CareQuality Commission

Claregrange Limited

Aslockton Hall Nursing & Residential Home

Inspection report

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23 November 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 21 and 23 November 2017 and the first day was unannounced.

Aslockton Hall Nursing & Residential Home is a 'care home with nursing'. 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. Aslockton Hall Nursing & Residential Home accommodates up to 62 people in one adapted building. At the time of our inspection 39 people lived at Aslockton Hall Nursing & Residential Home.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection visit the manager was not registered but was going through the process to become registered. The manager is now registered.

During our previous inspection on 6 and 7 September 2016 we rated this service as 'Requires Improvement' overall. At this inspection, we also rated this service as 'Requires Improvement' overall and the well-led question was rated 'Inadequate'.

We also identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. You can see the action we have told the provider to take at the back of this report.

Risks were not always managed so that people were protected from avoidable harm.

Sufficient staff were on duty but they were not effectively deployed to meet people's needs at all times. Some medicines management practices required improvement though people received their medicines as appropriate.

The home was clean but staff did not always follow correct infection control practices. Themes and trends in relation to accidents and incidents were reviewed and investigations of specific incidents were carried out though action taken in response to specific incidents was not always clearly documented and lessons were not always learned.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Staff were recruited through safe recruitment practices.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

The premises had not been adapted to ensure that it met people's needs especially those people living with dementia. People received sufficient to eat and drink but the mealtime experience upstairs required improvement. Staff received appropriate supervision but did not attend dementia training and appraisals were being planned but had not been completed.

People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination and was in line with evidence based guidance. People's healthcare needs were monitored and responded to appropriately.

People were cared for by staff who were pleasant and kind, however, staff were rushed and task orientated. Staff did not always respect people's privacy and dignity. However, they did promote people's independence and people's relatives and friends were able to visit them without any unnecessary restriction.

People were involved in decisions about their care and support and information was available in accessible formats. Advocacy information was made available to people.

Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. Processes required improvement for supporting people with end of life care where appropriate.

People were involved in planning their care and support. People were treated equally, without discrimination. The manager had limited knowledge of the Accessible Information Standard, however efforts had been made to ensure people with communication needs and/or sensory impairment received appropriate support. Complaints were handled appropriately.

The provider was not fully meeting their regulatory responsibilities and systems in place to monitor and improve the quality of the service provided were not fully effective.

A clear vision and values for the service were in place. However, we observed that staff did not always act in line with those values.

Staff felt well supported by the manager. People and their relatives were involved or had opportunities to be involved in the development of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not always managed so that people were protected from avoidable harm.

Sufficient staff were on duty but they were not effectively deployed to meet people's needs at all times. Some medicines management practices required improvement though people received their medicines as appropriate.

The home was clean but staff did not always follow correct infection control practices. Themes and trends in relation to accidents and incidents were reviewed and investigations of specific incidents were carried out though action taken in response to specific incidents was not always clearly documented and lessons were not always learned.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

The premises had not been adapted to ensure that it met people's needs especially those people living with dementia. People received sufficient to eat and drink but the mealtime experience upstairs required improvement. Staff received appropriate supervision but did not attend dementia training and appraisals were being planned but had not been completed.

People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination and was in line with evidence based guidance. People's healthcare needs were monitored and responded to appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were cared for by staff who were pleasant and kind, however, staff were rushed and task orientated. Staff did not always respect people's privacy and dignity. However, they did promote people's independence and people's relatives and friends were able to visit them without any unnecessary restriction.

People were involved in decisions about their care and support and information was available in accessible formats. Advocacy information was made available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. Processes required improvement for supporting people with end of life care where appropriate.

People were involved in planning their care and support. People were treated equally, without discrimination. The manager had limited knowledge of the Accessible Information Standard, however efforts had been made to ensure people with communication needs and/or sensory impairment received appropriate support. Complaints were handled appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was not fully meeting their regulatory responsibilities and systems in place to monitor and improve the quality of the service provided were not fully effective.

A clear vision and values for the service were in place. However, we observed that staff did not always act in line with those values.

Staff felt well supported by the manager. People and their relatives were involved or had opportunities to be involved in the development of the service.

Care Quality Commission

Aslockton Hall Nursing & Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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

Aslockton Hall Nursing & Residential Home is a 'care home with nursing'. 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. Aslockton Hall Nursing & Residential Home accommodates up to 62 people in one adapted building. At the time of our inspection 39 people lived at Aslockton Hall Nursing & Residential Home.

This inspection took place on 21 and 23 November 2017 and the first day was unannounced.

On day one of the inspection, the inspection team included two inspectors, a specialist professional 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. Their area of expertise was in the care of older people. One day two, the inspection team consisted of one inspector.

Before the inspection we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning

group. We also checked what information Healthwatch Nottinghamshire had received on the service. Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

During the inspection we observed care and spoke with 16 people who used the service, three relatives or other visitors, two visiting healthcare professionals, a domestic staff member, a housekeeper, the medication coordinator, the activities coordinator, two care staff, two nurses, the manager and representatives of the provider. We looked at the relevant parts of the care records of eight people who used the service, five staff files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Risks were not always managed so that people were protected from avoidable harm. A person was at risk of falls and should have been supervised when sitting in the lounge. During our inspection visit we saw that the person was not always supervised. This put the person at risk of avoidable harm.

Individual risk assessments had been completed to identify people's risk of falls, developing pressure ulcers, nutritional risk and moving and handling risks. However risk assessments were not always individualised to the specific risk factors for a person. This meant there was a greater risk that risks to people would not be identified and addressed and people could be put at risk of avoidable harm.

We looked at the care records for a person at nutritional risk. Their care plan stated they should be weighed weekly and stated if the person refused to be weighed then another measure to approximate their weight should be used. However, the most recent weight documented in the records was recorded four weeks previously and we saw a gap in the record of the person's weight of four months prior to this.

We spoke with staff about the person's food and fluid intake and we checked their food and fluid charts. The food charts were generally completed well but did not allow space to insert snacks provided additional to the main meals. However, fluid charts were less well completed and some indicated the person was receiving very little fluid although there were some entries on some days indicating the person was offered but refused fluids or only accepted sips. Nutritional supplements were prescribed and given to the person three times daily and recorded in the MAR but were not entered on the food and fluid charts.

Records of people's weights were initially recorded centrally in a weights folder. However, this was disorganised and the weekly weight records were frequently not dated making them impossible to utilise to monitor weight gain or loss.

Personal emergency evacuation plans (PEEPs) were in place for all people using the service. However, some PEEPs did not contain sufficient detail so that staff would be aware of people's needs in the event of an emergency which could put them at risk of avoidable harm.

We saw that risks related to the premises and equipment were not always managed to minimise the risk of avoidable harm. There were uncovered radiators in corridors and panel heaters in some bedrooms which had very hot surfaces. Staff did not ensure that all potentially harmful substances were safely stored at all times. The call bell system was not fully working which meant that it was not always clear which room staff need to go to. Working call bells were also not always in reach of people. We also saw that there was an open staircase in the middle of the home which was not restricted and there was no documentation assessing this risk to people.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People thought there were enough staff in place to support them safely and meet their needs. A person said, "Mostly there's enough around to help." Another person said, "When I ring for staff, they don't take too long to come." Visitor feedback was more mixed. A visitor said, "It seems like there are more staff on duty here today than there usually are. You don't see this many [staff] in the lounge for instance. Sometimes [people] are calling out for help for a while before someone comes. It's a big place."

Issues raised at the meeting for people and their visitors in October 2017 were still present at our inspection. Issues raised were, "Never seems to be enough staff on in the afternoons. Often feels like no one is around to help ... Residents are often needing to go for personal care and having to wait a long time. Residents feel that it appears staff are struggling and perhaps need more staff on" and "Some residents appear to be struggling with meals and it seems like they could do with more help at mealtimes." A staff member said, "I feel stretched to the limit. Early mornings can be difficult." A visiting healthcare professional told us that whatever time of day they visited staff were very busy and they were kept waiting to be provided with assistance.

Sufficient staff were on duty but they were not effectively deployed to meet people's needs at all times. There were usually two nurses and two nursing assistants on duty during the day and one nurse and a nursing assistant at night. Care staff were on duty in addition and they were also supported by two general assistants during the day who could provide additional support at mealtimes. However, we observed staff did not always respond to people's needs in a timely manner. We also saw that lounge areas were not always supervised by staff to keep people safe and we saw that on occasion, staff relied on one of the people using the service to call for assistance if any was required.

The manager told us that a staffing tool was not used to calculate staffing levels but staffing was based on the needs of people who used the service and the skill mix of the staff on duty. They told us that there had been a staff consultation on changes to working hours so that they better met the needs of people who used the service. They expected the contract changes to take place from 1 December 2017.

Some medicines management practices required improvement though people received their medicines as prescribed. People raised no concerns regarding how their medicines were managed. A person said, "They watch me while I take the tablets and bring me some water." Staff told us they had received a check of their competency to administer medicines and they had undertaken medicines training.

We observed the administration of medicines and saw staff administered these safely. Medicines were stored securely. Medicines administration records (MARs) did not always contain a photograph of the person to aid identification, or the person's preferences for taking their medicines; however, MARs were fully completed.

When medicines were prescribed to be given only when required, protocols were not in place to provide the additional information to ensure they were given consistently and safely. Liquid medicines and topical creams and ointments were not always labelled with a date of opening to ensure they were used within the appropriate timescale and remained effective. This placed people at risk of avoidable harm.

People did not raise any concerns about the cleanliness of the service. Staff understood their roles and responsibilities in this area and had attended food hygiene training. The home was clean, however; people were not fully protected against the risk of infection. Staff did not always follow correct infection control practices. A staff member gave biscuits to people using their fingers and people were not allocated individual moving and handling slings.

Learning from incidents and accidents was not always acted upon. A member of staff told us they had been doing a lot of work in relation to preventing falls. They talked about the actions taken to reduce falls, such as reviewing a person's medicines with the GP, maintaining and utilising walking aids, checking fitting of shoes, lighting in bedrooms and people's fluid intake. They told us they were working with the community matrons to take monitor falls.

However, we saw an accident form that stated a person had had an unwitnessed fall in the lounge. The accident form stated that, "…should be staff in the lounge at all times." However, we saw this person sitting in the lounge unsupervised by staff. The manager told us that they would be holding general staff meetings so that these incidents could be discussed and learned from.

People were protected from abuse and discrimination. People told us they felt safe living at the service. One person said, "I feel very safe as the staff look after me really well." Another person said, "I know I need help now and I suppose there are people here that can help me when I need it. That makes me feel safer than I was at home." The manager told us that new staff received equality and diversity training as a part of the care certificate and all staff were observed to ensure that people were not discriminated against. They also told us that showing respect for people's diverse needs was emphasised in policies and team meetings.

Staff were aware of safeguarding procedures and the signs of abuse. Appropriate safeguarding records were kept. A safeguarding policy was in place and staff had attended safeguarding adults training. The manager told us that information on safeguarding was to be displayed in the service to give guidance to people and their visitors if they had concerns about their safety.

People told us that they didn't feel unnecessarily restricted and had the freedom to walk around. We did not observe anyone being unnecessarily restricted.

There were plans in place for emergency situations such as an outbreak of fire and a business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

A visitor said, "I think it's very good here. I'm finding it hard because [my family member's] dementia is getting worse and [they] can be argumentative but the staff know how to calm [them] down." A visiting professional said they felt there was a lack of staff awareness and understanding of people living with dementia and how to settle and reassure them when they showed highly distressed behaviours. Staff told us that they would like training in this area.

We observed staff providing support for a person who was highly distressed. The staff member kept the person safe but was clearly finding it difficult to calm the person and divert them to more pleasurable activities. We were told on the second day of our inspection that the person had been moved to a different service more able to meet their needs.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The requirements of the MCA were not being followed. When people were not able to make decisions for themselves, mental capacity assessments and best interest decisions were not being documented. This meant people's rights were not fully protected in this area.

Staff did not know who had an authorised DoLS in place or which person a DoLS application had been made for. The manager told us that they would contact the local authority immediately to get that information. This meant people's rights were not fully protected in this area.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff asked for consent first and explained what they were doing before providing support for people. A person said, "They are always asking me. Everything they do, they say is it okay? I'd soon tell them if I didn't like anything. I've got an advantage because I'm compos mentis but not everyone is. I've never seen anybody being forced to do anything though. The staff are all respectful." Another person said, "They never take anything for granted."

The premises had not been adapted to ensure that it met people's needs, especially those people living with dementia. A staff member said, "The carpets are not suitable for people living with dementia. It freaks them out, I've seen people trying to step over carpets, it disorientates them." Carpet in parts of the home had a complex pattern which would be difficult for people with visual difficulties.

The entrance to the home was not clearly identified and bedrooms, bathrooms, toilets and communal areas were not clearly identified. Clocks were not easy to read and accurate information regarding the date and day of the week were not in place. This meant people had difficulty orientating themselves to the day and time.

Some toilets and bathrooms did not have working locks. There was also no directional signage in place to

support people to move around the service independently. Staff used an intercom throughout both days when requesting staff for telephone calls or other reasons. This intercom could be heard in all parts of the home and meant the atmosphere of the home was negatively affected. We raised this issue and the volume was turned down on the intercom. The call bell system had a loud piercing noise and was intrusive when it was not quickly responded to by staff.

Feedback on the quality of food was generally positive. One person said, "The food here is quite nice. I have it in my room [by choice] and it is warm enough when it gets here. They told me I could have something else if I was unhappy with it." Another person said, "I think the food here is good. I never go hungry and it's certainly better than I can cook." A third person said, "I like the food here though why on earth do we have to sit at the dining table for half an hour before we eat beats me."

We observed lunch being served. The mealtime experience required improvement, especially upstairs. Issues raised at the meeting for people and their visitors in October 2017 were still present at our inspection. Issues raised were, "Meal times seem to take too long for the time you need to eat. Often sat waiting for food for a long time before and after" and "The service at mealtimes is poor, food is often just given to you, takes too long to serve and left waiting around afterwards." We saw that some people were sitting for a long time at tables before the meal was served and after they had finished. We heard two staff members say that they were going to take their break at 1pm (five minutes after meals had arrived) and they both left together. This put additional pressure on remaining staff during lunchtime upstairs.

One person with advanced dementia who tended to call out a lot had been brought into the upstairs dining room by staff. Other people became very distressed by the noise. Later in the meal, a person said, "I'm going. I'll be glad to get out of here. I just can't stand that noise, it's put me off my dinner." A staff member told us that the person normally had lunch in their room but had been brought into the dining room because their bedroom carpet was being cleaned.

One person told us before the food arrived that they did not like sweet and sour. We asked if they had told the staff and been offered an alternative. They said they had told them but they, "didn't seem to be listening." The meal was given to the person and three times we heard them say, "I don't like sweet and sour" but staff did not appear to hear them.

We saw limited evidence of choice of main meal and also of drinks for people. Staff did not always see when a person required assistance and as a result some people did not receive assistance promptly. The manager told us that they would be working with an external healthcare professional to improve the mealtime experience.

People spoke positively about the skills and knowledge of the staff. A person said, "They are very good. They help me to get dressed and they are very gentle." We observed that people were supported safely and competently by staff when being moved using equipment.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep up to date, but some staff felt that they would like to have training in the areas of dementia and supporting people with behaviours that might challenge. A visiting professional said they felt there was a lack of awareness and understanding of people living with dementia and how to settle and reassure them when they showed distressed behaviours.

Most staff told us that they received regular supervision. Training records showed that staff had attended a wide range of training but some staff were not fully up to date and specific dementia and equality and

diversity training for all staff were not provided. The manager told us that appraisals were being planned but had not been completed.

People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination. Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act, were considered in people's care plans with them. This helped to ensure people did not experience any discrimination. For example, where people had a particular faith this was recorded and staff told us about arrangements in place for those people to continue to practice with their faith communities.

Where people required specific assessments associated with their health conditions we saw referrals had been made so the assessment could be made by the appropriate professionals and in line with their professional standards. Care records contained some best practice guidance and evidence based information about certain medical conditions. For example, NHS guidance on mashable foods and NHS choices information about cellulitis.

Staff provided care to people who had skin damage or were at risk of skin damage in line with guidance. There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly. We saw that one pressure cushion was not in place for a person who required it; however, staff realised and put one in place. Records showed a person was assisted to change their position every two to three hours to prevent pressure ulcers as detailed in their care plan.

People's healthcare needs were monitored and responded to appropriately. People told us that they were able to see a doctor when necessary. A person said, "I have no issues with that whatsoever. I see whoever I need to see really. I had my feet done last week by my own Chiropodist." The staff and GP had worked together to move visits to the morning to enable staff to obtain people's new medicines in a timely manner. Care records contained evidence of the input of a range of professionals including the GP, speech and language therapist, optician, and chiropodist. We spoke with two visiting professionals during our inspection and they told us staff referred people appropriately and were able to provide up to date information about them.

The people using the service were under the care of a local GP practice. The nominated GP visited the service on a specific day each week for routine patient reviews and concerns and visited additionally on request. They told us staff sent through an escalation form to provide them with details of the reasons a visit was being requested. They said sometimes these did not provide enough information, but when they rang the service for further information it was forthcoming and staff were able to justify why a visit was necessary. They told us staff generally knew the residents well and acted on the requests they made for further investigations and advice given.

The service was a part of the red bag pathway which looked to improve the way services worked together. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout their hospital episode and is returned home with person. The standardised paperwork will ensure that everyone involved in the care for the person will have necessary information about the person's general health, e.g. baseline information, current concern, social information and any medications, on discharge the care home will receive a discharge summary with the medications in the red bag. This meant that the service had systems in place to ensure a person's needs were met when they moved between services.

We checked the care records for people who had a decision not to attempt cardio-pulmonary resuscitation

order (DNACPR) in place. There were DNACPR forms in place which had been fully completed.

Requires Improvement

Is the service caring?

Our findings

People were cared for by staff who were pleasant and kind, however, staff were rushed and task orientated. People told us that staff were very kind and friendly. A person said, "They're all lovely with us. They are really super people." Another person said, "They're all nice to us. I tell it how it is and I would say the staff are very good. They're very nice staff." The manager told us that they felt that the current staffing levels felt ok, but they wanted to build in more time so staff could talk with people and build better relationships. Care staff told us they did not have time to spend quality time with people, and our observations supported this. We saw that staff did not have time to spend with people.

People told us that staff respected their privacy and dignity and we saw that staff knocked on bedrooms doors before entering and kept them closed when undertaking personal care for people. However, we saw examples of staff not respecting people's privacy and dignity.

We observed that care documentation was not stored securely at all times which did not respect people's right to privacy. We also saw that a person's dignity was not respected by staff as they did not take care to ensure the person was presentable after having been taken to the toilet. We saw another person being assisted to eat but the staff member kept being distracted and having a conversation with another staff member about a staff Christmas party. We also saw the nurse and a staff member reaching over the head of a person in a wheelchair to extract folders from a cupboard. This did not respect the person's dignity.

We observed staff speaking with people in a kindly way and providing reassurance when they were distressed. For example a person was very anxious about being moved using the hoist and said, "I am terrified." A member of staff offered to hold the person's hand and talked with the person throughout explaining what was happening. Then said, "Is that better? Are you alright now?" when they were finished. Another person was very tearful about their family and one staff member was particularly kind, got down on their knees and comforted them. We also saw that staff knew people well.

People were involved in decisions about their care and support and information had been made available in accessible formats. People we spoke with were not aware of their care plans, however, they told us they were given choices by the staff and staff respected their wishes. A person said, "I don't know about a care plan but I tell them exactly what I want or don't want." Visitors felt involved. A visitor said, "I was involved in the care plan and we've had review meetings which is a good thing." Another visitor said, "They are good in that respect. They will always get in touch if [my family member] isn't well or they are worried about them at all. They do involve me all the time." Care records contained evidence that people and their relatives, where appropriate, had been involved in their care planning.

Advocacy information was available for people if they required support or advice from an independent person. When people had difficulties in communicating verbally, guidance was in place for staff on how to understand the person's wishes and strategies staff should use to maximise people's understanding and enable them to indicate their wishes. Information was also available in different formats where required.

People told us their independence was encouraged by staff. We observed that people were supported to eat their meals and mobilise independently where appropriate.

A person said, "My family can visit whenever they like and I go out with them sometimes for a nice ride in the car and a coffee or lunch somewhere." A visitor said, "I come every other day and can stay as long as I want." We saw relatives visiting people throughout the inspection. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive personalised care that was responsive to their needs. A person said, "I don't really like showers. I like a bath and they helped me have a good one this morning." Another person said, "I get everything I need." A third person said, "Staff are very pleasant to me and I only have to say if I need something." However, another person said, "I feel it's a case of they [staff] need to do things (tasks) and they have a way of doing it, so I just have to fit in with what they need to do. I sometimes feel they don't really listen." We observed that call bells were not always responded to promptly and saw examples of staff not always hearing people asking for help in the dining room.

People were mostly positive regarding the activities provided at the service. A person said, "I have been out on two river trips, which were nice. They have their own minibus for that." Another person said, "I enjoy the flower arranging and the cooking. In fact I help to organise it with [the activities coordinator]. We are cooking Christmas cakes this afternoon and we are putting some brandy of mine in it to give it a lift." A third person said, "I really enjoy the board games." A person said, "I like going to the Church Service here because I can't get out to Church anymore." A staff member told us that a vicar visits the home regularly.

There was an activities coordinator who worked at the service three days a week. They said, "When I first came I went round and spoke to all the people to try and understand what each person likes or enjoys. I want to make activities as individualised as I can. This morning I'm just about to start a game of bingo which they all like. I tried to get a knitting group going but nobody was interested, although a lot of people enjoy crafts like painting or making cards. We do have trips out in the minibus to garden centres or tearooms but the problem is that the bus takes either six able bodied people or one wheelchair. I've started 'doubling up' on trips so that people don't get left out. When the weather is better, I want to organise wheelchair football outside because I feel that the men do get a bit left out and they tell me that some things are too feminine for them. We have singers and a choir sometimes and next weekend we've got the Christmas Fayre which everyone is excited about."

We saw a number of activities taking place during the day. The activities coordinator led a game of bingo in the morning that several people participated in and appeared to enjoy. People were participating in a baking activity in the afternoon. We saw a person knitting. However, we also saw that when an organised activity was not taking place people were withdrawn and appeared bored. The manager told us they would be looking at increasing the amount of staff time that was available to support people with activities.

People weren't asked for their preferences, but people you spoke with said they were happy with any gender providing personal care. There was one male carer on duty on the day of our visit and we saw that people responded warmly to him and that he was particularly kind to people. A person said, "I don't mind who helps me though. They are all lovely."

An initial physical and social assessment had been completed before people were admitted to the service. The service involved people in discussions about their care. This helped to ensure any communication needs associated with their health and wellbeing were identified and met in a responsive and individualised

way. The manager had limited knowledge of the Accessible Information Standard (AIS), however efforts had been made to ensure people with communication needs and/or sensory impairment received appropriate support. The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. We saw clear guidance for staff was available on how they needed to support a person with a visual impairment.

Each person's records contained a range of care plans relevant to their needs. Care plans provided a basic level of information but they frequently lacked detail and there was little information about the person's preferences in relation to their care. For example, a person's nutrition care plan stated the type of diet they required, that they received nutritional supplements, food and fluid intake should be monitored and they should be weighed weekly. However, it did not include some of the recommendations made by a speech and language therapist a few months previously and did not contain any information about the person's preferences. This person was reluctant to eat and drink at times and information about the foods and fluids they especially liked would have been helpful for staff.

Another person's personal hygiene care plan stated they needed the help of two staff but advised staff to guide the person through what they wanted to person to do to help if they could, rather than explaining what the person was able to do for themselves and what they needed help with. It did not state if the person had preferences as to the gender of the staff supporting them. However, staff were able to tell us about individual people and their likes and dislikes.

When people had health care needs care plans were developed for these. For example, one person had a care plan in relation to Parkinson's disease. This contained the contact details for the specialist nurse, issues the person might experience with their grip and the importance of administering their medicines on time. Other information in relation to the impact of the disease on the person's support needs were provided in other care plans. For example their communication care plan explained the person could be slow in processing information provided and made them slow to react at times. We raised our concerns regarding care plans with the manager. Following the inspection visit we were sent further information regarding the improvements they planned to make in this area.

Processes required improvement for supporting people who needed care at the end of their lives. The manager told us that they had received a lot of compliments from relatives whose family members had received end of life care at the service. However, they had previously worked in a hospice and felt that this area could be further improved. They told us they were looking to re-introduce end of life care training and improve systems and processes in this area including support for people who use the service who have been bereaved and staff.

End of life care plans were in place for two people whose care we reviewed. They contained some basic information about contacting relatives and their wishes regarding cremation. However one person was prescribed an opiate medicine for their pain and this was not mentioned in the care plan and did not contain advice to staff as to what action they should take in specific circumstance such as the person becoming more reluctant to eat and drink (this was currently the case).

A member of staff said they had not completed end of life training recently, but talked with us about the provision of pain relief, the involvement of families in the person's care and the provision of food and fluid in a form they could digest.

People raised no concerns regarding making a complaint. We saw that complaints had been responded to

appropriately in accordance with the provider's policy. Guidance on how to make a complaint was in the guide for people who used the service and displayed in the main reception area. However, the Local Government Ombudsman details needed to be added to the information. Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint.

Inadequate

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received. However, it was not effective as it had not identified and addressed the issues we found at this inspection. These issues included safe care and treatment, staffing, consent and the suitability of premises. The registered provider visited the service regularly but did not have a care background and did not document their visits.

Improvements to the service had not been made and sustained following inspections by us. The CQC inspection in March 2016 identified breaches in regulations and the service was rated 'Requires Improvement'. At our inspection in September 2016, we found that all regulations had been complied with, however, the service was rated 'Requires Improvement'. At this inspection the service has again been rated as 'Requires Improvement'. We also found that a number of issues identified at our previous inspection had not been addressed which included training, application of the Mental Capacity Act 2005 and care documentation. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.

People told us that there were meetings for relatives and people who used the service which were happening every couple of months but they were not interested in them. A person said, "I haven't filled out a paper question thing [questionnaire] but I do go to the meetings. It's the same people talking about the same things really, so I don't go often." We saw that a meeting for people who used the service and visitors had taken place in October 2017 but there was no documentation to show that actions had been identified and taken in response to any suggestions made. Comments were made on the mealtime experience and staffing which were issues that we found at this inspection. We saw surveys had been completed by people who used the service and visitors. Most people were happy with the quality of care but 67% of responses felt that the call bell was not answered in an acceptable time on all occasions. There were also comments on the amount of staff on duty. These were both issues that we found at this inspection. This meant that the provider did not have effective systems in place to respond to feedback to improve the quality of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that audits had been completed by the manager and other staff. Audits were carried out in a number of areas including infection control, medication, care plans and health and safety. Where issues had been identified, an action plan had been put in place and actions were starting to be taken. Actions had been taken by staff to address issues identified during an infection control visit by commissioners.

A clear vision and values for the service were in place. The provider's values and philosophy of care were in the guide provided for people who used the service and displayed in the main reception area. Part of the provider's philosophy of care stated, "Our philosophy of care is based on the respect of privacy and the preservation of dignity." Part of the provider's residents' charter stated, "To be treated with dignity as an individual … To have personal privacy for yourself, your belongings and your affairs … to perform any

activity you feel capable of doing." However, we observed that staff did not always act in line with those values.

Staff were positive about the manager. A member of staff said, "We are more at ease and confident with the manager. If anything has gone wrong we are told straight away and not left in the dark. Communication is much better." Staff told us the manager was supportive and they could discuss issues openly with her. Staff also told us that they received feedback in an open and constructive way. However, staff told us there had been no recent staff meetings and the manager said they were looking to reintroduce general staff meetings which would improve communication. We saw that a nurse staff meeting had taken place and the manager had clearly set out their expectations.

The manager had started at the service in September 2017. At the time of our inspection the manager was not registered but was going through the process to become registered. The manager is now registered. Statutory notifications had been made where required and the CQC rating was clearly displayed from the previous inspection.

A suggestion box was also in the main reception area. We also saw that an independent advocate visited the service each month, spoke with a couple of people who used the service and, with their permission, shared their views on the quality of the service with the manager.

A whistleblowing policy was in place and contained appropriate details and staff told us they would be confident to raise issues using the processes set out in this policy.

People told us, and records confirmed where other professionals had been involved in their care and treatment. Any information provided by other agencies had been used to inform and develop people's plans of care to ensure good outcomes for them. The service worked in partnership with other agencies.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. Regulation 12 (1) (2) (a) (b) (d) (e) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b) (c)