Regal Healthcare Homes (Coventry) Limited

Haven Nursing Home

Inspection report

New Road
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Coventry
West Midlands
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Tel: 02476368100

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09 June 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 June 2017. 8 June was unannounced. Haven Nursing Home is a large nursing home, which is registered to provide care for 70 people, of which 12 beds are part of the 'Discharge to assess' (D2A) scheme (funded by Clinical Commissioning Groups and North Warwickshire Foundation Trust). The D2A scheme aims to ensure people are moved out of hospital (when medically stable) to receive a period of rehabilitation/re-ablement in a
community setting prior to assessment of their long term care needs. Some people on D2A may have complex health care needs and may not be able to return to their own home. At the time of our inspection visit there were 65 people living at the home, 11 of whom were on the D2A scheme.

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

At our last inspection in September 2016, there was one breach of the legal requirements and Regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. This breach was in relation to the level of staffing at the home which impacted on the support people received. The care and treatment was not focused on, and did not meet the needs of, each person. Service user's individual needs had not been assessed to ensure they were appropriate, or that their preferences had been taken into account.

At this inspection, we found action had been taken to ensure care plans were reviewed and updated so people's needs had been properly assessed and could be met. However, people's care records were not always detailed enough to ensure people received consistent support from staff.

People did no always have their medicines administered as prescribed, and medicines were not always stored safely. Medical equipment was not always stored in line with safety guidelines.

We found this was a breach 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 the report.

People felt safe, and risks had been assessed so people were supported safely. However, risk assessments were not always followed by staff, for example where people had specialised equipment to protect their skin, we found this was not always used properly.

There were enough staff to meet people's needs safely, and the provider had reduced the use of agency staff so people had consistent staff supporting them. Staff were recruited safely and were aware of their responsibilities to protect people from harm or abuse.

Staff received essential training to meet people's individual needs, and effectively used their skills, knowledge and experience to support people and develop trusting relationships. Food and fluid intake was monitored where people were at risk, and action was taken where required.

Staff were clear about their responsibilities under the MCA (Mental Capacity Act 2005) and DoLS (Deprivation of Liberty Safeguards) legislation. People's capacity to make decisions had been assessed, and DoLS applications made as required. However, it was not always clear which decisions people needed support to make and who was involved in making the decisions.

People told us they were supported with kindness and respect, and staff ensured people's privacy and dignity was preserved.

Staff did not always take opportunities to engage with people, or to ensure the environment was as responsive as possible.

A range of activities were on offer, and people could maintain any hobbies or interests they had.

The provider ensured they received, handled and learnt from complaints and concerns raised by people.

People, relatives and staff were positive about the registered manager and the senior team, and felt they were effective and approachable.

Systems designed to check on and improve the quality of the service provided were not always effective, and had not picked up on some of the issues we identified.

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.

Medicines were not always administered as prescribed, and were not always stored safely. Medical equipment was not always stored in line with safety guidelines.
Staff knew what action to take to safeguard people from the risk of abuse, and the provider had measures in place to ensure they recruited people who were suitable to work in the home.
There were enough staff to meet people's needs.
Risks were assessed and managed, in line with what was recommended in people's care plans.

Is the service effective?

Good

The service was effective.

People were supported by staff that were competent and trained to meet their needs effectively. People were offered a choice of meals and drinks that met their dietary needs, and where they were at risk, their food and fluid intake was recorded and action taken where required. People received timely support from appropriate health care professionals.
Where people lacked capacity to make day to day decisions, this was assessed and documented, though it was not always clear which decisions people lacked capacity to make, and who should make decisions in their 'best interests.' Staff understood the need to obtain consent from people in relation to how their needs should be met. DoLS applications had been made as required.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs and showed respect for people's privacy and supported people to be as independent as possible. The provider had taken steps to improve people's living environment and enhance their well-being.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always clear enough to ensure people were supported consistently, and staff did not always take up opportunities to interact with and respond to people. Care was sometimes task focussed.
People knew how and when to complain and felt confident to do so. There was a range of activities on offer, and people were supported to maintain any hobbies and interests.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems designed to check the quality of the service being provided and to improve it as a result were not always effective. They had not identified some of the issues we found during this inspection. People, staff and relatives told us the registered manager and senior team were responsive and approachable, and were making improvements.

Haven Nursing Home

Detailed findings

Background to this inspection

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

The provider displayed the rating from the previous inspection clearly on the premises and on their website.

The inspection took place on 8 and 9 June 2017. 8 June was unannounced. The inspection was conducted by three inspectors and an expert by experience, (an expert by experience is person who has personal experience of using or caring for someone who uses this type of care service), and by one inspector on the second day.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

During our inspection visits, we spoke with 10 people who lived in the home. We also spent time observing interactions between people and staff. We spoke with five relatives, and one health professional. We also spoke with the registered manager, the clinical lead and eight staff.

We reviewed eight people's care records, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

We identified some areas relating to the management of medicines that were not safe. A nurse told us people who lived at the home for a short stay had their medicines stored in a lockable drawer in their bedrooms. We found drawers were not always locked and even when they were, they were not secure, because the key was kept either on top of the drawer or hung on the bedroom wall. This posed a potential risk to some people living at the home, who could access medicines.

People did not consistently receive their medicines as prescribed, which posed a risk to their health and wellbeing. For example, we identified a nurse had stopped one person's daily injection because they had incorrectly read the hospital discharge information. This person had not been given their injection, as prescribed, for the past four days and other nurses had not identified this error. We raised this with the clinical lead nurse who contacted the GP immediately. On the second day of our inspection visit we checked and found the person had received their injection.

Some people were prescribed medicinal skin patches. Whilst body maps were used to document the skin site used when skin patches were applied to a person's body, we found nurses had not followed the manufacturer's instructions to safely apply the patches. We looked at two people's skin patch records and found nurses' had incorrectly used the same skin sites to apply the patch, without leaving it for a minimum of three to four weeks, as stated on the information leaflet dispensed with the pack. Three nurses we spoke with told us they had not been aware of the manufacturer's instructions.

When we returned on the second day of our inspection visit, action had been taken to properly record medicines which were applied to people's skins to ensure they were in line with manufacturer's guidance.

The provider's system of managing stock and ordering people's medicines was not effective. For example, we saw one nurse had sent 78 tablets of one medicine prescribed to a person for safe disposal, because they had reached the end of the medicine cycle. The tablets were not carried forward to the next cycle for this person, which then meant they had run out. We discussed this with one nurse who told us, "It's really bad; the night nurses do the ordering and returns and don't do a good job of it. [Person] needed those tablets and ran out and went without them for quite a few days, we had to order more." We saw another person's medicine administration record (MAR) where a nurse had recorded, 'medication out of stock' but did not record any action they had taken to ensure this was resolved.

Some people had health conditions that meant they used compressed oxygen gas to help with breathing difficulties. Risks associated with oxygen cylinders had not been assessed and actions to reduce risks were not taken. We spoke with two people that used oxygen and one person told us, "I used my oxygen all day and night." We saw this person had eight oxygen cylinders in their bedroom. In addition to the one in use, these included five new cylinders and two empty used ones stored just inside the doorway of the person's bedroom door that was propped open by a plastic wedge.

The registered manager and provider had not taken account of guidance that related to the safe storage of

oxygen cylinders. Guidance states that when not in use, cylinders should ideally be stored in a secure outdoor location. Cylinders stored indoors for clinical use, should be stored upright in a suitable rack or trolley, secured in such a way that they cannot easily fall over.
We saw a further three unsecured oxygen cylinders in the locked clinical room. The clinical lead nurse told us they had identified, in December 2016, that the storage of these three cylinders, for general emergency use by people that lived there, needed to improve. However, action had not been taken.

People who lived permanently at the home had guidance available for staff to refer to for 'when required' medicines. For example, one person had medicine prescribed for when they became anxious or agitated, and guidance told nurses when this should be given which ensured nurses took a consistent approach. However, when people were on a short stay at the home, they did not always have guidance in place for their 'when required' medicines. Some of these people were able to verbally request their medicine but others were not.

Three people using the service for a short stay told us they were due return to their own homes soon and managed their own medicines at home. They told us they had not been asked if they wished to maintain (self-administer) their own during their short stay at the home. One person told us, "I prefer the nurses doing mine here in case I make a mistake." However, the other two people said they would have managed their own if they had been asked. One person said, "The bossy nurse here won't let me do my own." We found no risk assessments to determine why this person could not manage their own medicines.

Medicines prescribed for people that lived at the home permanently were stored securely. A medicines fridge was available for items that required cool storage. However, we found some items were not disposed of in a timely way and remained in the fridge despite no longer being in use and past their safe use by date. This meant there was a risk these medicines might be administered to people and might not be effective.

This was a breach of Regulation 12 (1) (2) (g) HSCA (RA) Regulations 2014 Safe Care and treatment.

At our last inspection in August 2016, we found there were not always enough staff available at the right times to ensure people received the support they needed.

During this inspection, we found there had been some improvement, and that action had been taken to ensure there were enough staff on duty to support people safely. We also found action had been taken to reduce the use of agency staff, which meant people had more consistent support from familiar care and nursing staff.

People had mixed views on whether there were enough staff to meet their needs. One person said, "If you want your pad changed or something you sometimes have to wait. Not that long though." Another person we spoke with said, "Oh yes, I think there are enough staff." A relative commented, "It would be a much nicer home if there were more care workers."

Staff told us there were enough staff on duty to meet people's needs, and that the situation had improved since our previous inspection visit. One staff member commented, "Staffing is a lot better now. I have never worked in a home with so many carers. There are definitely enough to meet people's needs. The more people who come to the home, staffing increases." Another staff member commented, "We have had staff on maternity leave and are still recruiting. We need more staff at certain points. Mornings are busy, okay, but busy. We have staff breaks one at a time for each floor. Care staff care, and are not involved in kitchen or laundry crises."

We observed staff attended to people quickly if they needed support. For example, one person told staff in a communal lounge that they wanted to use the toilet. The staff member assured the person they would fetch colleagues quickly as the person needed support from two care workers. Very soon after the request, two care workers arrived and supported the person to transfer from an easy chair into a wheelchair so they could be assisted.

Since our previous inspection, the provider had taken action to ensure there were enough staff to meet people's needs, and that these staff were familiar to people. The provider told us they were now fully recruited for care staff, and so the use of agency care staff had decreased. Nursing staff had been increased so that there were always two nurses on duty overnight. Total staff numbers on duty had also increased in recognition of the increase in people living in the home.

At our previous inspection in August 2016, we found risks were not always properly assessed and managed, as some people's care plans had not been reviewed and updated with current and accurate information. At this inspection we found some improvements had been made, and that care plans had been reviewed and updated to ensure risk assessments were accurate. However, staff had not always put recommendations to keep people safe into practice.

Risks to people's skin becoming sore or damaged were assessed and people had 'skin integrity' care plans. We looked at two people's care records who were identified as being at 'very high risk' of developing sores to pressure areas. Guidance was available to staff and included actions to 'carefully wash' people due to their 'tissue like skin.'

Special equipment was in place, such as airflow mattresses to relieve pressure and reduce the risks of people's skin becoming sore. One person's care plan stated their airflow pump should be set at 'medium' but we saw the pump did not have written settings, so staff did not know where the medium setting was, the dial was set toward the maximum. Another person's care plan did not state what their airflow pump should be set at. We asked one care staff member how they would determine if the setting was correct, and they told us they did not know. We discussed this with one nurse, who told us the airflow pump settings should be set according to a person's individual body weight. This nurse told us, "In my previous place of work, we had stickers so staff could check the setting was right. We don't have that here and I do not know where staff would find the information." The nurse told us they would take action to check people's airflow pump settings were correctly set and ensure the information was available to staff.

When we returned for the second day of our inspection, we found information had been added to care plans and to people's beds so staff could see where pressures should be set for individuals to protect their skin.

Other risks, such as those linked to the premises, or activities that took place at the service, were risk assessed and agreed actions to minimise those risks were in place. Staff took action to follow the risk assessments which helped to ensure people were safe in their environment. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. The provider ensured equipment was safe for people to use. For example, we checked records of maintenance of hoisting equipment, and found this was up to date.

The provider ensured a plan was in place so they could continue to support people in the event of a fire or other emergency situation which led to the building being out of use. Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow. Care records showed people had personal fire evacuation plans in place which took account of their needs and guided staff on how best to support people in the event of a fire.

People we spoke with told us they felt safe living in the home. One person said, "Yes, I feel safe here all the time." Relatives agreed, one commented, "The doors are always secure and there are lots of staff."

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures to try and ensure new staff were of 'good character.' Two recently recruited members of staff told us they had a DBS check which the home completed and they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. They understood how to look for signs that might be cause for concern, and were aware of their responsibilities to raise a safeguarding alert. One staff member told us, "People might have bruising, be withdrawn, their behaviour might change. If I was concerned I would speak to [clinical lead] or [registered manager], who would raise a safeguarding." They added, "We have a whistleblowing policy, we have all the numbers."

Staff told us there were policies and procedures for staff to follow should they be concerned that abuse had happened. The manager had made safeguarding referrals to the local authority, and had worked effectively with other agencies to ensure people were protected. Records were kept to ensure any safeguarding concerns were monitored and lessons could be learnt from them.

Good

Is the service effective?

Our findings

At our inspection in August 2016, we found that where people were at risk of dehydration or malnutrition, this had been assessed. However, records intended to help monitor and address these risks were not always accurate. At this inspection we found the provider had made improvements to record keeping to ensure people's nutritional needs were more closely monitored.

People told us they had a choice of food and drink, and spoke positively about what was on offer. One person commented, "The food is good, we have a couple of choices." Relatives who visited regularly at dinner time also commented positively on the food. One told us, "There is a variety of food available, mealtimes are flexible and nutritious. Snacks, drinks and food are always available."

The provider ensured fluids were available to people throughout the day. The registered manager explained that, in addition to drinks being offered at mealtimes and at various points during the day, flavoured jellies and milkshakes were offered to people to find different ways of encouraging people to drink plenty of fluids.

The registered manager told us about one person who needed their fluids thickened, and who took a long time to drink; needing lots of time and patience from staff. We observed later in the day that staff assisted the person to drink. We saw the person's drink had been thickened, and we saw staff sat with the person, communicated with them throughout and did not rush them while they drank. We reviewed the person's care plan and found this was consistent with what had been recommended for them.

We reviewed a number of food and fluid records and found that, whilst these had all been fully completed, they did not always contain fluid target amounts. This meant we could not be clear whether people were having enough fluids to maintain a healthy level of hydration. We raised this with the registered manager, who explained they currently monitored fluid intake for everyone, even those who had not been assessed as being at risk. They told us targets were included for people most at risk, and planned to change the way they monitored fluid intake to focus solely on people who had been assessed as being at risk of dehydration.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People told us staff asked their permission before supporting them. We also observed people were asked for their consent and were supported in ways that were respectful. For example, we heard one care worker say, "[Name], would you like this [item to protect shirt while eating] on?" The person replied, "No, I'm okay thanks." The care worker then said, "Okay, I'll leave it here in case you change your mind."

Staff we spoke with had a good understanding of the principles of MCA and how they followed them. One staff member spoke with us about whether or not people living in the home had capacity to make their own decisions. They said, "It is all about whether or not people are able to give their consent. You treat everyone as if they can first. Things like not being able to leave the building without supervision. If they do need supervision they might need a DoLS." Staff understood that decisions sometimes needed to be made in people's 'best interests' and told us they would refer to senior staff if they were unsure.

Care plans showed where people lacked the capacity to make all of their own decisions, a mental capacity assessment had been undertaken. However, the capacity assessments did not always document which decisions people needed support with, and which decisions they were able to make themselves. Where people were unable to make their own decisions, around managing their finances for example, care records did not show who should be involved in making 'best interests' decisions.

For example, one person's care plan instructed staff to assist the person with personal care with two staff and in the 'least restrictive' manner. However, there was no information for staff on what the least restrictive practice would be for this person. Staff told us how they supported people in a way that did not restrict them more than necessary, but we could not be sure 'best interests' decisions were made consistently or by the right people, or that staff were always clear what the 'least restrictive' option was for individuals.

Care records showed that where people had been assessed as lacking capacity to agree to their care and treatment, and restrictions were in place, the provider had applied to the 'managing authority' for this to be assessed to ensure the person was not deprived of their liberty unlawfully.

People we spoke with were positive about staff skill and knowledge. One person commented, "The staff are brilliant, they know what they are doing." Another person told us, "I think the staff know what they are doing and the night staff are excellent."

Staff received training suitable to support people with their health and social care needs. Most staff we spoke with told us they had received basic training to help them keep people safe and well. At our inspection in August 2016, there were some gaps in staff training. Training records were incomplete and it was not possible to tell which staff had been trained and when. At this inspection, we found most of the gaps in training, particularly in safeguarding adults had been addressed, and training records had been completed so the registered manager had a clear picture of what training staff needed and when.

Recently recruited staff, told us they had an induction when they started working in the home. Training records showed new staff were undertaking the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. Staff spoke positively about the support they received on induction, with one staff member commenting, "I had fantastic support from [senior team]."

Staff had the opportunity to undertake training to enhance their skills so they could support people more effectively. One staff member said, "I have had training in 'react to red'. Now I know when to tell a nurse and they will check if the person requires treatment." A number of staff told us they had attended 'moving and handling' training recently. We observed staff putting this into practice, and saw they used techniques they had been taught to assist people safely to transfer from a wheelchair to an easy chair for example.

Records showed nursing staff received training relevant to their clinical role, and that the provider conducted regular checks to ensure nursing staff retained their professional registration.

Staff had regular individual meetings with the registered manager or clinical lead nurse. Staff said they valued these meetings and saw them as an opportunity to discuss any concerns and opportunities that led to their own and the home's development. One care worker said, "Supervisions are positive. They [managers] ask if we are alright, if we have any problems."

Staff told us communication within the home was good, and that, in particular, information was shared more effectively between care and nursing staff than previously. They explained this was done through regular 'handover' meetings. One staff member commented, "We have handover every morning with the nurse in charge to tell us what has happened during the night. Also one at dinner time for the afternoon staff."

People told us they were supported by staff to maintain good health, or to access health professionals where necessary. One person said, "The nursing staff are excellent, they seem to have an answer to what is wrong with you, I haven't seen the doctor as I haven't needed to call one." Relatives agreed, one commented, "[Name] had high blood pressure, they monitored her and sent her to hospital as they suspected a stroke." A visiting health professional told us staff ensured people's health needs were met. They said, "Any instructions or recommendations I make are carried out, such as removing dressings for example."

Care records confirmed people were supported to access health professionals on a routine basis, as well as when their health changed. For example, one person's care record showed how staff had contacted medics when they suspected the person might have an infection. The person was later prescribed anti-biotics when tests had been conducted and their health improved as a result.

Good

Is the service caring?

Our findings

At our inspection in August 2016, we found care records were not always written in a personalised way. At this inspection, we found some improvements had been made but that personalised care records were still a 'work in progress'.

Some of the care plans we reviewed contained a 'This is Me' document. This included a range of personalised information on people's social history that staff could use to form bonds with people and provide caring, personalised support. Information provided included people's likes, dislikes and preferences, as well as their history and background. However, not all care plans for people who were permanently staying at the home contained this information. We raised this with the registered manager who told us they had focussed on ensuring care plans reflected people's health and care needs and that risk assessments were accurate and updated. They explained now they had an established senior team, they would work on making care plans more personalised.

People and relatives told us staff were kind and caring and treated them with respect. One relative commented, "When [Name of SU] 'fs and blinds' staff understand. They are kind and behave nicely towards people." We also observed a number of interactions between people and staff that demonstrated this. For example, we observed one person was upset and tearful, saying, "I'm fed up, I have no one to talk to." A nurse stopped administering medicines briefly, and took the person's hand to reassure them. The nurse said, "Come this way, let's find your friend," and settled the person before returning to the medicines room.

Staff told us what being 'caring' meant for them. One staff member told us, "I care for people how my family or friends would want to be cared for." They added, "I like to go home knowing I've done everything I can for people." Another staff member said, "It is much more person-centred care than before." The registered manager told us it was important for them to create a caring, respectful culture within the home. We observed the registered manager and senior nursing staff displaying compassionate, respectful care practices throughout the two days of our visit, which helped staff understand what was expected of them.

The provider and registered manager had taken steps to improve the living environment of the home, to create a more pleasant environment for people and enhance their well-being. For example, there was new signage in place, and various displays had been added to the walls to provide stimulation for people as well as provide a visual reminder to people of where they were in the building. The provider had also improved the garden area by introducing raised flower beds for people who were interested in gardening or enjoying the smell of plants. There were also chairs and tables in situ to create a space where people could relax and enjoy being outdoors if they wanted to. The majority of people's bedroom doors also included numbers, names and photographs to help people find their way around back to their own room.

Staff told us they understood the importance of respecting people's privacy and dignity and we saw people were supported to private areas of the home when they needed help with personal care. We also observed staff ensuring people's dignity was respected. One staff member noticed a person's trouser leg had ridden up. They asked the person if it was okay to pull the trouser leg down, and did so when they person agreed

they could. Another person had some soup on their chin. A staff member noticed this quickly and gave the person a tissue.

One visiting health professional told us the registered manager and staff respected people's privacy and promoted their dignity. They commented, "Staff are really friendly and really caring. If I saw something I was concerned about I would report it, and I have never had to. Of all the homes I go to this is one of the ones that insist I use a screen when treating people (to ensure their privacy)."
People were supported to maintain relationships with family and friends. Relatives told us they visited people on a regular basis, and that they were made to feel welcome. One relative told us, "We can visit at any time; we work in the daytime so come in the evenings or weekends normally." Over the two days of our inspection visit, we saw a number of relatives and friends visiting people, and observed positive and friendly interactions between the senior team, staff and visitors.
We observed people's care plans were kept securely and were only accessed by those who needed to access them. This helped to ensure people's privacy and dignity was maintained.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in August 2016, we found care was not always responsive to people's individual needs, and staff could not always respond to risks to people's health, safety and well-being. This was because care plans were not always up to date or accurate. We found this was a breach of Regulation 9(1) (a) (b) (c) HSCA (RA) Regulations 2014 Person Centred Care.

At this inspection, we found some improvements had been made and the provider was no longer in breach of the regulations.

Care plans we looked at had been reviewed and updated so information in them was accurate. For example, one person's care plan identified they needed support to help them communicate. Staff were advised to talk calmly, maintain eye contact, and give the person time to comprehend what they were saying. Another person's care plan directed staff to conduct basic tests if a person became anxious or agitated, as it had been assessed that their physical health could impact on their mental health. This meant the provider could respond to this person's needs effectively.

Care plans in place for people on the D2A scheme included information about any risks associated with their care and support, as well as goals that had been identified for the person to work towards while staying at the home. They showed how staff communicated with professionals involved in people's rehabilitation and assessment so the service could respond as people progressed.

People's main care plan was supplemented by an additional folder in their bedrooms, which included 'at a glance' information for staff to refer to. The registered manager explained these had been developed to ensure staff (including agency staff) had time to read important personal information about people so they could respond appropriately to their needs.

Whilst care plans contained information for staff on how to respond to people's needs, some did not always give sufficient detail for this to happen. For example, one person's care plan advised staff to 'comfort and distract' the person should they become emotional, upset or agitated. However, there was no information for staff on how best to comfort and distract the person, and there was no background or 'social history' information in the person's care plan that staff could refer to and use to help the person remain calm. We raised this with the registered manager, who explained their focus had been on ensuring all care plans were updated and accurate, and this had taken some time given that many were out of date and inaccurate when we last inspected. They told us now they had an established senior team; work on refining care plans and ensuring they were all clear could progress.

People we spoke with told us they were involved in putting together and reviewing their own care plans. One person said, "I know of my care plan and it is revisited." Another person commented, "They have discussed my care plan with as to what they are doing. My son is satisfied with the care." Care records showed care had been reviewed and that people and their relatives or representatives had been involved in the process.

The provider liaised effectively with commissioners in order to respond to changes in people's needs. Care records for one person showed the provider had assessed the need for the person to receive one to one support from staff, to ensure they had adequate food and fluid intake. In order to ensure this happened in the medium to long term, the provider had contacted health commissioners to request extra funding.

We observed a number of interactions between people and staff that demonstrated how people received responsive care. For example, one person told us the activities co-ordinator had brought them some craft card materials as they had asked for them. The person said, "I really enjoy doing these at home and I can use these." The person then showed us the designs they had made. On another occasion, we observed a staff member talking with a person about their ongoing care and support. The person was asking what the process was for discussing this formally. The staff member sat with the person and explained the role of the person's social worker and the local authority which helped the person understand what was happening.

People told us they were supported to engage in activities on offer in the home, and that they could maintain any hobbies or interests they chose to. One person said, "I choose to stay in my room and do my knitting and crocheting." Another person commented, "I take part in the activities here." We observed one activity which a number of people took part in and enjoyed. We observed activities staff approaching individual people with a box of accessories and a camera, inviting them to try on masks, glasses, hats and feather boas for a photo. One gentleman wanted to try on the feather boa, which he did, to his own amusement and laughter between him and staff.

However, we also observed, throughout the two days of our inspection visit, staff did not always respond to people, and that support was sometimes focussed on tasks to be completed. We also observed staff did not always consider the environment people spent their time in, and how this could be made to be more responsive to people's needs. For example, we observed staff attending to people on a number of occasions without taking the opportunity to engage in conversation with them. Staff sometimes gave people food without speaking with the person, and were sometimes focussed on the task in hand. On one occasion, the radio was on in the conservatory off one lounge area. The radio was playing 'light music' to begin with. Staff did not notice or react when the radio started to play 1990s nightclub style music, which was not conducive to relaxing. Another person's care plan said, 'agitated by loud noises' and 'likes to sit in her chair next to TV at mealtimes', but we observed the person was not sat next to a television during lunch.

We also observed that, for much of the day, a TV was on in one of the lounge areas and no-one seemed to be watching it. We asked staff if anyone might prefer music to be playing. The registered manager put on a CD of songs from the second world war, and some people immediately began singing and tapping their feet where previously they were sat not engaging with anything. However, some time later the CD was still playing and had done so repeatedly. We raised these issues with the registered manager, who told us they would audit people's experience of being in the lounge areas of the home and take action. Following our inspection visits the registered manager sent us information on the action they had taken, including rearranging chairs to create a more convivial environment, as well as opening out the conservatory area of one of the small lounges and ensuring music was played, along with the television at times, but for short periods so people had a variety of experiences.

People were aware of how to complain, and, whilst they told us they had not had to, they felt confident to do so. One person said, "I have no concerns or complaints, I would go the manager if I did." Another person commented, "Never had to complain, no need. I am happy here and the staff are pleasant. They have not come across offish or heavy handed. Nothing is too much, I have no concerns." People knew about different ways to complain if they did not want to raise issues directly with the staff or registered manager. One person said, "There is a complaints box in reception."

The registered manager kept a record of complaints received, and this showed they were responded to in line with the provider's policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in August 2016, we found care was inconsistent when the registered manager was not in the home, which meant people were at risk of receiving a poorer service at these times.

At this inspection, we found improvements had been made. The provider had taken action to ensure there was a stable and consistent management team in place to provide leadership over a 24 hour period. The registered manager explained they now had a clinical lead nurse, and, recently, two senior nurses had also joined the management team. They told us they felt confident and positive going forwards now there was an 'established' senior team to help them 'drive the home forwards.'

People and relatives were positive about the management team, and told us they were effective and approachable. One person commented, "I think that the management has a good team here." A relative told us, "The manager is approachable, makes time to speak to everyone and listens."

Staff also told us the management team were approachable, effective and had made improvements. One staff member said, "I love it. I have seen lots of changes, lots of different staff and new ideas in the last five years. [Registered manager] and [clinical lead] are good, we have a good relationship. The environment is brighter, the pictures and artefacts and signs for people. [Registered manager] is visible. They go around the building and work alongside staff." Another staff member commented, "It's improved a lot. I know I'm doing a good job, because they tell us."

One visiting health professional told us, "[Registered manager] is brilliant. They always resolve any issues." They added, "This is one of the best homes I go to."

Staff spoke favourably about changes to the management team, and told us they now felt well supported by the senior nursing team as well as the registered manager. Whilst some issues had been identified in relation to how night staff dealt with medicines in particular, the registered manager had already identified this and was taking action to address this.

At our inspection in August 2016, we also found systems in place to check the quality of the service provided had not always identified some issues which we found during our visit. At this inspection, we found that, whilst some of these checks had improved, this was still the case.

For example, the most recent audit of medicines had not identified the issues we found relating to medicines stock, medicines errors, or how medicines were stored. Other checks, such as managers 'daily walk arounds' had not taken place for some time. This meant some issues had not been identified by the registered manager. For example, in one lounge area, a number of easy chairs were found to be dirty and torn, which could present a risk of infection. When we raised this with the registered manager and other staff, the chairs were removed and we were assured they would be replaced. The registered manager explained they had found it difficult to maintain some of these audits as they had been concentrating on ensuring all care plans were reviewed. However, they told us now they had an established senior team in

place, auditing would be more frequent and more effective.

The registered manager, while they clearly role-modelled responsive and interactive care, had not identified that this was not always what people experienced, and that staff sometimes supported people in ways that were task and time focussed, and did not necessarily meet people's needs or enhance their well-being. The registered manager acknowledged this, and told us they would begin to address these issues in staff meetings and supervisions.

The registered manager had developed a range of new checks and audits to assure themselves of the quality of service provided. In the few months before our inspection visit, the registered manager had begun to record events that happened in the home with a view to benchmarking the service so they could measure whether or not care was improving. For example, pressure ulcers, falls and incidents of infection had all been recorded monthly, and a score awarded in each area. These checks were designed to help the registered manager to identify areas that needed to be addressed, either through extra training for staff, or through a review of procedures used in the home.

The registered manager explained the provider was developing a different approach to how provider audits were completed. Until recently, the provider had appointed an external body to complete these audits, but, whilst they had not yet done so, was now looking at completing regular audits themselves.

Staff told us they met regularly as a staff team which gave them the opportunity to contribute ideas and discuss their views. One staff member said, "We have team meetings. We tell [registered manager] about any problems and she listens. She listens to us." Another staff member commented, "We have care meetings and whole team meetings. We can air our views and it is about teamwork now. Morale was poor, now it is good." Records of a recent staff meeting showed practice issues had been discussed to ensure staff knew what was expected of them. For example, there had been a discussion about the importance of staff completing food and fluid charts to help protect people who were at risk of dehydration or malnutrition.

The provider had received a number of compliments from people about the service they had received. One read, "Words are not enough to express mine and my family's gratitude for the love and support, care and kindness shown not only to [person's name] but also to every single one of my family."

The provider had systems in place to gather feedback from people. For example, questionnaires had been sent out to people and their relatives in May 2017, and the results were yet to be returned. However, the registered manager told us they would analyse the results and work with the provider to develop a plan to address any concerns or areas for improvement that were identified. People and relatives told us they missed the opportunity to attend relatives and residents meetings, and said these used to take place but had not done so for a while. We raised this with the registered manager who told us they would talk to the provider with a view to re-introducing them.

The manager understood their legal responsibility for submitting statutory notifications to us. This included incidents that affected the service or people who used the service. These had been reported to us as required throughout the previous 12 months.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines, or ensure medical equipment was stored safely.