HC-One Limited

Springwater Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection was brought forward as a result of information received from the police about the way people were receiving medication. At the time of the inspection the police investigation was ongoing. The inspection did not look at the specific incidents being investigated but did look at whether medicines were being managed safely.

This inspection took place on 8 September 2016 and was unannounced.

Springwater Lodge Care Home provides nursing and personal care for up to 50 older people and people living with dementia. On the day of our inspection there were 36 people using the service.

Springwater Lodge Care Home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection a registered manager had been in place since November 2013.

During our previous inspection on 3 and 4 March 2015, we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to how people's medicines were managed.

We received an action plan from the provider to say they would complete the required improvements by August 2015.

During this inspection we checked to see whether improvements had been made. We found some improvements had been made and the breach in regulation had been met. However, further improvements were required to the administration of prescribed creams.

Staff were aware of their responsibilities to protect people from abuse and avoidable harm. Staff had received adult safeguarding training and had available the provider's safeguarding policy and procedure.

Although systems were in place to ensure people's safety was effectively managed, these were not always followed. Risks to people's individual needs had not been completed for all people. Staff had information available about how to meet people's needs, including action required to reduce and manage known risks. These were reviewed on a regular basis but some risk plans lacked specific detail to support staff. Accidents and incidents were recorded and appropriate action had been taken to reduce further risks. The internal and external environment was safe but some clinical equipment was identified as not fit for purpose.

People felt staff were too busy to spend time with them and some people felt this impacted on how long they had to wait for assistance. People's needs were monitored and reviewed and this information was used

to calculate the staffing levels required. Staff leave was covered by permanent or agency staff. We identified there to be sufficient numbers of staff but the deployment of staff required reviewing.

Concerns were identified with the cleanliness of the service and practice in relation to infection control measures and best practice guidance was not always followed.

Safe recruitment practices meant that, as far as possible, only suitable staff were employed. Staff received an induction, training and appropriate support. However, not all staff were sufficiently trained in end of life care. Not all nursing staff had received appropriate training in the use of some clinical equipment. This process of monitoring training needs and development was not as robust as it should have been.

People were supported to maintain good health. People's healthcare needs had been assessed and were regularly monitored. New care plan documentation was in the process of being introduced. This period of change found some care records incomplete and information difficult for staff to follow. The provider worked with healthcare professionals in meeting people's healthcare needs.

People received sufficient to eat and drink and their nutritional needs had been assessed and planned for. People received a choice of meals but did not always receive the support they required at mealtimes. Staff did not promote people's independence to eat and drink.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found appropriate applications had been made to the authorising agencies for some people who needed these safeguards. However, the registered manager had not progressed with further applications in line with their action plan. In addition we found that although staff had received training in the MCA, they lacked knowledge in this area.

People could not be assured that their end of life needs, wishes and preferences would be understood and met. This was because staff did not have this information available.

Staff were kind, caring and respectful towards the people they supported. Staff's knowledge about people's needs, routines and preferences was variable.

The provider enabled people who used the service and their relatives or representatives to share their experience about the service provided if they chose to. However, not all people were aware of these opportunities. People were involved as fully as possible in decisions about their care and support.

The provider's complaints policy and procedure was available. People were confident that the registered manager and staff would take any concerns they raised seriously. People had access to information about independent advocacy service should they have required this information.

People received opportunities to participate in activities but there were limited opportunities for people to pursue their hobbies or interests.

The provider had checks in place that monitored the quality and safety of the service. However, these were not effective. The concerns and shortfalls identified in this inspection had not been identified. One safeguarding incident was found not to have been reported in a timely manner to the local authority who have responsibility for investigating safeguarding incidents .

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see the action we have told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The processes for the safe management of people's medicines had improved, but further improvements were required with regard to the administration of prescribed creams.

Concerns were identified with cleanliness of the service. Best practice guidance in relation to infection control measures was not always followed.

Not all clinical equipment was fit for purpose. Risk assessments were not always completed.

There were sufficient staff available but the deployment of staff was an issue. New staff completed detailed recruitment checks before they started work.

Staff were aware of their responsibilities to protect people from abuse and avoidable harm. Staff had received appropriate safeguarding training.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not fully understood by staff or adhered to.

People were supported by staff that received appropriate induction, training with the exception of end of life care and support.

People received choices of what to eat and drink and menu options met people's individual needs and preferences. However, people did not always receive the assistance they required to eat their meals.

People had the support they needed to maintain good health and the staff worked with healthcare professionals to support people appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People could not be assured that their end of life needs, wishes and preferences would be understood and met.

Staff were caring and kind. People's privacy and dignity were respected by staff.

Staff's knowledgeable about people's individual needs was variable.

People were involved with decisions about their care and support needs.

People had access to information about independent advocates to represent their views if this was needed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records did not provide staff with sufficiently detailed guidance to ensure consistent care to each person.

There were limited opportunities for people to pursue their hobbies or interests.

People had access to information on how to make a complaint and were confident their concerns would be acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's internal quality assurance procedures were insufficiently robust. Concerns identified in this inspection had not been appropriately identified, compromising the quality and safety of people.

There were systems in place to enable people to give feedback to the provider on the service. However, they were not always effective because people were not always aware of these.

The provider had not always met their legal responsibilities to inform the CQC of important events in a timely manner.

People and their relatives on the whole were positive about the

service they received. Staff said the registered manager was supportive and approachable.

Springwater Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 September 2016 and was unannounced.

The inspection team consisted of one inspection manager, one inspector, a specialist advisor in end of life care, a member of the CQC medicines team and an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed information we held about the service, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided.

We spoke with ten people who used the service, and visiting relatives for their experience of the service. We also spoke with the registered manager, the provider's representative, a nurse, the cook, a nursing assistant and two care staff.

We looked at all or parts of the care records and other relevant records of six people who used the service, along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes. We also checked the management of medicines.

Some of the people who used the service had difficulty communicating with us as they were living with

dementia or other mental health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 3 and 4 March 2015 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the management of medicines. Medicine administration records (MAR charts) had not always been signed to confirm people had received their prescribed medicines. We also saw that there were no photographs on some of the MAR charts to help staff identify they were administering medicine to the correct person. Additionally, we found when people were administered creams and lotions, records to show these had been applied were not correctly completed.

During this inspection we checked to see whether these improvements had been made. We found there had been some improvements but further action was required.

At this inspection people told us they received their medicines when required. One person said, "We often get our tablets in the middle of a meal. I am sure they [staff] have explained what they are all for but I just open my mouth and swallow them." Another person said, "I get tablets to help the pain when I need them."

MARs were clearly completed to show that medicines other than creams were administered regularly. We found MAR charts had a cover sheet with a dated photo of the person and appropriate information staff required to administer medicines safely. Staff had recorded detailed information on how each person liked to take their medicines to make sure they were given consistently. Protocols were used to manage the use of medicines to be taken when needed, for example for pain or anxiety. Where variable doses were prescribed, for example one or two tablets, we saw that the amount given was usually recorded. However, one person was prescribed a liquid medicine with a variable dose and the amount given each time was not recorded. Staff told us this was down to lack of space on the chart. This told us that staff may not have been able to appropriately determine the effectiveness or possible side effects of the medicine being given.

The procedure for recording the application of creams, for example for dry skin, was unclear. Prescriptions for creams were recorded on the MARs, there were body map diagrams to show where they should be applied, and record charts to record when they had been applied. However, we saw discrepancies between these documents. It was not always clear which creams were prescribed for people, which creams were actually being used, or how often they were applied.

We saw that staff had been trained in the administration of medicines, and the provider had assessed their competency. We observed a nurse administering people medicines and saw that good practice guidance and the provider's medicine's procedure was followed. The temperatures of where medicines were stored were not regularly checked in one of the two clinic rooms. These checks are important to ensure the effectiveness of people's medicines is not compromised due to too high or low temperatures. We found the stock of medicines were correct.

At the last inspection we identified concerns with the cleanliness of the service. We were aware that in May 2016 the local Clinical Commissioning Group visited the service and completed an infection control audit.

They identified a number of recommendations for improvement. At this inspection we saw the provider had an infection control action plan to address the recommendations made. The registered manager told us that the action plan had been completed.

We identified continued concerns with regard to cleanliness and infection control. For example, some people spoke with us in their room. We saw bed tables were not always clean. Drinking glasses were in some cases very dirty with tidemarks and dried lip stains which indicated they may have not been changed for a while. There was an odour in some areas of the building and infection control measures were also not consistently followed. For example, the National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. We observed the clinical care of a percutaneous enteral gastrostomy tube (PEG) and found this was not in line with NICE guidance. For example, the tube site/ positioning checks were not taking place before each feed and the site was not being cleaned frequently enough. Unwashed enteral feeding equipment (syringe) was left in the person's room for re-use. The nurse said there was no record of, and could not tell us, when this syringe had been opened or how long it had been in use. This may increase the risk of an affection occurring. After our inspection we asked the clinical commissioning group to revisit the service.

People who used the service felt they were safe living at Springwater Lodge Care Home. One person said, "I feel safe with the staff, they know what they are doing." Another person told us, "I have no problems, I feel safe. I would say if I didn't." Visiting relatives were also positive that their family member received a safe service.

Staff told us they felt people were cared for safely and showed they had a good understanding of their role and responsibility in protecting people from abuse in their care. Staff were able to identify the signs of abuse and told us what action they would take if they had any concerns.

The provider had procedures in place to inform staff of how to protect people from abuse and avoidable harm. We observed safeguarding information was available for staff, people who used the service and visitors. Records confirmed that staff had received appropriate safeguarding training. This ensured staff knowledge met current best practice guidance. .

People who used the service gave examples of how risks associated with their needs had been assessed and minimised. One person said, "I had a little sore but the staff spotted it so I have cream on it and have to lie on my bed a bit. It is getting better now."

Staff gave examples of the action they took to support people with any risks including environmental risks. One staff member said, "People with high needs are closely monitored. Some people at risk of falls have equipment in place to alert staff when they are moving. We check equipment is safe to use before we use it."

There was inconsistency with the completion of risk assessments and some risk assessments had not been completed. For example, one person had not been assessed on, or since, their admission to establish if they were at risk of malnutrition. This meant staff were unaware if this person had any nutritional needs.

Accidents and incidents were recorded and monitored by the registered manager. We saw examples of action taken to reduce further risks, such as using assisted technology in the form of sensor mats. These were used by people at high risk of falls and alerted staff of when people require assistance. Staff held monthly meetings to discuss any falls people had experienced and to consider themes, patterns and lessons learnt in order to reduce the risk of reoccurrence.

The provider had systems and processes in place to monitor the safety of the environment and equipment. Safety check records showed these were up to date; however clinical equipment used at the service was not included in the safety and maintenance audits in place. We asked that all clinical equipment was checked by the registered manager. They found that two pieces of equipment, a nebuliser and suction machine to support people with breathing, was not fit for purpose. The registered manager told us they would order replacement equipment immediately.

Personal evacuation plans were in place in people's care records. This provided staff with the required information of people's support needs in the event of an emergency evacuation of the building. Staff also had information of action required to respond to an event that could affect the running of the service.

A repeated concern made by people who used the service was how busy staff were and how this impacted on their availability to spend time with them. Eight people told us about their experience. One person said, "The staff don't sit and talk to me, they are too busy." Another person told us, "You sometimes have to wait, the girls [staff] are very busy." Additional comments included, "Sometimes it can take time for staff to come, especially at night when there are reduced staff, but they always come eventually. I don't think there are enough of them." Another person said, "You sometimes have to wait at night but it is much slower during the day. I think they think I can do more than I can for myself."

The registered manager had no way of monitoring how quickly staff responded to the call bell system, but did tell us that the provider was in the process of addressing this. Staff told us that that they ensured people were safe and had their needs met. However, staff felt they were rushed and had limited time to spend with people other than meeting their physical care needs. The registered manager said there was a high amount of staff sickness and that shortfalls were covered by staff taking on additional hours, staff from the provider's other services assisting, and using agency staff. Care records included a dependency needs assessment for people which were reviewed on a regular basis. The registered manager said this was used to determine what staffing levels were required. We saw from the staff roster and in discussion with the registered manager that the staffing levels provided on the day of our inspection, matched what staffing had been assessed as required.

A high number of people upstairs required assistance from staff with eating and drinking. We noted that whilst some people had received both their courses other people had to wait for up to 30 minutes to receive their first course. We also noted that staff were not continually present in dining rooms where people required support with their meals. Whilst we judged there to be sufficient staff on duty there was an issue with the deployment of staff.

The provider operated an effective recruitment process to ensure that staff employed were suitable to work at the service. Staff we spoke with confirmed they had undertaken appropriate checks before starting work. We looked at three staff files and we saw all the required checks had been carried out. This included checks on employment history, identity and criminal records. This process made sure, as far as possible, that new staff were safe to work with people using the service. The provider also had systems in place that checked nursing staff's registration was up to date with the nursing and midwifery council. This ensured that nurses were appropriately registered to practice.

Requires Improvement

Is the service effective?

Our findings

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

Care records showed where concerns had been identified that people lacked capacity to consent to specific decisions about their care and treatment, the MCA had been considered, but not consistently applied. For example, mental capacity assessments were not always completed before best interest decisions were made. Neither were these records always dated and signed. This meant that the MCA was not being fully adhered to.

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us about two appropriate applications that had been sent to the supervisory body. The registered manager also showed us an action plan that identified people that may need an authorisation. However, it was not clear from discussion with the registered manager why there was a delay in making other applications or if they were required.

Staff demonstrated a basic awareness and understanding of MCA and DoLS. They said that best interest decisions had to made on behalf of people at times and that, "other professionals have to be involved." However, they were unable to tell us when MCA and DoLS should be considered and what the process was to effectively support people who lacked the mental capacity to make certain decisions for themselves. Training records confirmed staff had received training in MCA and DoLS.

We observed people's lunchtime experience and identified concerns with how people's needs were met. We noted that a group of six people living with dementia in the downstairs dining room were eating independently. One person was seen to use a knife to put food into their mouth and another person's food kept spilling onto the table. No adapted utensils such as plate guards or adapted cutlery to support independence were provided. Another person living with dementia was observed by an inspector eating paper with their meal. Due to staff not continually being in the dining room to provide support or supervision, we had to request the assistance of a staff member to support the person.

Some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place. This is important information to advise staff of the person's end of life wishes or the best interest decision made on behalf of a person who lacks mental capacity to make this decision. These were found to be appropriately completed.

Everyone we spoke with felt staff were well trained to carry out their role. However, two people remarked that some staff were more skilled than others. One person said, "They seem well trained the staff. They

attend to my needs as and when required." Another person told us, "They know what they are doing although some seem to be more confident than others."

Staff told us about the induction, training and support they received. Staff were positive that the induction prepared them for their role and responsibilities. One staff member said, "In addition to training, I shadowed experienced staff and had a mentor whist I was on my induction which was really helpful."

We saw records that confirmed staff received a planned and structured induction, using best practice guidance in training and development for health and social care staff. This told us that staff received appropriate support that enabled them to effectively carry out their role and responsibilities.

Staff said that they received supervision and appraisals, which provided them with opportunities to discuss their work, training and development needs, but that the frequency of these meetings varied. One staff member said, "We have meetings with our line manager quite a few times during the year." Another staff member told us, "I've not had a supervision meeting for a very long time, I can't remember the last one."

The registered manager showed us records that confirmed staff had received opportunities to discuss and review their work during 2016. The registered manager said that they tried to provide staff with six meetings a year, whilst the provider's policy stated staff should receive two meetings a year to review their work.

Staff told us about the training opportunities they received; they felt this was appropriate and helped them meet the needs of the people they cared for. However, staff said the majority of training they received was online and they raised some concerns about this, saying they preferred face to face training which they found to be more effective. We shared this with the registered manager and provider's representative. The nursing assistant told us that this was a newly developed role which they had received additional training for. They said they were trained to support nursing staff with some clinical tasks such as wound dressing.

Records showed staff were trained in the subjects deemed mandatory by the provider. This included emergency procedures, fire drills, infection control and manual handling. The registered manager said staff received additional training in areas such as dementia care and pressure care. A nurse told us about the specialist and clinical skills training they had attended to support their clinical practice. This included pressure area care training and percutaneous endoscopic gastrostomy feeding (this is where nutrition or medicines are delivered by tube directly into a person's stomach), both delivered by external healthcare professionals. However, not all nursing staff had completed appropriate training in the use of clinical equipment. This was in relation to the use of a syringe driver. A syringe driver is used to help control symptoms for people at the end of life by delivering a steady flow of liquid medicine through a continuous injection under the skin. This told us that there were some shortfalls in the training and monitoring of staff's development.

The registered manager also told us that staff had not all received training around end of life care, advance care planning, breaking bad news or symptom management. However, they said they expected that the provider was due to provide this training. This meant there was a risk that people may not have received personalised care that met their individual needs.

People spoke positively about the food choices they received. One person said, "The food is not bad. I'm a fussy eater but they usually have something I like." Another person told us, "They [staff] come round in the morning and ask you what you want. You usually get a choice like today i'ts cottage pie or stew I think. It is all very tasty." Additional comments included, "It is perfectly satisfactory the quality and quantity. I have been very happy with the variety and am sure if I wanted different I could have it." We saw that people

received opportunities to share their feedback about the menu and this was shared with the hospitality team at the provider's head office who had responsibility of developing the menus.

We spoke with the cook who was knowledgeable about people's dietary needs and preferences. They told us how they provided meals that were appropriate for people's individual needs. For example, some people required a soft diet due to concerns about their swallowing. Other people required a fortified diet due to issues with weight loss. Some people were living with diabetes and needed a particular diet. Kitchen staff had written records of people's needs, likes and dislikes, portion size and allergies. There was an effective process in place whereby care staff advised kitchen staff when people's needs changed. The cook told us that snacks such as cakes, sweets, biscuits and fruit were available. We saw these foods were available for people to help themselves and staff also offered them throughout the day. We checked food stocks and found these to be sufficient and managed appropriately.

People's dietary and nutritional needs had been assessed and planned for. Nutrition plans had been developed to advise staff of people's needs. These plans showed us that consideration of people's cultural and religious needs was also given in menu planning.

People were weighed on a regular basis to enable staff to monitor their weight so action could be taken if changes occurred. Staff had recorded people's food and fluid intake, but records did not show that these were being monitored. The nurse confirmed that this information was not recorded. However, they assured us that they and the nursing assistant checked these records daily to ensure they were fully completed and to pick up on any concerns. We saw examples of referrals to external healthcare professionals when concerns had been identified about people's weight and food and fluid intake.

People told us they were supported to access external healthcare professionals and health services. One person said, "If I'm not well I tell the staff and they get the doctor." However, a person told us of their anxieties in understanding their healthcare needs. They were aware their health was deteriorating but felt staff had provided little explanation and support. We shared this with the registered manager to ensure the person received appropriate support and information.

Care staff said that they monitored people's healthcare needs daily and there were good systems in place for staff to exchange information about people's needs. Staff said that any concerns raised with nursing staff were quickly acted upon.

Care records confirmed that the service worked with external healthcare professionals such as the GP and dietician. The nurse said that the community practice nurse visited on a Monday and gave feedback to the named lead GP for the service. This told us that people had their healthcare needs monitored and external healthcare professionals were regularly involved in people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

A visiting relative told us their family member's health was significantly deteriorating and that they felt there was a lack of discussion and plans in place for the provision of end of life care. Comments included, "Coordination and continuity of care is poor, due to short staffing and use of agency staff. If we [family] were not here things would get missed."

The registered manager told us that four people had been identified as nearing the end of their life. We asked the registered manager for these people's end of life care plans. The registered manager was unable to provide these care plans or give adequate explanation as to why these had not been completed. They said they had recently returned from a holiday and the deputy manager, who normally completed these care plans, was not currently working at the service. The registered manager said the home used the 'Abbey' pain scale to assess pain. This is a nationally recognised tool which is used to assist in the assessment of pain in people who are unable to clearly articulate their needs. However, the registered manager could not find a completed pain chart for the four people receiving end of life care. As a result no symptom control plans, pain management care or end of life wishes were documented. Mouth care and eye care for those in the last few weeks of life were also not planned for. This meant staff did not have the required information available to appropriately care for people identified as being at the end of their life.

The registered manager agreed to complete end of life care plans as a matter of urgency and forward to us. Following our inspection end of life care plans were sent to us and three out of four had been completed the day after our inspection. The fourth care plan was dated August 2016 although this care plan was not provided on the day of the inspection.

The 'Five Priorities for Care' are what health care professionals should be aspiring to when delivering end of life care. We found the end of life care plans had considered the 'Five Priorities for Care' but lacked specific detail that would enable people to receive an effective, caring and responsive service at the end of their life. For example, care plans stated they would be regularly reviewed but did not provide timescales or advised who was responsible for this. This meant people could not be assured that they would receive care that was personalised to their individual needs and wishes.

For people who were approaching the end of their life they had been prescribed medicines in anticipation of symptoms such as pain or distress. There were clear instructions available to staff on how to use these medicines, but these had not been transcribed on to the medicines administration records. The registered manager told us this was to prevent them being used unnecessarily. However, there was also a risk that there might be a delay in using them when needed while the records were completed. There was also a risk that agency nurses would not be aware that they were available if required. .

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

Records were kept were kept in a room which required a code for access. However, we observed the room

was not always locked, even when unsupervised. We were concerned the room could have been accessed by anyone visiting the building resulting in a risk to confidential information being accessed.

People told us most staff were caring, kind and courteous. They said staff understood their needs and would do anything they asked of them. One person said, "I believe the staff are very good I am perfectly happy with the relationships. They go to great lengths to do the job right." Another person spoke of the cook, "[Name of cook] is very kind she panders to my needs. If she knows I don't like something that is coming up on the menu she will suggest something else." A relative said, "It seems to be they [staff] care for you as you would wish to be cared for."

However, two people felt that not all staff were as naturally caring as others. One person said "[Name of care staff] is excellent she really understands us, she is a natural. They are not all like her, they are not unkind just don't seem to have that little extra." Another person said, "Most of the staff are caring. One or two are a bit 'take it or leave it'. I think one or two think you're past it when you're old."

One person told us that they did not always experience a positive, caring approach when they had their wound dressing changed. We discussed this with the registered manager who agreed to discuss this further with the person.

A relative was positive about the approach of staff and said, "The staff are very good with [my family member]; they encourage [them] to get out of bed into the reclining chair. I think [my family member] has given up and it is good for me to see [them] interacting more."

Staff spoke in a kind and caring manner about the people they cared for. One staff member said, "We try and provide a home from home and respect people's wishes. I like to speak with people, keep their minds active and bring memories alive." Another staff member said, "All staff are very caring and give the best care, people are respected as individuals."

Our observations of staff interaction with people were limited due to people spending the majority of their time in their rooms. The interactions we did see were positive and caring. For example, we saw one person living with dementia in a communal lounge taking comfort from nursing a doll. We saw a staff member regularly speak with the person asking how they were, offering drinks and sitting and chatting with the person. They used good verbal communication skills, including gaining eye contact before speaking and responding warmly and in a kind and caring manner. The staff member respected the person's wish to nurse the doll, recognising that this was important to them. We observed staff welcoming visitors, and they conversed with each other in an easy and friendly manner.

Staff member's awareness of people's particular care needs was variable. We spoke with a nurse who was the named nurse for a particular person. This meant they had additional responsibility for ensuring the person's needs were understood and met. Whilst they could provide detail in some aspects of the person's care, for example, in relation to a recent infection, they could not confidently or clearly explain the person's regime in relation to their prescribed cream. We spoke with other care staff who showed us they were aware of people's routines and what was important to them.

People felt they were involved in their care although they were unable to tell us if they had a care plan. Two relatives told us that they felt involved and fully informed in their family member's care. The registered manager told us that people who used the service and their relative or representative were invited to six monthly review meetings, to discuss the care and treatment provided. They said this meeting was sooner if required. In some care records we saw a document that stated the person had been involved in the

development of their care plan. However, we noted there was no signature or other means of confirming this to be correct.

People told us how staff respected their privacy and dignity and gave examples such as staff knocking on their doors before entering. One person said, "They [staff] always treat me with respect I am very lucky to have some very caring helpful staff."

Staff gave examples of how they protected people's privacy, dignity and respect. One staff member said, "I do my best to care for people, I'm polite and respectful, asking people if they are okay." Another staff member told us, "I show dignity when helping people with personal care, I keep people covered up and give them privacy."

We found staff to consider people's privacy and dignity. For example, staff sensitively and discretely supported people when care was provided.

Information about independent advocacy support was available. This meant should people have required additional support or advice, the provider had made this information available to them. Visiting relatives told us that there were able to visit their family member at any time.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that they and their family member where possible, had been involved in the person's pre-admission assessment. This is important to ensure the provider can meet people's individual needs before admission to the service. One relative said, "Yes, we met with a senior member of staff to discuss [name of family member] needs before they moved to the service. I feel staff have quickly picked up on their character and personality." Additional comments included, "Communication is okay, it's a bit ad hoc at the moment but overall I'm pleased with the standard of care."

Records viewed confirmed pre-admission assessments had been completed. Initial, 72 hour care plans [as described by the provider] were used to provide staff with information about people's needs. More detailed care plans were then developed. We found the level of information in people's individual care plans showed some elements of person-centred care. For example, some but not all care records, contained a "Remembering together" document and or a profile about information that was important to the person. These detailed significant people and events including hobbies, past employment, routines and preferences, they provided staff with a good picture of each individual. We noted that people's needs associated with regard to their diversity, religious and spiritual needs were largely not recorded. Staff demonstrated that they were aware of these needs however and gave examples of how some people had community religious representatives from their chosen faith visit them.

The level of detail in some care plans associated with people's health care needs lacked specific detail in places. For example, we identified that healthcare needs such as diabetes and catheter care lacked specific detailed information. Signs of an infection and what a person's normal blood sugar levels should be were not recorded. However, when we asked staff about how they supported people to manage these needs, they were knowledgeable. This indicated that the issue was about recording. Clearly recorded information is important to ensure consistency of care is provided by all staff, including agency staff that may be unfamiliar with people's needs.

Some people were living with dementia and experienced periods of anxiety that showed in behaviours that could be challenging to others. Care records showed, and the registered manager agreed, that there were no behavioural plans in place that advised staff of coping strategies to support and respond to people at times of anxiety. The registered manager told us that they would ensure these care plans would be completed immediately.

People told us that they were supported with their routines and preferences. For example, everyone we spoke with told us they were able to get up and go to bed when they felt like it. One person said, "I usually go to bed after tea as there isn't much to do. I like to read so make myself comfortable." Another person told us, "Oh we can do what we want when we want really. I like a shower a couple of times a week and I only have to say." An additional comment included, "They do two breakfasts one early one late and if I don't feel like getting up for the early one I have the option of eating later." We saw people had personalised their rooms with familiar items from home such as pieces of their own furniture, and things of sentimental value such as pictures, photographs and ornaments.

People said they felt there was not much to do to occupy them although they recognised they did get to go out sometimes. One person said, "They [staff] do have some things in the lounge to do but there is not always anyone around to share with. The staff are too busy to sit and do things with you." Another person told us, "My family come and take me out quite often and I sometimes go out with the staff but it is only a couple of us at a time."

On the day of our inspection two activity coordinators supported two people to visit a park. Whilst they left activities such as arts and crafts out, we did not see that staff offered these to people. We did not see staff provide any activities, occupation or stimulation other than having the television on which people were seen not to take any interest in.

A monthly activity timetable of activities was on display that showed various activities such as arts and crafts, bingo and puzzles, cards and scrabble was provided. A hairdresser visited weekly and external entertainers visited and provided activities such as exercise to music. We saw a room that the registered manager said was used for reminisce which had items of memorabilia for people to reminisce about. However, we did not see this room was used during our inspection neither was it on the planned activities displayed for the month. Whilst there was some memorabilia items in communal areas this was limited and provided little stimulation to people. The registered manager told us that they were working with the external dementia outreach team in developing reminisce boxes for people to use.

No person we spoke with was able to tell us about the provider's complaints procedure but felt confident they could raise any issues or concerns with the staff. One person said, "I am not sure who to complain to but if I had a problem I would speak to the staff. I am sure they would pass it on." Another person told us, "I would speak to the manager I am sure she would deal with it."

The provider's service user guide that was available in people's rooms, provided people with information about the complaints policy and procedure. The complaints log showed 11 complaints and concerns had been received since our last inspection and all but one that was being investigated had been responded to and action taken.

Requires Improvement

Is the service well-led?

Our findings

Our inspection identified concerns with the leadership of the service. Whilst the provider had quality assurance systems and processes in place for assessing quality and safety, these had failed to identify the concerns and shortfalls we identified at this inspection.

The provider had taken insufficient action to ensure all the required improvements identified at our last inspection in relation to the administration of medicines had been completed. For example, the management and administration of prescribed creams continued to be an area that identified shortfalls. There was a risk people were not receiving their prescribed creams appropriately.

We found the provider's action plan to address the shortfalls in the infection control and cleanliness of the service identified by the local clinical commissioning group in May 2016 was insufficient. The prevention and control measures of infections and cleanliness in place at the service did not fully protect people. For example, areas of the service were found to be unclean and there was an odour in some areas of the building on the day of our inspection. Clinical care observed for a percutaneous enteral gastrostomy tube (PEG) was not carried out following best practice guidance. For example, the equipment used to administer the feed was inappropriately managed.

The provider had failed to identify that not all clinical equipment at the service was fit for purpose. For example, a nebuliser and suction machine was not working. This equipment is required to support people with breathing and may have been required at any time for people at the service.

The provider had failed to identify that staff did not adhere to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). For example, mental capacity assessments were not always in place where best interest decisions had been made. An action plan completed by the provider for people who may have required an application for a DoLS had not been actioned. The action plan also demonstrated the registered manager had a lack of understanding about DoLS.

These are examples of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to report safeguarding incidents to the local authority who have responsibility for investigating such concerns. The provider is also legally required to notify the Care Quality Commission (CQC). We were aware that one recent safeguarding incident had not been reported to the local authority or the CQC in a timely manner.

Staff were aware of the provider's whistleblowing policy. A 'whistle-blower' is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation. Staff told us that they would not hesitate to act on any concerns and were confident their concerns would be addressed.

People were offered opportunities to give their feedback about the service. For example, there were

feedback forms in the reception area and an electronic feedback system which went directly to the provider's representative. People also had the opportunity feedback through meetings held at the service and surveys.

Whilst some people told us they felt informed about what was happening in the service we received a mixed response from people about the opportunities available to share their experience. One relative said "I feel fully informed and in fact more than perhaps was necessary when there was a recent issue. They dealt with stuff very efficiently. I think the place is well organised and the manager is very approachable".

A person who used the service told us, "I usually attend meetings if I can. We talk about things that go in the home, the food and such." However, another person said, "I am not aware of any meetings." A relative told us they were not aware of any meetings although. They said, "I am not aware of any resident or relatives meeting and although I didn't have one I know there has been a survey."

Most people were able to tell us the registered manager's name although we received a mixed response to how often people saw them. One person said "Her name is [manager's name]. She is very nice. I sometimes see her pop her head in."

We saw that the dates of resident and relative meetings were on display and these were held monthly. The registered manager told us that they were looking at other ways of encouraging relatives to attend meetings as there was poor attendance. We saw examples of resident meetings for 2016; these records showed that people were asked about future activities and any changes to the service, such as security. The provider sent yearly surveys to people who used the service and their relatives and representative. We saw action plans were devised following receipt of surveys. Discussions with the registered manager showed that these plans were being actioned. For example, additional hours in the kitchen had been provided and bedrooms were being redecorated. This told us that the provider listened to people's feedback and enabled them to participate in the development of the service if they chose to.

The service had 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.

Staff were positive about the leadership of the service and described the registered manager as approachable and supportive. Staff told us that they attended staff meetings and were able to raise any issues or concerns or make suggestions. Staff also told us about daily meetings with heads of department and that there were effective communication systems in place to exchange information. We viewed records that confirmed what we were told.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people must be appropriate, meet their needs and reflect their preferences. The provider must carry out collaboratively with the relevant person, an assessment of the needs, and preferences for care and treatment of the person. 9 (1) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must establish effective systems or processes to assess, monitor and improve the quality of service. The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of people use the service. Regulation 17 (2) (a) (b)