

Porthaven Care Homes No 2 Limited

Savernake View Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on the 3 and 4 April 2018 and was unannounced.

Savernake View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Savernake view is registered to accommodate 64 people in one building across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. At time of our inspection 38 people were living there.

There was a registered manager in post. '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.'

During our last comprehensive inspection in August 2017 we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not managed safely and people did not always have access to on-going healthcare that was responsive to their needs. In addition, care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs and consent to care was not always sought in line with the Mental Capacity Act (2005). We also found that records kept in respect of people using the service, were not always accurately recorded or complete. Internal audits identified shortfalls, but sufficient action was not taken to address these.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, caring, responsive and well-led to at least good. During this inspection we found the provider had met two of the Regulations but two still remained in breach.

Care plans were not consistently person centred and recordings in daily records were not always professional. We found care plans did not contain guidance for staff on managing behaviours which could be challenging to others. Care plans were not reflective of people's needs and staff did not always follow the most up to date guidance.

People received care from staff who had the right skills and knowledge. Staff had received training in areas such as manual handling, safeguarding, dementia and mental capacity.

Medicines were managed safely, following the service's introduction of an electronic medicines management system. However, we found shortfalls with the management of people's topical creams.

The service had improved their relationship with the GP surgery and people now had better access to the GP. Staff told us communication between the home and the GP had improved.

People told us they felt safe living at Savernake View. Staff had a good understanding of protecting people from avoidable harm and said they were confident that any concerns raised would be acted on.

Improvements had been made to gaining people's consent to care and treatment, and where needed, associated mental capacity assessments had been completed. Where people lacked mental capacity to consent, the registered manager had made applications for Deprivation of Liberty Safeguards.

People told us they liked the food on offer and if they did not like what was on the menu, they would be offered an alternative. There were plenty of drinks and snacks available.

People spoke highly about the care they received. They said staff treated them with kindness and compassion.

Staff felt supported by the management team. There were quality assurance systems in place to monitor the quality of the service people received. People and/or their relatives had opportunities to provide feedback about their care.

We found two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. 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?

We found that action had been taken to improve the safety of the service. This meant that the provider was now meeting legal requirements.

Medicines were managed safely. However, we found that for prescribed topical creams, this was not always the case..

Risks to people's personal safety had been assessed and plans put in place on how to minimise these.

People we spoke with told us they felt safe. Staff were aware of their role and responsibilities around safeguarding people.

There were sufficient staff to meet people's needs.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Requires Improvement ●

Is the service effective?

We found that action had been taken to improve the effectiveness of the service. This meant that the provider was now meeting legal requirements.

Staff had a good understanding of working within the principles of the Mental Capacity Act (2005).

People had plenty available to eat and drink and told us they enjoyed the food on offer.

People had access to healthcare and staff told us they now received a visit from the GP surgery once a week.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

Requires Improvement ●

We will review our rating for effective at the next comprehensive inspection.

Is the service caring?

Good ●

We found that action had been taken to improve the caring nature of the service. This meant that the provider was now meeting legal requirements.

Staff knocked before entering people's bedrooms and treated people with dignity and respect.

People told us staff were caring and we observed positive interactions between people and staff.

We have revised the rating for this key question to Good.

Is the service responsive?

Requires Improvement ●

We found that sufficient action had not been taken to improve the responsiveness of the service.

The service had started to implement a system of reviewing and updating all care plans. However, care plans continued not to be person centred and lacked detail. For example around people's life histories or guidance for staff on managing challenging behaviours.

Complaints were investigated and responded to in a timely way.

People had opportunities to take part in activities but were not always supported to follow their interests or hobbies.

Is the service well-led?

Requires Improvement ●

We found action had been taken to improve the leadership of the service.

However, records kept in relation to people's care continued to be incomplete.

Staff told us management was approachable and they had seen a positive change in the culture within the home.

The registered manager had completed internal audits and where shortfalls had been identified, these were addressed.

People and/or their relatives had opportunities to give their

views on the quality of care received.

Savernake View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 4 April 2018 and was unannounced. The inspection team consisted of one inspector, one bank inspector, a specialist nurse adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

This inspection was brought forward due to complaints received about the quality of care people received since our last inspection. Following that inspection, the provider developed an action plan to address the shortfalls, which they submitted to us. During this inspection, we checked if the provider had done what they said in their action plan.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

We used a number of different methods to help us understand the experiences of people who used the service. This included talking with 10 people and four of their relatives about their views on the quality of the care and support being provided. During the two days of our inspection, we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included 11 care and support plans, daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke to the registered manager, training manager, three nurses, three health care assistants, the head chef, leisure and wellness coordinator, domestic staff and maintenance. We received feedback from one

health and social care professional.

Is the service safe?

Our findings

At the last comprehensive inspection in August 2017 we identified that the service was not meeting Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because medicines were not managed safely and people did not always have access to on-going healthcare that was responsive to their needs. Where risks to people's health and safety had been identified, the service did not do all that was reasonably practicable to mitigate any such risks. As a result of these shortfalls we issued a requirement notice. The provider sent us an action plan, which showed how they would make improvements.

During this inspection we found improvements had been made, following the introduction of an electronic medicines management system. Medicines administration records (MAR charts) had not previously been signed consistently, to evidence that people had received their medicines as prescribed. With the introduction of the new system, the records showed people were now receiving their medicines as prescribed. We observed parts of two medicine rounds, which were being carried out by two permanent members of staff. During both rounds we saw that staff asked people if they needed any pain relief and checked they had swallowed their medicines prior to signing the MAR chart. We asked the permanent staff member what happened when gaps with no signatures were noted. They said that the system was good as it alerted staff if a medicine was missed. Staff told us they had training on the new electronic system and we observed that they were confident in using this. Medicines were stored and disposed of safely.

However, topical medicine administration was not always managed safely. For example we identified some people had been prescribed topical creams. The dates on which these had been opened, had not been recorded. This meant people were at risk of the use of expired creams, which might not be effective after their 'use by' date. Topical administration records were not consistently completed and we found there was no topical cream chart in one person's room to guide staff on where to administer the cream and frequency of administration. This meant there was a risk that people's skin integrity was not managed effectively. We raised this with the nurse in charge, who told us they would action it immediately.

Some people had behaviours which could be seen as challenging to others. Where a safety risk had been identified, risk assessments were in place on how to manage the risk of conflict and confrontation. However, there was no clear guidance for staff on how to reduce the risk. For example, in one risk assessment the significant hazards had been listed as the person's 'mood swings'. Staff had documented the existing measures as "staff well informed" and "immediate action by staff when conflict arises". However; the immediate action that staff should take was not described. Another person's risk assessment for conflict and confrontation contained the same information and again provided no detail for staff on how they should respond to this.

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. When risks were identified, the majority of the care plans contained guidance for staff on how to reduce the risks of harm to people. For example, one person had been assessed as having a high risk of falling. The plan guided staff to ensure the person had well-fitting footwear, to remove obstacles, ensure lighting was suitable and to

make sure the person had their mobility aid with them. Another person had been assessed as having a high risk of developing pressure sores. There was a pressure relieving mattress in place and this was set correctly. All of the air mattresses we looked at were also set correctly.

People told us they felt safe living at the home. Comments included "Yes, very much so, it's very secure here and there are always people about", "Yes, I do. There are always staff about and it's hard to get in here at night, yes I feel very safe" and "I do feel safe with the staff around and feel safe at night in the main." A relative commented "Yes, she [person] is safe. All the doors are coded so she can't get out on her own and nobody can get in."

Staff said they had received training on how to protect people from avoidable harm and abuse. Records showed that staff reported any concerns, such as unexplained bruising. Where people were involved in incidents or accidents, these had been reported appropriately. Staff knew how to observe for signs of poor care and said they were confident to report these. One staff member said "If I wasn't happy about something; I would report it and I know it would be dealt with." Another told us "The management team tell us we're their eyes and ears. They want to know about the good and the bad; we're encouraged to speak up."

During our last inspection we found a significant number of people, relatives, visitors and staff expressed concerns about lack of staff, the use of agency carers/nurses and the impact that this had on the quality of care. During this inspection we found staffing levels had improved and the use of agency staff had decreased. Staff told us there was enough staff on duty to meet people's needs. Comments included "It's fine, unless someone goes off sick at the last minute" and "We've recruited quite a few new staff which has made a huge difference. We have minimal agency use now" and "We've got enough staff. It's very rare that we're short." People told us that staff responded to their call bells quickly in most cases. They said "Yes, I have a call bell in my room and I've only used it once and they come really quickly" and "Yes, I do have a call bell. I feel very vulnerable without it and when I use it they come fairly quickly, they're very good usually."

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Staff had been trained on infection prevention and control. Personal protective equipment such as gloves and aprons were readily available for staff and they understood the importance of using it. When people needed staff to use moving and handling equipment such as hoists and slings, people had their own slings for individual use. The building looked clean and smelt fresh throughout. One staff member said "The cleanliness here is exceptional. There's never any unpleasant odours."

Is the service effective?

Our findings

At the last comprehensive inspection in August 2017 we identified that the service was not meeting Regulation 11 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because the service did not follow the requirements set out in the Mental Capacity Act 2005 when people lacked the ability to give consent to their care and treatment. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found improvements had been made. 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. We found consent to care was sought in line with the MCA. We saw evidence that people had signed their care plans to indicate their consent. Some people had sensor mats in place. In these instances people's mental capacity to consent to this had been assessed. When people lacked capacity, best interest decisions had been made. These were clearly documented and showed that other health professionals and people's advocates had been involved in the decision making process. However, we found for one person that a decision was made to change their food to a soft diet, without a best interest decision recorded. The registered manager told us this was not due to a health concern, but the person's choice.

Where needed, the registered manager had made applications for DoLS to the supervisory body. Only one person had an authorised DoLS in place, others were awaiting assessment. There were conditions attached to this, and records showed these had been met. During our inspection we saw staff giving people choice and involving them in decisions about their daily living.

Staff told us they had the training and skills they needed to meet people's needs. A new home trainer was in post, who assured us that staff had completed relevant training and refreshers when due. Records showed staff had completed training such as moving and handling, safeguarding, mental capacity and fire safety. Staff also completed the Care Certificate (an identified set of standards which health and social care workers are expected to adhere to) as well as additional training specific to their roles. This included understanding dementia and oral hygiene. Comments from staff included "The training is so much better now. The new system means we can track people's learning, so nobody slips through the net" and "The training is regular and it's really good. I've completed my care certificate. The home trainer really motivates you."

We found on the dementia unit that people's individual needs were not always met by the adaptation, design and decoration of the environment. People did not always have enough meaningful activity to engage with. Several people walked along the corridors, until they came to the end and a locked door. They looked through the window in the door, trying to open the door. Some people became distressed and staff had to distract them away from the door. Some staff also commented negatively about the environment and how dementia friendly it was. They said "It's more like a hotel really than a dementia friendly place" and "Personally I think the colours in the corridors are bland and need to be brighter. I've also raised it before that I think we should change the crockery and table cloths."

Staff said they felt it would be beneficial if the dementia unit was moved downstairs so that more people could access the garden. They said they did not think people had enough to do. They commented "There's not enough space here for people to walk around. They pace up and down and then come to a locked door" and "We don't have anything for people to rummage through. I try and get the ladies to help me fold the laundry sometimes." One staff member said "I think people's basic needs are met, but not their emotional needs." A health and social care professional said "It's no good looking like a 5 star hotel, when there are not enough activities for people living with dementia. Challenging behaviours can sometimes be a cause of boredom." We raised our concerns with the provider who told us they were working with an admiral nurse to ensure people's individual needs with their dementia were taken into account and to inform their care plan.

People had access to on-going healthcare. At the previous inspection staff had reported difficulties accessing the GP for advice and support. At this inspection staff said this was much improved. One said "Access to healthcare for people is so much better. The advanced nurse practitioner comes every week. The relationship between us and the surgery has improved and because of this, the stress of getting people reviewed has been removed." Records showed that people had been reviewed by other health professionals such as the care home liaison team and the diabetes nurse. The advanced nurse practitioner who visited the home during our inspection told us the relationship between the home and GP surgery had improved. They said "I am pleased with the progress they have made. Staff seem to be more knowledgeable."

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had.

We found that people's nutritional needs were not consistently recorded in their care plans. The chef told us kitchen staff spoke to people about their food preferences; however, this information was not always written in care plans. People's likes and dislikes had not always been documented. Of seven nutritional plans we looked at, only two had people's food preferences documented. The chef was aware of people's dietary needs. For example, they knew which people were having textured diets. They said although there was nobody with any particular cultural needs in relation to their diet, they could cater to this if needed. They said "We have two people who don't eat pork and two pescatarians [a person who does not eat meat but eats fish]. We cater for everyone."

Where people were on a soft or textured diet, it was not clear if a health professional was involved in that decision. For example for one person it was documented that staff had observed the person was finding it difficult to chew and swallow meats. Staff had written "I have observed [person] finds soup and soft options easier. As of today to have a soft diet". Records showed the person had been given a pureed diet, but there was nothing documented to show that other soft food options had been considered or tried rather than pureed food. There was no evidence of a referral to a speech and language therapist.

In another person's plan it was documented they could eat a normal diet, but preferred finger foods.

However, when we discussed this person with a member of staff and asked about this they said "They're down for finger foods but I prefer to give them a soft diet. It makes a change from having the same finger foods all the time." This meant that care plans were not reflective of people's needs and that staff did not always follow the most up to date guidance.

People had plenty available to eat and drink. We observed staff regularly offered people drinks and snacks and cakes were available throughout the day. There was a drink making dispenser for hot drinks and cold drinks were held in a fridge in the reception area, which people and their visitors could have. Where people were at risk of malnutrition or dehydration, we saw people's weight was monitored and food and fluid intake was recorded. When people lost weight, records showed that fortified diets and drinks were provided.

People told us they liked the food on offer. Comments included "I think it's pretty good on average and we get a good choice. I don't have a favourite meal as I eat everything and at night I have biscuits in my room and I always get a hot drink at night", "The food is very good. The lamb was really good as I don't like spicy food and we get a good choice" and "It's good and plenty of it." A relative commented; "Food is good and I've eaten here. I think they [people] get a good choice."

Is the service caring?

Our findings

People spoke positively about the care they received. Comments included "Oh yes I like it here. It's well-appointed and the staff are very good", "Yes, I like it here, the staff are very nice and it's comfortable", "Words fail me. They [staff] are so kind and my friends came from London today and they were given lunch and it was wonderful. The staff seem to get great pleasure in pleasing you" and "I think the staff are very good." Relatives commented "The staff are lovely even the agency staff are very good" and "[Staff] are delightful people."

We observed some positive interactions between staff and people. Staff knew people's names and the names they preferred to be called by, including nicknames. Staff spoke kindly with people and didn't rush them. People seemed relaxed around staff. For example, we saw a staff member crouch down to one person's eye level to speak to them, asking "Are you okay there?" The person smiled and said "Yes, I'm fine thanks my darling." On another occasion a staff member said to one person "You look cold. Would you like me to bring you one of your scarves? Which one would you like?"

Staff said they felt the care they provided was good. Comments included "The care here is good. People get regular baths or showers. I observe that the residents are clean, their hair smells fresh. I keep an eye on the standard of care", "I know the care is good here because I roll my sleeves up and get involved. When I observe staff it's like they're caring for their own relative" and "The care is very good. Staff recognise people's individual needs." All staff said they enjoyed their jobs. Comments included "It's a lovely place to work" and "I wouldn't want to leave here."

We observed that staff mostly maintained people's privacy and dignity. We saw that staff knocked on people's doors before entering and personal care was carried out behind closed doors. People told us staff asked for permission before supporting them. They said "Yes, they do ask for my permission before they do anything for me" and "Yes, they always knock on the door before they come into my room and they always close the curtains and the door before they do anything for me." However, during our lunchtime observation we saw some staff supported people with eating by standing over them and not always explaining to people what was on their plate. We also observed on one occasion that staff provided personal care, without closing the person's curtains. That meant that people walking outside past the person's bedroom, would be able to look in.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People's views were sought through care reviews and annual surveys. We saw compliments about the quality of care, stating "Attention to detail by carers. Nothing is too much trouble" and "Excellent care."

People were supported and encouraged to be independent as much as possible. For example, we saw in people's care records that it stated what they were able to do for themselves. It stated "[Person] is able to wash his hands, face and chest, though will require assistance of one member of staff for his back and legs."

Is the service responsive?

Our findings

At the last comprehensive inspection in August 2017 we identified that the service was not meeting Regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs. Some records were contradictory and not a true reflection of people's current care needs. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found care plans were still not always person centred. They lacked information about people's life histories and did not always contain information about people's preferences in relation to the support they wanted staff to provide. When we asked staff about jobs people had in their earlier lives, some knew this information and some didn't. One staff member said "I know about this because I ask people or their families. I make a point of finding out." A relative told us when [person] first moved to the home, the service had no concept of a person centred approach to care planning. They said they were given a form to complete and were not involved in the care planning. They said they provided information about their family member's interests and hobbies and were disappointed to find this was not followed.

Personal hygiene plans provided limited detail about people's choices and in some cases contradicted what we saw. For example, in one person's plan it was written "Likes to grow his beard" and yet when we saw this person they were clean shaven. In another person's pre-assessment it was written that being well presented and looking good was very important to them. This information was not included in the care plan. The same person liked to wear make-up and we saw this had been applied, but there was nothing documented to inform staff how to apply this.

Plans for people living with dementia contained no information about how their health condition impacted on their lives. There were "Individuality in Dementia" care plans in place, but these were generic and not person centred. They included statements such as "enable the service user to feel like a person and a unique individual", but did not detail how staff should do this.

In one person's daily notes staff had documented about episodes of aggression and agitation. The care home liaison team had been involved to offer support and advice, but there was nothing documented to inform staff how to support the person during these periods. Additionally, there was nothing documented in relation to any triggers that staff had identified. In another person's plan staff referred to "challenging" behaviour, but again there was nothing to inform or guide staff on how to deal with this. This meant there was a risk that staff who were unfamiliar with people such as new staff or agency staff would not know what to do. Despite this, when we spoke to staff about how they managed people with agitation and challenging behaviours, they demonstrated they did know how to resolve situations, but not all were able to describe triggers for people.

Some comments in the plans demonstrated a lack of understanding of people's needs and were not always professional. For example, in one plan it was documented "prefers a shower not a bath as tends to be

challenging at times "and "unable to sit in dining room to have dinner due to dementia." In another person's records staff had written "went back to bedroom when [person] realised they can't win" and "I raised my voice and I told her I will call the police, you are trying to attack me."

The registered manager told us they were due to introduce an electronic care planning system, which they were hoping would support a more person centred approach to care planning. Staff were due to receive training on how to use the new system effectively.

This remains a breach of Regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Plans in relation to people's health needs were detailed. For example, diabetes plans described any medicines people were prescribed and included the signs and symptoms of low blood sugar. Actions staff needed to take if this happened were also documented. Regular reviews of care plans had taken place. People and their next of kin were invited to contribute to these reviews every three months. Records showed this had taken place.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. The leisure and wellness coordinator told us "We [leisure and wellness staff] do one to ones with people, which could be scrabble and cards. Some just like to talk and we have a carer who will do the lady's nails and some like to come to the Cinema." People also had opportunities to go out on day trips. However, we found that people were not always supported with their hobbies and interests. Some people told us of important achievements in their lives, which was not recorded in their care plans. This meant staff would not be able to talk to them about their achievements or support them with their interests.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. These had been investigated and people and their relatives were generally satisfied with their responses. We found however; that the registered manager did not always write an acknowledgement to the receipt of the complaint, as per the provider's complaints procedure.

Although there was information within plans about when relatives wanted to be contacted at the end of a person's life, advanced care plans were not always in place. When in place, these plans provided staff with information about people's preferences in relation to where they wanted to die and anything that might be important to them towards the end of their life such as spiritual preferences. We saw some positive comments from relatives about their family member's end of life care. Comments included "Been really impressed by the skill and kindness of all the staff who looked after my mother. We could not have asked for more" and "Savernake View showed her warmth and gentle care with great compassion."

Is the service well-led?

Our findings

At the last comprehensive inspection in August 2017 we identified that the service was not meeting Regulation 17 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because internal audits had identified shortfalls and action had been taken. However, the action taken was not sufficient to resolve the shortfalls. This included the safe management of medicines. In addition, records kept in respect of people using the service, were not always accurately recorded or complete. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found improvements had been made, however records kept in respect of people using the service, continued to be inaccurately recorded or incomplete. The registered manager told us as part of their action plan, that they were due to introduce an electronic system for recording. The registered manager expected this would improve the consistency and accuracy of information recorded.

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

Overall staff spoke highly of the management team. They told us there had been a change in the culture within the home and had seen positive changes. Comments included "We have regular staff meetings and we're encouraged to put our views across", "It's much better since the last inspection, from the top to the bottom" and "The management team is so much better. It feels like everyone is singing from the same hymn sheet now." However, one member of staff said "I don't feel like I always get support from the managers. They're nice but it sometimes feels like they don't listen."

The registered manager had support from a deputy manager, operations director, director of quality and a regional manager. They said the management team shared the organisation's values and wanted the service to succeed. The registered manager told us they felt supported within their role.

The registered manager told us there had been many staff changes since our last inspection. This was because they had recognised that some staff did not promote a positive culture that was person-centred, open, inclusive and empowering. The registered manager said they were trying to create a positive culture through working alongside staff and promoting respect amongst the team. They said "Everyone is important and part of the team." The registered manager told us staff were committed to their roles and would do extra shifts to cover staff sickness, instead of using agency staff. During the recent bad weather, local staff came in to cover staff that were unable to get to work due to the snow. The registered manager said "I am very proud of them [staff]."

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. We saw regular resident and relatives meetings took place and people and their relatives were able to make suggestions about the service. For example we saw in the March 2018 meeting minutes, that a suggestion was made to have more reminiscence items on the dementia unit, including a

clock indicating the day and time. We observed during our inspection that this suggestion had not yet been acted on, but the registered manager told us items had been ordered.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. We saw that internal audits had been completed for example for medicines management, pressure ulcers, infection control and accidents and incidents. The audits were analysed and an action plan developed to address any shortfalls. The registered manager told us the head injury protocol had changed as a result of learning from falls and they had identified that care planning and communication needed to improve. We saw the provider completed 'spot checks' during out of hours to ensure people were receiving quality care.

The registered manager told us they were continually striving to improve the service. For example they were currently looking at identifying staff to take the lead in areas such as tissue viability, infection control, diabetes, dementia and palliative care. Regular staff meetings took place.

The service worked in partnership with various agencies, such as the GP surgery, local schools and other health and social care professionals. The service met three monthly with the GP surgery to maintain and build relationships. The registered manager told us it was also a learning opportunity and guest speakers were invited. This included the palliative care team.

The service also made other community links. A nursery school visited the home once a week and people from the local community were able to come for lunch or attend some of the activities. The registered manager said they were also excited about being invited to take part in a generational integration pilot with a primary school.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>Care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs. Some records were not a true reflection of people's current care needs.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Records relating to people's care were not always complete and correct. We found a repeated breach with regards to person centred care planning.</p>