Mr Paul Bliss

Primley Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Primley Court provides accommodation and personal care for up to 80 people. Of these, 59 beds meet the needs of people living with dementia or mental health needs and 21 beds for people that require nursing. Primley Court is divided up in to two separate units, the Court Unit and the View Unit. The Court Unit has 51 beds with a further 29 beds at the View Unit. Most of the people who live at the home are older people with dementia. Some people may have complex needs or behaviours that challenge. At the time of our inspection there were 51 people living at the Court Unit and 26 people living at the View Unit.

The home had 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 and associated Regulations about how the service is run.

During our previous inspection on 27 April 2015, we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home was rated as 'Requires Improvement'. At this inspection we found some improvements had been made. There had been financial investment in the environment and improvements had been made around safety and auditing such as the medicine systems and processes. The home had implemented an electronic care planning system that had enabled care planning to be more effective and individualised. Primley Court's ethos was to enhance the quality of life of residents by providing a home for people that had the flexibility to adapt to the needs of individuals. Throughout the inspection we saw they were continually working to improve the service provided to ensure that people who lived at the home were content with the care they received.

However, we found there were still some aspects of the service that needed improvement. Although the service responded to concerns raised with them, the governance systems in place were not yet established or operating sufficiently robustly to always identify and address improvements that were needed, in a timely way.

People were not provided with consistently kind and compassionate support. Although some staff were kind and respected people's privacy and dignity, we observed this was not always the case. Some staff were rushed in their interactions with people and we saw that people were not always spoken about in a respectful manner. We also saw some good examples of practice such as staff comforting people by putting their arm around them or holding their hand.

Sufficient action had not been taken to ensure the environment was safe and suitable for people. For example, in the View Unit we saw some windows did not have window restrictors and chemicals were left in an unlocked room.

The Court Unit's 'new wing' presented a difficult environment for people to feel safe or experience a homely living environment as the room was noisy and busy. The Court Unit did however, have a small quiet room

with a more peaceful environment, and two smaller units with lounge areas for people to use.

The View Unit had an area designed for people living with dementia with a homely feeling lounge and comfortable chairs.

People living at Primley Court can only access the garden from the 'new wing' of the Court Unit. People living in the View Unit and older side of the Court Unit had no access to outside space.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and training sessions were planned for any due or overdue refresher training. Staff received regular supervisions and appraisals.

Some risk assessment and management plans included guidance for staff to enable them to support people with behaviours that might present risks to themselves or others. However, some of these needed more detail to ensure care could be given consistently and safely. For example, guidance for staff of how to support people with their anxiety and identify triggers for aggressive behaviours.

Improvements had been made to the reporting and reviewing of incident forms, which allowed for a better understanding of the incident, actions taken and to allow for a management review of actions to prevent a re-occurrence.

Prior to the inspection we received concerns about staffing levels at the View Unit regarding the provision of one to one support. We found people requiring one to one support were prioritised and regular staff, who knew them well, were employed from agencies to cover. We saw staff did not appear rushed or stretched to meet the needs of people. Staff spent time talking with people and were on hand to provide support with care needs when required. People, relatives and staff told us they felt there were enough staff on duty.

People who were able, told us they felt safe at the home. Some people were living with dementia and were unable to tell us if they felt safe. From our observations of interactions between staff and people using the service we found that people felt safe at the home.

People were protected against the risks of potential abuse. Policies were in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken. Records showed staff had received training in safeguarding adults. Staff were able to describe to us the different types of abuse and what might indicate that abuse was taking place.

We saw there were policies, procedures in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. Records showed that the service was applying these safeguards appropriately and making the necessary applications for assessments when these were required.

A range of activities were available to meet most people's needs and particular interests. The home had four activities coordinators that interacted with people in groups and on a one to one basis. The home had a programme of organised events that included singing entertainers and a man visiting with animals. People had the opportunity to take trips out. However, there seemed to be little available to aid in reminiscence or sensory stimulation, such as rummage boxes, empathy dolls, sensory aprons or objects to stimulate people's memories.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in

the safe administration of medicines and kept relevant records that were accurate. People were promptly referred to health care professionals when needed.

People had enough to eat and drink and were supported to make choices about their meals. People's nutritional needs had been assessed and people were provided with meals and nutrition that met their individual dietary requirements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made one recommendation. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The premises were not always safe in the View Unit as not all windows had restrictors and some furniture items were unstable.

Care plans recorded risks that had been identified in relation to people's care. Some of these needed more detail to ensure care could be given consistently.

People were protected by a robust staff recruitment process.

People received their medicines as prescribed and when they needed them. Medicines were ordered, stored and administered safely.

People were protected from abuse by staff who knew how to recognise and report the signs of abuse

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Is the service effective?

Requires Improvement

The home was not always effective.

The building design did not fully support people living with dementia.

People's rights were protected because staff understood the Mental Capacity Act 2005 and put it into practice to support people to make decisions.

People received care from staff who knew people well, and had the knowledge and skills to meet their needs. Staff received induction, on-going training, support and supervision.

People were provided with a choice of meals and were supported to maintain a balanced diet and adequate hydration.

People had access to healthcare and were supported to maintain their health by staff who liaised with health

professionals effectively and appropriately whilst promoting peoples' choices and independence.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people respectfully, or support people to maintain their dignity and privacy.

We observed some good examples of positive interaction between staff and people who used the service but also noted occasions when opportunities to engage with people in a meaningful way were missed.

People were given choice and supported to make decisions about their care.

People's confidentiality, privacy and dignity were not always respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were personalised and provided information of how staff should support them.

People were not always supported to be engaged with a range of varied activities. We saw that some people received one to one interaction.

People and their relatives felt listened to and were confident in expressing any concerns they had.

People were consulted and involved in the running of the home, their views were sought and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to monitor practice were not robust resulting in the service not being completely safe, effective, caring or responsive.

The quality of the service was monitored and the service was keen to further improve the care and support people received.

People, their relatives, staff and visiting professionals were positive about the way the home was managed.

People we spoke with felt the manager was supportive and approachable and expressed confidence in the manager to address any concerns raised.

People benefited from staff that worked well together and were happy in their roles.

Primley Court

Detailed findings

Background to this inspection

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

We carried out this inspection over two days on 9 and 10 August 2016. The first day of the inspection was unannounced. Two adult social care inspectors, a specialist nurse advisor and an expert by experience carried out this inspection on the first day. One adult health social care inspector returned on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of the inspection we reviewed the information we held about the home. We looked at previous inspection reports and other information about the home including notifications. Statutory notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We contacted the local authority and the Quality and Improvement Team who provided information about the service. We used all of this information to plan how the inspection should be conducted.

During the inspection we looked around the home and observed the way staff interacted with people to help us understand the experience of people who could not talk with us due to living with dementia. We also spent time carrying out a Short Observational Framework for Inspections SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care. We met with people living at the home and spoke with thirteen people. We spoke with ten relatives and visitors. We spoke with two visiting healthcare professionals. In addition, we spoke with the registered provider, registered manager, operations director, clinical director, deputy manager, six registered nurses and ten care workers.

We looked in detail at the care plans, records and daily notes for five people with a range of needs, and sampled a further five care plans for specific information. We looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and complaints policies, audits and quality assurance reports. We also looked at seven staff files to check that the home were operating a full recruitment procedure, comprehensive training and provided regular supervision and appraisal of staff.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in April 2015, we identified a number of areas where people's safety had not been ensured. At this inspection, we found some improvements had been made, and further improvements were needed.

At the last inspection we told the provider to make improvement in relation to ensuring window restrictors were in place and hazardous objects such as razors, were removed. At this inspection, we found some improvements had been made. The windows we looked at in the Court Unit had window restrictors and the glazed door had a protective film cover applied. We did not see any hazards such as razors left unattended. However, this was not the case with the View Unit. For example, we found that not all windows had window restrictors. An unlocked room contained unattended potentially harmful chemicals. People's room's had wardrobe furniture that was unstable and could potentially fall on people causing injury. We discussed these issues with the provider and management team and immediate action was taken. During the second day of the inspection we found all of the issues identified during day one had been addressed. The registered provider gave assurances these matters would be kept under review.

The registered manager had systems in place to review the safety of the service by carrying out a series of audits. These included gas safety checks, fire, legionella, care plans, and infection control. Arrangements were in place for the emergency evacuation of people in the case of a fire. Fire-fighting equipment and systems were monitored and reviewed. First aid kits were available in appropriate locations so that they could be accessed in a hurry.

People who were able, told us they felt safe at the home. Some people were living with dementia and were unable to tell us if they felt safe. Therefore we observed how they interacted with staff. People smiled and took hold of staffs' hands when talking to them, showing us they felt safe in their company. Relatives told us that they were happy with the home and they thought their loved ones were safe living at Primley Court. Staff said "I think they are really safe. Staff know how to handle the people and keep them safe".

People were protected against the risks of potential abuse. Policies were in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken. Records showed staff had received training in safeguarding adults. Staff were aware of their responsibilities and they were able to describe to us the different types of abuse and what might indicate that abuse was taking place. All the staff we spoke with had a good understanding of the correct reporting procedure. Staff said they felt supported to raise their concerns and were confident the registered manager and deputy would take any action required. They also told us they would take their concerns to senior managers or external organisations if they felt appropriate action had not been taken. One staff member told us "I would report anything to the manager. I would definitely do that if I was concerned".

Prior to the inspection, we received concerns that the home did not have enough staff on duty to provide safe effective care, particularly with people who require one to one support in the View Unit. We spoke with the registered manager about staffing levels and skill mix. They told us they ensured there were sufficient

numbers of staff on duty to keep people safe and meet their needs. People requiring one to one support were prioritised and regular staff were employed from agencies, who knew them well, to ensure continuity. We looked at rota's from the Court and the View Unit to see if there were consistently sufficient staff on duty to meet the needs of the people. Staffing levels were determined by people's dependency that was captured in risk analysis reports by the clinical director. We were told by the registered manager that minimum levels of staff for the Court Unit were 15 staff during the day and eight staff covering the night shift. The smaller View Unit's minimum staff level was four staff during the day and three at night. On the day of inspection the home was well staffed and exceeded Primley Court's assessment of minimum staffing levels required. This was seen consistently throughout the rotas we looked at. The Court Unit had 21 care staff, including five agency carers on duty during the day and 13 staff covering the night shift. The View Unit had six staff covering the morning shift, five carers working in the afternoon and three night care staff. Both units were supported by the registered manager and deputy manager. The registered manager told us that staff were relocated around the home to ensure people in both units received safe effective care. The registered manager told us they were continuously assessing and responding to changes in demand by effective recruitment. We were told three new members of staff were currently undergoing employment checks.

We observed that call bells were answered quickly. Staff did not appear rushed to meet the needs of people. Staff spent time talking with people and were on hand to provide support with care needs when required. For example, over lunch, people who needed support to have their meal received this in a timely manner. People, relatives and staff told us they felt there were enough staff on duty. One person said "the staff are very good, quite attentive, they answer the bells quickly". One relative told us their relative liked to walk around during the day. They had become unsteady on their feet which caused them to fall and injure themselves. The home responded to this by allocating an extra member of staff to support them during the day so the person was free to walk about as they wished. One member of staff said "staffing levels are good here. Some homes I've worked in have been understaffed. There's some agency staff, but regular ones that know the residents".

During our last inspection we found people were not always protected by safe staff recruitment practices. At this inspection we saw safe recruitment and selection processes were in place and the registered manager was aware of their responsibilities to ensure staff were of suitable character. We looked at the files for seven of the staff employed and found appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references. Full employment history was established and any gaps in employment, fully explored. Disclosure and Barring Service clearance (DBS) and evidence of their identity had also been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

People had their individual risks assessed and each person had a plan in place to help mitigate those risks. For example, we saw one person had been assessed as being at risk of poor nutrition and hydration. Their records showed they had lost weight, and had a poor appetite preferring chocolate and biscuits to meals. They had been prescribed food supplements and their care plan indicated they were to be offered small amounts of food and often, as is good practice. Their food and fluid intake was being monitored and recorded. Records from after this intervention showed the person was putting on weight. A nurse told us the person had been assessed the week before the inspection as no longer being at risk, so food charts had been discontinued.

Another person had been assessed as being at risk of falls. Their care plan showed they had been referred to the physiotherapy team. An action plan was drawn up for staff to follow ensuring the person had sturdy shoes, were supervised during the day and had an alarm mat at night to alert staff to their movements.

Some risk assessment and management plans included guidance for staff to enable them to support people with behaviours that might present risks to themselves or others. However, some of these needed more detail to ensure care could be given consistently. For example, one person's care plan indicated they were at risk of self-harm, but there was no clear action plan identifying triggers for this behaviour or how to manage any risks associated with this. Charts were being completed to record incidents of behaviours that had a negative impact on the person or others. We discussed this with the registered manager who told us improvements had been made to the reporting and reviewing of incident forms, which allowed for a better understanding of the incident, actions taken and to allow for a management review of actions to prevent a re-occurrence.

We discussed triggers for referring concerns through to other support agencies, as we saw that one person had been involved in 12 incidents of aggressive behaviour since February 2016. This person's care plan indicated that triggers for their aggression included frustration and that the person "Does not like others invading their personal space". However, this person was being supported with one to one staffing, in a large communal day room where there were more than 20 other people. The environment was noisy, busy and active with people walking about constantly. There was no reflection in the care plan that the person could be better supported in a quieter area or outside of the home. This could help to reduce their frustration and triggers for risky behaviours and risks to themselves or others. Their care plan stated the person was "constantly trying to get out". There was no guidance to staff as to how to support this person with their anxiety.

We observed some poor moving and handling practice taking place. One person was supported by being moved partially under their arms and another person was being hoisted by staff that did not know the correct way to position the sling. The provider was aware of some poor practice taking place as minutes from a staff meeting in June 2016 indicated that the management team had witnessed some carers not following correct manual handling procedures. This was discussed with staff and additional equipment was purchased to aid manual handling procedures. However, continued poor moving and handling practice indicated that sufficient action had not been taken in a timely way.

The lack of effective risk management systems to protect people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found people were not fully protected against the risks associated with medicines. At that time we found prescribed creams for individuals throughout the home, including in other people's bedrooms. This meant there was a risk of people using creams which did not belong to them or prescribed for them.

At this inspection we found people's creams were kept in their rooms and dated with their expiry date. We saw that steroidal based creams were also being kept in people's rooms and that care staff who were not trained in medicines, had applied these during the morning. The application of steroidal based creams should be applied only by staff who have had medicines training and should not be a task delegated by nursing staff to carers. This was discussed with the deputy manager and action taken immediately to address this.

Medicine Administration Records (MAR) were found to be up to date with all signatures in place and appropriate codes used when medicines had not been administered. For example, if people had refused their medicines. Protocols were in place for medicines that were required to be given on an 'as required' basis, sometimes called PRN medicines. Staff had documented when these medicines were administered. People's photographs were attached to their MAR sheets to aid identification and any medicine allergies

were recorded. Processes were in place to ensure medicines that were no longer required were disposed of safely. Medicines were stored securely. Fridges were available to store those medicines that required refrigeration and temperatures were checked and recorded daily. Medicines were administered by qualified nurses who had received training in this area. Some people received their medicines covertly, and this had been discussed with the person's GP and relative's before decisions had been made and recorded. Best interest decisions had been made following assessments of capacity where people were no longer able to make decisions about taking their own medicines.

At our previous inspection in April 2015, we identified that the provider did not have adequate infection control arrangements for managing laundry. At this inspection, we found significant improvements to the laundry room at the Court. The laundry room had been completely re-decorated and was clean and clear from the build-up of excessive laundry waiting to be washed. The registered manager demonstrated they had a clear system for the separation of clean and contaminated laundry. However, the laundry room at the View Unit still needed significant attention particularly the system for the separation of clean and contaminated laundry. This was discussed with the provider who immediately responded with an action plan to re-organise the laundry room to provide an increase in useable space and shelving in order to achieve recommendations and reduce the risk of cross contamination.

Staff told us they had good access to aprons and gloves and we saw staff change these frequently. Staff had completed training in infection control and the registered manager had introduced an infection control audit, which covered all aspects of the home. This meant people were protected from the risk of cross infection as the service had good systems in place to manage infection control and promote good hygiene.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection in April 2015, we identified some concerns about the way the building was laid out and did not fully support people living with dementia. At the time of the 2015 inspection alterations were under way to make the premises more suitable in accordance with best practice with dementia care. During this inspection we found that action had been taken to improve the environment. However, further improvements were needed.

Although there were two smaller units in the Court Unit, the main 'new wing' presented a difficult environment for people to feel safe or experience a homely or domestic living environment. This room was noisy, with at one time, three different noise sources in the one area. This meant it was not a restful or relaxing place to be. This is not an environment suitable for effective dementia care, particularly for those with anxiety, agitation and behaviour difficulties. We saw one person was walking around in a confused state. Although difficult to understand, we heard them say "too many people". We observed that there was a very small separate, dedicated quiet room with a more peaceful environment, for people to use. One member of staff talking about the quiet room commented "the residents get some quiet in here. They don't always want music – just like us, their moods can change from day to day". We saw that there was a definite need to divide the large lounge room into at least two smaller, less confused areas, partitioning was there to help achieve this but we were told by staff that it was not used.

We recommend that the provider and management team consider advice relating to dementia friendly environments available from organisations such as the Department of Health, Alzheimer's Society or National Institute for Health and Care Excellence (NICE).

People in the Court Unit's large 'new wing' dementia unit were freely able to go outside into a safe enclosed private area without needing doors unlocked or having to be accompanied by staff. We saw people sitting outside in the sunshine, and then choosing to come in independently when they got too hot. Staff took them out hats and cold drinks. However, people in the smaller two units of the Court Unit did not have any access to outside space and would have to be brought to the conservatory area to access this. The conservatory glass roof had been fitted with an anti-glare film covering to make it feel more comfortable. In some parts of the Court Unit we saw orientation aids such as use of colour to highlight certain areas was being provided, and the handyman told us about further plans to increase this. Bedroom doors had some identifying information such as photographs and pictures to help people, and some bathrooms had been made more domestic with the use of colours and objects that would be familiar to people. Coloured toilet seats were in use to help people recognise the toilet. Many people with dementia experience difficulties with their sight and perception which may cause them to misinterpret the world around them. Colour and contrasting colour in particular, can help people with dementia to live better in their homes. We noted some quality issues were not being managed well. We found some areas of the home had an odour problem and beds had been poorly made. Some walls showed damage to the paintwork and some furnishings in bedrooms were poor.

The View Unit was separated into a unit providing nursing care and a unit designed for people living with

dementia. The nursing care area and décor appeared to be somewhat tired and in need of updating. Some walls showed damage to the paintwork and some furnishings in bedrooms were poor. We discussed this with the deputy manager and provider who told us that the View Unit was currently undergoing a refurbishment programme. In contrast, we saw the View Unit's dementia wing was designed more appropriately and with the needs of people living with dementia in mind. There was a homely feeling lounge with comfortable chairs. Corridors had contrasting paint work on doors and walls with easy to read pictorial signage to help people identify important rooms or areas, such as their bedroom, toilets and bathrooms, and communal areas. However, people living in the View Unit did not have access to outside space in which to enjoy if they wished.

At the last inspection, improvements were needed to how people were supported to eat and drink. At this inspection we found improvements had been made and people received the support they needed.

There was a system in place to monitor food and fluid intake where necessary. We looked at people's food and fluid charts. The chart's had been completed clearly and were up to date. They showed the amounts of fluid the person needed to maintain their health each day, and the total fluid they had taken in on each day. This meant it was easy to monitor if the person was taking enough fluid. However, the amounts of food taken were not always recorded. For example, one person's record stated, "Pureed cottage pie" and not how much of this they had been able to eat. It was not possible to assess that the person was taking in sufficient food to maintain their health. Because this person was living with a dementia and was very active, they had an increased need for calories and they were not able to make decisions about the amounts of food they needed. We brought this to the attention of the management team who told us they would discuss this with staff.

People were weighed regularly and where there was a concern about weight loss, guidance was sought from, for example, the speech and language therapist (SALT) or GP. Nutritional risk assessments had been completed and nutritional care plans were in place with actions to reduce the risks to people, for example, from choking.

We saw people were offered a choice of meals. Where people had difficulty selecting their meal they were shown two plates of food to choose from. We saw that staff understood people's dietary needs and people who required softened or high calorie food received this. Staff had access to care plans that identified people who were in need of a special diet and how staff should support them. Those that needed assistance were supported by staff to eat their meal in a calm and unhurried way. People were allowed to dictate the pace of the meal and staff responded to this. We saw people were offered drinks and snacks throughout the day. There were several jugs of juice placed around the home and these were regularly replenished. All meals were well presented and inviting.

We spoke with the chef from both the Court Unit and View Unit about the food provided for people. We found they were knowledgeable about people's dietary needs. Information about allergies, texture-modified diets and dietary requirements for people was displayed in the kitchen. People's preferences about their meals and drinks were also recorded, such as how they preferred their hot drinks and how they liked their meals to be served.

We had mixed views from people about the food. One person told us "the food is fine". Another said "the food's lovely, you get a good selection and always enough". One relative said "[name] has always had a good appetite and still eats well. [name] seems to enjoy the food, it looks appetising and smells nice". Some people were not so complimentary. One person said "I hope it's better than last time, not swimming in water". Another said a previous meal was 'swimming in grey fluid'. One person commented the food is often

cold by the time it gets to them, when we asked if they raised this with the staff, they replied "yes, they say they will heat it up". We discussed the negative feedback we received with the provider and management team. They told us that they were aware of the negative comments about the food and were in the process of reviewing their menus and food preparation and were working towards and looking forward to achieving standards that people are happy with.

People had access to a range of health care professionals such as their GP, SALT, physiotherapists and dietician. The GP visited regularly and people were referred when there were concerns with their health. Where necessary the home worked with a team of specialists to support people with very complex needs. We spoke with a visiting speech and language therapist who had come to the home to assess two people following a referral from the home. They told us the referral had been appropriate and timely. A member of staff told us they had reported the concerns over one person's swallowing to the nurses who had made the referral. They understood the signs that someone's swallow had deteriorated and had taken prompt action. Another person had recently had an increase in falls. They were referred to their own GP to investigate any medical reason for the falls and to the physiotherapist to assess their mobility. An action plan was made and we saw that this was recorded in their care plan, for staff to follow.

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.

We checked whether the home was working within the principles of the MCA. We found the home was taking appropriate actions to protect people's rights. People's care plans contained a variety of mental capacity assessments which assessed people's ability to make their own decisions in a wide range of areas. Most people who lived at the home did not have the capacity to express their view about their care; however we saw that their relatives had been consulted. We found detailed information in the care plans to establish people's preferences over a range of areas such as their diet, personal care and activities. Staff explained how they could tell from body language and gestures whether someone was happy or not with the care being offered. Staff were aware of people's right to refuse support, and we saw instances of where people had done so. We saw people being offered choices and being asked for their consent throughout the inspection, for example with drinks and food being shown to them to help them make a decision.

Best interest decisions had been recorded for significant events or issues, for example, where the person lacked capacity to make a decision about moving to the home. One person had a best interest's decision in place about not drinking alcohol. MCA assessments included information on the principles of the legislation for example about choosing the least restrictive option.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made for authorisations to deprive people of their liberty. However, we found staff were not always clear about which people had a DoLS in place or what conditions were attached to the DoLS. This included knowing about restrictions on people leaving the home. Staff told us the information was available in the main office if they needed to locate it. We found that this was the case.

People received care and support from staff who had the skills and knowledge to meet their needs. Records showed that staff received a wide ranging induction that involved training new staff and familiarising them

with the service and relevant policies. There was also a period of shadowing and observation together with competency assessments by senior staff. Staff who had completed the induction spoke positively about it.

Staff were provided with a training programme designed to equip them with the skills needed to support people effectively. Training was carried out in a number of areas such as dementia awareness, safeguarding adults, MCA and DoLS and safe moving and handling procedures. Records showed training for staff was constantly reviewed, up to date and training updates planned. We also saw that with the support of the registered manager, some staff had completed national qualifications in Health and Social Care. This showed that staff were supported to develop their knowledge and skills to aid them in caring for the people effectively at the home.

Staff were supported through regular supervision and annual appraisals in line with the provider's policy. During supervision session's staff discussed a range of topics including issues relating to the people they supported and progress in their role. Annual appraisals had been conducted for all staff. The frequency of supervision meant that any shortfalls in knowledge or training could be picked up promptly and addressed so that people continued to receive appropriate standards of care.

Requires Improvement

Is the service caring?

Our findings

People were not provided with consistently kind and compassionate support. People we spoke with gave mixed feedback about the approach of the staff team. One person told us "one or two of them are nice but some of them couldn't care less. They are always rushing off, they don't care" and "they are good, some are rough with handling me, they grab me under the arms, but are very nice with it". However, other people told us that the staff were kind and caring saying, "they're all very helpful" and "I'm cared for well". Relatives were also complimentary about the care their loved ones received. Comments included, "they are excellent, they are for the people and they come first. Nothing is too much trouble" and "the care that I observe is absolutely first class".

People's right to confidentiality, privacy and dignity was not always respected. Whilst we observed that staff were aware of the importance of knocking on people's doors and ensuring doors were closed when providing personal care we also saw instances where people's privacy and dignity was not promoted. For example, we heard staff discussing people's intimate care needs in front of people, without including them and in communal areas. We saw a staff member move a person in their chair without letting them know what they were doing. This startled the person who had been asleep. We observed one person being hoisted in the main lounge with other people present. Staff started rubbing the person's sacrum whilst they were suspended in the hoist, before repositioning them in the chair. This could have been achieved in a more dignified way. We also saw that people were not always spoken about in a respectful manner. For example, we heard one member of staff referring to people needing a pureed diet as "the softs". This did not demonstrate a respectful approach to people's needs.

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

Throughout our inspection we observed staff in all of the lounges in the Court Unit and the View Unit. We observed some staff were task focused and had limited interaction with the people they were supporting. For example, we observed two staff providing one to one care having limited engagement with the person they were supporting other than following them around with a file. A number of people appeared to be left on their own for long periods, either seated or moving around, without any interaction from the staff. We observed that staff were often standing around and only making interventions when necessary, such as when helping people go to the toilet.

However, we also saw positive interactions between staff and people living at the home. We saw some staff were caring and respectful. For example, they made eye contact, gave people time to respond and explored what people had communicated to ensure they had understood them. We saw a staff member put their arm around a person and give them a hug when they had approached them. We saw another member of staff interpreting a person's behaviour and intercepting them to take them to the toilet to protect the person's dignity. We saw staff supporting people with having a drink, which was done well. We heard some staff being respectful when discussing people and their care needs. One staff member told us "I enjoy working with the people. I treat everyone as an individual, treat everyone like they are my nanny or granddad".

Not all staff at the home knew people's care preferences and needs well. For example, one person was being supported on one to one care. The staff member supporting the person was not clear why they were doing this. They consulted the person's file and said that it was because of their behaviour.

We saw examples where staff knew people and communicated with them about things they were interested in. For example, one member of staff, providing one to one support to a person, told us about the person's career as a session guitarist. They said "we try to encourage them to play the guitar but they won't in the lounge". They went on to describe how they would encourage the person to talk about their career and experiences.

Staff told us they encouraged people to maintain their independence as long as they were safe to do so. For example, when a person asked for a cup of tea we heard staff asking them if they wanted to make it themselves and supported them to do so. Another person had problems using cutlery. This was noticed and they were provided with easy grip cutlery and plate guards so that they could maintain their independence with eating and drinking. Throughout our visit, we saw staff encouraged people to make their own decisions and prompted them to move around independently. This showed that staff promoted people's independence.

Throughout the day we saw that people wherever possible were encouraged by staff to make decisions about their care and support. This included when they wanted to get up or go to bed, what activities they wanted to do, what they wanted to eat and where they would like to be. We heard a member of staff say to a person, "would you like to have lunch in the lounge or the dining room?" This showed that people's choices were respected by the staff and acted on.

People and relatives, where appropriate, had been involved in planning their care and support. Care plans contained assessment of people's communication need and abilities. Plans also contained some information about people's independence and retained skills rather than just losses and dependency associated with dementia. We saw that attempts had been made to make some information at the home available for people with dementia, for example with the use of menu boards and activities information with pictures to aid recognition.

People were supported to maintain positive relationships with friends and family members who were welcome to visit them at any time. We saw people's relatives and friends visiting throughout the day. Information from the Provider Information Return (PIR) states that relatives were welcome into the home at all times and invited to discuss their relation's care where appropriate.

Primley Court ensured that people were supported at the end of their lives. The home's PIR state that people's advanced wishes will be discussed with them, their relatives and multi professionals to ensure that the home was aware of their wishes and the end of life care was delivered appropriately. The home had an End of Life Champion who also empowered other members of staff to support relatives during the end of life process. Staff had received training in supporting people at the end of their lives and the home had established good links with the local hospice.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in April 2015, we found the care being provided was not always focused or centred on the individual. The care and treatment of people was not always appropriate or did not meet people's assessed needs. Care delivered was not always in accordance with people's care plan and plans did not always contain sufficient detail on people's needs. At this inspection, we found improvements had been made with the introduction of the electronic care planning system. However, we found that people living with dementia were not engaged in meaningful interaction or activity and there seemed to be little available to aid in reminiscence or sensory stimulation.

People received an initial assessment of their care and support needs so the provider could assure themselves that they were able to meet the person's needs before they moved in to Primley Court. Most people's care plans were based on their initial assessment, and were comprehensive and detailed. They provided staff with relevant and appropriate guidance in how to support each person, for example, with their mobility, personal care and nutritional needs. Care plans were reviewed each month or when people's needs changed which ensured up to date information was available for staff. Care staff did not write the care plans, however one told us they had an input and the nurses would ask them about people's needs when reviews were taking place. One staff member told us "care plans are brilliant, really detailed and person centred. The carer's read the care plans in the afternoons".

We discussed the admission criteria and process with the registered manager. This was because we had identified the mix of people in one dementia unit was not leading to positive outcomes for people. For example, people who were recognised as having the potential to become distressed in loud noisy environments, located in the large 'new wing' where the environment was just that. The registered manager told us they considered the whole unit needs before people were admitted, and had refused to take in people who they knew would not be compatible with other people at the home. They added that people were assed individually and they would look at re-addressing the mix of people in this area.

Personal information in people's care plans described how the person wanted to spend their time, their likes and dislikes and other preferences. People and families were encouraged to complete a "life profile history" to ensure staff had as much detail about people as possible to provide person centred care to meet their needs, wishes and choices. For example, one person, who called out loudly when distressed, had guidance in their care plan stating that massaging their hands, helps to alleviate any distress. We observed staff doing this with good effect. Daily record entries also showed person centred care. One person's record said they were a little emotional but after staff sat with them chatting and offering reassurance, they calmed. Another said "[name] is very responsive to people showing kindness and gentle approach".

We spent time with staff discussing the people they were supporting in one of the dementia areas. The staff were clear about people's needs and how their past history, personality, lifestyle choices and interests could be reflected in their current behaviour. Some people had clear information about their social and personal history recorded in their care plans. However, we did not see that this was always reflected in activities or the care provided to ensure people received stimulation or enjoyment in their life, whatever their abilities.

On the day of our visit staff played music and turned the television on for some people in the lounges. We saw some staff talking and interacting with people on a one to one basis. However, we did not see staff engaging in long periods of interaction and this interaction was often incorporated in to a care task. A large proportion of people were living with dementia. However, there seemed to be little available to aid in reminiscence or sensory stimulation. For example rummage boxes, open chests of drawers, magazines, empathy dolls, sensory aprons or objects to stimulate people's memories. This meant that for much of the time, people were unengaged and sitting watching other people walking around the unit. We found many people had the capacity to engage in conversation or activity, but staff had not taken advantage of this. This meant that there was not a holistic approach to people's care and support to ensure their general wellbeing.

Activities at the home were being provided by activities co-ordinators, rather than being seen as a 24 hour process that all staff could engage with. The home employed four activities co-ordinators. We spoke with two activity co-ordinators who were enthusiastic about their roles. They told us how they ensured everyone benefitted from their input and made sure they spent time with people who chose to stay in their rooms. They told us about the activities people enjoyed which included singing, reminiscence and group games. The home had a programme of organised events that included singing entertainers and a man visiting with animals. People had the opportunity to take trips out. They had recently visited Buckfast Abbey and a trip to the zoo and a summer fete was planned. The activity co-ordinators described how they engaged with people who were less able to take part in the group activities. "I do hand massage, head massage, read them poetry. I have a feel for the person, know their likes and dislikes and learn to read their way of communicating" and "you need to know your residents and what they can do. Just touching, talking and giving quality time when you can is important".

Following the inspection, we were informed by the management team that they held discussions on how to approach this situation. The home is considering training based on the Butterfly Care Home Project to help provide the tools for staff to engage people with greater meaningful activities whilst continuing to ensure the service is safe. This process will be managed and audited closely to ensure the staff team receive the support to be confident with changes made. The Butterfly Project is about injecting humanness and compassion to support patients with dementia and memory impairment. It focuses nurses and care staff back from task allocation and creates a culture which promotes person-centred care.

A complaints procedure was in place and displayed in the hallway of the home. People told us they felt confident in raising any concerns or making a complaint. One person told us, "yes I know how to make a complaint but don't need to". Relatives said, "I would tell one of the staff and I know it would be listened to". One relative told us how quickly the deputy manager responded to their complaint and how it was resolved efficiently and without fuss. Complaints were recorded and responded to and if needed, action and improvements taken. All complaints were addressed in line with their complaints procedure policy.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, who was supported by a management team that included the provider and operations director. During our inspection, the management team welcomed any guidance and feedback we gave. We identified concerns about the service and breaches in legislation during this inspection that had not been identified by the home's own internal management systems. The provider had identified areas where the service needed to improve and recognised that further work was needed to meet the fundamental standards of quality and safety.

The registered manager told us they wanted to provide good quality care. Primley Court's ethos was to enhance the quality of life of residents by providing a home for people that had the flexibility to adapt to the needs of individuals. Throughout the inspection we saw they were continually working to improve the service provided to ensure that people who lived at the home were content with the care they received. In order to ensure that this took place, they worked closely with staff and multi-professional teams working to achieve good quality care.

During this inspection we found improvements had been made in many areas but we also found continued shortfalls that had not been fully actioned. We discussed this with the management team, who told us they felt they had made improvements around safety and auditing, such as the medication systems. Staff had received training in supporting and managing behaviours that might place people at risk and the care team were more experienced. However, they felt there was still work to be done in moving the service towards a more person centred culture. Since the inspection the provider has shared their plans for improvement with the inspector.

At the previous inspection we identified concerns related to the safety of the premises. At this inspection we found safety shortfalls within the View Unit. This was immediately rectified and completed by the end of the inspection. However, this was in response to the concerns that had been identified during this inspection, rather than having been identified by the provider. This meant that concerns related to the safety of the premises identified at the last inspection had not been kept under review.

Systems were used to monitor the quality of the service, including surveys for people and relatives and internal audits. The registered manager and operations manager met weekly to discuss the general running of the home including quality assurance. Areas included looking at cleaning and hygiene, the environment and health and safety. Where improvements had been identified action points were recorded for each month and followed up. The home had a maintenance team and plan for the year, including updating and re-decorating people's rooms in the View Unit.

However, some quality issues were not being managed well. We found some areas of the home had an odour problem and smelt of urine and beds had been poorly made. Some walls showed damage to the paintwork, some furnishings in bedrooms were poor and carpets stained and worn. There were on-going issues with regards to people's laundry provision, despite similar issues with the Court Unit's laundry area identified at the previous inspection. The laundry system in the View Unit did not allow for the separation of

clean and contaminated laundry. This was an infection control risk.

The provider did not have efficient systems in place to monitor and improve poor practice. During the inspection we observed some poor moving and handling practice taking place. The provider was also aware of some poor practice as minutes from a staff meeting in June 2016 indicated that the management team had witnessed some carers not following correct manual handling procedures. However, the continued observation of poor practice indicated that sufficient action by the management team to address this, had not been taken in a timely way.

People's privacy and dignity was not always respected and people were not always spoken to in a respectful manner. Management monitoring of the home such as the observation of staff practice had failed to identify shortcomings. The senior staff were not always on the floor to observe practice so they were unable to address issues and ensure staff were acting in accordance with the standards that the provider required. This meant that the provider's governance arrangements for questioning of practice required improvement.

We found that the governance systems in place are not yet established or operating sufficiently robustly to always identify and address improvements that are needed, in a timely and effective way. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People and their family members knew who the registered manager was and spoke highly of the management team. They told us that they felt all the staff, including senior and management staff members, were friendly and approachable and willing to help them with any concerns they had. A relative said "the management is good and they do respond". Staff members were also positive about the support they received from the registered manager. They explained that they were able to go to them with any issues or concerns that they may have and were confident that a solution would be found. One staff member said "management listen to and respond to suggestions. [name] is always approachable".

The home was prepared to work in partnership with other agencies. We saw that the registered manager had been engaging with external stakeholders, such as the local authority in reference to the quality of care that was being delivered from the service. This included audits and investigations into specific incidents following safeguarding referrals. The home's management team had also worked well with the local authority quality improvement team who we spoke with prior to this inspection.

The registered manager communicated with staff about the home and staff were encouraged to give their feedback. There were meetings for staff to share their views and keep updated about people's individual needs and matters that affected the service. We looked at some staff meeting minutes which were clear and focused on people's needs and the day-to-day running of the home. Records of these meetings included discussions around the care provided and keeping staff aware of good practice such as manual handling, dignity in care, care documentation and care planning. Staff also shared information through shift handovers. Staff confirmed daily handovers took place so they were kept up to date with any changes to people's care and welfare.

All staff were made aware of their role and responsibility within the organisation and received regular feedback on their work performance through the supervision and appraisal systems.

Surveys were undertaken with people, their relatives and health care professionals to ask their views about how the home was run. The surveys identified various topics for people to comment on such as perception of the general ambience of the home, the cleanliness and décor of the home, the quality of the food, how

staff treat the residents and if staff and management were approachable. These views were collated and analysed with action plans set to address any short falls. We were told by the registered manager that they had invited people's relatives to residents meetings twice a year and held residents meetings once a year but found that due to the large amount of people living with dementia, meetings were not well supported. The management team always ensured that people knew they could approach them at any time.

Records were kept securely. All care records for people were held electronically and in individual files which were stored in the care offices. Records in relation to medicines were stored securely. Records we requested were accessed quickly and were consistently maintained, accurate and fit for purpose.

The registered manager knew how and when to notify the Care Quality Commission (CQC) of any significant events which occurred, in line with their legal obligations. They also kept relevant agencies informed of incidents and significant events as they occurred. This demonstrated openness and honesty. The registered manager understood and was knowledgeable about the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated at all times with dignity and respect.

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 The provider had failed to ensure that effective risk management systems were in place to protect people from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the service people received were not effective. Risks had not always been assessed, monitored and mitigated in respect of the environment.