Care South

Talbot View

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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection on 14 and 15 April 2015.

Talbot View is registered to provide personal care for up to 59 older people. There are four living units. 'Highmoor' is for older people and the other three living units are called 'Warehams', 'Lollipop Lane' and 'Butlers Brook' for people who are living with dementia. Butlers Brook is specifically for up to 13 men who are living with dementia. Nursing care is not provided at Talbot View. There were 48 people living at the home when inspected.

The registered manager has been in post since August 2014. 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.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Risks to people were not always assessed, monitored and planned for to make sure people were consistently safe from harm. People's care plans and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support people needed or that had been provided to people.

Care plans for 'as needed' medicines were not always in place so that staff knew when, how often and how much medicine to give people.

There was a core of staff who knew people well but there was a high use of agency staff on some weekends. This meant that at times people were cared for by some staff who did not know them well. Staff did not all have the right skills and knowledge to provide personalised care for older people living with dementia. This was because they did not have all the training they needed.

Staff did not fully understand about the Mental Capacity Act 2005, and how to assess people's capacity to make specific decisions or about those people who were being restricted under Deprivation of Liberties Safeguards. Which meant people's consent may not have been lawfully obtained.

Food and fluid plans were not in place for people who were at risk of losing weight so that staff knew what action to take to support them. People's food and fluid intake was not monitored and reviewed when they lost weight. People's food preferences were not always provided and coloured crockery was not used so people living with dementia could see their food easily.

Some people living with dementia did not always receive personalised activities because their personal information had not been used to plan their need for activity, stimulation and occupation.

The governance at the home was not always effective because learning was not always effectively shared, record keeping was inconsistent and shortfalls identified in action plans had not all been addressed to make sure the service continually improved.

People and relative knew how to make a complaint or raise concerns. Complaints were fully investigated but learning from complaints was not always effective.

People told us they felt safe at the home and we saw people were relaxed with staff. Staff knew how to recognise any signs of abuse and how to report any allegations.

People received personal care and support in a personalised way. Staff knew people well and understood their physical and personal care needs. Staff were kind, caring and treated people with respect. Relatives were very positive about the quality of care their family members received at Talbot View.

People, relatives and staff were consulted and involved in the home. Some people told us they were involved in planning their care. Relatives said they were involved in their family members care and support. They told us they were listened to by managers and senior staff.

At our last inspection in November 2013 we did not identify any concerns.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Improvements were needed to make sure the service was consistently safe. Risks to people were not always managed and planned for so that people were kept safe.

Overall medicines were managed safely but not everyone had an 'as needed' medicine care plan in place.

People told us they felt safe and staff knew how to recognise and report any allegations of abuse.

There were enough staff to meet people's needs but some of these staff were from an agency. Staff were recruited safely.

Is the service effective?

Requires improvement

The service was effective but some improvements were needed.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

When people lost weight and their food and fluid intake was not monitored. People were offered a choice of food. Hot and cold drinks were offered regularly throughout the day and people were assisted to eat and drink when required.

Staff had some core training to carry out their roles. Staff needed further training to be able to fully meet the needs of older people living with dementia.

People accessed the services of healthcare professionals as appropriate.

The design and décor of the home did not always take into account the needs of people living with dementia.

Is the service caring?

Good

The home was caring. People and relatives told us that staff were kind, caring and compassionate.

People were involved in decisions about the support they received and their independence was respected.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Requires improvement

The service was responsive but some improvements were recommended.

People's needs were not always assessed and some care was not always planned and delivered to meet their needs.

Summary of findings

People were supported to take part in activities that they enjoyed. People said their visitors were always made welcome. However for some people living with dementia, their need to be kept occupied and stimulated was not consistently met.

People and their relatives knew how to complain or raise concerns at the home.

Is the service well-led?

Requires improvement

Some aspects of the service were well-led but improvements were needed.

There were shortfalls in the care plans and record keeping for people and this meant we could not be sure of the care they received.

There were systems in place to monitor the safety and quality of the service. An improvement plan was in place but the shortfalls had not yet been addressed.

There was not consistent learning from complaints, accidents, incident and investigations into allegations of abuse.

Observations and feedback from people, staff and professionals showed us the service had an open culture.

Feedback was regularly sought from people, staff and relatives. Actions were taken in response to any feedback received.

Talbot View

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 April 2015 and was unannounced. There were two inspectors in the inspection team and they visited on each date. We met and spoke with all 48 people living at Talbot View over the two days. Because most people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine visiting relatives and two visiting GP's during the inspection. We also spoke with the registered manager, deputy manager, four senior staff and nine staff.

We looked at five people's care and support records and all 48 people's medication administration records and documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of. We also contacted one commissioner to obtain their views. We contacted two health care professionals following the inspection.

We asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make.

Following the inspection, the registered manager sent us information about policies and procedures, survey results, staff training and the training plan.

Requires improvement

Is the service safe?

Our findings

People who were able to said they felt safe at Talbot View. One person said, "If I was ever worried about anything I would tell someone". Relatives told us they felt their family members were safe at the home. We saw that other people freely approached and sought out staff. They smiled and responded positively when staff spoke with them. This indicated people felt comfortable and safe with staff.

Most staff had been trained in safeguarding adults at risk. The provider's safeguarding policy was accurate and up to date with the relevant local authority contact details for staff to access. All the staff we spoke with were aware of how to respond to and report concerns about abuse, including outside agencies they could contact. Information about safeguarding adults was displayed in the office.

The registered manager and a senior staff member told us about a safeguarding incident that had been reported to the local authority. This had been investigated by the registered manager and provider as requested by the local authority. However, following discussions with registered manager, we identified there was a lack of risk management and management oversight of the arrangements put in place following this safeguarding investigation. This meant the registered manager could not be sure that the risk of harm to people had been minimised and that people were consistently safe. The registered manager agreed to put a risk management plan in place following the inspection.

This shortfall in monitoring and mitigating the risks to the health, safety and welfare of people was a breach of Regulation 17 2 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medicines plans, administration and monitoring systems in place for people. Medicines were stored safely and we checked the stock balance of some specialist medicines. Regular medicines audits checked that medicines in stock and disposed of could be accounted for.

Most senior staff had been trained in the administration of medicines and records showed they had their competency assessed to make sure they were safe to administer medicines.

Staff told us one person had their medicine covertly; this meant the person was not aware they were taking medicines, for example in a drink or food. This person was living with dementia and may not have been able to consent to this. This decision had been made in consultation with the person's GP, family, consultant and had been made in line with the Mental Capacity Act 2005 (MCA). However, the pharmacist had not been consulted to check whether the medicines could safely be crushed. The senior staff contacted the pharmacy for advice on the second day of inspection.

Some people did not have 'as needed' medicine plans in place. These plans were needed so staff knew when, how often and the maximum dose of medicines to be given in 24 hours. This meant some people may not have received their 'as needed' medicines when they needed them. For example, one person had a sedative medicine prescribed on an 'as needed' basis. This medicine had previously been administered at set times. Senior staff told us the 'as needed' care plans had not been updated following the change in the prescription. This meant that staff did not have clear instructions as when to administer this medicine to make sure the person had it when required.

People had risk assessments and management plans in place for falls, moving and handling, pressure areas and nutrition. However, risk assessments and management plans were not in place for some areas of risk and were not reviewed as people's needs changed. For example, one person had multiple falls but their risk assessment and management plan had not been updated to reflect what support they needed. Staff told us how they were now supporting this person to manage and reduce the risks but these actions were not recorded. This meant that any new or agency staff may not know how to manage the risks for this person.

Senior staff told us staff knew people well and were able to identify when they were in pain. However, there were not any pain management risk assessment tools in place for people who may not have been able to verbalise when they were in pain and tell staff when they needed pain relief.

Three people living at the home had a diagnosis of epilepsy. There were not any risk management plans in place for the three people. Staff and senior staff did not

Requires improvement

Is the service safe?

know what action they needed to take if the people had an epileptic seizure and at what point to call paramedics. This placed these people at risk of not receiving the correct medical treatment when they had an epileptic seizure.

These shortfalls in the proper and safe management of medicines and risk management plans were a breach of Regulation 12 (2) (a)(b)(g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives said there were enough staff to meet people's needs. We reviewed the staffing rotas for four weeks. The registered manager told us they kept people's needs under review and had recently increased the staffing at night in response to the increased needs of people. Staff told us that there were enough staff most of the time. However, staff on Butlers Brook identified that at times it was difficult to safely monitor all of the people all the time. They told us this was because at times when a person needed additional monitoring this only left one other member of staff to support and care for the other 11 people.

There was a core of staff that had worked at the home for a number of years and they knew people and their needs well. However, the registered manger and staff told us that agency staff were routinely used. Staff and rotas showed that on alternate weekends out of the 10 staff on duty up to four of the staff were from an agency. The registered manager and staff confirmed that agency staff always worked with a regular staff member on the living units.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people. This included up to date criminal record checks, fitness to work questionnaires, proof of identity and right to work in the United Kingdom and references from appropriate sources, such as current or most recent employers. Staff had filled in application forms to demonstrate that they had relevant skills and experience and any gaps in their employment history were explained. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

The deputy manager showed us the system that was in place to monitor accidents and incidents in the home. This included this information being reviewed by the provider. This meant that all accidents and incidents were reviewed, analysed and action taken where necessary.

There were emergency plans in place for most people, staff and the building maintenance. In addition to this there were weekly maintenance checks of the fire system and water temperatures. There were robust systems in place for the maintenance of the building and equipment which were undertaken by the maintenance worker who was employed by the provider.

Requires improvement

Is the service effective?

Our findings

One person said, "Staff seem very skilled, some are better than others but all are ok". Three people told us they felt staff were skilled at using hoists to transfer them.

Staff had a good understanding of how to meet people's physical and personal care needs. However, we identified, observed and some staff told us they did not have the right skills and knowledge on how to care for and provide meaningful occupation for people living with dementia. For example, staff were not sure how to respond or interact with one person who communicated differently because they were living with dementia. This meant that staff rarely interacted with this person and spent more time with people who were able to chat with them and tell them what they wanted.

Staff told us they felt supported by their line managers but that they had not all had the opportunity to have formal one to one supervision sessions. This meant they had not all had the opportunity to discuss their work and individual training needs. The registered manager acknowledged that staff had not all received one to one or group supervision sessions as set out in the provider's supervision policy. This was an area for improvement so staff received the support and supervision they needed. Staff and senior staff told us they had started to have formal observed sessions with staff as detailed in the policy.

Staff told us and records showed they completed core training, for example, infection control, moving and handling, safeguarding, fire safety, health and safety and food hygiene. Staff told us the induction training they received had been effective and that they had felt well supported throughout their induction period. According to the information sent to us by the registered manager there were significant gaps in the staff training. The provider had determined how frequently staff should receive training and how often they should have an update. All of the senior staff's safeguarding training was out of date. None of care staff and only one of the 12 senior staff had received MCA 2005 or Deprivation of Liberty Safeguards (DoLS) training. Most staff had one day's dementia awareness training and Talbot View is a specialist dementia care home. Following the inspection, we asked the registered manager if there was a plan to address the training shortfalls. This information was not provided when we requested it.

The shortfalls in staff training to ensure that staff who were providing care had the competence, skills and experience to do so safely was a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to tell us said they were not restricted in any way at Talbot View. One person said, "They don't mind what you do at all". We observed people moving freely about their living units and being supported to access the gardens.

The service was not meeting the requirements of the Mental Capacity Act 2005. Staff were not aware of the Mental Capacity Act 2005, making best interest decisions, or which people were being deprived of their liberty and who had Deprivation of Liberty Safeguards (DoLS) applied for or authorised. Staff did not fully understand the presumption that people have capacity to make decisions for themselves. For most people whose records we looked at, capacity assessments had not been completed so specific decisions could be made in people's best interests. For example, one person had restrictions placed on their fluid intake because of a specific medical condition. They also had their ensuite bathroom door locked to further restrict their access to fluids. This decision was made by a community mental health professional and the staff at the home. However, there was no mental capacity assessment or best interest decision recorded anywhere in the person's care records. In addition to this there were not always mental capacity assessments or best interest decisions recorded about the use of bed rails and pressure alarm mats where people were unable to give consent. The registered manager acknowledged that mental capacity assessments and best interest decisions were not recorded for most people. They were aware of the need for these to be completed.

The staff's lack of awareness of the code of practice and principles of the MCA 2005 and the lack of mental capacity assessments and best interest decisions was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only

deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Some of the people living at the service had been assessed as lacking mental capacity due to them living with dementia. DoLS applications were correctly completed and submitted to the local authority. However, they had not yet been assessed by the local authority. We met and spoke with the one person who was subject to DoLS, reviewed their care plans and spoke with staff. Staff and senior carers did not fully understand what DoLS was and the implications for this person. The person's care records made reference to 'DoLS in situ' but did not include any further details for staff such as when the authorisation expired and whether there were any conditions.

Most people told us they enjoyed the food and there was always a choice. One person said, "The food is very good and they always cut up my meat for me. I'm offered lots of different choices when I don't want what is on the menu". However, another person told us there was a choice but they were vegetarian and they wanted Indian foods such as chapattis, dhal and curries. They said this was their cultural preference as these were the foods they had always eaten prior to moving into the home. They told us they had raised this with staff before but nothing had happened. This person's care plan included they were vegetarian but not that their preference was for Indian foods because of their culture. We raised this with the registered manager who agreed to arrange meals to meet the person's food preferences.

Staff either offered people a verbal choice or showed them two plates of food to choose from. This was based on the staff's knowledge of the person and how the person was best able to make a choice. However, on one living unit people living with dementia were not offered a choice of drink with their main meal. Condiments such as salt and pepper were not available or offered so people could add additional seasoning and flavour to their foods.

On three of the living units fruit and cold drinks were readily available for people to help themselves. Drinks were not readily available on one of the living units. Staff explained the reasons for this and told us they offered and gave people drinks frequently to make sure they were hydrated. We observed this happening throughout the inspection.

We observed the lunchtime period in two of the living units. There was a relaxed atmosphere during the mealtimes. Staff supported people to eat and drink at a pace suitable for each person and explained to them what they were eating. However, staff told us they used to be able to sit and have a meal with people. They said this had contributed to very positive mealtime experiences particularly for those people living with dementia who needed support and prompting to eat. This practice of having a meal with people had stopped following a decision by the provider. Staff felt this had a negative impact on people's mealtime experiences. This decision does not currently reflect the good practice as recommended in published dementia care guidance.

Research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more. Coloured crockery was not available in the home. One of the meals was cauliflower, potatoes and chicken pie and was served on a white plate. Some people living with dementia would have found the food hard to see. We observed one person leave half of this meal and walk off. This may have been because they could not clearly see what food was on the plate.

People who were identified as at risk of malnutrition or weight loss were not having their food and fluid intake monitored. This meant that staff did not have a way of monitoring whether the person was having enough to eat or drink to maintain or increase their weight.

Two people's care plans did not reflect their weight loss over a period of time. For example, one person had lost 5kg from August 2014 to April 2015 but this was not reflected in their nutrition plan. There was not any monitoring of what they were eating to make sure they were having the correct amount of food to increase their weight. In addition to this, the person's care plan included they needed their drinks thickened but not to what consistency. Staff knew how many scoops of the prescribed thickening powdered to use but not what the consistency should be. We reviewed a further two people's care plans and they also did not include the consistency required. This placed people at risk because there were not any written instructions for staff to follow to ensure they had their fluids at the correct consistency. In addition to this the guidance from Speech And Language Therapist (SALT) team was not available in some people's care plans.

Another person was having their fluids monitored in relation to making sure they did not drink over a specific amount due to a health condition. Three staff we spoke

Requires improvement

Is the service effective?

with told us about this but the person's care plan did not include this information or the reason for monitoring their fluid intake. The fluid monitoring records were not being reviewed or totalled to ensure the person was having sufficient to drink but also that they did not exceed the recommended amount.

These shortfalls in the assessment, planning, monitoring of and meeting people's care needs.in addition the shortfalls in meeting people's preferences in relation to nutrition and hydration were a breach of Regulation 9(1)(b)(c)(3)(i) of the Health and Social care At 2008 (Regulated activities) Regulations 2014.

People's health needs were met and they were supported to access healthcare. Records showed people saw GPs, chiropodists, district nurses, specialist nurses and community mental health staff. GP's spoke highly of the staff and care people received at Talbot View. They told us the staff sought medical advice appropriately, staff knew people well, there was good communication between staff and health care professionals and they had confidence in the senior staff at the home.

People who were at risk of developing pressure sores were regularly repositioned to relieve pressure areas and records of their position throughout the day were kept. Some of these people were cared for on specialist air mattresses or cushions. Records showed that there were daily checks to make sure the specialist ait mattresses were on the correct setting for each person.

We looked at the design and adaptations in the home to see whether it met the individual needs of people living with dementia. There was some signage in the home so people could identify and recognise their bedrooms, toilets and bathrooms. The majority of décor was in neutral colours and for some people living with dementia they would not have been able to distinguish the differences between doors, furniture and walls. For example, there were not any bright contrasting coloured toilet seats so people could easily recognise the toilets. This was an area for improvement.

We recommend the provider follow nationally recognised dementia good practice guidance for environments and equipment.

Good

Is the service caring?

Our findings

We saw good interactions between staff and people. They were chatting and were relaxed with each other and this showed us they enjoyed each other's company. People spoke highly of staff and the care they received. One person told us they were impressed with the politeness of staff. Another said, "All the girls are lovely to me". Other comments included, "They look after me so well" and "We have a laugh and giggle they are all so caring".

People who were able to said staff maintained their dignity. One person told us they felt relaxed with staff because they maintained their dignity in a fun way. We observed staff treating people with respect. They discreetly offered people support with their personal care. People's privacy was respected. People's bedroom doors were closed when they were being supported with their personal care needs. When people were hoisted staff ensured they were covered with a blanket to maintain the person's dignity. Staff knocked on people's doors before they entered and called people by their preferred names when speaking with them. People's care records were kept securely in a locked cupboard and no personal information was on display.

Staff smiled and they were relaxed and friendly, they were kind and they treated people with patience and respect. They spoke fondly about people and told us they enjoyed the time they were able to spend with people. They all spoke positively of their roles at Talbot View.

People or their relatives told us they were involved in planning their care. However, this was not consistently recorded in people's care records. People told us staff asked them about their care needs and involved them in their care routines. They said staff encouraged them to maintain their independence in their day to day lives.

People and relatives told us they were supported to maintain their relationships. One person told us they kept in touch with their friends by mobile phone and staff made sure it was always charged. The registered manager told us a number of people used the computer to make video calls to their friends and family. Visitors told us they were made to feel welcome when they visited. One visitor said, "They don't mind who comes or they don't mind what time".

We did not specifically look at end of life care at this inspection. However, we spoke with the family of one person who was receiving end of life care. They said they, "Could not thank staff enough for their care and compassion" and that "Being here gives us great peace at this time".

Requires improvement

Is the service responsive?

Our findings

People's care needs were assessed before they moved into the home and were used to develop care plans to meet those needs. However, assessments and care plans were not always reviewed and updated when people's needs changed, and care plan reviews did not always identify where needs had changed. This meant that staff did not have up-to-date information about how to provide care in order to meet people's needs. For example, one person had a number of falls and needed a wheelchair. All of the staff knew this person's mobility had deteriorated and they needed two staff to assist them. However, their care plan had not been updated to reflect their changing needs. The care plan included the person walked independently with a walking frame. Another person had also fallen on a number of occasions. Their care plan had not been updated to reflect this increase in falls. Their care plan stated the person should be encouraged to wear appropriate foot wear. However, throughout the inspection the person was walking about in just their socks. Staff said the person was now reluctant to accept any staff support with wearing footwear but this was not reflected in their care plan. Other types of non slip socks or alternative footwear had been explored to minimise the risk of the person falling.

People's needs were not all addressed by care plans, which meant that staff did not have clear, written information about the care people needed. Care plans and records did not all contain sufficiently detailed information so staff knew how to support people, or had received the care they needed. For example, one person's skin integrity care plan did not specify how often they needed repositioning at night to help prevent pressure ulcers. Staff told us they repositioned this person every three hours and repositioning records reflected this. This meant staff did not have clear instructions as when to reposition this person. This was a risk because of the use of agency staff at the home and they did not know people's needs.

Two staff said that they were concerned that some people were not consistently receiving the personal care they needed. They said this was particularly for some of the men who were not shaved every day as detailed in their care plans. Staff told us this was more likely to happen at weekends. We saw on the two days of inspection two different men had not been shaved. We looked at one of their care plans and saw they preferred to be shaved daily but the records showed they had not been shaved as requested.

People were supported to take part in group activities. People who were able to tell us said they really enjoyed the activities on offer. Some people had access to a computer and they said they enjoyed watching animals on the internet. Group activities were provided by activities staff and during the inspection people had manicures, a music session in the garden and some people went out for a day trip. However, there was little for people living with dementia to pick and do to keep themselves occupied. We observed some people living with dementia were not occupied or engaged in any activities for long periods of time.

The shortfalls in people's assessments, care plans and delivery of some personal care were a breach of Regulation 9 (1) (a)(b)(c) (3)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew people well, and spoke knowledgeably about some of their life histories and information about what was important to them. Some people had detailed life histories recorded but this was inconsistent. However, the staff we spoke with did not have an understanding of how to provide personalised activities for some people and this information was not included in their care plans. They did not understand how they could use people's life history and how they had previously kept themselves occupied to develop individual ways of stimulating and occupying people. One of the senior staff said they had planned to use this information to encourage staff to develop more opportunities for meaningful activities for people. This was an area for improvement for some of the people who were living with dementia.

People and a relative told us they could raise concerns with any of the staff and managers and they felt confident they would sort their concerns out. None of the people we met or spoke with had needed to make a complaint. The registered manager told us that they encouraged people, relatives or representatives to raise any concerns on behalf of people and they were able to address their concerns satisfactorily. There was a written complaints procedure displayed in the home. We reviewed the complaints received in the last year. The registered manager had responded in line with the policy and had acted

Requires improvement

Is the service responsive?

appropriately where people had complained or raised concerns. The registered manager told us they shared the outcomes and the learning from complaint investigations with staff during handovers. However, they acknowledged there was not a consistent way of ensuring that all staff were made aware of learning and actions from complaints. This was supported by the reoccurrence of shortfalls identified in a previous complaint.

Requires improvement

Is the service well-led?

Our findings

The registered manager and staff acknowledged the home was going through a period of change. There had been a number of changes including which living units staff worked on and the staff rotas. Staff had been fully involved and updated through staff meetings about the planned changes. There was an improvement plan in place that had been produced by the provider through their quality assurance systems. The registered manager was working through the improvement plan and had met some of the actions. The local authority contract monitoring team visited in April 2014 and identified the same shortfalls in care planning, MCA 2005 assessments, best interest decisions and dementia care training we have identified at this inspection. The contract monitoring team told us they had completed a further support visit following the appointment of the registered manager in August 2014. They told us the registered manager was in the process of addressing the shortfalls.

The registered manager acknowledged there were major shortfalls with the accuracy of people's care and risk management plans and mental capacity assessments and the recording of best interest decisions. They were confident that people were receiving the care they needed but acknowledged that care records did not support this. They told us that senior staff had been given some additional training, support from the provider and time to update and complete care plans. However, senior staff told us they were not confident and did not fully understand how to complete the care plans, particularly in relation to some risk assessments and decision making.

We saw that sample care plan audits were completed and identified numerous shortfalls but it was not clear how these were then followed up. The deputy manager showed us a new care plan audit that had been introduced in March 2015 the new documents did include who would be responsible for addressing the shortfalls.

Records for people were not accurately maintained or monitored. We identified shortfalls in people's assessments, care plans and monitoring records. Fluid records were not accurate and body maps not consistently completed for people following falls or injuries. These records were not consistently reviewed. For example, fluid records were not totalled to ensure that people had the right amount of fluids. Body maps that were completed were not reviewed as prompted by the documentation to check whether people's injuries had healed.

There were not any robust systems for ensuring that actions and learning from complaints, safeguarding, accidents and incidents were disseminated to all staff. There was not any consistent way for the registered manager to monitor that actions and learning identified were being completed. For example, the shortfalls identified from a previous complaint about communication with people's relatives had not been fully addressed.

These shortfalls in the governance of the home and record keeping were a breach of Regulation 17 (2)(a)(b)(c)(f) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Observations and feedback from people, staff, relatives and professionals showed us there was an open culture. All of the staff, relatives and people were positive about the registered manager and they felt able to raise concerns and approach them. People told us they were kept informed about things happening at the home. There were regular residents meetings on Highmoor and Wareham living units. Staff consulted with people and their relatives on an individual basis on Lollipop Lane and Butlers Brook. This was because not all of the people were able to participate in group meetings. There were annual surveys of people and staff and these results were analysed by an external company. The findings contributed towards the home's improvement plan. The registered manager had held a relatives meeting as some relatives had identified they wanted to be more involved.

There were a number of thank you cards from relatives and staff told us these were displayed so they received the positive feedback.

Staff knew how to raise concerns and were knowledgeable about the process of whistleblowing. They confirmed the registered manager, listened and acted on any concerns they raised.

The registered manager told us they obtained information about good practice in dementia care from The Alzheimer's Society and attending local learning groups and provider meetings. This information was displayed on notice boards but it was not clear how this information was shared with staff to make sure they had read and understood it.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: There were shortfalls in: · The monitoring, managing and mitigating the risks to people. · The safe management of medicines · The staff training to ensure staff had the competence, skills and experience to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: There were shortfalls in: · The assessments, planning, monitoring of and meeting people's needs and preferences in relation to nutrition and hydration. · People's assessments, care plans and delivery of some personal care.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The staff's lack of awareness of the code of practice and principles of the MCA 2005 and the lack of mental capacity assessments and best interest decisions.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There were shortfalls in the governance of the home and record keeping.