QH (Rosewood) Limited

Estherene House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Estherene House 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. Estherene House provides accommodation and personal care for up to 36 older people, some living with dementia. The service is divided into two units, Estherene and Barton units, each of which has bedrooms, and communal dining and lounge areas. There is a main kitchen where meals are prepared.

There were 33 people living in the service when we undertook this comprehensive unannounced inspection on 7 and 8 November 2017.

There was a registered manager in place. 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.

This overall rating of this service was Requires Improvement at our last inspection of 26 and 29 September 2016. The key questions Safe, Effective and Caring were rated as Requires Improvement. Responsive and Well-led were rated as Good. In Safe we found breaches of Regulations 12 Safe care and treatment and 18 Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014. 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 breaches of Regulation.

During this inspection, the overall rating remained Requires improvement. There had been some improvements made in the service such as staffing levels and systems for reducing risks to people. The breaches of Regulations 12 and 18 had been addressed. However, we found shortfalls relating to how the service recorded people's care and how staff interacted with people. The key question Safe had improved to Good. Effective and Caring remained Requires Improvement. Responsive had deteriorated from Good to Requires Improvement. As a result Well-led had also deteriorated from Good to Requires Improvement. This was because the service had not made the improvements required to provide people with good quality care at all times.

There were quality assurance systems in place which assisted the provider and the registered manager to identify shortfalls and address them. Where shortfalls were identified there were plans in place to address them to improve the service people received. However, these were not yet fully implemented and embedded in practice to ensure that people were provided with good quality care at all times.

Improvements were needed in people's care plans to identify how they were provided with person centred care which was tailored to meet their specific needs. There were some inconsistencies in care records which needed attention to ensure that staff were provided with the most up to date guidance on how people's

needs were met.

Improvements had been made in the staffing levels in the service and these were ongoing. However, improvements were needed in how staff interacted with people. There were missed opportunities for staff to include people in how the daily records of people were completed.

Interactions which people received from staff varied in quality. Some were very caring and positive and some did not demonstrate compassion for people's condition and how they expressed themselves. The service's management team were taking action by a programme of training which had been delivered and was booked to address this. This had not yet been fully implemented at the time of our inspection.

People's nutritional needs were assessed and met. However an incident, which occurred during the first day of our inspection, had affected people's dining experience in one unit.

The environment was clean and hygienic and there were infection control systems in place. There was a programme of refurbishment and redecoration in the service being undertaken.

Improvements had been made in how the service managed risks to people. This included how risks were assessed and systems put in place to minimise these.

There were systems in place to keep people safe; this included appropriate actions to report abuse. Staff were trained in safeguarding and understood their responsibilities in keeping people safe from abuse.

Recruitment of staff was done safely and checks were undertaken to ensure staff appointed were fit to care for the people using the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with the opportunity to participate in activities that interested them.

People were supported to see, when needed, health and social care professionals. The service worked with other professionals involved in people's care to improve people's lives.

There were systems in place to provide people with their medicines safely.

There was a system in place to manage complaints and these were used to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Improvements had been made in the staffing levels in the service. The systems for the safe recruitment of staff were robust.

Improvements had been made in how the service assessed risks to people and the systems in place to minimise the risks.

People were provided with their medicines when they needed them and this was done safely.

There were infection control systems in place designed to protect people from risks.

Lessons were learned when things had gone wrong and these were used to improve the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained and supported to meet the needs of the people who used the service. However, this training was not always applied effectively. There were further training opportunities for staff planned but this was not yet fully implemented.

People's dietary needs were assessed and met. However, improvements were needed in people's dining experience.

The Deprivation of Liberty Safeguards (DoLS) were understood and referrals were made appropriately.

People were supported to maintain good health and had access to appropriate services, which ensured they received ongoing healthcare support. The service worked with other professionals involved in people's care.

There was a programme of refurbishment ongoing in the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People not always treated with care and compassion.

People's privacy and independence was promoted and respected.

People's choices were respected and listened to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed in how people's needs and changing needs were identified, recorded and used to guide staff on how these needs were met.

People were provided with the opportunity to participate in meaningful activities. However, there were missed opportunities for staff to interact with people in a meaningful way.

There was a system in place to manage people's complaints.

People were supported in a compassionate way at their end of life.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were quality assurance systems in place which helped the provider and registered manager to identify shortfalls. There were some improvements made in the service. Some improvements were ongoing and not yet fully implemented and embedded in practice to provide people with good quality care at all times.

Estherene House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced comprehensive inspection took place 7 and 8 November 2017 and undertaken by one inspector 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 care service. Our expert had experience of caring for older people. In addition, a Care Quality Commission (CQC) member of staff who was a report writing coach observed the inspection process.

Before our inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We looked at information we held about the service including the previous inspection report, the information the provider sent to us about the improvements they were making, and notifications they had sent to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with eight people who used the service, four relatives and one person's visitor. We observed the interaction between people who used the service and the staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service with us.

We looked at records in relation to six people's care. We spoke with the registered manager, two of the provider's directors and 10 members of staff including the deputy manager, senior care, care, activities, domestic and catering staff. We looked at records relating to the management of the service, three staff recruitment files, training, and systems for monitoring the quality of the service.

Good

Is the service safe?

Our findings

Safe was rated as Requires Improvement at our last inspection of 26 and 29 September 2016. At this inspection, we found that improvements had been made and Safe was now rated as Good.

At our last inspection, we found that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the staffing numbers during that inspection were not sufficient to ensure people's needs were met safely. At this inspection of 7 and 8 November 2017, we found improvements had been made and the service was no longer in breach of Regulation 18.

There were more staff for the evening period, which had been identified as a shortfall at our last inspection. In addition, the way that the rota was managed had been improved. Staff were allocated named people to support, for example with getting up in the morning, and were allocated to tables to assist people to eat their meals. Staff spoken with told us about the recent improvements made in the staffing numbers and how the arrangements were sufficient to meet people's needs safely.

The director told us that new staff had started working in the service and another four were due to start. They had agreed with the registered manager that they employed more staff than was reflected on the dependency tools they used to calculate the numbers of staff to meet people's needs. This was to ensure that any shortfalls such as staff leave did not affect people's care.

We received mixed comments from people and relatives about if they felt that there were enough staff to meet people's needs. One person commented, "They [staff] are here when I wish, they help, oh yes." Another person told us about if they felt there were enough staff, "Yes, I think so, they [staff] are very good, yes. All the time they get things for me." Another person said, "It's mainly at night, they [staff] seem to be a little bit short at night, something I observe, rushing to get people into bed because everybody requires their attention at the same time. They [staff] will always be here as soon as they can. The response is fairly good, just on the odd occasion… much the same at weekends." We found that with the addition of the new staff who had starting working in the service this was improving and further staff were due to start. One other person said, "They [staff] are always on hand if you need them."

One person's relative told us, "I think they have got seven [new staff] started this month." They went on to say that they had raised concerns in meetings about the staffing levels, which was in the process of being addressed. Another relative commented, "There's never enough [staff] on, there's no one around, people need attention." Another relative said, "[Staff] are always approachable, can't do enough, will make the time to do anything asked. In my mind there is enough staff."

During our inspection, we saw that staff were available to meet people's physical needs and requests for assistance were attended to, including call bells. There were some times when staff had missed opportunities to interact with people, such as when they completed care records. This was discussed with the registered manager and a provider and they assured us this would be addressed.

Recruitment records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

At our last inspection, we found that there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all of the risks associated with individual people's daily activities had been assessed to minimise these risks. This included risks for one person who smoked and others who used the stairs independently. In addition, the environmental risk assessments were generic and did not specifically relate to the layout of the premises and the specific needs of people. During this inspection, we found improvements had been made and the service was no longer in breach of Regulation 12.

Care records included risk assessments which provided staff with guidance about how to minimise risks to people. This included risks associated with mobility, using the stairs and/or chair lift, pressure ulcers, nutrition and falls. A person's relative told us that they felt that when people were supported with mobility equipment this was done safely. They said that there were always two staff present, "They definitely go by the rules with that." Where there were specific risks, for example if people smoked, risk assessments were also in place. The risk assessments were regularly reviewed and updated.

Where people were at risk of developing pressure ulcers, systems were in place to reduce these; this included seeking support from health professionals. Where people were at risk of falls, actions were taken to reduce future risks. For example, there was equipment which alerted staff if people attempted to stand when alone in their bedrooms. One person's relative said, "They [staff] put a mat on the floor by their [person's] bed, and the alarm mat, since [person] had that fall [previous fall]."

Some people living in the service demonstrated behaviours that others may find challenging. There were risk assessments in care plans in place. These records identified potential triggers to people's behaviours and how they were supported to minimise their anxiety.

People and relatives told us how the behaviours of people which may challenge others were managed. One person told us about a person who walked into their bedroom uninvited. They said, "All I need to do is ring my buzzer and they [staff] come and take them [person] away… staff have explained their condition which I do understand." One person's relative told us, "The staff are caring, if [they] get punched I feel the staff manage it well." A staff member we spoke with told us about how they supported people if they hit out at them. They were knowledgeable about people's conditions and how these may affect them relating to their behaviours. They demonstrated that they knew how to support people in a calm and caring way to protect them and others.

There were environmental risk assessments in place which identified the potential risks to people using the service. This included slips, trips and falls, and using the stairs and chair lift. Risks to people injuring themselves or others were limited because equipment, including hoists, portable electrical appliances and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. There were also records in place to show that there were systems to check the risks of legionella bacteria in the water in the service.

Carpets were worn in places in the Barton unit, where the edges of a join in the carpet had begun to lift. This could be a risk to people if they tripped over these as they deteriorated. We were advised by the director and registered manager that these were to be replaced, the carpets in the Estherene unit had been replaced and

Barton was next for refurbishment.

There was a side exit to the service which could be accessed from the main Estherene unit. The door was open and the gate had a padlock but this was not secured. There were four stone steps from the gate which was risk of people falling down if they opened the gate. We told the registered manager and a director about this and they promptly took action to bolt the gate and a notice was in place to ensure it was locked. This was not to limit people's access to outside but to ensure that the risks of people falling down these steps were reduced. We were also advised that a key pad would be installed to further reduce the risks to people.

People told us that they were safe living in the service. One person said, "I've had nothing like that," when we asked them if they felt safe from abuse. One person's relative said, "I've not got a single worry about [person]…There has never been a bruise or unexplained incident…I have no qualms at all about [person's] safety."

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. Where a safeguarding concern or incident had happened, the service had taken action to report this to the appropriate organisations who had responsibility for investigating any safeguarding issues. The service had taken action to reduce the risks of future incidents, this included undertaking internal investigations and disciplinary action. Staff understood whistleblowing and told us that they would have no hesitation in reporting any bad practice in the service.

People told us that they were satisfied regarding the arrangements for their medicines. One person said regarding if the staff provided their medicines at the right time, "Yes, they do, I can manage independently [taking their medicines], no [never missed]." They also said that if they required pain relief, "I would ask, they [staff] would be cooperative and on the ball in that direction." One person who had left the dining room after breakfast but returned said, "I have come back from my ear drops and medication." We asked the person if they were happy with the ways that staff supported them with their medicines, "Oh yes, very gentle, no problems at all." One person's relative commented, "There have never been any problems with the tablets, [person] gets them on time."

We observed staff administering people's medicines and found that this was done safely. Medicines administration records (MAR) were appropriately completed and showed that people received their prescribed medicines when needed. Where people were prescribed medicines to be taken as required (PRN), for example to reduce their anxiety, protocols were in place. These guided staff at what point these medicines should be considered for administration. This reduced the risk of inappropriate administration of PRN medicines.

People's medicines were kept safely but available to people when they were needed. Checks were undertaken to ensure that medicines were kept at a safe temperature. Medicines that were stored in their original packaging were in date and the date of opening had been recorded by staff. This reduced the risk of people being provided with medicines which were not as effective because they were past the use by date. Staff were provided with training in the safe management of medicines and had competency tests on the safety of their practice.

Regular audits on medicines management were undertaken this allowed the staff and the registered manager to identify shortfalls and take action to address them. This included issues identified with the ordering and receiving of medicines. The service had raised a complaint with the supplying pharmacy, GP and other professionals. A system had been implemented to change the ways that medicines were ordered

to reduce risks.

Systems were in place to reduce the risks of cross infection. One of the bathrooms held no paper towels or hand wash liquid. All of the others provided these and, in addition, aprons and gloves for the use of staff to reduce the risks of cross infection. When we were looking in the bathrooms, a staff member told us that they cleaned these as part of their daily routine and was working round the unit to get these done. Where items needed to be replenished this was done as part of their cleaning routine.

We looked at the kitchenette in the Barton unit and found that this was clean and hygienic, including the microwave and containers which held coffee, sugar and cereals. A staff member told us that they were always washed when emptied before they were refilled. In addition, they said that the microwave was cleaned after each use. The service had achieved the highest rating in a food hygiene inspection. Staff had been provided with training in food hygiene and understood their responsibilities relating to this.

People who used hoists to mobilise were provided with individual slings which reduced the risks of cross contamination. Staff told us that they were provided with training in infection control, including domestic staff. This was confirmed in records.

The service operated a King or Queen for the day. This meant that people were allocated one day each month where their care plans were reviewed, individual medicines audits were carried out, and their bedrooms were deep cleaned. This included, as well as the daily cleaning of bedrooms, on their King or Queen day carpets and curtains were deep cleaned and mattresses were checked. This practice ensured that people's bedrooms were clean and hygienic. A staff member told us and records showed that mattresses were checked more regularly outside of the King and Queen day. If issues were found with the mattresses they were cleaned or replaced. This was to ensure that people were provided with clean beds to sleep in.

Regular infection control audits were undertaken to ensure that the service was clean and hygienic. In addition, hand washing audits were completed and staff were coached on the appropriate methods of handwashing.

Staff had been provided with infection control training and the registered manager attended an infection control forum with other care and health care professionals. Records showed that the registered manager had used their learning to improve infection control in the service this included advising staff not to wear their uniforms in public to reduce the risks of cross infection.

Where things had gone wrong the service's management team had learnt from these to reduce future risks. Systems were in place to report concerns to the appropriate organisations and other professionals. This included actions taken following concerns raised by people, safeguarding and health and safety concerns. Discussions with the registered manager and records showed that they had taken appropriate action including making complaints on behalf of the people who used the service to reduce risks and disciplinary actions where required.

Requires Improvement

Is the service effective?

Our findings

Effective was rated as Requires Improvement at our last inspection of 26 and 29 September 2016. This was because staff were not knowledgeable enough to understand dementia care and our observations identified that improvements were needed in how staff interacted with people living with dementia. In addition, not all staff were receiving regular supervision. Not all of the staff were up to date with information about people's dietary needs. Meal times needed improvement, including how staff supported people to eat their meals. At this inspection of 7 and 8 November 2017, we found that some improvements had been made, however these were ongoing and Effective remained Requires Improvement.

There were systems in place to provide staff with training and to achieve qualifications in care to assist them in meeting people's needs. Records showed that the staff had attended the training they were required to do by the service and when they were to be updated. This included training in moving and handling, safeguarding, medicines, dementia care, dignity, challenging behaviour, fire safety and diversity and equality.

Despite staff receiving training in dementia care and dignity, we found that this was not always effective. For example, the interactions between some staff and people demonstrated they understood people's conditions and how they affected them, and were able to apply their training to deliver effective care. We observed inconsistent interactions from staff, some were very good and caring and some were not so. When we fed back our findings to the registered manager, they addressed these with staff. They had already identified the need for further training for staff in dementia care and understanding people's needs. They had organised, with the local authority, for staff to receive training in dementia that was practical and included the use of, for example, body suits. This training was designed to provide staff with the experience of what it may be like to live with dementia. This was booked for the week after our inspection. Staff learning needed to be embedded in practice to ensure that people received effective care at all times.

Staff spoke with told us that they felt they were trained to meet people's needs. One staff member said, "We have a lot of training, on line and face to face, safeguarding, DoLS [Deprivation of Liberty safeguards], COSHH [control of substances hazardous to health], dignity. We had dignity training last week." They told us what they had learned in this training and how they used their learning when working with people, "We talked about how people lose things when they come into care, like their house, control of their lives. I think about this when I am working with someone."

People told us that the staff had the skills to meet their needs. One person said, "It's just the fact that they [staff] go about their jobs well." Another person told us, "They're friendly and helpful; they seem to know what to do in any given situation." One person's visitor commented, "I think a lot of the staff are experienced, they do definitely understand."

New staff were provided with an induction course and with the opportunity to undertake the Care Certificate. This is a recognised set of standards that staff should be working to. This showed that the service had kept up to date with the staff induction process and took action to implement them. In addition, new

staff worked shifts where they shadowed more experienced staff during their induction.

Staff told us that they felt supported and received regular one-to-one supervision meetings, which was confirmed in records. These provided staff with a forum to discuss the ways that they worked and receive feedback on their work practice. The meetings also were used to identify ways to improve the service provided to people and to check on any further training needs that the staff member had.

There had been some improvements made in people's dining experience. For example at our previous inspection, we found that staff were standing next to people when they were supporting them to eat. This practice had ceased and staff sat next to people. However, we found inconsistencies in how people were supported during mealtimes. Some practices were very good with people being supported to eat at their own pace and staff speaking with them about their meal, and some were not. On both units, people were served with their choice of meals and to aid their understanding what was on offer, staff showed them the choices they could make. The meals looked and smelled appetising.

A positive dining experience was created in the Estherene unit during breakfast and lunch. The meal times were relaxed and people sat at tables together chatting over their meals. Staff served people with their meals and offered assistance where needed.

On the first day of our inspection on Barton unit, there were two emergencies and a visit from a health professional at lunch time, which staff were addressing. This affected the organisation of the lunch service. There was a gap between people being served their meal of over half an hour and people became irritated when waiting. Staff members attempted to engage people in conversation, but they addressed people who were reasonably settled and able to converse at the expense of those that were upset. One person said, "You don't like me, can I have some food?" This person was served with their meal 20 minutes after the service had started despite asking for food. They received no support and ate their meal using a knife. One person sitting at one table said, "It will be tea time in a minute." A staff member told us, "There was an emergency it affected the lunch time service and timing."

On the second day, the lunch time experience for people was much improved on Barton unit and was calmer. People were provided with their meals in a timely manner. However, we saw two staff who sat at the same table assisting people to eat their meals. These staff members talked with each other rather than with the people sitting at the table. One of the staff was expressing how stressful they found the care role. Another staff member sat with a person supporting them to eat, at another table. They did not hurry the person but there was no meaningful interaction, no attempt to describe what was on the fork and no effort made to enhance the person's experience.

The inconsistencies in meal times were confirmed by people and relatives we spoke with. One person said about the meal time experience, "I think they [staff] do [support people], I think it works as well as it can, given the mixed bunch, those who are a bit noisier, demanding. They [staff] do understand, they know people's level of help varies. They manage it as well as can be." One person's relative told us how the lunch time experience for people varied. They said, "Today was a bad day, they have good and bad days [lunch time]. As soon as they [staff] bring the meal in for somebody, they'll sit and help them, especially if there's enough carers. It's terrible, if there's only one senior and only two carers it's a hell of a job, especially this side [Barton]."

Records showed that the registered manager had systems in place to observe meal routines and that they acted to improve people's experiences. They told us that they would do these observations more often. The registered manager also told us as part of the refurbishment plans for the Barton unit, they were going to

change the location of the communal areas, which they had assessed would improve people's meal time experiences.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. One person told us, "I enjoy the food, it's good under the circumstances, oh yes they do vary it. They come round to ask you [what you want] but they haven't been yet [12.30pm]. [Staff member] tells you what there is, just the main course." One person's relative said, "The food is good, the chef's quite good, they have a choice, they always ask them what they want." One person's relative said, "Food is great. [Person] has not lost weight so I know [they] are eating well."

People were provided with choices of hot and cold drinks. This meant that there were drinks available for people to reduce the risks of dehydration. There was a cold water machine in each of the units and jugs of juice and cups where people could have drinks, if they were able. We observed that one person had a jug of juice in their bedroom and they confirmed this was always available to them. However, one person told us they would like a cup of tea, which was provided by staff when we asked. The staff member placed the cup of tea on a portable table adjacent to the person but out of their reach, and it was left to us to move the table nearer to the person so they could reach their drink.

One person's relative said, "There's plenty of tea given out." One person's visitor commented that people were, "Not necessarily supported drinking, but tea is left for them. They [staff] would put it in a plastic cup but then just leave it, and people would do what they would do with it, which might not be drink it."

The records for people who were at risk of dehydration were detailed with the actual amount they had to drink and these were totalled each day. However, where people's care plans directed staff to ensure that people were drinking enough, there was no indication how much drink these people should have. The registered manager and deputy manager said they would address this.

Staff had a good understanding of people's dietary needs. Catering staff we spoke with were knowledgeable about people's individual needs, including consistencies of softer diets that may be required for people who were at risk of choking. They explained how people were provided with fortified diets, including high calorie drinks to maintain a healthy weight. They shared examples with us about how they provided different meals to people to meet their dietary needs. For example, one person's condition meant that they did not have onions with their diet. When cottage pie was on the menu, a separate dish was made with no onions for this person.

People's records showed that people's dietary needs were assessed and met. Where issues had been identified, such as weight loss, guidance and support was sought from health professionals, including a dietician, and their advice was acted upon. For example, providing people with food and drinks to supplement their calorie intake. People's records included information on their preferences relating to food and drink and any conditions that staff needed to be aware of which may be affected by their dietary needs, for example diabetes.

People told us that they felt that their health needs were met and they were supported to see health professionals if needed. One person said, "The chiropodist comes fairly frequently, that's adequate." They also said if they needed to see a doctor, "Oh yes they [staff] would [call doctor out]."

People's health needs were assessed and where they required the support of healthcare professionals, this was provided. Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. We saw that the service had made referrals to

health professionals when they had been concerned about people's wellbeing, this included relating to their mental health, continence and falls. Staff told us that they could call health professionals when needed and they worked with them to improve people's health.

We saw records which were provided to other professionals if people, for example if they required hospital admittance. These included important information about the person that other professionals needed to know about when providing care and treatment to people. They showed for example, any allergies, their medicines, next of kin and if they wished to be resuscitated.

People told us that they could use the communal areas and if they chose could have the privacy of their bedrooms. One person said, "I have got a lovely bedroom, I spend time there and in the lounge with my friends." One person's relative told us, "We visited before [person] moved in, had a look around. We liked it immediately. [Person's] bedroom is clean, carpets and paintwork nice."

There was an ongoing programme of refurbishment and redecoration in the service. The Estherene unit had been provided with new carpets and there were plans in place to do the same in the Barton unit.

We saw that there was contrast between the colour of the carpets and that the walls. Signage was present and comprised laminated printed signs with arrows stating 'dining room' and 'lounge'. The doors leading to the communal toilets and bathrooms were painted yellow and white and there was also signage in place in both word and picture format. These supported people who may be confused to navigate around the service.

We observed that people's bedrooms had natural light and were personalised which reflected people's choices and individuality. The door leading to people's private bedrooms had been painted different colours but otherwise lacked personalisation and any reminders which could help people to navigate independently. A staff member told us that people could find their own bedrooms but it had been discussed how people's bedroom doors be more personalised, such as photographs.

A large walled area in the Barton unit had been devoted to an attractive life-sized mural of traditional trades including a butcher and hairdresser. We saw a staff member talking with a person about their favourite painting. There were also items on the wall which reflected the season.

There was a secure garden which people could choose to go into in the warmer weather.

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

The registered manager understood when applications should be made and the requirements relating to MCA and DoLS. Applications had been made as appropriate to ensure that any restrictions on people were

lawful. The registered manager told us and records confirmed about how best interest meetings were held with others involved in people's care. These included other professionals and relatives, when people needed assistance with making decisions.

We saw that staff sought people's consent before they provided any support or care. This included if they needed assistance with their meals and where they wanted to spend their time in the service. One person's relative said, "When I have been here they [staff] always ask if it is alright before they do anything for [person]. We signed some things in the care plan to say we agreed with the care [person] was getting."

Care records identified people's capacity to make decisions. Where people required support there was evidence to show that decisions had been made in their best interests. People had signed care records to show they consented to the care planned for and delivered.

Requires Improvement

Is the service caring?

Our findings

Caring was rated as Requires Improvement at our last inspection of 26 and 29 September 2016. This was because we observed that not all interactions from staff to people were respectful and respected people's dignity. We recommended that the provider extended their training programme to incorporate further guidance for staff with regard to respecting people's privacy and promoting their dignity. At this inspection, we found that some improvements had been made including the provision of dignity training to staff. However, we observed varying quality in interactions between staff and people, some of which were very good and some required improvement. Therefore the rating for Caring continues to be rated as Requires Improvement.

Some staff interactions were caring and compassionate. We also observed some which were not fully caring and respectful. We only found positive and caring interactions in the Estherene unit. For example, there was a relaxed and friendly atmosphere and people and staff clearly shared positive relationships. We observed examples of kind and compassionate care. Staff asked people about their family and in turn people asked about theirs. This led to chatting about others who were important to people and their lives before they used the residential care service.

There were some interactions which were not caring and compassionate in the Barton unit, where the majority of people lived with dementia. There were also inconsistencies in the approach of staff to different people. This showed a lack of insight into people's conditions and behaviours that may arise because of their conditions, such as distress reactions associated with dementia. In addition, relatives told us that there was a difference in the attitude of staff on different shifts. One person's relative told us they felt that staff varied in attitude and ability on this unit, "Yesterday the staff were terrific, they've got a different attitude." They added, "Some of them [staff] are better than others, I call them the 'A' team, they were on yesterday, one or two are really lovely."

We observed people being supported to mobilise by using a hoist. One person was assisted with the hoist. The staff members were very caring in their interactions and explained what they were doing. When the person was in their wheelchair, to put the person's feet safely on their foot plates, one staff member asked the person to, "Lift your leg up please, that's it well done, bend at the knee." This interaction also respected the person's abilities and independence. However, another person was being assisted by two staff members and their interactions were not as caring. One of these staff conversed with the person, "Up we go my darling… there we go, down we go [person's name], now going down, mind your head darling." One of the staff did not interact with the person even when the person became tearful. Once safely in their armchair the person remained anxious and upset but neither of the staff members provided the person with any reassurance.

We sat with two people at a dining table after breakfast. A staff member cuddled one person and chatted with them, the other person at the table was ignored. Whilst the caring attitude shown to the first person was positive and made them smile, the other person sat and stared ahead.

We observed one person was becoming anxious and distressed and had hit out at a staff member. The staff member said to them, "Would you not hit me please? I am not having it." We spoke with the registered manager about what we had seen and how this could be seen as provocative by the person and lacked insight into the person's condition. They said that they would address this directly with the staff member.

One person called out during our inspection. The quality of interactions from staff were varied and they did not always intervene appropriately or find out what the person wanted. This person showed signs of distress which had escalated to them calling staff a name. A staff member walked away from the person saying, "Charming." This could be heard by others and the person and was not respectful of the person or their condition and dignity. In addition, this staff member smiled at another person when they were making gestures behind the first person's back. Another staff member who had also spoke with this person walked away saying that the person was, "In one of those moods today." Again this could be heard by the person and others. However, staff did respond when the person started to apologise for their actions, "I know I am rude, please accept that I am rude, I apologise." The first staff member sat with the person and told them that they were a good person. Another staff member later sat with the person and interacted in a kind and caring way.

These inconsistent and inappropriate interactions were not helpful or supportive to the person. We spoke with the registered manager about how these interactions could make the person feel as though they were not valued. They recognised that there were concerns about the quality of some interactions and were working to address them. Whilst this person received their varied interactions, other people who sat quietly received no interaction from staff at all. One person sat with a napkin and wiped the table for over an hour with only one interaction from staff when they asked if they wanted to go into the lounge.

On Barton unit, we saw caring interactions by the domestic staff who chatted with a person when they were cleaning their bed. Both were laughing and chatting away.

Discussions with a director and registered manager identified that they felt that they had improved the culture of the service and recognised that this was ongoing work. They were responsive to our comments and had spoken with staff immediately when we had pointed out the interactions we had seen. They told us that the team was being developed and they were willing to listen and learn. There had been recent new staff working in the service. They said they had now built a foundation and would continue working on it to improve the culture of the service, which was ongoing. This was evident in the plans in place for training for staff, for example dementia training booked for the week after our inspection.

Despite the shortfalls we had identified during our inspection, people spoken with said that the staff were caring and treated them with respect. One person said, "I'm treated all right, they [staff] are very attentive." Another person commented, "The staff are kind, yes, all of them, oh yes, they're quite good." One person's visitor said that staff were, "Reasonably caring and friendly, they do speak to them as a person." One person's relative told us, "A lot of them [staff] are friendly, they do care about them [people] I think." Another relative said, "Staff are polite and friendly, not ever short or rude. I cannot fault them."

We saw several cards and letters received by the service from relatives and people. These thanked the staff for their caring approach, for example, "Estherene House is always very friendly and welcoming and had a very homely atmosphere," and, "The staff are lovely and there seems to be a lot of them. Extremely helpful, cheerful and friendly and very approachable."

Staff talked about people in a caring and respectful way. They knew people well and were able to tell us about people and their needs. A staff member told us about how they supported people and it was

important to them to make people happy, "If I can make one person smile at least once a day it makes my job worthwhile." Other staff shared examples of how they treated people in a caring and compassionate manner.

People told us that their independence was promoted and respected. One person said, "They [staff] help me to do as much as I can. I'm happy with that." We saw that staff encouraged people with their independence, such as when assisting them to mobilise and eat.

One person's relative told us how the staff respected their relative's privacy and dignity when they were being supported. One person said regarding if their privacy was respected, "Oh yes, they [staff] do, they always close my door [when being supported with personal care]. They [staff] cover me up." We saw the staff supporting a person to ensure their privacy in their bedroom, their door was promptly closed and a staff member supported the person in privacy. There were no privacy locks on a bathroom and a toilet had a lock that had to be fiddled with to lock the door. This had a sign which we saw was hung outside the door saying the room was engaged. People were offered fabric aprons to wear when eating to prevent their clothing becoming soiled and to respect their dignity.

People's care records guided staff on the importance of respecting people's privacy, dignity and independence. The records identified the areas of care that people could attend to independently and where they needed the support of staff.

People's views, and those of their representatives where appropriate, were listened to and their views were taken into account when their care was planned and reviewed. This included their choices and usual routines, such as the times of getting up in the morning and going to bed at night. One person said that the staff understood their needs, "Yes they do, they do seem to understand my likes and dislikes."

Records of care reviews were in place where people and their relatives were consulted about the care provided. One person's relative said, "We had a chat about what [person] needs, it was all written down. They [staff] ask me if it is all okay. They [staff] do everything I have asked them to do. If [person] has a fall they ring me up, I have been told at 2 or 3am. They did exactly what I asked them to do to ring me whatever the time is." Another relative said that the service kept them updated in any changes in their relative's need, "They [staff] try to keep me informed, of late they have, yes."

Where required, people were provided with support to access advocacy services to assist them in voicing their views.

People told us that relatives could visit them when they wanted to, which was supportive of people maintaining relationship with people who were important to them. One person's relative said that they could share a meal with their relative, "I get a lovely meal every day if I want it, there's no charge. I pay a voluntary amount." Another relative said, "I come when I can, never had a bad experience." We saw a staff member tell a person that their relative was going to visit them, this made the person smile.

Requires Improvement

Is the service responsive?

Our findings

Responsive was rated as Good at our last inspection of 26 and 29 September 2016. At this inspection, of 7 and 8 November 2017 we found that this was no longer the case. Improvements were needed in how people's care needs and changes in their wellbeing were identified and recorded to guide staff in how to meet these needs. Responsive was now rated as Requires Improvement.

People's needs were assessed before they moved into the service. These assessments fed into people's care plans which identified how their care was planned for and provided. This included people's diverse needs and preferences and how these were met. The care plans mainly provided guidance for staff about how people's needs were to be met. However, we found that some improvements were required to ensure that people received responsive care at all times.

The service operated a 'King' or 'Queen' for the day where people were allocated one day each month for special attention and to have their care plans updated and reviewed. This allowed relatives to know which day the care plans were due to be reviewed and attend the service to participate. Records showed that relatives and people had been involved in the review process and their comments were documented and addressed. However, we found that one person's records showed that they had been referred to the falls team. Whilst review records identified that the falls team had visited the person, there was no indication in the records or plans what the outcomes or advice received was. Their records did not therefore contain any guidance for staff about how to act on their advice when they delivered care. This showed that the system in place to reviewing and updating the care plans was not always effective.

We found some inconsistencies in care plans. For example, one person's records stated that they were living with dementia and when the diagnosis was made. In another part of their records these stated that they were not living with dementia. This person's records also said that they were referred to Parkinson's nurse. However, discussions with the registered manager identified that the person did not have Parkinson's disease and so had no need to be referred to this health professional. This was removed by the registered manager during our inspection.

We saw, during our observations, that a person had a pattern of behaviours which included calling out for assistance. For example, when they were eating they called out for food, which was in front of them. There was no reference to these behaviours in their care plans or guidance for staff on how this person was supported to reduce their anxiety and distress reactions. We saw that this was an issue because different staff supported the person in different ways, some resulted in the person becoming calm and others resulted in the person calling out more and then apologising for the way that they acted.

There were also some improvements required in the use of language in people's care records. For example, one person was described as, "Bed bound." This was not a positive and up to date use of language. Another person's records described their behaviours as, for example, "Very aggressive," and, "Agitated." There was no specific detail of what these behaviours were to make the author see them as the terms described and how these may be a result of their distress reactions associated with dementia. We told the registered manager

about this and they assured us it would be addressed.

People's daily care records identified the care and support provided to people. Improvements could be made to include any interactions and quality of these interactions. There was no detailed information about the quality of the person's day, instead the records were more task based, for example, "Pad changed," "Fluids given," "Assisted with full wash," and, "Made comfortable." The registered manager told us that training in report writing had been organised to address this. There was information about the provision of activities and how people presented during these.

There were missed opportunities for staff to have meaningful interaction with people when completing their daily notes. Staff sat in the communal lounges and dining rooms completing these records but did not use the opportunity to ask people how they felt their day had been to include them in the process.

Despite the shortfalls we had identified in records, discussions with staff showed that they knew people well. In addition, we saw examples of where staff had responded appropriately to people's needs. One staff member told us how the service responded to people's individual needs. They shared an example of a person who had a previous job which meant that their sleep patterns were different to the others using the service. This person was supported to maintain their usual routines. The staff member said, "Does not matter what time [person] gets up, and if they want a bacon sandwich at any time in the day they can have it." They knew this person well. The person confirmed what the staff member told us and said about the service, "I love it. I am very happy here."

However, this was not consistent across the service and at all times. For example, on the second day of our inspection we saw one person who had been brought in their wheelchair by staff to have breakfast in the dining room in the Barton unit. This person had nothing on their feet. It had not been identified until a member of staff from the other unit arrived to support one hour and 50 minutes later and noted that the person did not have anything on their feet. They came into the dining room and showed the person their slippers and said, "Have you forgotten these? Shall I help you to put them on?" The person agreed and the staff member assisted them with their slippers and said, "Oh your feet are freezing, that's better." We were concerned because no other staff had noticed that this person had nothing on their feet.

Despite the shortfalls we had identified, people told us that they felt that they were cared for and their needs were met. One person said about what the service did well, "The general care and wellbeing. If you're not happy you tell them [staff] and they put it right." Another person said, "We are happy aren't we [name of person sitting next to them]? We are neighbours." Another person said about their personal care needs and choice of having a bath, "Well yes, but they work a rota system so when you're due one [bath] you have it, once a week. It's usually when it suits me."

One person's relative said, "I think the care is reasonably good." Another person's relative commented, "[Person] is looked after well, always shaved, nails trimmed, [staff] change [person's] jumper if a spill [of drinks], [staff] never leave in [person] dirty clothes…I give the care 11 out of 10 and a gold star, praise where praise is due."

People told us that there were social events that they could participate in. One person said, "There's an activities lady here that organises things, gets as many people involved as she can, yes I enjoy them. I join in the group activity." One person's relative commented, "They [staff and family/friends] take people that can walk to the seafront." Another relative told us, "There's not enough stimulation, [activities staff] is good at their job, they do try and do that [one to one activities]. They do get out in the garden in the summer, several together up the seafront, but nothing in the winter." They added, "I think [activities staff] has linked up with

another care home and they [people] sometimes go there, and vice versa. We walk up to one of their fetes." The activities staff member told us how these shared activities with another service had developed friendships with people. Another relative commented, "[Activities staff member] is brilliant, they have had Elvis, sports, bowls, outings in Fen Park, [person] went out in summer."

One person's relative also told us about how the staff in the service had arranged a birthday party of their relative, "They really made an effort." They showed us photographs of the party and the person with their birthday cake, "They [staff and people] sang happy birthday it was really nice." The registered manager and activities staff told us about an example of how a recent birthday party and coffee morning had resulted in a person making contacts with people from before they moved into the service. They now attended a local club which they used to attend.

People were provided with social activities which interested them. The activities staff told us about how activities were planned to meet with people's interests. They said, "Some people used to read but they cannot now so we are trying them out with talking books from the library. We have recently found out that a lot of people used to play bowls so we have introduced carpet bowls, they like that." The activities staff were enthusiastic about their role and wanted to show us what they had been doing with people. They said, "We have a gentleman's club, they have a drink and crisps, play dominoes. [Person] usually likes to stay in [their] room but they come out for that. The ladies' club is flower arranging, knitting. We are testing out to see what people like. Baking biscuits and sweets."

The service also had themed days. The second day of our inspection, a Hoedown was being held. A staff member had done a poster for the event which included country music, line dancing and dressing up. The lunch time meal had been designed to reflect the day such as barbecue spare ribs, potato wedges and American style puddings. The activities staff told us, "[Person] is good at dancing. They said they know a few line dances, they are going to teach us some." We saw a person was wearing a cowboy hat and they keenly showed us it, "Do I look nice?"

The activities staff said that they regularly visited people, who preferred to stay in their bedrooms. They added that one person liked to play crib and they were teaching the staff member how to play. Another person had also mentioned that they liked to play so they were going to do a crib club.

There were items in the service to aid people's memory and interest. For example an old style sewing machine, photographs of film stars from the 1940s and 1950s. There were also 'fiddle' items in the service with things such as beads sewed onto them, which people could use and handle to stimulate their senses.

People told us that they could have visitors when they wanted them and relatives confirmed that there were no time restrictions on when they visited their family members. We saw people entertaining their visitors. This reduced the risks of people becoming lonely and isolated.

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. One person told us about making complaints, "There have been minor things occasionally, but they [staff] have always sorted them out." They said that they had been satisfied with this. One person's relative said, "I see the boss [registered manager], [they] did mention a problem to the staff and it did happen [resolved]".

People's complaints were investigated and responded to in line with the provider's complaints procedure. Complaints had been used to improve the service and experiences of people. This included guidance to staff on how to support people with their personal care needs and staff were reminded about the process of

informing relatives about any changes in people's wellbeing. Where complaints were upheld, people and their representatives, where appropriate, were provided with an apology. This was in line with the duty of candour.

Where people were at the end of their life there were systems in place to support people to have a comfortable, dignified and pain free death. Staff were able to tell us about people's end of life care and how they supported their wishes. In addition, where people had chosen to discuss it, their records detailed their end of life wishes. Staff told us how a person's wellbeing had recently deteriorated and they were receiving end of life care. An end of life care plan had been produced. This detailed the care and support the person required to ensure their end of life was positive and their wishes were respected. We spoke with a person's relative about the end of life care that they were receiving. They said that the service was caring for their relative in a way which they were fully satisfied with. Following our inspection, the provider sent us a letter from this relative which thanked the staff for the compassionate way that the person had been cared for at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Well-led was rated as Good at our last inspection of 26 and 29 September 2016. At this inspection, of 7 and 8 November 2017 Well-led was rated Requires Improvement. This was because some improvements had been made in Safe, but Effective and Caring remained Requires Improvement and Responsive had deteriorated to Requires Improvement. We recognised the improvements the service had made. Some development of the service and further improvements were planned but not fully implemented and embedded in practice to provide people with a good quality service at all times.

There was an open culture in the service. People and relatives had the opportunity to share their views about the service and these were acted on. This included in quality assurance questionnaires. Discussions with the registered manager and a director and records showed that there had been improvements in people's views about the service since they had taken over the service. The management team were committed to further improve the service and had plans in place to do so. They told us improvements that had been made as a result of people's comments, such as ensuring that there were allocated laundry staff employed to improve people's satisfaction. On Barton unit following suggestions from relatives, they were provided with access to make drinks for themselves and their relatives when they visited. This showed that people's views were valued and acted on.

There were other systems in place to receive people's comments about the service including, 'Feedback Friday' meetings and the registered manager's availability to speak with people and relatives where needed.

Relative meetings were held. One person's relative told us, "We had one [relative's meeting] in September and one last year as well." Another person's relative explained, "At the meeting in September, they said we're very sorry we didn't get your blinds, fix the water machines, [provider] said it would be done straight away but nothing happened." The deputy manager told us that the blinds were on order and we used the two water machines during our inspection, which were working.

One person's relative told us that improvements had recently been made. They said, "I think there's more organisation, the staff know what they're doing, it depends what staff are on, some are good at their job, some less so. I feel that they do understand people individually, and their needs."

There were mixed views about if the service was well-led. One person said, "Oh yes, a nice person, oh yes [registered manager] would [respond positively / resolve a concern]." However, one person's relative commented, "I think [registered manager] keeps them [staff] on their toes. [Registered manager] is not too approachable. I would go to one of the seniors first." Another relative told us that they were very happy with the care that their relative received and the service, "[Registered manager] is very nice, always approachable. Anything I say it is done. I could not believe my luck to have found here."

Staff were positive about the registered manager. One staff member said that they had worked in the service for many years, "It is much better now [since provider and registered manager took over]. I love it here.

Nothing is a problem, can go to [registered manager] at any time." Another staff member said, "[Registered manager] is a good manager and is understanding. [They] really have time for us carers."

Staff meeting minutes showed that they were kept updated with any changes in the service and people's care needs. The minutes from a meeting in June 2017 identified the improvements in the staffing numbers and that staff had been offered jobs. Staff had the opportunity to share their views and ideas to improve the service and these were listened to.

A director and registered manager told us that they felt that the foundations were in place to provide a good quality service to people. They had recently developed staff into champion's roles including nail care, infection control, nutrition and end of life. They were asking staff what area they wanted to champion and they were talking a role to guide and advise staff in best practice. They felt that they now had the right team in place and were moving in the right direction. They were fully aware of the further improvements needed and had independently identified the shortfalls we had noted, including in records and staff. They had plans in place to make these improvements. The director told us that they had external consultants who they were able to call for advice and assistance with driving improvement in the service.

The provider's and registered manager's audits demonstrated that checks were made in the service to minimise the risks to people and actions were planned and taken when shortfalls were identified. These audits included medicines, falls, care records, health and safety, infection control and hand hygiene. Incidents and accidents, such as falls, were analysed and possible trends were identified to support the registered manager to identify how improvements could be made to reduce future risks.

The Provider Information Return (PIR) identified what improvements the service's management team were putting into place in the next 12 months.

The registered manager kept their knowledge up to date. This included attending area infection control meetings. As a result of the information received a memorandum had been sent to staff about their uniform in public to reduce the risks of cross contamination. They had achieved a qualification relevant for a registered care home manager. They told us that they were working on an extension to their level 5 qualification, which was Residential Pathway Award. They were also completing the 'My Home Life' course and had used their learning to improve people's quality of life. This included greetings cards that were in the entrance hall of the service, and a post box. People could purchase a card and post it and then staff emptied the box and posted them in a local post box. The registered manager also attended a dignity forum and they had shared their learning in sets of training provided to staff.

Where incidents and complaints had happened we saw that the registered manager had taken action to ensure that all staff were guided on the expectations of their role. For example, a document had been provided to staff about how to support people effectively with their personal care. Staff told us that this information was good and if they had received any concerns, each staff member was told about what was expected of them. Discussions with staff and records showed that following a shortfall with medicines, increased checks were made, including when doses may change at times. This included checks to ensure the changes were documented and for the correct person.

There were ongoing plans in place to update the furnishings and décor in the service. The registered manager showed us an area in the service where they were planning to install a passenger lift.

The registered manager and activities staff told us how they were working with another service in the area to share ideas and activities. In addition, contact had been made with services, such as a local sixth form

college to ask if they were interested in working with the service. A staff member told us that a local YMCA had assisted the garden. This showed that the management were making efforts to make contacts with the community that people lived in.

The service's staff worked in partnership with other professionals. This included seeking advice and guidance from, for example safeguarding and infection control teams. We saw records where they had contacted these professionals which showed that they worked in an open and transparent way.