Mr & Mrs K M Hodgins

Avery Lodge Residential 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 inspection took place on 9 and 22 May 2018 and was unannounced.

At our last inspection on 17 and 18 January 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the management had failed to have effective systems and processes in place to monitor the safety and quality of the service provided. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of effective, responsive, and well-led, to at least good.

At this May 2018 inspection we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to the governance of the service, and one new breach in relation to consent procedures.

Avery Lodge residential home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The care home accommodates 14 people in one adapted building. At the time of this inspection there were 13 people living in the service, some of whom were living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had not ensured that all areas identified as requiring improvement at our previous inspection were completed promptly.

The registered manager had applied for Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS) when people who lacked capacity to consent, had their liberty restricted. However, we did not see that a capacity assessments had been carried out in advance to determine that this was required, or how any restrictions would be managed. Consent forms relating to decisions about people's care were generic to several people living in the service, and had not been reviewed since 2016.

There were audits in place to monitor the quality of the service provided, however, there was still no care plan audit to check the quality of the content. People's records still did not show that they had been involved in the planning of their care, and review procedures were not robust or meaningful.

Risk assessments were completed to ensure that people were kept safe. However, we found that the level of information was not sufficient to ensure that staff had up-to date and clear guidance to help them support people safely.

Care plans were not person centred due to the format being used. The registered manager acknowledged improvement was needed, and had sourced a template which would allow for more person centred detail to be added. These were being implemented.

Staffing levels were not always sufficient to meet people's physical, emotional and social needs. The registered manager had identified a need for additional hours during the day and was trying to recruit.

Activities were provided by care staff when time allowed. More detailed information on people's social care needs was required to inform individual needs and preferences for social activity, and we have made a recommendation about this.

The provider had improved some areas of the service to modernise rooms, and ensure decoration was updated. The provider told us that people were happy with the 'homely' environment and current decoration in the service. However, we advised that they reviewed some areas of the premises for the benefit of people living with dementia, and we have made a recommendation about this.

People's end of life wishes were sought and advance care plans were in place.

People who used the service had access to regular health care input, and advice given by health care professionals was followed appropriately.

Records showed people living at the service received their medicines as prescribed. Some improvement was needed to ensure documentation was clear, and the registered manager implemented the changes promptly.

Staff respected people's privacy and dignity and interacted with people in a caring manner. However, some feedback from people indicated the staff approach was variable.

Systems were in place which safeguarded people from the potential risk of abuse. Staff understood their roles and responsibilities in keeping people safe.

People and relatives said if they needed to make a complaint they would know how to. There was a complaints procedure in place for people to access if they needed to. The views of people, relatives and staff were sought via an annual survey.

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.

Staffing levels were not sufficient to ensure that they were meeting people's needs at all times, but this was in the process of being reviewed by the service.

The likelihood of harm had been reduced because risks had been assessed. However, documentation relating to particular risks needed to be more detailed so clear guidance was available to staff.

Staff recognised types of abuse which they could come across in their work, and their responsibility to protect people from abuse.

People received their medicines in a safe and timely manner. Some improvement was needed to ensure recording was accurate.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found the registered provider did not always work within the guidelines of the Mental Capacity Act 2005.

We received positive feedback about the food provided. Kitchen staff were aware of people's dietary requirements.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed to be caring and kind in their interactions with people. However, some feedback indicated that the staff approach could vary.

People's care plans did not demonstrate that they had been involved with creating them and their views sought.

People were supported to see their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not person centred. More detail was required within people's care plans to demonstrate that all areas of people's care had been robustly reviewed.

Day to day activity provision was provided by care staff when time allowed. We were not assured that this was meeting individual and specialist needs.

There was a complaints procedure in place for people and relatives to access.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Not all areas identified as requiring improvement at our last inspection had been completed, and there were new breaches of regulations.

Audits were in place to monitor the quality of the service, but not in relation to care plans.

There were systems in place to ensure regular feedback from people, relatives and staff.

Avery Lodge Residential 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 checked 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 9 and 22 May 2018, and was unannounced.

The inspection team consisted of one inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector returned for a second day to complete the inspection, and announced this in advance.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding team prior to the inspection.

At the time of inspection there were 13 people living at the service. To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with six people who lived at the service, two relatives, a health professional, the registered manager and provider, deputy manager, administrative manager, and three members of care and catering staff.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 17 and 18 January 2017, we rated this key question as 'Good'.

At this inspection on 9 and 16 May 2018, we found improvements were required with staffing levels, medicines, and documentation relating to risks. We have therefore rated this key question as 'Requires Improvement'.

We asked people about the staffing levels and feedback showed a mixed response. One person said, "During the day it's okay, but I think there should regularly be two staff on at night. There is only one staff on at night and they can call the manager if they need to, but if they're out it can get difficult. The nights run much better with two staff on. The staff here don't want to do nights as it's too much responsibility. We do get checked on at night, every hour." Another said, "You just press your bell. They [staff] can get a bit stretched at night." And a third person said, "Yes and they [staff] always come sharpish. They [staff] check up on us at night too."

The registered manager told us that there was one staff member on at night, and as they lived on site, the staff member could call on them when needed. In the event that the registered manager was away from the service, a second staff member was placed on shift. There was one person requiring assistance of two staff during the night. We were concerned that if the one staff member was assisting a person during the night, there would be no one else available to monitor the welfare of other people in the home. The registered manager told us that they would come down to assist in this case.

During the day there were two staff on shift, and the registered manager was available if needed until 4.30pm. On the late shift, one of the staff members was required to make supper, leaving only one staff member available to monitor people's welfare and deliver care. Additionally, one person required the assistance of two staff. A staff member told us that if they needed support, they would stop preparing food and assist. We observed hot food being prepared, which if left would spoil. There was also a risk that care would not be delivered to people in a timely way if they required it. Also, if two people required support at any one time, or in the case of an emergency, there would be no staff available to provide support to anyone else using the service. We did not consider this was a sufficient number of staff to meet people's needs.

The registered manager told us that they had already identified the need for extra staff and were advertising for a third member of staff to work for a short shift to cover mealtimes. They also showed us via the staff rota, that some hours were already being covered by staff doing overtime.

People's care records listed risks that people affect people in their daily lives. This included falls, mobility, skin integrity, and behaviours which may cause distress. However, we noted that falls prevention plans were compiled as a 'tick list' and did not always provide sufficient information on how to reduce the risks to individuals. For example, one person had been assessed as being at high risk of falls. However, there was no corresponding information on what was in place to mitigate the risk of falls occurring so staff had specific and clear guidance.

Pressure ulcer risk assessments were in place, which identified the likelihood of developing a pressure ulcer. Two people were scored as being at high risk of developing pressure ulcers, and we saw that pressure relieving equipment was in place. Guidance said that staff were to monitor pressure areas, but not how the person's skin should be checked, such as particular areas of the body which were vulnerable, or where to record the findings. Furthermore, the assessments were scored over six months ago, and although staff had written 'no changes' in April 2018, the assessments had not been re-scored recently to demonstrate the review was carried out robustly. Following the inspection, the provider told us that the scores were correct but they should have documented that there were no changes to the original score. The provider informed us that they will put a much fuller statement in the assessments going forward.

Moving and handling plans were not sufficiently detailed. For example, one plan said that the person used a hoist at all times, but there was no information on what hoist they used, the sling type, or colour coding of loops which is important as it aids safe positioning. Another plan said the person needed one staff member to stand them from a seated position or out of bed, but required two staff if 'difficult'. There was no information about what factors staff would need to consider in relation to the person's safety when making a decision about how to move them and in what situations two staff might be needed. The registered manager told us that staff knew people's needs well, and if they have more service users requiring a hoist, they would change their current practice to ensure the information was available for each service user requiring a hoist.

People's behavioural risks were assessed in the same way, via a tick list assessment. These showed that at times people could experience periods of distress which manifested in verbal and sometimes physical aggression. The behaviour risk assessment gave no information about how staff should support the person, or strategies which staff should use to keep the person, themselves, and other people safe.

We discussed this with the registered manager, who acknowledged the information was not sufficient. They showed us that for two people, they had completed a 'daily care plan' which outlined their physical and emotional needs, and which provided more person centred detail. They planned to implement these for all people. However, it would be beneficial if staff were easily able to access information about specific risks in one, prominent position along with guidance to staff about how people could be supported and what to expect if they became distressed or unwell.

The daily care plans did not always provide sufficiently detailed information, for example, one person experienced periods of distress whereby they could become physically and verbally aggressive. The daily care plan said that staff should use distraction or interaction to calm them, but did not describe what specific distractions would be most effective for the person.

There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria. However, the recent monthly hot water checks being carried out showed that hot water temperatures were too high in some areas of the service, posing a risk of scalding. The registered manager informed us that this was as a result of the boilers being set too high following statutory servicing of them. They informed us that the boilers had been since been adjusted and the temperature range was now within safe limits. We also noted that there was visible scale on some taps in the service, which can increase the likelihood of legionella bacteria. The service had recently implemented a weekly tap de-scaling programme, but following the inspection informed us that all taps in the service had been checked and de-scaled. They also ordered a legionella testing kit whilst we were present as an additional safety measure to ensure water was free from bacteria.

Weekly fire alarm tests were carried out in the service, and people had personal evacuation plans in place

which outlined the support people would need in an emergency situation.

Staff received safeguarding of adults training and were able to tell us types of abuse they may come across in their work. One staff member said, "We could come across physical, sexual, financial or emotional abuse. If I had concerns I would raise this to my colleagues. If there was no resolution I would speak with the managers, or if needed, the adult protection team."

People were protected by procedures for the recruitment of new staff. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions.

People told us they felt safe. One person said, "Well I have to say they [staff] do look after me well. I wouldn't stay if they weren't. Yes I feel safe. It's the whole shebang. I have no worries. If the staff can't help with something they soon find someone who can." Another said, "Yes I'm very safe I wouldn't stay here if I wasn't. Feeling safe's worth a lot to a woman on her own."

People told us they received their medicines as required. One person said, "The staff are regular and thorough with your medicines, always dead on time". Another said, "That's [medicines] all okay, they [service] never run out."

Staff authorised to handle and give people their medicines had received training to do so, and received checks of their competency every six months.

We checked the systems in place for managing people's medicines. Generally medicine administration records (MAR) were completed consistently to show what medicines people had been given. However, we found some areas for improvement. For example, where people were receiving medicines as required (for example, one or two tablets), we found staff had written the amount given on the MAR. However, due to limited space this was not always legible. This meant when we checked stock levels they were incorrect as we could not be sure how many tablets people had been given. We advised staff to write the number of medicines given on the back of the MAR chart so it was clearer.

When people were prescribed medicines on a when-required basis, there was sufficient written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities.

Medicines were stored securely in lockable facilities for the protection of people who used the service. This included medicines associated with higher risk, and we found these stock levels were correct.

There was an infection control 'lead' in the service, who attended local infection control meetings to learn about best practice and share their knowledge with the team. Cleaning schedules were in place and monthly checks on the cleanliness of people's rooms. However, we found some practices in the service which posed an infection risk. For example, we found personal protective equipment (such as gloves) and continence aids were stored in one of the bathroom areas. Some carpets in the service were also in need of replacement. Following the inspection, the registered manager confirmed that they had purchased brackets to be fixed to the wall to hold gloves outside of toilet and bathroom areas. They were also reviewing the quality of the carpets in the service. One person commented, "We have clean towels and flannels every day and clean clothes. If there was a speck of anything on my sheets they would be changed. Even the domestics

[staff] have to press the buzzer when they arrive in my room and press it again when they leave. Look how clean it is in here!"

The service had developed some of their practices to ensure that lessons were learned and improvements made when things had gone wrong. For example, in May 2018, the service had worked with a pharmacist from the Clinical Commissioning Group to complete reviews of people's medicines, and also to improve the current system in relation to obtaining prescriptions from the local practice which had previously caused delays. We also found that systems had been updated to improve the monitoring of staff training, and management had also undertaken training in MCA. However, compliance with the MCA was still not fully adhered to. Additionally, minimal work had been undertaken to improve the care plans since our last inspection, or the review process of risks. Therefore, the service needed to continue to develop their practice further and respond promptly to areas for improvement.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2017, we rated this key question as 'Requires improvement'. This was because we found that people did not have clear, regularly reviewed capacity assessments, and because staff did not understand what MCA and MCA DoLS meant in practice. We made a recommendation that the service seeks advice about how to meet the requirements of the MCA and MCA DoLS.

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

The registered manager told us that they and the management team had attended advanced training in MCA to increase their knowledge of the subject. They had also handed out an MCA 'quiz' to test staff knowledge, and arranged training in 'restrictive practices'. Whilst these were positive steps, we found that MCA DoLS was still not understood fully by either the management team or staff working in the service.

The registered manager showed us a template they used in relation to people consenting to their care. These included statements such as, "In my best interests, I give my consent for staff at Avery Lodge to assist me". This was a generic template used for several people living in the service, and listed things like administering medicines, assisting with personal hygiene, accessing health professionals, not smoking in the building, and leaving the premises. The three we reviewed were signed by people in 2016. There was nothing to show that these had been reviewed to take account of changes in people's mental capacity, and ensure they were still relevant.

For example, we saw that one person had signed the consent form to say they were able to leave the premises, but needed to notify staff and sign out when they leave. The registered manager told us that the person was previously attempting to leave the building but were unsafe to do so, and a DoLS application was made. An application for DoLS would indicate the person lacked capacity, and therefore the person would be unable to consent to this. Another person had signed to say they could leave the premises if they signed out first, however, staff told us that they could not go out alone, as they did not understand road safety. There was no information contained in the consent form in relation to this, and a DoLS application had been made, which again indicated the person lacked capacity to consent.

We asked staff what they understood of MCA and DoLS. One staff member said, "I wouldn't know where to start. I think everyone here has a DoLS. I do know that it's about giving people choice, I always ask people

first, whatever the decision is." Another said, "MCA is about not restricting people, but I'm not sure how many have DoLS here."

The registered manager had made four applications for DoLS. There were no mental capacity assessments or best interests decisions in relation to DoLS which had been applied for. There was no reference to DoLS having been applied for in people's care plans so staff were aware of what this meant for people on a day to day basis, and if there were any restrictions in place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We observed that staff sought people's consent before assisting them with day to day tasks such as moving position, assisting to eat, and deciding where they would like to sit. One person told us, "The staff show respect. They [staff] always ask me if I want tea, they'd never just bring it." Another said, "They [staff] always ask first, and they [staff] always knock on the door."

We asked people if they thought staff were well trained. One person said, "Yes they are [well trained]. You can always tell when [carer's name] has trained the new ones as they are thorough and even dry between your toes." Another told us, "They [staff] seem to know what they're doing. They're [staff] not too bad."

Logs were in place which listed training each staff member had undertaken for the year. This included moving and handling, medicines, first aid, managing behaviours, safeguarding, and health and safety. The training consisted of a combination of online and face to face training. Where staff had completed online training, their score was noted. The registered manager told us that if staff scored below 75%, they had to repeat the training within one month. Further training for 2018 had been planned, and included restrictive practice, falls prevention, MCA, and infection control.

Staff told us they received an induction before working in the service. One staff member told us, "I had a good induction, I had time to read information and get to know the residents." Staff also received supervision. Supervision sessions provide staff with the opportunity to discuss how they are working, receive feedback on their practice and identify any training needs. The registered manager told us they had prioritised this work, but had still not completed supervisions for all staff. One staff member told us, "I haven't had supervision for a while, but I was just given a self-assessment form, in preparation for my supervision."

Supervision records showed that training was discussed, and any agreed actions had a date for completion. Observations of staff were also included in the supervisions records, where their practice was observed so the registered manager could assure themselves that staff were professional and kind when interacting with people. The registered manager told us they spoke with staff to check their knowledge of training undertaken, although they did not always document this. We advised they do so to demonstrate that staff competency was being checked.

Staff working in the service had qualifications in care at various levels. For staff working in the service who did not have formal qualifications in care, they were expected to complete the Care Certificate, which is a set of standards that care workers are assessed on to ensure they are providing good quality care. We saw where this training was in place, discussions had taken place with staff members to ensure workbooks were being completed in a timely manner.

People were able to visit the service and have their needs assessed before they made a decision about whether the service could meet their needs. People's initial assessments had been used as a basis on which

to formulate a care plan which detailed some of the support people required to meet their physical and personal care needs.

The service had considered new technology as a means of improving the care provision. For example, they had installed a new call monitoring system, which included wrist bands which could be worn by people who experience falls, and which alerts staff if a person has fallen. The registered manager told us the system was proving very beneficial, and enabled them to have oversight of staff activity.

We asked people about the food provided in the service. One person told us, "The food's very good. You can ask for an omelette or something like that if you don't like the choices for lunch. We have a roast on Sundays. I go down to the dining room for most of my meals. It's often quiet in the dining room but then lots of people eat in their rooms. They [staff] bring me a cup of tea in bed." Another said, "The food here is adequate. You look at the menu board and make up your mind. I normally eat in the dining room but there's no atmosphere. They [staff] usually play music in the background." A third said, "I can't sit in a chair for long, so I stay in here [in room] for my meals. The food's good. We get asked at breakfast time what we want for lunch and they'll [staff] get you something else if you don't want what's on. I usually have a sandwich for my tea but there are some who have scrambled eggs or beans on toast. During the evening and night do you know you can get a drink or something to eat every hour."

We observed the lunchtime meal. Six people ate in the dining area. The dining area was themed in an American style, with old radios and pictures of Elvis. The tables and chairs were a fixed 'canteen style' design, which meant that for some people with physical disabilities, these tables were not suitable. We saw a separate table had been placed in the dining area, where two people who used wheelchairs were able to access more easily. Two people were seen to struggle to sit at the tables, but managed independently. However, the design of the dining area could potentially limit how many people used it, depending on their physical abilities.

The provider had not fully considered how to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast. Some carpets were heavily patterned. Patterned carpets can cause confusion if you have dementia, as it becomes increasingly difficult to distinguish between design and actual objects that they need to pick up or step over, and could potentially cause a person to fall.

There were few clear signs, symbols or colours to help people to recognise their own bedroom. For example, not all bedroom doors had names or pictures on to help people identify their own room. The registered manager told us that that they had asked people if they wanted a photo or name on their bedroom doors and those who did not were removed. Some decoration in the service was tired and in need of improvement, and some doors were heavy to open. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence) to further improve the design and decoration of the service, and consider best practice for people living with dementia.

Following the inspection, the registered manager confirmed that they had already started to explore ways to improve the design of the home in response to our feedback. They had arranged a new carpet for the two lounges, and purchased new dining chairs and tables. They had also decorated rooms which were empty, and considered the furniture layout.

The service had worked together with other organisations. This included the medicines optimisation team, local GP practice, and the Clinical Commissioning Group. We saw referrals to healthcare professionals had been made appropriately. For example when people had experienced falls, their GP and the falls team had been contacted for advice. People's weight was monitored and when gains or losses had been identified these were documented in people's care records.

The service also had a paramedic practitioner who visited the service on a weekly basis. This was to ensure people's health needs were met promptly, and any issues could be triaged by the paramedic who gave advice to the service, or passed the information on to the GP if necessary. The registered manager told us they found their input very beneficial, and prevented people's health from deteriorating. For example, diagnosing urine and chest infections earlier. They had also liaised with the paramedic in relation to malnutrition and the assessment of this risk. The paramedic told us, "I usually liaise with the deputy manager, who remains with me whilst we review residents, and this provides consistency. They follow recommendations I make, and we work well together."

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we rated this key question as 'Good'. At this inspection we have rated this key question as 'Requires Improvement'. This was because we were unable to ascertain how people were actively involved in making decisions about their care and treatment as their records lacked information to show this.

We received responses from people about their involvement in their care planning. People's comments included; "They [staff] do ask me if I'm okay but I've never been involved in writing anything, no." Another said, "No, never." And a third person said, "Yes they [staff] do ask me if I'm happy. Care Plan? Not put like that no." Therefore we were not confident people were involved in the planning of their care.

Staff we spoke with clearly knew people well but some care records did not always reflect people's life histories, past employment, family lives and relationships. This could make it difficult for new staff to get to know people and support them to initiate meaningful conversations. The registered manager told us that in some cases they were unable to gather a personal history as some people have no family, or very limited information. Additionally, some people did not wish talk about their history. This meant that sometimes the information was unavailable, but was an area they continued to work on.

Whilst we observed kind and caring interactions between staff and people who lived at the home, staff were sometimes busy and task focused. For example, there was little time available to spend chatting with people. One staff member told us that if there was one thing they could change in the service, it would be to spend more time just talking with people, as they often didn't get the chance to do this.

We received mixed feedback from people about the approach of the staff. One person said, "The majority of the staff are okay. I think they [staff] know me well. 90% of the staff treat me with kindness." Another said, "The staff are friendly. I think they know me well. Me and one of the carers don't like each other much." And a third person said, "I get on with them [staff] all. Yes, I think they know me by now, I've been here a while. They [staff] show respect and are caring folks." Where people had given less than positive feedback about staff they did not give us further details about why they felt this way, however, the registered manager can monitor this going forward.

We did however observe that staff communicated with people effectively and respectfully. We observed that staff communicated with people in a warm, friendly and sensitive manner that took account of their needs and understanding. Staff took care to maintain and promote people's well-being; for example, during the inspection one person became very upset, wanting to pack their belongings and leave. The registered manager and staff showed effective communication skills when supporting and calming the person. The registered manager told us they were going to get their dog as they knew the person would benefit from seeing the dog, and it would calm them down. This showed us that the registered manager and staff knew people well, and how to use the most effective methods to support people who were distressed.

People felt their privacy and independence was respected. One person told us, "No problem with privacy.

The staff show respect. I have no worries but please myself." Another said, "I do wash and dress myself. I take my time and am happy. The staff are there if I need them."

People were supported to maintain relationships with people that mattered to them. Visitors were welcomed into the service and could visit at any time.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in January 2017, we rated this key question as 'Requires Improvement'. This was because there was insufficient information about people's needs in their care plans to support staff to deliver person centred care. Additionally, there was no information showing that people had been involved in the planning of their care.

At this inspection in May 2018, we found this was still the case. People's records did not always show people's input and were not individualised. For example, by signing the record to show they agreed with the content. Care plans consisted mainly of a generic tick list to various questions, which did not allow for person centred detail to be added. Some support needs relating to moving and handling, falls, and behaviours and distress, were not properly described, or detailed in how to mitigate the risks in these areas.

Reviews were not robust or meaningful. In most cases there was a sentence added saying "Reviewed, no changes required". This did not demonstrate that reviews were robust or what details were considered when deciding that no changes were required. Where changes had been made, these stated, "Re-done and updated". No other information was documented, such as what had changed. This was highlighted in the previous inspection, but improvement had not been made since. However, in relation to the people whose care we reviewed, we checked the practical arrangements in place and were satisfied that they were receiving the appropriate support.

We discussed the care plans with the registered manager who agreed that the care plans needed to be updated and were not person centred. On day two of the inspection they showed us a template they were planning to use which would allow for person centred detail to be added, therefore making the care plan individual to the person, rather than a generic set of questions. Following the inspection, they confirmed work had begun on implementing these.

We asked people if there was enough to do and if they ever felt bored. One person said, "I'll sit down there [lounge] if there's music on sometimes. Do I get bored? Yes I do sometimes, but I have my TV here in my room." Another said, "The home tries its best. I like to get out or sit in here [lounge]. We play pool or darts or watch sport in here."

We observed that some people went out in the community to pursue their interests, but others remained in the service and we did not observe any activities taking place. One relative told us, "We're a bit disappointed about that [activity provision]. When [relative] first came in here they [staff] used to play bingo and games but now they seem to just watch TV and listen to music sometimes. When you're paying to be in here you'd think they'd [staff] do a bit more with them." Another said, "[Relative] just seems to sit in here [lounge] all day." And, "The care is varied I'd say. It would be good if they [staff] did a bit more with [people] instead of them just sitting in here [lounge] all day."

The registered manager told us that events were organised, and we saw that these had been arranged for the year ahead, and included an Easter, Halloween and Christmas party. They had organised a group outing

for people, but at the last minute people changed their minds about attending. They had also purchased an electronic games console which connects to the television and offers various games for people to participate in.
Whilst this was positive, it was the day to day stimulation we did not consider was fully meeting people's individual and specialist needs, such as those living with dementia. The registered manager told us they had trialled sensory stimulation for people living with dementia such as sensory mitts, which some people can find comforting, however, these had not been successful. They also told us that they had a suitcase full of old memorabilia, but this was not met with interest. People's care plans included a section on 'activities and interests', but we did not see that these preferences were being encouraged.

We recommend that the service explores current guidance from a reputable source in relation to the range of approaches and interventions which can be considered in meeting people's individual social needs.

At the front of the building, there was an attractive decking and seating area and a sizeable water feature with fish. The density of trees and bushes shielded the building from the busy road outside and people and visitors were able to utilise this space. We observed people seated outside socialising on both days of our inspection.

Advance care plans were in place to support people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life. Care plans made reference to people's end of life wishes, such as who they wanted involved, and where they wanted to be at this time. Some contained more detail than others, however, we saw that information was being gathered from families where necessary. Staff had completed training in end of life care.

The service had not received any complaints, but had a complaints procedure in place. The procedure for making a complaint was displayed in the main reception area. We asked people if they knew how to raise a complaint. One person said, "It's excellent here, I have no complaints. If I had, I'd see one of the carers and they would sort it out. We have no worries in here you see. The staff help you with whatever you need." Another said, "The care's very good in here on the whole. If I needed to complain I would deal with whoever or whatever was causing the problem. [Manager's first name] would be my last resort." A relative told us, "I would speak to [registered manager]. If I had a complaint. "

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in January 2017, we found the registered provider did not have effective systems and arrangements in place for the management and oversight of the service to ensure the quality and safety of people's care. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection we found some areas had improved, such as the monitoring of staff training and supervision. However, we found new breaches in relation to consent procedures which means the service remains in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection in January 2017, we reported that MCA DoLS was not fully understood by staff, and that capacity assessments were not regularly reviewed. We found this area of people's care had not progressed. Consent forms that were in place were generic for several people living in the service, and did not demonstrate adherence to the principles of the MCA. The registered manager had not ensured that this area of people's care was improved upon.

People's records still did not show that they had been involved in the planning of their care, and review procedures were still not robust or meaningful. Though the registered manager took swift action in several areas in response to our feedback during the inspection, they had not independently identified where improvement was required.

There were audits in place to monitor the quality of the service provided, which included a weekly/monthly medicines audit, infection control and bedroom checks, health and safety of the building, monthly weights, hoist slings, and a quality audit which monitored that people's personal care and sensory needs were being met. For example, that people's glasses were clean, hearing aids were in place (where needed), and footwear was appropriate and safe. However, there was no care plan audit to check the quality of the content. This was raised at the last inspection, and although we saw that the registered manager had been monitoring the daily written records, they had not completed any quality audits in relation to the actual care plan content to help them identify where improvement was needed.

We concluded that the provider had been unable to make and sustain improvements required at the last inspection.

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

The registered manager understood their responsibilities to inform CQC of events that occurred in the service, such as serious injuries. However, we found that a recent incident had not been reported to us and should have been. The registered manager promptly sent us the information following the inspection.

People living in the service knew who the manager was. One person said, "Oh the manager is good. She often pops in to see me. She does lots for us at Christmas and during the holidays and organises

entertainment." Another said, "[Registered manager] does her best. Yes, she's always around and often chats to us."

Staff meetings were held in the service to ensure relevant information was discussed and known by all staff working in the service. Staff told us they felt supported. One staff member said, "I think the service is well-led to a degree, and I do feel appreciated. I think people lead a happy life here. I have worked in other homes and this is the best one." Another said, "It is well led, I can't fault [registered manager]. I can approach them with anything. I get positive feedback and feel valued."

The registered manager had been reading inspection reports for other residential homes in the local area which had been rated 'Inadequate'. This had resulted in positive outcomes for the service. For example, they had ensured all radiators and pipes were covered to ensure the risks of scalding were minimised. They had also ensured that heavy furniture was secured to the walls to minimise the risk of injury to people.

The registered manager had implemented a new improvement plan which linked to the key lines of enquiry which CQC use. This will help to focus the improvements more accurately, and evidence how each area is being met.

Annual surveys were issued to people, visitors and professionals to gain feedback on their views of the service. We saw these contained mainly positive feedback about the care people received. One professional commented, "Residents are happy and comfortable. They [registered manager] look at CQC reports to see what others have introduced." A relative said, "Very happy with care provided, keep up the good work."

The service was working work with local schools and their choirs who visited at Easter and Christmas. They also had a visiting programme with The Princes Trust based at the local college, where young volunteers visited for informal activity sessions and chats. The registered manager told us the next one was planned in June 2018, and that people living in the service really benefitted from interacting with younger people.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent in line with MCA 2005 DoLS safeguards. 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems in place did not always enable the provider to identify where improvement was needed. 17 (1) (2) (a)