Care Quality Commission

Finecare Homes (Stevenage) Limited

Roebuck Nursing 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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 15 and 23 April 2015 and was unannounced. At our last inspection on 14 November 2013, the service was found to be meeting the required standards. Roebuck Nursing Home is a purpose built nursing and residential care home. It provides accommodation and personal care for up to 63 older people, some of whom live with dementia. The home is comprised of residential nursing units and a dementia care unit spread over three floors where staff look after people with varying needs and levels of dependency. At the time of our inspection there were 60 people living at the home.

There is a manager in post who has registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

The CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS

Summary of findings

are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection we found that some people had aspects of their freedoms restricted in a way that did not fully comply with the DoLS or relevant requirements of the MCA 20015.

During our inspection we found that most areas of the home were clean, well maintained and smelt fresh. However, although staff had received training in relation to hygiene and infection control, we found that some did not demonstrate a sufficiently good understanding of their roles and responsibilities in practice. People told us they felt safe at the home. Staff had received training in how to safeguard people against the risks of abuse. However, not all staff knew how to report concerns externally.

People who lived at the home and their relatives expressed mixed views about staffing levels. We found that the effectiveness of staff deployment lacked consistency across different units at the home. In some units we saw there were sufficient numbers of staff to meet people's needs promptly in a calm and patient way. However, in others units, particularly where people's needs and dependency levels were greater, there were often insufficient staff to cope with the demands placed upon them.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs. We saw that plans and guidance had been put in place to help staff deal with unforeseen events and emergencies.

We found that people had been supported to take their medicines on time and as prescribed by staff who had been trained. People told us that potential risks to their health and well-being had been identified, discussed with them and their relatives and reduced wherever possible. The environment and equipment used, including mobility aids and safety equipment, were well maintained and kept people safe.

Staff obtained people's consent before providing the day to day care they required. Where 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions were in place, we found that these had been made with the full involvement and consent of the people concerned or their family members.

People were positive about the skills, experience and abilities of the staff who looked after them. We found that most staff had received training and refresher updates relevant to their roles. The manager and senior staff carried out observations and competency checks in the work place which, together with regular supervision meetings with staff, enabled them to tailor training provision to staff development needs.

People expressed mixed views about the standard and choice of food provided at the home. We saw that the meals served were hot and that people were regularly offered drinks. Fresh fruit was available on dining tables and people were offered alternative menu options such as salad, sandwiches and soup. However, although care staff were familiar with people's dietary requirements, we found that the chef who developed the menus and prepared meals was not. For example, they were unable to tell us if anyone had specific nutritional needs or were at risk of malnutrition or adverse weight gain.

People told us that their day to day health and support needs were met and they had access to health care professionals when necessary. We saw that GP's from a local surgery attended the home regularly to review people's care and ensure they received safe treatment that reflected their changing needs and personal circumstances.

We saw that people were looked after in a kind and compassionate way by staff who knew them and their relatives well. Information about local advocacy services was available for people who wished to obtain independent advice. We found that staff had developed positive and caring relationships with the people they looked after. They provided help and assistance when required in a patient, calm and reassuring way that best suited people's individual needs.

However, people and their relatives expressed mixed views about the extent of their involvement in the planning, delivery and reviews of the care and support

Summary of findings

provided. Some people told us they had been involved but others less so. We found that the guidance and information provided to staff about people's involvement lacked consistency across the different units at the home.

The confidentiality of information held about people's medical and personal histories was not sufficiently maintained across the home. In every unit personal information was kept in unlocked cupboards located within insecure and frequently unattended offices which were in areas used by people and their visitors.

We found that personal care was provided in a way that promoted people's dignity and respected their privacy. However, when we started our inspection at 7:30am we found that the majority of people's bedroom doors were wide open. Many people were still in bed asleep, with bed clothes and night wear positioned and worn in such a way that did not always preserve people's dignity or respect their privacy.

People told us they received personalised care that met their needs and took account of their preferences. We found that staff had taken time to get to know the people they looked after and were knowledgeable about their likes, dislikes and personal circumstances. However, we found that the guidance and information provided about people's backgrounds and life histories was both incomplete and inconsistent in many cases.

People expressed mixed views about the opportunities available to pursue their social interests or take part in meaningful activities relevant to their individual needs. We saw that where complaints had been made they were recorded, investigated and the outcomes discussed with the people concerned. People and their relatives told us that staff listened to them and responded to any concerns they had in a positive way.

Everybody we spoke with was very positive about the management and leadership arrangements at the home. However, we found that the methods used to reduce risks, monitor the quality of services and drive improvement were not as effective as they could have been in all areas.

At this inspection we found the service to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not adequately protected against the risks associated with health care related infection.

People told us they felt safe at the home. However, some staff members did not know how to 'whistle blow' and report signs of abuse externally.

Sufficient numbers of staff were not always available to meet people's needs at all times and in all areas of the home.

Safe and effective recruitment practices were followed.

People were supported to take their medicines safely by trained staff when they needed them.

Potential risks to people's health were identified and effective steps taken to reduce them.

Requires improvement

Is the service effective?
The service was not always effective.

Some people's freedom of movement had been restricted in a way that did not always satisfy the Deprivation of Liberty Safeguards (DoLS) or the requirements of the Mental Capacity Act (MCA) 20015.

Staff received regular supervision and training which meant that people's needs were met by competent staff.

People were supported to eat a healthy balanced diet. However, information about people's dietary needs was not always used or shared effectively.

People's day to day health needs were met and they had access to health and social care professionals where necessary and appropriate.

Requires improvement

Is the service caring?
The service was not always caring.

People were looked after in a kind and compassionate way by staff who knew them well and were familiar with their needs.

People and their relatives expressed mixed views about the extent of their involvement in the planning and reviewing of their care. The guidance provided to staff did not accurately reflect their involvement in all cases.

Care was provided in a way that promoted people's dignity and respected their privacy.

Requires improvement

Summary of findings

Information and guidance was provided to help people access independent advocacy services.

The confidentiality of people's medical histories and personal information had not been adequately maintained in all cases.

Is the service responsive?
The service was not always responsive.

Requires improvement

People told us they received personalised care that met their needs and took account of their preferences.

However, the guidance provided to staff did not always contain sufficient information about how to provide person centred care that reflected people's individual needs.

People expressed mixed views about the activities provided. Some felt that there were not enough opportunities to pursue social interests, particularly outside of the home and in the absence of the activity coordinator.

People were confident to raise concerns and have them dealt with to their satisfaction.

Is the service well-led?
The service has not always been well led.

Requires improvement

People, their relatives, staff and healthcare professionals were all very positive about the management and leadership arrangements at the home.

Staff told us they understood their roles and responsibilities and were well supported by the manager.

Measures were in place to identify and reduce risks and to monitor the quality of services provided at the home.

However, the systems used to quality assure services, manage risks and drive improvement had not always been as effective as they could have been.

Care Quality Commission

Roebuck Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 15 and 23 April 2015 and was unannounced. The inspection team consisted of three Inspectors, an expert by experience and a specialist professional nurse advisor. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, the provider to completed a Provider Information Return (PIR). This is a form that requires the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with 9 people who lived at the home, 11 relatives, 12 staff members, the provider and the home manager. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspection.

We looked at care plans relating to 13 people who lived at the home and four staff files. We also carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires improvement

Is the service safe?

Our findings

During our inspection we found that most areas of the home were clean, well maintained and smelt fresh. A relative commented, "The Home is always clean and the rooms are kept nice."

However, although staff had received training and refresher updates in relation to hygiene and infection control, we found that some did not demonstrate a sufficiently good understanding of their roles and responsibilities in practice.

For example, we saw that some staff members provided personal care to a number of different people without changing their disposable aprons and gloves in between. A senior staff member placed people's dirty laundry in a bag and then helped a person eat breakfast in their bedroom, without first changing their apron and gloves or washing their hands. They then went on to provide personal care to a number of other people wearing the same protective clothing. We also found that slings used to hoist and transfer people with limited mobility were shared. They had not been allocated to individuals or washed in-between use as a matter of course which may have increased the risks of infection.

This meant that people had not been adequately protected against the risks associated with health care related infection which was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe, well looked after and happy at the home. One person said, "It's lovely here. They [staff] are very kind and I feel very safe and secure. I am lucky to be here." Relatives were also confident that people were safe and protected from harm by staff who listened and responded positively to any concerns they had. One relative commented, "[Family member] is really safe and staff look after their every need. In the early days I was here all the time and have never seen or heard anything I was concerned about."

Staff had received training in how to safeguard people from harm and keep them safe. We saw that information about how to report concerns, including contact details for the local authority, had been provided to new staff members as part of their induction. The manager told us that staff awareness about safeguarding was maintained by regular discussions and reminders at meetings and shift handovers. However, although staff were knowledgeable about the risks of abuse and how to raise concerns internally, some did not know how to report matters externally or where to find guidance about 'whistle blowing.' One staff member told us they would research the internet if they needed to find out which organisation to contact. This meant that the support provided to help staff report concerns was not as effective as it could have been.

People who lived at the home and some of their relatives expressed mixed views about staffing levels. One person told us, "Sometimes they are a bit thin on staff, it's alright but sometimes in the morning I have to wait to get up." A relative commented, "Sometimes there are quite a few [staff] but other times not, but they do come quick when you press the buzzer [call bell]." Our observations found that the effectiveness of staffing levels and deployment varied across different units at the home, particularly during busy periods such as first thing in the morning and at meal times.

In most areas, although constantly busy and occasionally stretched, we found there were sufficient numbers of staff available to meet people's needs. For example, we saw throughout our inspection that staff were quick to respond to call bells. In one instance, a person who pressed their bell, because they needed help with personal care, was attended to and provided appropriate levels of support within three minutes. However, on some occasions, particularly in areas where people's needs and dependency levels were greater, we found there was not always sufficient numbers of staff to meet everybody's needs in a timely way.

For example, in the unit where people lived with dementia we saw that a person became increasingly distressed as they walked around unsteadily on their feet and called out for help. The two staff members on duty in the unit were unable to go to their assistance for several minutes. This was because they were already engaged in providing personal care to another person. Staff told us they were constantly busy and often had little time to spend talking with people on a 'one to one' basis. One member of staff said, "The mornings are really, really busy; we have more time with residents in the afternoon." A relative commented, "There are enough staff most of the time but it is difficult [for them] to juggle. [The home] would improve by having some more staff."

The provider told us they planned to recruit volunteers and additional permanent staff to meet people's changing

Requires improvement

Is the service safe?

needs more effectively, particularly at busy times. We found that safe and effective recruitment practices were followed to check that all staff who worked at the home, including temporary and agency staff, were of good character, physically and mentally fit for the role and able to meet people's needs.

People told us that staff helped them take the medicines they needed at the right time and reminded them what they were for. One person said, "They [staff] are really good at making sure I get the right medicine at the right time." People were supported to take their medicines by staff trained to administer them safely. There were suitable arrangements for the safe storage, management and disposal of people's medicines.

We found that identified risks to people's health and well-being had been assessed and reviewed on a regular basis. This included areas of risk such as malnutrition, dehydration, falls and pressure ulcers. Staff were knowledgeable about the risks and the steps required to reduce them, for example, they knew which people to be repositioned in bed, how often and the methods needed used to help them move safely. Information about changes to risks and people's needs was shared at shift handover meetings and senior staff carried out regular checks to ensure that the guidance provided had been followed. We saw that risks had been managed in a way that also took account of and promoted people's independence.

For example, we saw that staff had been asked to encourage and support one person to walk with the aid of a mobility frame, provided that any obstacles were cleared from their path. A relative told us, "I find the care really good. They [staff] check on [family member] every hour and help them move in bed because of ulcer risks." A health care professional, who visited the home regularly, told us that the manager and care staff were quick to identify risks and seek specialist advice and guidance where appropriate.

We saw that plans and guidance had been put in place to help staff deal with unforeseen events and emergencies which included relevant training, for example in fire safety. Personal evacuation plans, tailored to people's individual health and mobility needs, had been drawn up for every person at the home. Maintenance staff carried out regular checks which ensured the environment and equipment used, including mobility aids and safety equipment, were well maintained and kept people safe.

Requires improvement

Is the service effective?

Our findings

People told us that staff obtained their consent before they provided day to day care. One person said, "They [staff] always ask me first before doing anything. I decide and they listen and follow my wishes." During our inspection we saw that staff explained what was happening and asked people for consent before providing personal care and support. We also found that where 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions were in place, these had involved and been agreed by the people concerned and, where appropriate, their family members.

Staff told us they had received training about the Deprivation of Liberty Safeguards (DoLS) and how to obtain consent in line with the Mental Capacity Act (MCA) 2005. However, some staff members were unable to demonstrate an adequate working knowledge of how the MCA and DoLS applied in practice. For example, some staff members who worked in the dementia care unit could not explain the DoLS or the significance of whether or not people in their care lacked capacity to make their own decisions. A staff member in another unit mistakenly thought that DoLS authorities entitled them to make best interest decisions or people in general. They told us, "If the resident lacks capacity the deprivation of liberty authorisation gives us the authority to take decisions for the resident." Staff did not know whether or not DoLS authorities had been obtained or applied for in connection with the people they looked after.

We found that most people had their freedom of movement restricted because they were unable to leave the home or the unit they lived in at will. This was because access to and from each unit, together with the home itself, was restricted by a key coded security system. Most people who lived at the home, whether they had capacity or not, were unable to use the system and move about freely without the help and assistance of staff or family members. For example, information provided to staff about one person who lacked capacity described how they frequently asked to go home. Staff were advised to ensure that doors on the unit were kept secure and that the person concerned could only leave or access other areas of the home under close supervision. However, in the guidance about DoLS, staff were informed there were no authorities in place because the person's freedom had not been restricted.

We saw that many people had bed rails in place to keep them safe in a way that also restricted their freedom of movement to varying degrees. We saw that in some cases consent had been provided by the person concerned or, where appropriate, a family member who was legally entitled to give consent on their behalf. However, in some instances we found that bed rails had been used in connection with people who lacked capacity to consent but that DoLS and the MCA 2005 had not been followed.

We spoke with the provider who agreed that some people's liberty had been restricted in a way that did not comply with the MCA 2005. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider told us that immediate steps would be taken to review their circumstances, in liaison with the local authority, and to obtain DoLS authorities where necessary.

People were positive about the skills, experience and abilities of the staff who looked after them. One person told us, "The carers do a wonderful job. The manager makes sure they [staff] are trained." A relative commented, "They train [staff] here….they train them on the job and also you see them with their NVQ [national vocational qualification] books." We saw that new staff members had completed a structured induction programme before being allowed to work unsupervised. The manager and senior staff carried out observations and competency checks in the work place which, together with regular supervision meetings with staff, enabled them to tailor training provision to meet the development needs of individual staff members.

We saw that staff were up to date with refresher training in areas such as safeguarding vulnerable people, infection control, health and safety, moving and handling, fire safety and dementia care. However, we found that most staff members had not yet had their overall development and performance linked together, monitored or reviewed by a formalised system of appraisal. We saw that the provider had taken steps to train and develop staff as 'champions' in key areas which included dignity and dementia care.

People and relatives expressed mixed views about the standard of food provided at the home. One person said, "It's alright I suppose, it is hot anyway." Another person told us, "There is no real choice of food and sometimes [lunch] is a bit early." We observed the lunchtime meal in a number of units during our inspection and saw that the menu choice available consisted of a meat or vegetable curry. A relative commented, "[Food] is OK, it is probably the

Is the service effective?

weakest point here and there isn't much choice." The food served was hot and people were frequently offered hot and cold drinks. We saw that fresh fruit was available on dining tables and that people who did not want curry were offered alternative options such as salad, sandwiches and soup. However, we found that some people who were in bed and some communal lounges did not have access to water because there was a shortage of clean jugs.

We saw that people who needed help to eat and drink, either in the communal dining areas or their own bedrooms, were given appropriate levels of support in a calm, relaxed and patient way. Most people appeared happy during lunch and told us they enjoyed the food provided. We saw that people were encouraged to eat and drink in sufficient quantities by care staff who were knowledgeable about their individual dietary needs and preferences. However, in some cases we saw that staff supported people to eat with little or no personal interaction or conversation with the person concerned.

We found that people at risk of not eating enough had been provided with supplementary drinks and fortified food appropriate to their needs. Advice, guidance and support had been obtained where necessary from health care specialists such as dieticians and speech and language therapists (SALT). The provider told us that a nutritionist had been recently recruited to help ensure that menu choices offered people a healthy balanced diet which met their individual needs. However, although care staff were familiar with people's dietary requirements, we found that the chef who developed the menus and prepared meals was not. They were unable to tell us if anyone had specific nutritional needs or were at risk of malnutrition or adverse weight gain. For example, a number of people lived with diabetes and some others few were at risk of obesity, but the chef did not know who they were because the information had not been shared. This meant that people relied on the nursing and care staff to make sure they were provided with meals appropriate to their needs.

People told us that their day to day health needs were met in a timely way and they had access to health care professionals when necessary. One person said, "The [staff] are lovely, they really look after me." A relative commented, "I am very happy with the care here. They really look after [family member] well and they do understand them." We saw that appropriate referrals were made to health and social care specialists when needed and there were regular visits from dieticians, opticians and chiropodists. A relative said, "If [family member] needs to go to hospital for an appointment, the home will phone us and we can go or they will send a carer with them." During our visit a person being visited by a relative complained to the manager about an eye condition. The manager, also an experienced nurse, examined their eyes, discussed the options available, reassured them and made arrangements for a referral to a hospital specialist. The relative commented, "That is how it always is, you ask and it is sorted out."

We saw that GP's from a local surgery attended the home regularly to review people's care and ensure they received safe treatment that reflected their changing needs and personal circumstances. We spoke with one GP during our inspection who told us that the care provided was "Brilliant and second to none." They felt confident that people's health needs were met and told us that pressure care in particular was very good with quick referrals to health care specialists where necessary and appropriate. A relative commented, "I am happy with the care and that staff meet family member's needs."

Requires improvement

Is the service caring?

Our findings

The confidentiality of information held about people's medical and personal histories was not sufficiently maintained across the home. We found that in every unit, personal information was kept in unlocked cupboards located within insecure and frequently unattended offices in areas used by people and their visitors. A member of staff told us, "The offices are normally open but the cupboards should be shut."

In an unlocked room in one unit, used to store people's mobility equipment, we found a large quantity of care records that had recently been completed in relation to the personal care and support provided to a number of people. These included information about how much food and fluids people had consumed and when those at risk of pressure ulcers had been repositioned in bed. The provider told us that immediate steps would be taken to improve the security of confidential information, for example by installing key coded locks to the doors of offices where people's medical records were held.

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

People told us they were looked after in a kind and compassionate way by staff who knew them well and were familiar with their needs and preferences. One person said, "The [staff] are really kind and help me all the time." Another person told us, "The staff are really good and help me whenever I need them." Friends and relatives told us there were no restrictions as to when they visited and that they were always made to feel welcome. One relative commented, "[Family member] has blossomed in their care, there is a nice family atmosphere here." We saw that information about local advocacy services had been made available for people who wished to obtain independent advice or guidance.

During our inspection we saw that relatives were encouraged to join in at mealtimes and help support their family members to eat and drink. In one dining room we saw that a relative helped to serve meals and clearly enjoyed having a laugh and joke with the people concerned and staff alike. We saw that children were made welcome when they visited and allowed to play in the communal gardens. It was a sunny day when we visited and staff encouraged people and their visitors to make good use of the gardens. People told us they enjoyed sitting on the patio area and we saw that staff offered them sun hats and cream to keep them safe and comfortable. One relative told us, "I love the [staff], I love the place. It is 100%, everything is marvellous. I am here every day….the care is good." Another commented, "I find the care really good. I am made to feel welcome and can come at different times."

We saw that staff had developed positive and caring relationships with the people they looked after. They provided help and assistance when required in a patient, calm and reassuring way that best suited people's individual needs. Staff were knowledgeable about the people they cared for and knew them all by name. One staff member was able to tell us the names of all relatives who visited one person, when they last came and how the person liked to be cared for and supported. They told us there were handover meetings between shifts to ensure that all staff had up to date information in the event that people's health needs had changed. For example, staff were updated about people who had been unwell during the previous shift.

We saw a number of positive interactions between staff and the people they looked after. For example, when one person became confused and disoriented, a staff member distracted them and provided appropriate levels of comfort and reassurance by talking about members of their family. Another staff member commented on a person's "pretty dress" and offered to help them go to their bedroom to choose a matching cardigan when told they felt cold. One person told us, "The staff that I know I've found to be very helpful, they will always do things for me."

People and their relatives expressed mixed views about the extent of their involvement in the planning, delivery and reviews of the care and support provided. One person told us, "There is no discussion around care plans. I've never seen one and never signed one." Another said, "Don't know [about care plans], I've never seen one." We found that the guidance and information provided to staff about people's involvement lacked consistency across the different units at the home. In some cases it was clear about when and how people had been involved but in others there was no information available to confirm whether they had been consulted or not because the relevant sections had not been completed. A relative commented, "No, I have not

Requires improvement

Is the service caring?

had a care plan review but there is no need because they [staff] know the families really well. Care plans happen as they go along." Another person's relative said, "We are very proactive in [family members] care and always have been."

We found that personal care and support was provided in a way that promoted people's dignity and respected their privacy. For example, we saw that staff knocked on doors and asked for permission before entering people's bedrooms. We also saw examples of where staff had hoisted people with restricted mobility to help them move in a calm, patient and considerate way that upheld their dignity. One person's relative commented, "It's good for my [family member] and gives them privacy." Where people preferred, the design of bedroom and en suite bathroom doors were such that they could be positioned to afford privacy without being fully closed. One person commented, "I like the design; it means I'm not shut in the room." The same person told us that their wishes about the gender of staff who provided personal care had been respected at all times which they felt preserved their dignity.

However, when we started our inspection at 7:30am we found that the majority of people's bedroom doors, in all of the units at the home, were wide open. The majority of people were still in bed, many of them asleep, with bed clothes and night wear positioned and worn in such a way that did not always preserve people's dignity or respect their privacy. We spoke with staff about this who said that some but not all people liked to sleep with their bedroom doors open. A relative told us that staff liked to keep bedroom doors open because it was easier to check on people as they walked along the corridors. We saw that in some cases the guidance provided to staff about people's preferred night time routines indicated that they liked to sleep with their bedroom door open. However, we also found cases where the guidance provided did not state or include a preference either way. This meant that staff could not always be sure who preferred to sleep with their door open and may have led to most doors being left open as a matter of course or routine.

We also saw that very few members of care staff who worked at the home wore name badges to identify them. This meant that people may not always have known, or have the means to easily remind themselves, the names of staff who looked after them without having to ask. The manager told us that name badges had been provided and that staff would be reminded about the importance and benefits of wearing them at all times.

Requires improvement

Is the service responsive?

Our findings

Most people and their relatives told us they received personalised care that met their needs and took account of their preferences. One person told us, "The staff have taken the time to get to know me and how I like things done." A relative commented, "They [staff] are very good at treating people like individuals. My [family member] can be difficult but they know how to cheer them up. They treat people like family."

We saw that most people's rooms had been personalised with decorations, family photographs, flowers and ornaments of their choice. People and their relatives told us they had been able to contribute and share their views about how care and support was provided. One person's relative said, "The staff have gotten to know us and will always listen to what we have to say and are quick to make any changes we ask for." A health care professional who visited the home regularly told us that the service was "totally person centred." They also said that people and their families were kept updated and fully involved in discussions about any changes required and the options available. A relative commented, "They respect [family member's] personal choices and look after them very well."

We found that care and treatment was delivered in a way that was responsive to and met people's individual health and support needs. This included where risks had been identified in areas such as pressure care, mobility and nutrition. We saw that staff were knowledgeable about the people in their care and how they preferred to be looked after and supported. A GP who knew the home well told us that people received person centred care that took full account of their changing needs and any identified risks to their physical health and mental well-being. They told us that, in their long experience of the home and people who lived there, the dementia and advanced palliative care provided were "second to none."

However, although staff were knowledgeable about people's needs in practice, we found that the information provided about their individual life stories, likes, dislikes and preferences lacked consistency.

The guidance used by staff did not always accurately reflect or contain sufficient information about exactly how people wanted to be supported and cared for or their changing needs and circumstances in all cases. For example, guidance did not always explain what people's preferred day, night time or personal hygiene routines were in terms of how and when they wanted things done. We also found that people had not always been asked about their previous employment, important life events or relationships that were important to them.

The information contained in guidance did not always provide staff with the level of detail necessary for them to know and understand how to provide all aspects of the care and support required in a person centred way. For example, we saw that guidance relating to some people at risk of pressure ulcers advised staff to reposition them in bed 'regularly' but did not explain how or when. In other guidance we saw that staff were told that people needed a bath, continence care and pressure relieving equipment checked 'regularly', again with no further information about how or when these should be done. This meant that the guidance provided to staff may not have accurately reflected people's individual care needs and preferences in all cases.

People and their relatives expressed mixed views about the opportunities available for people to pursue their social interests or take part in meaningful activities relevant to their needs. One person said, "Sometimes we go into the garden and water the pot plants. We haven't had any trips out this year." Another person said, "I go to bed about 3:00pm, then I just watch TV." A relative commented, "There are not enough activities, not enough 'one to one' involvement."

A full time activities coordinator is employed at the home and works Monday to Friday during the day but not on weekends. Most people told us that the coordinator was "wonderful" and tried very hard to arrange things for them to do, including bingo, exercise sessions, watching films, arts and crafts and birthday parties. We saw that arrangements were made for people to take part in religious services of their choice both at the home and in the wider community.

A member of staff told us, "[Activity coordinator] is really good; planting, exercises, painting. Something every day and [they] encourage people out of their rooms." The provider told us that themed events had taken place throughout the year and that entertainers and children

Is the service responsive?

from local schools and organisations had visited on occasion. A relative said, "We bring our dogs in sometimes, we keep them mostly in [family member's] room, but some of the other residents like to see them."

However, at the time of our inspection the coordinator was on leave and we did not see any activities provided by other staff during the visit. Most people not visited by family stayed in their bedrooms or lounge areas and watched television. One person told us that they had no choice in the programme shown and could not change channel because they didn't know where the remote control was kept. We saw that information about planned activities had been displayed in communal areas but was four weeks out of date.

One person said, "They [staff] could improve the amount of interesting things to do here, there isn't much at all." Staff told us that people chose whether or not they wanted to join in with activities but that they rarely had the time to join in or help out in addition to providing the personal care and support people needed. This meant that the arrangements to help people pursue social interests, particularly in the absence of the activities coordinator, were not as effective as they could have been.

People and their relatives told us that the manager and staff listened to them and responded to any complaints or concerns they had in a positive and timely way. One person said, "I can't find anything to moan about." A relative told us about an occasion when they had found it necessary to complain about the poor attitude of an agency staff member, "I told the manager and the [person concerned] was not used again." Another person's relative commented, "Any problems are just dealt with straight away."

We saw that where complaints had been made the issues raised were recorded, investigated and the outcomes discussed with the people concerned and their family where appropriate. For example, we saw that one person's care and support needs had been reviewed and amended in light of concerns raised by a relative and the investigation carried out by the manager.

Meetings were also held at the home to provide an opportunity for people and their relatives to provide feedback and share their experiences about the services provided. We saw that the home had received a number of written compliments and 'thank you' letters sent in by the relatives of some people who had lived at the home. For example, a relative recently wrote, "Thank you and your wonderful staff for the fantastic level of care my [family member] received. They were always treated in such a friendly and professional manner. They seemed happy and content….the nursing care was so dignified and respectful to their needs."

Requires improvement

Is the service well-led?

Our findings

People, their relatives, staff and healthcare professionals, were all very positive about the management of the home. They were complimentary about the provider and registered manager in particular who they felt were approachable, supportive and demonstrated visible and strong leadership on a daily basis. One relative told us, "[The manager] is helpful and on the ball. I have no complaints." A GP with significant experience of the home, and treating many of the people who lived there, told us that in their view the service was very well managed and delivered high quality care.

People told us that the manager was well organised and walked the floors of each unit frequently each day, including some weekends, to check on them and monitor the services provided. One person said, "The manager is very caring, straight talking and competent." Another person told us that they trusted the manager "implicitly." A relative commented, "The manager is very professional and very aware of emotional as well as physical needs and of the family not just the resident."

People were also very positive about the leadership qualities demonstrated by the provider who also walked around the home and visited people most days. One person's relative told us that the provider had been very interested and responsive to ideas they had about the potential for improving some bathroom facilities. They were impressed with the 'hands on' approach and positive attitude and said, "[The provider] is very thoughtful and thanked me for telling them and told me they would investigate to see if my suggestions were possible."

We found there was a clear management ethos that was recognised throughout the home. The provider told us they were committed to delivering an "outcome based service," based on nurturing people's physical, psychological, environmental and social well-being. Staff told us that the provider and management team were supportive and always made themselves available. They were aware of their roles and responsibilities and knew what was expected of them. This was because both the manager and provider discussed the required standards on a regular basis at meetings, shift handovers and at supervisions.

One staff member said, "We are well trained and supported. The manager is very experienced and leads by example; they are around a lot and make it very clear what is expected." The provider told us they used the homes internal newsletter to recognise, acknowledge and promote the contribution of individual staff members where appropriate.

Care staff were supported to obtain additional skills where appropriate as part of their personal and professional development. This has included the internal provision of awareness training in areas such as wound dressing, monitoring temperature and blood pressure and risk assessment. The provider has also developed strong links with local adult social care support organisations to secure and make available other training and development opportunities for staff. This includes specialist dementia care, nutrition and falls management.

Measures have been taken to identify, monitor and reduce risks at the home. These included a comprehensive and independent review of medicine practices conducted by a local pharmacist, in addition to monthly checks carried out by the manager, daily checks of call bells, bed rails pressure relieving equipment and the amounts of food and fluids consumed by people identified as being at risk of malnutrition and dehydration. Information about falls, injuries and accidents was also collected and analysed on a regular basis to identify potential causes, trends and options available to reduce the risks. The provider and senior management team met on a monthly basis to review the outcomes of this work, together with any complaints and safeguarding issues that may have arisen. Survey questionnaires and meetings were also used to obtain feedback from people and their relatives about services provided at the home.

However, we found that some of the measures put in place to reduce risks and drive improvement in the quality of services provided were not as effective as they could have been in all cases. For example, the observations and reviews carried out had failed to identify that some staff, despite having been trained in infection control practices, did not change their disposable protective clothing or wash their hands when providing personal care to different people. Senior staff were also aware that slings used to hoist people were being shared which increased the risks of cross-infection.

We found that although staff had received training about DoLS, the MCA 2005 and how to use the 'whistle blowing' procedure to report safeguarding concerns, some were

Requires improvement

Is the service well-led?

unable to explain how they would apply it properly and to good effect in practical situations. This meant that adequate steps taken to check and validate the effectiveness of the training and staff knowledge in the workplace had not proved as effective as they could have been.

Although people's dependency levels had been assessed, the provider was unable to adequately demonstrate how this information was specifically used to determine and set staffing levels, how they ensured that there were sufficient numbers of staff available at all times, and in all areas of the home, to meet people's individual needs or they kept the situation under review to ensure staff were deployment was flexible enough to meet varying levels of demand. This led to inconsistencies in the ability of staff to deliver high quality care across all units at the home. Failure to adequately cater for and the planned absence of the sole activity coordinator meant that people were not supported to pursue social interests or take part in meaningful activities for a significant period of time.

Neither the provider nor registered manager had taken proper steps to ensure they discharged their duties and responsibilities for ensuring full compliance with the MCA 2005, particularly in the context of the DoLS that should have been applied in some cases where people's freedom of movement had been restricted. They also acknowledged that in some cases the measures used to monitor care practices, and the guidance provided to staff, had not identified the lack of involvement in planning or background information necessary to deliver person centred care. For example, a failure to ensure that information was shared effectively meant that the chef was unaware of some people's specific dietary requirements and needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Infection control How the regulation was not being met: The registered person did not proper steps in assessing, preventing and controlling the spread of infections, including those that are health care associated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. How the regulation was not being met: The registered person did not take proper steps to ensure that assessments, planning and delivery of care was carried out in accordance with the MCA 2005. In particular, applications were not made to deprive people of their liberty through the DoLS where necessary and appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not take proper steps to maintain securely such records as necessary to be kept in relation to the management of the regulated activity, namely confidential information relating to people's care and medical records.