Barchester Healthcare Homes Limited

Woodside House

Inspection report

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Date of inspection visit:
07 September 2016
13 September 2016

Date of publication:
02 January 2017

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 7 and 13 September 2016 and was unannounced.

Woodside House provides accommodation and care to a maximum of 56 people. The majority of people receiving care and support are older people and some people using the service may be living with dementia. The service is registered to support people both with their personal care and nursing care if they need this. At the time of our inspection, there were 53 people living in the home. People who are living with dementia are largely supported within the Memory Lane unit of the home.

There was a registered manager in post who was present for the second of our inspection visits. 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.

The service needed to make improvements to people's safety. There was inconsistent information about how drinks needed to be thickened to minimise the risks of choking for specific individuals and in one case the required thickener had not been used at all when a person was given a drink, presenting a serious concern for a person's safety. We ensured that action was taken immediately to rectify this and so that the registered persons could ensure the person was not exposed to serious and avoidable harm.

People were also exposed to risks from inappropriate storage of some toiletry products, creams and thickeners. This presented concerns that the products could cause harm by being swallowed, used inappropriately or contaminated. Staff used some products well beyond their expiry dates, presenting a risk they would not be safe and effective to use. Staff were using some creams and thickener, labelled as issued for others and which could therefore present confusion about the correct usage and management. Systems for assessing, monitoring and improving the service and for mitigating risks had not identified the concerns we found. Between our inspection visits, the registered persons told us they had taken action to improve. However, we were concerned that we have raised such issues in previous inspections and but again found similar failings. We could not therefore be confident in improvements would be sustained.

Staff understood the importance of reporting any concerns that people may be at risk of harm or abuse. They were recruited in a way which ensured proper checks were made, so contributing to protecting people from the risk of harm. There were enough staff on duty who were competent to meet people's needs safely, but they were not always well organised in the way that they supported people. This included during lunch time. Although people had a choice of enough to eat and drink, the mealtime lacked a calm, pleasant and conducive atmosphere for people to enjoy their meals. Some people did not receive consistent and sustained support from one staff member sitting with them throughout their meal to offer support and encouragement.

Staff understood the importance of seeking consent from people to deliver their care. They recognised how their individual approach could help people feel comfortable with receiving care and secure their cooperation. They were aware of the importance of acting in people's best interests where people were not able to give specific consent. People could be supported by their family members who knew them well, to make decisions and choices about their care if they found this difficult.

Where people's freedom may be restricted because of their lack of awareness of personal safety, the registered manager sought appropriate authorisation. This contributed to protecting people's rights and freedoms.

People had access to support and advice from health professionals to promote their physical and mental wellbeing. For example, staff arranged for people to see their GP, falls prevention team and dietician where necessary.

Staff understood people's individual preferences, likes and dislikes. These were clearly documented within people's plans of care so that staff knew what action to take to deliver care focused on individual need. Care records were kept up under review if people's needs changed. Staff responded to people warmly and compassionately when they were supporting people with their care. However, there were instances when people's privacy and dignity was compromised. In one case, we asked staff to intervene straight away because of the person's lack of dignity.

People had opportunities to express their views about the service, as did their relatives and staff. There were meetings to ensure information was shared with them about any developments in the service, as well as to ask what they would like to see happening within it. There was also a system for receiving and investigating concerns or complaints in a formal way so that people could have these addressed.

We found two breaches of regulations. One of these related to improvements needed to the safety of the service and the way risks were assessed and minimised as far as practicable. The other was because the systems in place for identifying where improvements were needed, and for sustaining these when necessary, were not working well. You can see what action we told the provider to take at the back of the full version 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 always safe.

Creams for external use were not being managed or secured properly, presenting a risk to people. Toiletries that could be harmful if swallowed were also accessible.

Risks to people's safety were assessed but the safety of people at risk of choking was not consistently promoted.

There were enough staff who were recruited in a way that contributed to protecting people from the risk of harm or abuse. Staff understood their obligations to report concerns about this.

Is the service effective?

Requires Improvement

The service was not always effective.

Although people had a choice of food and drink, the quality of people's mealtime experiences was variable due to poor staff organisation over the lunch time period.

Staff had access to training to meet people's needs although training to support the specialist needs of people living with dementia was not always completed.

Staff understood the importance of seeking consent from people. Where people were not able to give informed consent to their care, staff considered what was in people's best interests.

Staff supported people to access advice and treatment to promote their health and welfare.

Is the service caring?

Requires Improvement

The service was not always caring.

This was due to people's privacy and dignity being compromised on occasion.

Staff responded to people in a warm and compassionate manner and promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People's individual needs and preferences were assessed with guidance for staff about delivering care to meet their preferences.

People's complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The way the quality and safety of the service was monitored was not robust in that it did not proactively identify the concerns that we found. Some similar concerns were highlighted in previous inspections but resulted in temporary rather than sustained improvement.

There were opportunities for people to express their views and suggestions about the service.

Woodside 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.

The inspection took place on 7 and 13 September 2016 and was unannounced. It was completed by two inspectors 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.

Before we carried out our inspection visits, we reviewed all the information we held about the service. This included information contained within complaints or concerns raised with us. We also looked at information about events happening within the service, which the provider or manager notify us about by law.

When we visited the service, we spoke with six people who lived there and four visitors. We also spoke with the deputy manager, registered manager, chef and five other members of the care team, including two nurses.

We reviewed care records for eight people and checked how three people were supported at each stage of their care and treatment. We reviewed medicines records for three people. We also observed what was happening within the home, including in the Memory Lane unit. This part of the home provided support to people who were living with dementia. We checked how people were supported with their meals in two areas, including in the Memory Lane unit. We checked training records and recruitment records for three staff. We looked at a selection of records associated with the quality and safety of the service, including minutes of meetings for staff and people living in the home.

Requires Improvement

Is the service safe?

Our findings

When we inspected this service in July 2015, we found that people's medicines were not always managed safely and that people's creams and indigestion remedies were not stored securely. This presented a risk that they could be tampered with, contaminated, or swallowed presenting a risk of harm to people. The provider told us what action they would take and, when we inspected the service again in October 2015, we found that they had made improvements in these areas. The service was no longer in breach of regulations. We noted however, that there were still some creams left accessible. We asked the provider to improve within this area.

At this inspection, we found that staff had left prescribed creams accessible and unsecured on two units in the home. Whilst the manager felt that people in this part of the home were not at risk, they were prescribed items and should have been secured. There were also additional concerns that creams were in use beyond their expiry dates so presenting a risk that they could be contaminated and not safe to continue using.

For example, we found that one person's room contained two different creams, both were unsecured and so presenting a risk of contamination or misuse. One was labelled as intended for a person who was not the named occupant of the room. For another, the pharmacy label showed it as prescribed in February 2013 and with an expiry date of September 2015. This remained available for use. Creams that were opened may also have been at risk of contamination well before their expiry dates, so staff needed to be aware when they were opened and how long it was safe to use them for.

We found one person's room was unoccupied at the time of the inspection while they were in hospital. This room was unlocked, contained a cream for external use, which was unsecured, and the label had faded to the extent that it was not legible. This presented a risk that staff could not identify who it was for or how it should be used. The room also contained a bottle of nail polish remover that was unsecured. Another person's room contained denture-cleaning tablets. Both of these products risked harming people if they swallowed them.

We found that a toiletries cupboard in one person's room in the dementia unit contained prescribed items that should have been secured and non-prescribed items, including denture cleaning tablets. As these items had not been secured they presented a risk of misuse, misappropriation or accidental harm.

This was a renewed breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the serious nature of our concerns, we raised them straight away and asked that measures be taken to improve people's safety. Following the first day of this inspection, the general manager, deputy manager, regional director and clinical development nurse devised an action plan to ensure that medicines, creams and toiletries were secured so that people would not be at risk of harm. We found arrangements had improved when we returned for the second day of our inspection. However, given we have raised similar issues in the past, we could not be confident improvements would be sustained.

We noted that one person had been assessed as lacking capacity to understand the importance of them taking their medicines for their wellbeing. Staff had received guidance to give these medicines crushed and in thickened fluids.

Other aspects of the management of medicines contributed to maintaining people's safety. People received prescribed medicines as intended. Staff who administered medicines had their competency checked and assessed to make sure they had the skills to give people their medicines safely. The management team reviewed medicines records between the first and second day of our inspection. This review identified shortfalls in the recording of people receiving their medicines, which they could follow up to improve the safety of medicines management.

There was guidance about the use of medicines for occasional use and staff checked the balances of medicines regularly to ensure people received these as prescribed. For one person, we noted that their care plan described in detail how the person would express if they were in pain and how staff should assess this. This contributed to them being aware of when they needed to offer pain-relieving medicine to assist the person. For another person, staff revised their medicines regime slightly to accommodate the person's preference not to be woken early.

At our inspection in July 2015, we found concerns for the management of thickener used in drinks and sometimes in food. Thickener is prescribed to minimise the risk of choking for people at high risk due to swallowing difficulties. At that inspection, staff were using one person's prescribed thickener to thicken other people's drinks. There were clear instructions on the tin from the prescriber on how the person's drink should be prepared to minimise that individual's risk of choking. Using it for other people therefore presented a risk that staff may thicken other people's drinks incorrectly. It also raised concerns that the person for whom it was prescribed could run out. The provider took action to improve following that inspection. However, at this inspection, we found further concerns and that they had not maintained the improvements.

People were at risk of choking because this risk to their safety was not properly managed. In one part of the home, we found four open containers of thickener. Three were without the name of the person for whom it was intended, and one had the label torn off. Containers were not consistently properly stored. We found that a container of thickener was accessible in the activities lounge and in one person's bedroom, so presenting a risk of inappropriate use or harm from ingesting it.

We found that one person's care plan contained guidance for staff about how their food should be prepared and that gravy for their meals and drinks needed to be thickened. This guidance was put in place by a speech and language therapist to reduce the risk to the person of choking and aspiration. Aspiration is where food or drink can accidentally enter a person's lungs and cause illness or death.

A permanent member of staff told us in detail how they went about thickening that person's drink, and that the person should drink from a green, two-handled cup recommended for them. They said that staff mixed drinks as and when required and fetched the thickener from a cupboard to use. We found that there was no thickener labelled with the person's name and guidance about its use. The recommended suitable cup was not available in their room and that the drink in their room was without thickener added.

The person was receiving support from an agency staff member on their first shift in the service. We found that a jug of squash, and half a glass of squash in their room, was not thickened. The agency worker told us that they had not been made aware the person needed their drinks to be thickened, until after lunchtime. They had assisted the person with a drink during the morning. This presented a significant risk to the

person's safety.

For two other people, we found that guidance for staff within their care plans about the amount of thickener required, did not match the guidance provided by the speech and language therapist. This presented further concerns that drinks would not be at the consistency people needed to manage their choking risks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first day of this inspection, the general manager, deputy manager, regional director and clinical development nurse devised an action plan to ensure that thickeners were properly labelled and secured so that risks to people were reduced. However, given we have raised similar issues about unsafe practice with these products in the past, we could not be confident improvements would be sustained.

Other aspects of risks to people were assessed with guidance for staff about minimising them so that people's safety could be promoted. This included risks to people of not eating or drinking enough, to their skin integrity and from falls. One person confirmed that they received regular checks and treatment for a pressure area problem. This contributed towards addressing risks about their skin integrity.

A staff member told us that a nurse practitioner visited the service on a regular basis. They explained that, if there were concerns about people becoming prone to falls, they discussed these with the practitioner at that point. They explained how they made referrals to the falls prevention service through each person's GP if this was necessary.

In addition to risks for individuals, the risks associated with staff working practices and the premises were assessed. Staff received training in fire safety, first aid and resuscitation techniques. There were checks on the equipment in use to ensure it was properly maintained. This included checks on fire detection systems to ensure they would work properly in an emergency. There was guidance for staff about how they should assist people to leave the home if there was a fire. Arrangements for managing the premises and equipment contributed towards promoting people's safety.

People said they felt safe at the home and their visitors echoed this view. For example, one person using the service said, "Yes, I do [feel safe]. I have my bell and I can always use it when I need to." One person's relative told us, "I don't have any worries. I know that [person] is safe." A visitor said that, "I have never had any concerns when I have visited the home; nothing has stuck out to concern me or to be alarmed about."

Staff spoken with understood the importance of reporting suspicions that someone may be at risk of harm or abuse. They confirmed that they had been trained in this area, and they understood their obligations to report any concerns they had. Staff recognised neglect as potential abuse.

There were enough staff to meet people's needs safely. People and their visitors told us that they felt staffing levels were safe, although they recognised there were some occasions when they may need to wait. One visitor described staff as "…a bit stretched at weekends." One person using the service told us, "I feel fairly safe. The staff come when they can but they have others to look after as well."

The provider's representatives told us that they reviewed staffing levels to ensure they were safe. One staff member told us that the service was currently reassessing people's needs as some people were becoming more dependent and the home might need more staff. Staff spoken with did say that sometimes, high levels of sickness presented concerns and difficulties for covering shifts. However, they described staffing levels as

safe, and that staff picked up extra shifts. Agency staff provided cover to maintain staffing levels if necessary. Duty rosters we reviewed showed that the staffing levels the management team told us were necessary, were in place.

Staff recruitment records showed that robust checks were made before new staff started working in the home. This contributed to protecting people who used the service. The checks made included a review of staff employment histories and obtaining references. Prospective staff were subject to enhanced checks on their backgrounds to determine whether they were suitable for care work. These checks were completed before staff started working in the home.

Requires Improvement

Is the service effective?

Our findings

People expressed variable views about the quality of the food on the menu. One was very positive about it but three felt that there could be improvements. For example, one person told us, "The food is excellent, I can't fault it." A staff member told us that people had the choice to start their day with a hot breakfast if they wished. One person commented how much they enjoyed this. They said, "I love to start the day with a cooked breakfast. Another person said, "The food could be improved. It is not what I'm used to." Two others felt that they were not always keen on what was on offer. However, we saw that, if people did not like the main meal on offer, staff asked if they could get them something else they would like.

People had a choice of what they would like to eat. The menu for the first day of our inspection showed people could select from three different starters, two main courses and two desserts. The supper menu also reflected a choice of options. Staff reported that they could always make people sandwiches or offer yoghurts if they wanted something when the cook was not available.

People had support with eating and drinking if they needed this. They had enough to drink and to eat to maintain a stable weight. Drinks were accessible to people and we found that fluid charts contained details of the amounts people had to drink during the day. There was room to improve the quality of people's mealtime experience and the support people received.

We observed the lunchtime routine in the Memory Lane dining area for people who were living with dementia. We found that the routine for serving and supporting people with their lunch was disorganised presenting concerns that it was difficult to support people with choices and to settle to eat their meal.

A member of staff offered people a choice of "…meat or veg…". They did not show people the options available to help them make a choice. We noted that the activities coordinator prompted staff to show people what was on offer to better support them in making choices. The same situation arose later during the mealtime, and again a staff member had to be prompted before showing people what was on offer. However, when staff showed people the food, the second option was fish and not, "…veg." The menu displayed showed the options as chilli or a vegetable bake for main courses. This presented a further source of potential confusion for people in understanding the choice available.

One person's allocated one to one staff member started supporting them with their meal but left the dining area to attend to another task. After five minutes without the support they needed, the person started insulting another person seated at the same table. The activities coordinator had to intervene to sit next to the person and calm the situation. The staff originally allocated for one to one support was absent for 25 minutes before they returned to the person, but left again five minutes later. We noted that three different staff sat with the person in the space of two minutes, presenting a lack of continuity in their support with their meal. There were five different staff who provided support at the dining table where that person and three others were sitting.

A visitor to the home needed to point out that their family member was not close enough to the table to

reach their food properly, and was too low down to eat comfortably. They were sitting in their wheelchair without a cushion. The relative needed to suggest that staff needed to assist their family member transfer into a dining chair to improve their experience and comfort while they were having their lunch. These issues compromised the quality of mealtime as a social experience for people and the consistency of the support they received.

We observed that the activities coordinator took the lead in offering people encouragement and reassurance, as well as practical assistance to eat on occasion. We noted that they encouraged a new member of staff to engage a person about their favourite food and, when they refused the main meal, to offer a sandwich, which they accepted. We also saw that the activities coordinator chatted to one person about how nice their hair looked after visiting the hairdressers. They supported the person fully with their meal and explained to the person what was on their plate as they assisted them to eat at their own pace. This approach helped to diminish some of the effects of the lack of organisation and continuity we observed.

People were supported by a staff team who were competent to meet their needs. People did not have concerns about the way that staff were trained to support them. Staff spoken with confirmed that they had access to relevant training and one commented that training was good. They confirmed that their training in medicines management and moving and handling was up to date. They described how experienced staff were involved in the induction of new staff so that they could learn about the support people needed.

One staff member described how refresher training had been arranged for them about supporting a person who received their food and fluids through a tube inserted through their stomach wall (PEG tube). They said that it was some time since the home had supported a person with these specific needs. They said that arrangements were made for a specialist nurse to provide them with training. This contributed to staff being able to meet the person's needs competently.

The manager advised us that new staff covered basic 'dementia awareness' skills during their induction and then went on to do more in depth training. Two thirds of the staff team had completed refresher training to support people who were living with dementia. There was a timescale for ensuring that the remaining staff received this refresher training, with priority given to staff who worked on the dementia unit.

We observed a handover between the early and late staff shifts. This included discussions about each person's needs. It highlighted whether staff needed to be aware of any difficulties or changes they should follow up.

Staff had access to support through supervision. Supervision is needed so that staff have the opportunity for discussion and feedback about their performance and development needs. This was up to date for over half of the staff team although some staff were slightly overdue. However, we noted that, at a staff meeting held on 1 September 2016, staff not working in the dementia care unit expressed the view that ten minutes for supervision was not sufficient.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

A staff member was able to describe how they supported a particular person in a way that was positive. They explained how the way that staff approached the person would affect their response and make it more likely that the person would allow them to assist with their care. They were aware of the importance of securing the person's cooperation and consent to receiving their care.

People's care records contained information about the decisions that people found difficult to make themselves. Staff had completed MCA assessments to show whether people were able to consent to different aspects of their care and treatment. Where people could not give informed consent, their best interests were considered so that their rights were protected.

Where there were restrictions to ensure the safety of people who could not understand risks to which they were exposed, applications for DoLS authorisations had been made. The outcomes of these were awaited.

We found from discussions with staff and from people's records, that they were referred to health professionals for advice when this was needed. This included advice from their doctor, speech and language therapist, dietician and from the community matron. Specialist advice was also taken about how to support a person with managing diabetes. This contributed to promoting people's health.

Requires Improvement

Is the service caring?

Our findings

We observed occasions when people's privacy and dignity was compromised. For example, one staff member referred loudly, so others could hear, to a person needing to use the toilet. This drew attention to their difficulties maintaining continence. In another person's room, staff had left a full catheter bag on their bathroom floor. We saw that this was still on the person's floor almost three hours later. This drew attention to the person's continence management, compromising their dignity.

We noted that staff did not always knock on people's bedroom doors before going into their rooms, so compromising people's privacy. We also saw that two people living in the Memory Lane unit were unsupervised at one point and were going through another person's bedroom drawers, compromising the privacy and security of their personal belongings.

We observed that the dignity of some people was compromised because of their position within their rooms and having their bedroom doors open. For example, one person was sitting in their room facing the door and with their continence aids on view to others who walked past. Another person was lying on their bed with the lower half of their body exposed, without underwear and without staff intervention to promote their dignity until we requested this.

We received conflicting views about how staff considered people's wishes for how they wanted their care to be delivered. We found that there was some room to improve how staff acted upon people's wishes. One person told us, "They [staff] are so nice. They consider what your wishes are." Another person felt that sometimes staff were not wholly receptive to their views about how they wanted their care to be delivered. They felt that younger carers were more willing to listen to how they liked things done in a way that made them feel comfortable. They said, "I prefer the younger carers to the older ones. The older ones tend to tell you how it [assisting the person with a shower] should be done."

People's preferences about whether they received support with their care from male or female staff members were recorded. Where practicable, staff respected these. A staff member was able to tell us in detail how they supported one person if they became anxious about receiving assistance with washing and dressing.

The majority of people felt that the staff were caring and treated them with respect. They, and their visitors, were satisfied with the approach and attitude of staff. For example, one person told us, "The carers do treat me with respect." Another commented that, "One or two can be offish, but most of them treat me with respect." A visitor told us, "When I visit there are carers sitting with residents and engaging with them." Another said, "There is a nice atmosphere in the home, which is important."

A relative told us how staff were successful in engaging with their family member who they described as being content and settled in the service. They said, "There's a difference in [person] being here. [Person] is smiley and chatty now." We saw that staff took action promptly when people were anxious or distressed. They were warm and compassionate in their approach, and skilled at offering reassurance.

One relative had written to the service to express their appreciation for the care and kindness they had shown to their family member. They went on to say that they felt staff had tried all they could to make the person feel happy and cared for.

Staff encouraged people to be independent in aspects of their care, as far as practicable. For example, a staff member told us how they supported someone with their personal care but knew that the person could wash their face. They encouraged them to do so. Staff told us that another person could make their own drinks. We observed that a staff member gently encouraged another person to hold their own cup in their preferred hand so that they could have some control over the way they were supported to drink.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home. Staff had guidance about the care required to meet their needs. Staff felt that there was enough information within people's care plans to describe the support they should offer to individuals. Staff reviewed people's care plans regularly to ensure they remained up to date and reflected people's current needs.

Care was planned in a way that was centred on each person's individual needs. People's likes and dislikes were recorded so that staff knew what each person preferred. Their records also showed what was likely to trigger people's anxieties or distress so that staff could be aware of these. Experienced staff spoken with had a good understanding of the needs of people they were supporting and of the individual approach they should adopt when they were assisting each person with their care. We found that people's care records showed that they, and their family members if appropriate, were involved in making decisions about their care. They were also involved in reviewing their needs and any changes in the support they required.

We noted that one person had a pressure mat in use in their bedroom to alert staff to them moving around. However, their care plan did not reflect the use of the equipment to guide staff about the importance of it or the reason for using it. However, we noted that the other plans of care we reviewed were clearer. For example, one contained a lot of detail about the person's individual preferences for their night-time routine. This included the number of pillows they preferred and whether they wanted their door and curtains closed or not.

People had access to social and recreational activities that they could participate in if they wished to do so. For example, one person said, "Yes, there are things to do and we are making lavender bags today." We saw people engaged together in this in the conservatory. Some people told us that they were not inclined to join in activities, but that there were things they could do if they wanted to. For example, one person said, "I can't interest myself in anything and if I am late getting up…. I have missed it, but there's a piano player on Sundays and I like to go to that when I can." Another person said they did not usually choose to join in activities but told us, "I like walking about and I go round the garden."

Information about planned activities and entertainment was available in people's rooms so that they could decide whether it was something they would like to join in with. We noted that there were gardens with seating and a summerhouse that people could use, weather permitting. One person had their own small area of garden outside their bedroom window.

There was a system for receiving, investigating and responding to complaints and people's concerns were addressed. One person described their experience of having raised an issue with a nurse, which led to some difficulties resolving problems with the manager. However, they were satisfied that their complaint was sorted out. People identified the nurses or the manager as people they could complain to if they needed to raise an issue. A relative also commented about the help and support they had received from the manager

Requires Improvement

Is the service well-led?

Our findings

Systems for ensuring people received good quality and safe care, were not sufficiently robust. The provider had not identified the concerns that we found during this inspection. This included that creams were accessible to some people who used the service which may have posed a risk to their safely. Some creams in use were significantly beyond their expiry dates which meant they may not have been safe to use. One person had a cream that had been prescribed for someone else and there was inappropriate use of thickener for people at risk of choking.

We raised these concerns for people's safety at the end of the first day of our inspection and asked that the management team review what was happening in the service. They sent information to us promptly, showing what they would be doing to improve but the checks they made revealed further concerns in these areas. This supported that the arrangements in place before our inspection were not working sufficiently well.

The management team held a meeting with nursing staff after the first day of our inspection. Minutes of the meeting showed that staff reported, if someone ran out of a cream they needed for their skin, they borrowed from other people living in the home. This was not appropriate. Monitoring systems needed to ensure that people had access to their own supply of what they required to maintain the health of their skin. The meeting minutes also showed that the audit had found four creams in use that were out of date.

The minutes showed that additional concerns were identified in relation to thickener. Fifteen tubs of this product were found in the storeroom, which either were expired or had been prescribed for people no longer living in the home. The management team told us that they had taken action to remedy this and to ensure there was clear guidance for each person needing thickener and that this was easily available to staff for reference. These issues were neither identified as a concern for people's care and safety, nor reported as discussed in the minutes of a meeting for nurses held just over a week previously.

We raised concerns about the storage of toiletries and creams, and the use of thickener at our inspection in July 2015. At our inspection in October 2015, we found that staff had been reminded they should use thickener prescribed for specific individuals and saw that they did this, but the improvement was not sustained at this inspection. At the inspection in October 2015, we also raised concerns that some creams were not properly secured, presenting a risk to people's safety. We found similar concerns at this inspection.

The management team told us, after the first day of this inspection, that they had acted on our concerns to ensure that thickener, toiletries and external creams were stored safely. This contributed to reducing risks for people using the service, particularly people who were living with dementia who may swallow or use the products inappropriately. However, monitoring processes was not proactive in identifying where improvements were needed until we pointed out the issues. We were not confident that the improvement would be sustained, given similar findings at previous inspections.

Minutes showed that people's mealtime experiences and the organisation of the mealtime routine was

discussed with staff on 1 September 2016. The mealtime routine we saw in two different areas of the home was still not well organised. This had an adverse effect on the quality of experience for people and how they were supported.

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

The registered manager understood the requirements of regulations in relation to events taking place in the home, which they needed to tell us about. They made notifications of these in accordance with relevant regulations.

Staff, people using the service and their representatives, had opportunities to express their views to the management team. A relative gave us an example of something they raised which they felt would improve the quality of life of their family member. They said that the registered manager took their views into account and acted upon them.

We found that there were meetings with people and relatives to discuss the service. These provided opportunities for people to discuss the kinds of things they would like to see happen to reflect their interests and preferences. They also provided opportunities for the management team to inform people about changes or developments within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to risks of unsafe care and treatment. Risks were not robustly mitigated. There were risks to people's safety and welfare associated with the storage and management of creams and toiletries. There were also risks to people's safety associated with the way that thickening agents, for those at risk of choking, were stored, managed and used. Regulation 12(1) and (2), (2)(a), (b), (f) and (g)

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 Systems for assessing and monitoring the quality and safety of the service, and for monitoring and mitigating risks were not operating effectively. These did not identify concerns for people's safety that left people exposed to risk. Plans for improvement previously submitted to the Care Quality Commission had not resulted in sustained improvement to the standard of care provided with a view to ensuring people's health and welfare. Regulation 17(1) and (2), (2)(a), (b) and (f)