. They tell me what's happening." Another described the care workers as, "Caring and compassionate and kind" and told us, "There's always someone you can talk to."

The majority of relatives we spoke with also provided positive feedback about the caring nature of the staff, although one relative suggested there was some inconsistency and did not feel all care workers were as caring. Other relatives told us, "The staff are caring" and "The care has been 100%. I never believed we'd find somewhere that would provide such good care. The staff are wonderful. It's not just the care they give to [my relative], it's to us too – the relatives. They always have time for us and ask if we're okay. Every single one of them, they are just so caring."

We observed positive interactions between care workers and people who used the service. We saw examples that illustrated care workers knew people well and anticipated their needs. For instance, in the Cherry area of the home, we observed a care worker reassuring someone and engaging them by saying some phrases in French. The person responded really positively; smiling and replying in French. We also saw people and care workers singing together and there was a calm and friendly atmosphere. We saw care workers using humour appropriately to make people relaxed. We did, however, note some inconsistency across the home as the care workers in other areas of the home spent less time interacting with people socially. Many of their interactions were task focussed, rather than allowing significant time for conversation or promoting the person's emotional well-being. Care workers did though always acknowledge and speak to people as they went about their work.

We found care workers ensured people's privacy and dignity were upheld. They attended to people discreetly where required and knocked on people's bedroom doors before waiting and entering. Care workers gave us examples of how they ensured people's privacy and dignity were upheld, including ensuring people were not disturbed by others when receiving personal care, covering people whilst washing them and respecting people's preference with regard to the gender of care workers delivering their personal care. One person told us, "Staff always respect your privacy. They are on hand to give you whatever you need. I was embarrassed at first and found it hard, but they've been so good I'm not now, I feel very relaxed about it." Another said, "They always keep me covered and do what I want. They respect my privacy and dignity." We observed care workers speaking to people respectfully.

We saw that care workers encouraged and supported people to do things for themselves where they were able to. Care plans included some detail about personal care tasks and activities people could do themselves, in order to maintain their independence. We observed care workers offering people choices and involving them in decisions, such as what they wanted to eat, where they wanted to sit and what they wanted to do. People told us, "If I want anything people listen to me" and "I feel like a proper person. I can choose what to eat and go to bed when I like. I've made friends with people; we can talk together and laugh

together."

People were dressed appropriately for the temperature in the home. One visitor commented, "When we come she's always nice and clean and has her make up on. We asked for that because it's what she's been used to."

We spoke with care workers about how they met the diverse needs of people who used the service, including the protected characteristics of the Equality Act 2010. Care workers adapted their support in response to people's individual needs, physical abilities and age related conditions. People were supported to go to church, or could attend the monthly service held at the home if they wished. Care workers completed training in equality and diversity and the provider had an equality and diversity policy statement.

Visitors were welcome at any time and people were supported to maintain relationships with those important to them. We saw relatives visiting their family members during our inspection and they sat together either in communal areas or in their own rooms. One visitor told us they came very regularly and said, "They (care workers) look after me too, I always get drinks and cakes."

One person using the service had an advocate and all those who were subject to a DoLS authorisation had a relevant person's representative (RPR) as required by law. There was information available about local advocacy services for anyone else who may benefit from an advocate. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities. A variety of other information was available to people around the home on notice boards, such as feedback from satisfaction surveys.

Care workers spoke warmly about people they supported and one told us, "We try to make it home from home, we are passionate about care." A thank you card we saw from a relative said, 'Thank you to all of you for the lovely care you gave to my [relative]. I know they thought the world of you.'

Requires Improvement

# Is the service responsive?

## Our findings

Assessments were undertaken to identify people's support needs prior to moving to the service, to ensure the service could meet their needs. Care plans were then developed so that care workers had information on how to meet people's needs.

Care files contained information about people's life history and their needs in a range of areas, including mobility, personal care, nutrition, communication and skin integrity. Care files we viewed were generally personalised and detailed, although we noted some care plans only contained limited information about people's preferences about how they liked their support. We also found examples where more detail and clarity was required in specific care plans; one example related to the support someone required with their wound care, and another related to the support needs in relation to epilepsy.

We found care plans were reviewed monthly or more frequently if there were changes. Care workers told us that care plans were written with the involvement of relatives but we did not see evidence of this in the files we reviewed. One relative we spoke with confirmed they were involved in the annual review of their relation's care and another told us, "We are involved in all [our relative]'s care and their care plan and all meetings." Others couldn't recall if there were review meetings but did comment on discussions they had had with care workers when their relative moved to the home, and since living at the home, indicating they had opportunity to comment and make suggestions in relation to their relative's care.

We found care workers were knowledgeable about the people they supported. They were aware of people needs and preferences. For instance, one care worker we spoke with told us how they supported one person who could not communicate verbally. They demonstrated understanding of the person's non-verbal communication and described how they supported the person to take their hand and walk to express their consent to be helped to the bathroom. We also saw a very detailed and comprehensive 'communication passport' in place for one person who had a learning disability. This gave care workers the information they needed to understand the person's communication needs.

Care files contained information about people's end of life care wishes. In some cases, this information had not yet been fully completed in the person's care file. We were advised that these would be completed with the person and their relative's involvement when the person wished to discuss this. Care workers did not routinely complete training in end of life care, although they were able to describe how they would support people at this time. The registered manager described how they had supported one person who had recently passed away, ensuring that their cultural and faith needs were met prior to, and in the period following their death. This had been discussed and agreed with the person beforehand.

The provider employed an activities co-ordinator five days a week, although one of these days was used for their administrative tasks. On the first day of our inspection the activities co-ordinator supported five people to go to a local garden centre. On people's return they were animated about their outing and had clearly enjoyed themselves. On the afternoon of the second day of our inspection there was a visiting saxophone player, entertaining people in the Beech area of the home. This was also attended by some people who lived

in the Cherry area. Other than this there was limited evidence of care workers supporting people to take part in activities during the inspection, and no leisure or social activities took place in the Oak area of the home. We saw periods of the day where people were sat without stimulation or any objects of interest to keep themselves entertained.

Care workers and relatives commented on the lack of activities available to people. Relatives told us, "It says in the info you get they do activities; they don't do any up here (Oak)" and "Maybe there could be more activities up here (Oak). They have offered for [my relative] to go downstairs to the activities, but it's awkward in their chair. The last one-to-one was weeks ago. They just asked what [my relative] would like to do." Other relatives told us, "Activities are very, very rare" and "The girls (care workers) are very nice and they seem to have a lot of patience. It's just a shame that they don't have time to sit with them."

One person who used the service though spoke more positively about activities and told us, "They (staff) asked me if there was anything that I wanted to do that they haven't covered. I said I'd always wanted to hold a snake or a tarantula. They organised it and they (a visiting animal handling workshop) have been three times." Activities listed on the weekly programme included a pamper day and hairdresser, puzzles and jigsaws.

Although there were some activities available in the home it was evident that there was opportunity to develop activities further, particularly taking into consideration access to activities for people who lived upstairs in the Oak area of the home.

The service had a complaints policy which was on display in the entrance area of the home. There was a complaints log in place which recorded formal complaints received by the provider. There were records of the action taken in response to these complaints.

During this inspection whilst most visitors were satisfied with their relatives care, there were also a number of other visitors who raised concerns with us about aspects of their relative's care. Some of these concerns had been raised informally with care workers or with the registered manager, but these were not recorded in the complaints log so it was not clear from records what action had been taken to resolve the issues. Some relatives felt the issues had not been resolved to their satisfaction, or had been initially resolved but then reoccurred.

The registered manager advised that they only recorded formal complaints in the complaints folder and we discussed retaining information about verbal concerns or feedback received in order to be sure that these issues were consistently addressed, and prevent concerns and frustrations from escalating.

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager in post at the time of our inspection. They had registered with CQC in June 2017. The deputy manager for the service was working on secondment at another service, but came in to the service on the second day to assist with the inspection. The registered manager was supported by a unit manager for each of the three areas of the home.

Overall we received positive feedback about the management of the service. Relatives told us, "The management is really good; I can speak to them anytime. If I ring I can speak to [Name of unit manager] and they always have time for me," "Overall, without a doubt, well run" and, "The new manager is always visible and she's never refused to see us when we've had any problems. She will always put something in place." Another said, "The management seems good. They seem to be caring and have [my relative]'s interest at heart. They listen to us and our concerns. It's not a one-sided discussion."

Care workers told us the registered manager was, "Lovely, polite and understanding but gets the job done" and, "She's responsive and cares about the people who live here." Another said, "[Registered manager] and [Cherry unit manager] are very good. I feel supported." Care workers confirmed they had staff meetings and had opportunity to speak at them. They also said they had completed a staff satisfaction survey in the past, although could not recall receiving feedback about this survey or actions taken.

People and relatives had opportunity to give feedback and complete a satisfaction survey about the service, using a computer tablet which was available in the home. Staff could also leave feedback on this system. The results of these surveys and any actions taken were on display in the entrance area of the home. Results were published quarterly, although the registered manager was alerted straightaway when any feedback was left on the system, so that they could take action in the meantime. 'Relatives and residents' meetings were also held periodically, to engage people in discussions about issues at the home. The last one had been held in August 2017.

The service worked in partnership with other services. For instance, the district nursing team worked alongside care workers in supporting people who lived in the residential areas of the home, where people had healthcare needs. The service also worked with the advocacy service which was located geographically very close to the home. There were plans for a local school choir to come and sing at the home shortly after our inspection. The service also made use of community facilities locally, such as the nearby café and garden centre.

The registered manager understood their role and responsibilities, and was aware what events they needed to submit a notification to CQC about. Notifications had been submitted to us appropriately since our last inspection. This meant we could check that appropriate action had been taken.

There was a quality assurance system in place to monitor the quality of the service provided and ensure that care workers were following the systems in place. The registered manager carried out audits of the systems and practices at the home. We saw audits were completed monthly in relation to medication, bed rails and

mattresses. There was a monthly workplace inspection, which included a check of various aspects of the environment and the supplies of equipment, such as first aid and personal protective equipment. A food safety audit and a dining experience assessment were also conducted. We saw the most recent dining experience assessment conducted in November 2017 recorded a score of 267 out of 300. We saw that records of accidents, falls and pressure ulcers were analysed by the registered manager monthly.

At our last inspection we noted that some audits, such the weekly medication check, did not have a space to record when actions had been completed, in order to evidence that any identified improvements had been noted and acted on. At this inspection we found there were action plans on audits and examples to illustrate where action had been taken in response to audit findings. There were some examples where the action required, and the action subsequently taken to address the issue, could have been clearer on a workplace audit we reviewed. The registered manager updated this audit straightaway in response to our feedback. The provider had an electronic system where actions were formulated from audits, and these actions were required to be completed and checked by the registered manager or deputy manager before they could be removed. This helped to ensure that identified actions were completed. Despite the audits undertaken though, we found that the quality assurance systems in place had not been effective in addressing all of the issues we identified in our inspection, such as the provision of activities and the inconsistencies we found in the quality of care documentation and practice in different areas of the home. This had led to a variation in the quality of people's experience of the service.

The registered manager was aware of some of the inconsistencies and told us that since being in post they had been working with staff to focus on improvements and changes to the nursing area of the home in particular. We saw from minutes of staff meetings that issues had been discussed with care workers, including clarity given about the standards expected of all care workers.