

Somerleigh Court Ltd

Somerleigh Court

Inspection report

Somerleigh Road
Dorchester
Dorset
DT1 1AQ

Tel: 01305211833

Date of inspection visit:
10 November 2016
11 November 2016
17 November 2016

Date of publication:
12 January 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

At our last inspection in July 2014, we had concerns that there were not always a sufficient number of suitably qualified, skilled and experienced staff on duty and that records were not always accurate or complete. There were breaches in two regulations and we asked the provider to take action about these concerns. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches and told us that they would be compliant with the regulations by January 2015. At this inspection we found that there had been improvements in some areas, but that there was a breach around people's records and the governance arrangements at the service.

This inspection took place on 10, 11 and 17 November 2016 and was unannounced.

Somerleigh Court is registered to provide accommodation and nursing or personal care for up to 40 people. There were 37 people living at the service at the time of inspection. The home is situated in Dorchester and offers accommodation split over three floors. There are communal lounge and dining areas on each floor. There is lift access for the upper floors and all bedrooms have an en suite. There is a sensory garden to the side of the service which people are able to use and the main entrance is wheelchair accessible. Somerleigh Court also provides personal care support to 12 of the people who live in sheltered apartments around the home which they call the village. There are a total of 68 apartments in the village and people receive daily safety check calls and other services as part of their tenancy agreements.

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

People's risks were not always recognised or managed safely. Risks around the use of pressure mattresses were not accurately managed and there were no risk assessments relating to the introduction of a pet to the home. Risks around people's eating and drinking were not always identified.

Topical creams, as required medicines and nutritional supplements were not always given as prescribed.

There were sufficient staff to support people and we observed that call bells were answered promptly. There were systems in place to ensure that there were sufficient staff to meet people's needs. People received support from staff who had been safely recruited and understood their needs.

People felt safe at the service, they were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of how to whistle blow if they needed to and reported that they would be confident to do so.

Staff received training in a number of mandatory topics but did not receive training in specific conditions

which reflected the needs of people at the home. There were plans in place to improve training opportunities for staff.

Mealtimes were not a sociable occasion. Very few people used the communal areas for their meals and we observed little social interaction at mealtimes. Use of chairs and over chair tables also made eating more difficult for some people.

Staff did not receive regular supervisions which meant that they did not have planned opportunities to discuss issues with people or discuss their own learning and development.

Assessments were completed in line with MCA and where necessary, best interest's decisions were made. Decisions were evidenced, however assessments were not always signed or dated and in the case of covert medicines, had not included involvement of a relevant health professional and were therefore not in line with MCA best practice.

People had a choice about what they had to eat and drink and where people needed specific diets or equipment to enable them to eat independently, these were provided.

Where referrals to healthcare professionals were required, these were made promptly.

People were supported to make decisions about their care and staff understood their role in supporting people to make choices.

People told us that their privacy was respected. One person explained "If staff need to do anything personal, they leave me and give me privacy and I ring when I want them back".

People and their relatives were supported and involved in their end of life care. We saw that people had anticipatory care plans for end of life which included their wishes and those of their families where appropriate.

There were limited social opportunities for people and activities were not available at weekends. A high number of people at the service spent the majority of their time in bed and there were not sufficient opportunities for 1:1 time with people. Activities records showed that some people had very little interaction.

Peoples care records were not all person centred. Older style records were still in use for some people and were clinical in style, focussing on people's medical needs.. Newer paperwork was being introduced which was person centred and included details about people's likes and preferences, there was a schedule in place for all records to be moved onto the new paperwork.

People and relatives said that they were involved in reviews about their care and said that they would be confident to make a complaint or raise any concerns if they needed to.

Quality assurance measures did not consistently identify gaps or trends. Some audits were completed but had not identified gaps which we found during the inspection. Others were completed at random which meant that some areas were not audited for extended periods of time.

Staff had mixed views about whether they worked well and communicated as a team, we observed the use of some language which was not respectful. The registered manager told us that they were working to

ensure that the staff worked well together.

Surveys were used to identify possible areas for improvements and there were clear actions in place to manage these. The service had a clear development plan which included target dates and review dates for actions identified.

We found 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 report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not safe.

Peoples' risks were not consistently well managed

People did not always receive their as required medicines , topical creams or nutritional supplements as prescribed

People were protected from the risks of abuse because staff knew how to recognise and report concerns and were confident to do so.

People were supported by staff who had been recruited safely with appropriate pre-employment, reference and identity checks.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Staff did not have regular supervision and therefore had limited planned opportunities to discuss issues relating to people or their own learning and development.

People did not have access to social, accessible areas in which to eat their meals if this was their preference.

People had capacity assessments which were decision specific, however best interest's decisions did not always include the relevant health professionals in line with MCA best practice.

People at the home told us that the food was good and they had a choice about what they wanted to eat.

People had access to healthcare services promptly when needed

Is the service caring?

Good ●

The service was caring.

People told us that they had choices about their care and staff

understood their role in supporting people to make choices.

People were supported to maintain their privacy and dignity

People and their relatives were involved in decisions about end of life care.

Is the service responsive?

The service was not consistently responsive

People did not have sufficient opportunities for one to one social interaction or activities.

Peoples care plans were not all person centred, however work was being undertaken to ensure all peoples care plans were individual and reflected peoples preferences.

People and relatives knew how to raise any concerns and told us that they would feel confident to do so.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Quality assurance measures were not robust which meant that gaps and errors were not consistently identified.

Staff used some language about people which was not respectful.

Feedback was used to highlight areas of good practice or where development was needed. Information was used to plan actions and make improvements.

People, relatives and staff spoke positively about the management of the home and felt they were approachable.

Requires Improvement ●

Somerleigh Court

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 10, 11 and 17 November 2016 and was unannounced. The inspection was carried out by an inspector on the first day, a single inspector and a specialist advisor on the second day and an inspector on the third day. The specialist advisor had a nursing background and knowledge and experience of general clinical skills.

The provider had completed and returned a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does and improvements they plan to make. In addition we reviewed notifications which the service had sent us. A notification is the form providers use to tell us about important events that affect the care of people using the service. We also spoke with the local authority and Clinical Commissioning Group quality improvement teams to obtain their views about the service.

During the inspection we spoke with six people using the service, seven relatives, two visitors and two healthcare professionals who had knowledge about the service. We also spoke with seven care staff, three registered nurses, the chef, the head of care, the maintenance manager and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked around the service and observed care practices. We looked at the care files of 12 people and reviewed records relating to how the service was run. We also looked at three staff files including recruitment, training records and registration of trained nursing staff. Other records we looked at included Medicine Administration Records (MAR), emergency evacuation plans and quality assurance audits.

Is the service safe?

Our findings

At our last inspection in July 2014, we had concerns that there was not always a sufficient number of suitably qualified, skilled and experienced staff on duty. At this inspection we saw improvements had been made in this area and there were sufficient staff. However we found that the service was still not consistently safe because records did not provide sufficient details about how to manage the risks people faced.

People's risks were not consistently well managed in the home because records were not always correct or complete. For example, some people were identified as being at risk of developing pressure areas because they were not able to change position without assistance. Some people had special mattresses in place which needed to be set according to their weight. We saw that in people's rooms there were labels which told staff what setting was required for the mattress and how much the person weighed. These were not dated so it was not clear whether the person's weight was correct and whether the mattresses were set accurately. We looked at the weights for two people who had these mattresses and found that they had not been recorded for two months, for another person, the mattress was not set correctly according to the label and their care record. Where people had existing pressure areas, there were appropriate treatment plans in place and we saw that health professionals were involved where required.

People were not consistently protected from risks around eating and drinking in the home. Some people required a soft diet or thickened fluids to ensure that they were able to eat and drink safely. One person was receiving a puree diet from the kitchen, but this was not recorded in the person's care record or in the nutrition folder or dietary requirements information stored on each floor of the home. Trained staff told us that the person had found chewing difficult and needed a puree diet and for their drinks to be thickened because of this. This information was not clear for staff who supported the person with their meals and there were no records or indications that the person needed their drinks to be thickened. The trained staff member showed us the thickener which had been prescribed and was kept in the person's room. A member of care staff who assisted to prepare and provide drinks for people, was not aware that the person needed to have thickener in their drinks because this information was not recorded. We saw that the chef was providing a soft diet for another person; however the person's care record stated that they were able to manage a normal diet. We spoke with trained staff who explained that the person had been struggling with chewing a normal diet due to being tired and was now having a softer diet. This information was not recorded in the nutrition folder used by care staff and meant that there was the potential for staff to offer foods which could be difficult for the person to eat. This demonstrated that the records were not correct or complete and therefore did not support staff to ensure that people consistently had meals and drinks which were appropriate for them.

The home had a live in cat which had been introduced several months previously and lived on the ground floor of the home. Most people and relatives we spoke with felt that the cat was a positive addition to the home and one person explained how they enjoyed the cat visiting them in their room and giving it treats. However there had been no risk assessments completed in relation to the cat which meant that issues including allergies of people and infection control had not been identified or actions put in place. There had also been a formal complaint raised about the introduction of the cat to the home which was being

investigated. The manager told us that they had identified possible issues with the cat sitting on the worktop surfaces in the kitchenette area and had increased cleaning in response to this. They also assured us that the cat had up to date vaccinations and flea treatments. They said that they had checked and no-one had an allergy to cats on the ground floor of the home which was the only floor the cat had access to. However during the inspection, we heard a member of staff explaining that the cat had soiled the carpet and found that on the ground floor, one person's medicine chart advised that they had an allergy to fur. Staff told us that the person had not been exhibiting any signs of an allergy since the cat had moved into the service. The carpet was cleaned promptly and staff told us that the person showed no indications of any allergic symptoms; however this told us that the service had not effectively identified or managed the risks associated with the cat living at the home.

Where three people living at the home had been identified as losing weight, we saw that there were prescriptions for nutritional supplements. Although these people had a fluid intake chart where staff recorded how much they had drunk, there was no record on the Medicine Administration Record (MAR) that the nutritional supplement drinks had been administered in line with the prescription. Where fluid charts were in place, there were target amounts set for people but the daily intakes were not always totalled and rarely achieved the target intake set on the chart. Where people's intake was below the target, there were no systems in place to monitor people's intake and no consequential action plan achieved. This demonstrated that the service had not done all that was possible to safely manage people's nutrition or hydration.

Some medicines did not have clear directions about when they were to be administered. Some people had medicines which were 'as required', their medicines chart did not give clear instructions about when the medicine was to be given. For example, some people were unable to communicate verbally and would not be able to tell staff if they were in pain. There were no clear triggers or descriptions for staff to identify if people were in pain and no clear instructions about when any 'as required' pain medication might be needed. This meant that there was the potential for people's pain to not be effectively managed.

Some people at the service needed staff to assist them to apply topical creams which were prescribed. We saw that due to a change with the pharmacy paperwork, there were no records for the previous 10 days about whether people had received their creams as prescribed. Prior to this, where some people had creams prescribed two or three times daily, we saw that they were only recorded as being applied once daily in some cases.

The above demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around maintaining accurate, complete and contemporaneous records and assessing, monitoring and mitigating the risks relating to the health, safety and welfare of people.

People living in the home and the sheltered apartments told us that they felt safe and relatives generally felt the same. One person said that staff knew how to support them to move safely and use the equipment they needed. A relative said "she's in a good place, I have peace of mind". Other relatives told us that there were security measures in place and staff always ensured that they signed in which made them feel that their loved one was safe. Another relative said that they felt their loved one was safe and there were always staff around.

Medicines were stored securely at the home and two trained staff administered medicines for people across the three floors of the home. Where medicines required additional security for storage and administration, these were in place.

Fire evacuation procedures for people living at the home were easily accessible. Each person had a person

emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. There were regular checks on areas including the fire alarms, fire exits and extinguishers.

Staff understood the possible signs of abuse and how to report any concerns. One staff member told us about what signs they were aware of and looked for when they provided support to people. This included changes in the person's facial expressions or behaviour where they were unable to verbally communicate their needs with staff. They were confident in explaining who they would report to. Staff received regular safeguarding training and we saw that there were policies in place around safeguarding and also whistleblowing which gave guidance for staff on how to report. Staff told us that they would be confident to whistle blow if they needed to.

Staff told us that they had enough equipment in place to support people living at the home. We saw that where people needed a hoist to assist them to move, they had their own individual slings which were kept in their rooms. Where people needed specialist seating to be able to spend time out of bed, this was in place and the registered manager told us that they were arranging a trial for a new type of bed which they felt would be beneficial for people at the home. The new bed would reduce the risks of people falling and the registered manager said that they would be inviting managers from other local services so that they could also see the equipment being demonstrated and consider if it would benefit people they supported also. People who lived in the sheltered apartments had pendant alarms which alerted staff if they needed assistance in an emergency. Two people told us that staff always checked that they had their alarm on when they supported them. This told us that staff were aware of the risks people faced and their role in managing these.

There were enough staff to support people living at the home and in the sheltered apartments. We saw that people did not have to wait for support and that where people living in the home had call bells, these were answered promptly. One person said "I call my bell if I need anything and they are here in a few minutes and don't keep me waiting". We saw that call bell responses were audited and the registered manager had spoken to people and relatives about what they felt were an acceptable response time for staff. These were agreed and audits showed that responses had been progressively quicker over the past few months. The registered manager explained that they compared their staffing with other homes and had introduced a dependency tool to provide further guidance about what levels of need people had to further inform staffing numbers. The head of care explained that they listened to staff who would let them know if there were not enough staff to support people. The registered manager said that they utilised staff flexibly based on what support people needed. Staff told us that there were enough of them to meet people's needs. There were separate staffing rotas for people who lived in the sheltered apartments and people told us that there were enough staff to support them and that if they needed help quickly and used their pendant alarm, staff were prompt in responding. This demonstrated that the service was ensuring that there were suitable numbers of staff available to keep people safe.

Accidents and injuries were documented for people living in the home and in the sheltered apartments and included details about what had happened and any injuries sustained. Where actions were taken to prevent an incident from happening again, these were noted. The information was then used to populate a falls analysis document which enabled the registered manager to see whether there were any trends in the times or days of falls or whether staffing was sufficient to cover the times where information showed that people were at increased risks of falls. Where a person living in the home had experienced a high level of falls, this had been investigated and options considered, these included making staff aware that there were certain times where the person was at an increased risk. A person living in the sheltered apartments told us that their support visits had increased after they had suffered a fall. This showed that there were processes in place to identify falls and injuries and highlight any patterns or trends.

Staff were recruited for both services and worked in the home and supporting people in the sheltered apartments as part of their induction to the service. Recruitment records we looked at showed that appropriate pre-employment reference and identity checks had been completed prior to new staff starting. We also saw evidence that checks with the Disclosure and Barring Service (DBS) to ensure staff were safe to work with vulnerable adults had been completed. The registered manager explained that there had been a high level of agency staff previously and they had worked to recruit additional permanent staff and offer overtime for existing staff to reduce the need for agency cover. We saw that as part of the recruitment for activity staff, the registered manager had involved three people from the sheltered apartments and a relative in the interview process. They had designed their own questions and fed back positively about being involved. The registered manager said that they had also invited a GP to be involved and would plan to use a similar system for future recruitment.

Is the service effective?

Our findings

The service was not consistently effective. Staff we spoke with had training in a number of mandatory areas which the provider had identified as essential, but had not received specific training relevant to the needs of the people they were supporting. For example, staff received training in several topics including moving and assisting people, dementia, safeguarding and pressure area awareness. We saw that people living at the home had a number of conditions including Parkinson's, epilepsy and diabetes. Staff had not received training in these areas. The registered manager advised us that they were arranging for the registered nurses to provide condition specific training sessions for staff and were in the process of arranging topics including Parkinson's, diabetes and CVA(stroke awareness). They were planning to arrange other sessions in areas which were relevant to people's particular needs. The registered manager told us that they were planning to link with another local service to provide some joint training opportunities for staff and to enable staff to attend relevant training at the linked service. The registered manager told us that they had invited relatives to attend dementia training and some had expressed an interest and attended with staff. A relative told us that staff "understand how my relative works and have the skills and knowledge to support them".

Staff told us that their induction to the service had been positive and that they had shadowed other more senior staff and been supported to shadow for longer if they did not feel confident. We saw that new staff were completing the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Because some care staff had recently started in their role, some had not yet received supervisions. Staff still in their probation period had not met with more senior staff to discuss their progress or how they were developing. Staff who had worked at the service longer received supervisions, but these were not consistent for all job roles. For example, we saw that trained staff and housekeeping staff had regular supervisions. However care staff supporting people in the home and providing personal care for people living in the sheltered apartments had not consistently received supervision. The head of care told us that supervision was planned for staff six times annually. Records showed that this had not taken place and some staff had only received one or two supervisions since January 2016. This told us that staff had not had regular protected time to support them to discuss issues relating to people or their own learning and development.

We observed a mealtime at the home and saw that it was not a social occasion and that very few people chose to eat together in the communal areas on each floor of the home. Most people received their meals in their rooms and people and relatives told us that this was their preference. For people in the communal area, we saw most sat in low lounge chairs with over chair tables on which their food was placed. We observed that this was a difficult eating position for some as the tables were higher than the chairs and were a distance away, making it difficult for people to eat their food if they had reduced motor skills or movement. This also meant that there was little or no social interactions between people or staff. For people with a dementia, sitting at a dining table with cutlery and other people would offer visual prompts that it would be time to eat and these were lacking in the arrangement at the home. There were plans for specialist training to be offered around nutrition in dementia and the registered manager explained that this would include a focus on the dining experience of people at the home. On the second day of inspection we saw that more people had been supported to sit at a dining table for lunch, but they were seated in lounge chairs

which were again, not set at a height which made eating easier for people. This demonstrated that the service had not done all that was possible to provide people with a social, accessible area in which to have their meals if this was their choice.

People living in the home told us that the food available was good and that they had a choice about what they wanted to eat. We saw that one floor supported people who had a dementia and that menu choices were displayed with photos of each choice. The chef explained that they took the photos themselves and they were used to support people to make visual choices about their meals. The chef explained that they catered to a range of dietary requirements and provided choices which were respectful of people's specific religious beliefs. Where people required a softer diet, the kitchen provided this. Some people had been identified by staff as having a poor appetite and often declined main meals or ate very little. For these people, the kitchen prepared a snack plate which had a range of finger foods. The chef explained that these were available for people in between meals to encourage them to eat more and we saw that one person was snacking on some cheese mid- afternoon from one of the snack plates. Where people needed a particular type of cutlery or crockery, this had been provided which supported people to eat independently.

Some people who lived in the sheltered apartments also received meals from the service and the chef was aware of people's dietary requirements. Copies of the menu were on display in each of the blocks of apartments so that people could choose to order a meal on an occasional basis if they wanted. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

We saw that people in the home had clear capacity assessments which were decisions specific and where a person was unable to make a decision, this had been clearly evidenced. Where people had been assessed as lacking capacity to make a decision, a best interest's decision had been made but these had not always involved the appropriate professionals. For example, two people had medicines which were given covertly. Capacity assessments clearly evidenced that they did not have the capacity to decide whether to receive their medicines in this way and a best interest's decision had therefore been made. However neither of the best interest's decision had recorded input from an appropriate health professional. Some best interest's decisions also lacked signatures and dates for when they had been undertaken. This was not in line with legislation and told us that the service had not done all that was possible to ensure that they effectively followed the legislation in relation to MCA.

The service had made appropriate applications for DoLS for people living at the home but all were still pending at the time of the inspection. There was a clear record of DoLS applications that had been made and the date that these had been submitted. This demonstrated that the service understood when consideration of DoLS was required.

People in the home and living in the sheltered apartments were supported to access healthcare services

when needed. We saw that people's records included details about health professionals visits and that advice was sought promptly when needed. For example, one person had developed sore areas on her feet and the service had promptly contacted the GP and discussed their concerns, the GP visited and staff had updated again when the person's condition changed. One person told us "When I've had a pain, the GP has been to see me". A relative explained that the service had involved the GP promptly when their loved one moved to the home. A health professional told us that referrals from the service were appropriate and that they were proactive about requesting GP visits.

Is the service caring?

Our findings

The service was caring. People and relatives told us that staff were kind in their approach. One person told us that staff were "very kind and efficient". A relative told us that staff had a "friendly, positive, can-do attitude. Nothing is too much trouble". Another explained that staff were warm, welcoming and helpful. Another said that they had observed that staff spoke with people in a caring way and were kind. We observed a member of staff bending down to speak with a person and placing a hand on their arm while they engaged in conversation.

People living at the home and in the sheltered apartments were supported to make decisions about their care and staff understood their role in supporting people to make choices. One person explained that staff had asked them where they had wanted to eat their lunch and they had chosen to have it in their bedroom. A staff member explained that they provided appropriate choices for people and gave an example for one person for whom they visually showed them two choices which enabled the person to make decisions about what they wanted. We observed a member of staff offering person choices about where they wanted to sit when they supported them into the lounge. A relative told us that "staff communicate well, like their clothes by asking what they want to wear and letting me know if anything needs replacing".

Staff were getting to know people at the home but because quite a few staff had been recently recruited, it was taking time for them to get to know each of the 37 people living there. People had laminated sheets displayed in their room which showed the 'tree of life'. It provided snapshot of what was important to a person and included details about their previous occupations and favourite types of music. This provided staff with prompts for discussions with people about topics which were of interest to them. A staff member said that this "helps us to get to know the person and helped me get to know them when I started". We observed that staff communicated with people in a way that was reassuring and that they were patient and used body language where needed if people's verbal communication was limited. A staff member explained that they used a person's facial expressions to identify when they were unhappy about something.

People told us that their privacy was respected. One person explained "if staff need to do anything personal, they leave me and give me privacy and I ring when I want them back". Another explained that they felt "comfortable" when staff were supporting them with intimate care and that staff always knocked and waited for them to answer before they entered. A staff member explained that they closed the curtains in a person's room before supporting with any intimate care and ensured that the person remained as covered as possible to respect their dignity and privacy.

We saw that people who lived in the sheltered apartments had a document in their records which considered whether they wanted staff to enter their apartment if they did not answer when staff called on them. Some had consented for staff to enter while others had not wanted this option. This meant that people's privacy had been considered and they were able to choose when and how they wanted staff to enter their apartment.

The home had achieved beacon status with a national framework for providing end of life care. We saw that

people had anticipatory care plans for end of life which included their wishes and those of their families where appropriate. A health professional told us that the home was proactive about contacting if a person's health had deteriorated and we saw that some people had 'just in case' medicines prescribed which could be administered if required for end of life care. Two relatives explained that they had felt supported by the home when their loved one was in receipt of end of life care. They told us that the registered manager and head of care had been able to explain "what was happening and what we would expect to happen" and that they had been told that they could visit day or night and stay the night if needed. This demonstrated that people and their relatives were supported and involved in their end of life care.

Is the service responsive?

Our findings

The support for people living at the home was not consistently responsive. There had been staffing changes within the home which meant that there was not a main activity co-ordinator in post at the time of inspection. There were several staff who provided activities support on a part-time basis and this meant that there were planned activities on week days but nothing at weekends. On the first day of the inspection, people were supported to go to outside activities during the morning but there was nothing for people to do in the home. On the second day we saw that staff were supporting some people to have their nails painted, but for the majority of people in the home, there was little interaction available. People had activity records which were completed by staff. We saw that for one person, they had only one entry since August which was when an activities staff member had been to chat with them. For another, they had been chatting with an activities staff member in October, and had their nails painted while we were there but there were no other entries recorded. For some people we saw that they had increased interaction including one person who was taken to a local singing group and took part in craft activities, another person explained that they had been supported to go to the local market which they had enjoyed. However the majority of people at the service had complex needs and many spent most of their time in their bed. There were not sufficient opportunities for people to have meaningful time with staff either as part of planned activities or on a one to one basis. A relative said that they weren't sure that staff spent much time with their loved one and another said that they felt staff should spend more one to one time with their loved one. The PIR told us that the dementia floor of the service had lots of equipment which could be used to engage people including sensory objects, dolls and rummage boxes. We saw that these items were available as described but that during our inspection these were not used by people or used by staff to engage with people. The registered manager told us that these boxes were designed for people to use independently.

The registered manager told us that there was a new activities organiser starting imminently and that the plan was for there to be activities available for people every day of the week. The service used some volunteers in addition to other activities staff who visited regularly and spent one to one time with people which we observed during the inspection and was reflected in activity records. Although plans were in place for activities to be improved and extended, there were not sufficient opportunities for people to receive one to one support with staff and existing equipment designed to support people with a dementia, was not being used.

Three visitors and relatives we spoke with told us they did not always feel welcome at the home. One visitor said that they felt that some staff told them what they wanted to hear, but that this was not accurate. For example, staff members had told them that their loved one had eaten a very good lunch. The visitor said that this had not been the case. Another told us that they had been told that their loved one had a good appetite but they were losing weight which they felt meant that staff were not always sure about how their loved one was. Another said that they were not always offered a drink, although they had been told that they were able to use the small kitchen areas to make these independently. Other relatives spoke highly about the staff saying that they were always welcomed and came whenever suited them.

People had individual care records which gave details about what support they required. Care Record's for

people living at the home and in the sheltered apartments included details about people health needs but did not always include information about people's likes, dislikes and preferences. This had been identified by the management of the service and new assessments were in the process of being completed with people as part of implementing new care plans for people. There was a date for completion of these and the service were in line to meet this. The newer assessments were person centred and included people's likes and dislikes and what information people felt was important for staff to know about them. For example, one record gave details about hobbies the person enjoyed and what type of music they liked to listen to. It also explained how staff were to support the person in a way they preferred. The head of care explained that they were in the process of completing the new care plans with people and we saw that there was a schedule in place to manage this. A relative we spoke with said that they had been involved in an assessment with their loved one before they moved to the home and had been asked about what their preferences and dislikes were.

People's care plans were reviewed each month by trained staff and we saw that these checks took place. Relatives told us that they were involved in the reviews. One explained that they had recently had a review where they had been through the care plan and felt that it was quite detailed. Another told us that they had been invited to attend when there was a review arranged with their loved one.

Relatives told us that the service kept them up to date and contacted if they had any concerns about their loved ones. One relative told us that the home had rung them because they felt that their loved one needed to be seen by the GP and the service had already arranged for them to visit. Another explained that the staff kept in touch with them and had rung recently to discuss whether they wanted their loved one to have the flu jab this year. Another said that staff would "ring me if there were any changes" that they needed to know about.

People and relatives meetings were held regularly and we saw that the date for the next meeting was clearly displayed in the entrance to the home. We looked at minutes from the most recent meetings and saw that it was attended by the registered manager, and a member of the administration team who took minutes from the meetings. A speaker had been invited to a resident and relative meeting to talk about dental care for people and relatives asked questions about the project and whether it might suit their loved one. Other areas discussed included memory boxes which had been introduced for people but needed loved ones to populate them with items they felt would have significance. We saw that some items raised at previous meetings were followed up so people were aware of actions taken. Minutes included discussions about the introduction of the pet cat to the home and actions were agreed.

Separate meetings were held for people who lived in the sheltered apartments and there was a committee who met with the registered manager regularly to discuss issues which were important to people. Actions were agreed and planned and where it affected them, discussed with people and relatives at the home. For example, the committee had advised that people were interested in an area being developed for an outdoor activity. This was then discussed at the residents and relatives meetings in the home and actions were planned to develop an area in the way people living in the apartments had requested.

There was a clear complaints process for people to use and we saw that the service was in the process of investigating and responding to a complaint. The details were clearly recorded and there were timescales in place for responses to be provided. People living at the home and in the sheltered apartments and relatives we spoke with told us that they had not needed to complain, but would be confident to do so if they needed to and were aware of who to speak with.

Is the service well-led?

Our findings

The service was not consistently well led. At our last inspection in July 2014, we had concerns that records were not always accurate or complete. This was a breach of regulation and we asked the provider to take action. At this inspection we found improvements in relation to some records. However further improvements to the quality assurance systems were required to ensure they were robust and effective.

The quality assurance systems for both the home and the sheltered apartments were not always effective. The registered manager had been in post for a few months and had a clear plan for the service and its development. However the systems in place had not picked up the issues we found during the inspection. For example, we found incomplete records relating to support people needed to eat and drink safely. Quality assurance measures around infection control indicated that equipment stored in the treatment room had been cleaned. However three of the four pieces of equipment examined were clearly dirty with one still containing a dirty mask and tubing. This told us that the quality assurance measures were not accurately identifying issues.

The provider had failed to identify through their quality auditing systems that there was a culture in the home of using language which was not respectful. Staff were kind and caring in their approach with people but there were some cultural habits which we addressed with the registered manager. For example, staff referred to people who required support to eat as 'feeders' throughout our inspection. Staff used this language when speaking with us during the inspection and did not show awareness that this was not respectful. The registered manager told us that they would revisit the use of language with staff to ensure that communication was respectful and appropriate. This told us that the management team had not done all that was possible to ensure that staff spoke with people in a way that was respectful.

The quality auditing systems had not identified that some were not robust and needed changes to ensure that they were up to date and included the comprehensive detail required. For example, the fire risk assessment for the service was out of date and this had also been noted by the fire safety officer during their last fire safety audit. The registered manager said that they would arrange for an updated fire risk assessment to be completed. The manager subsequently advised that a new fire risk assessment was booked to be completed in February 2017. This told us that the management was responsive but had not been proactive in ensuring that these processes were robust and up to date.

This demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around assessing, monitoring and improving the quality and safety of the service.

Staff working in the home had mixed views about whether they worked well as a team. Some staff members felt supported and that the staff communicated well with each other and management. Others felt that they were not listened to and that communication was better on some floors of the home. One staff member told us "staff don't communicate well" and another said that "communication is ok, communication is better on different floors". Another staff member told us that staff were helpful and another said that "staff get on well

together, if I get stuck I'll ask and they are helpful". The registered manager said that staff sometimes had disagreements but that these were discussed and managed. They said that they had worked hard to develop a stable staff team and that they were now working on communicating and working well together. This told us that management had identified and were working on improving team work within the staff group.

People, relatives and staff told us that the management were approachable and listened to them. One relative described the registered manager as "personable and open with us". Another felt that management had taken steps to improve the training for staff and that the registered manager had good intentions for the service. Another said that they spoke with management frequently and always found someone to be available when they visited. A member of staff we spoke with said that they felt the registered manager would "put the home in the right direction" and another explained that the registered manager was "good, always attends handovers and is more involved".

The registered manager had links with other local managers and told us that they had had discussions about best practice and the use of an electronic recording system which the home was considering as part of their development plan. They had visited a home that were using the system and spoke with the registered manager there to see what had worked for them. They had also planned a demonstration of a piece of equipment and had discussed this with the registered manager of a local home who were already using the equipment to seek their views about how it worked for people. This told us that the management was working to discuss and develop the service to reflect best practice.

The service had eight members of staff who had become dementia friend champions. This is a national programme to encourage people to better understand how dementia affects people and how they can help. The registered manager explained that their involvement with the programme was part of the homes commitment to the local area becoming dementia friendly for people in the community. The registered manager also explained that the home had applied to be considered as a 'safe haven' as part of an initiative which provides a place of safety for anyone who may be living with dementia if they were found wandering and were unable to provide sufficient information to take them home. This showed us that the management of the service was improving and encouraging best practice and links with the community.

Staff working at the home had regular handovers daily to ensure that staff were updated with regard to any changes to people's needs. A staff member told us that the registered manager attended the handover meetings which they found useful. There were weekly flash meetings each Monday where the heads of department met with the trained nurses to update on changes over the weekend and planned actions and activities for the week ahead. There were also regular meetings for staff, heads of department and the health and safety committee who met quarterly to discuss issues relating to the sheltered apartments. We saw that meetings were recorded and that full staff meetings were held at different times to try to ensure that staff working night shifts were also able to attend.

The registered manager told us that they wanted staff to question and query practice. They said that they encouraged staff to speak at staff meetings and come up with ideas and suggestions. For example, a staff member had raised that soft furnishings for a person were in poor condition, these had then been replaced. They told us that they wanted to develop a close working team and had rotated all care and night staff through both the home and the close care provided to the sheltered apartments so that staff got to know each other and the support people received.

There was an employee of the month scheme in place which the registered manager had introduced and we saw that certificates for staff who had been successful were displayed in the home. Nominations were made

by people and relatives and the registered manager determined who was successful based on the reasoning for the nomination. They were also planning an awards ceremony annually to recognise staff. As part of the work to reduce agency staff, the registered manager had introduced overtime options for existing staff so that they were recognised and valued when they completed hours in addition to their contracted shifts. The service was recognising and valuing the staff which demonstrated good leadership.

Surveys were given to people, relatives and visitors annually and we saw that 28 responses had been received for the last survey in December 2015. Responses were generally positive and there was an action plan in place following the survey to address issues this raised. For example, over half of people felt that meals were generally of an acceptable quality; the action plan detailed a change in staff and plans to include people in discussions about foods. The chef told us that they had met with people as outlined in the action plan.

The home had a clear development plan which outlined planned improvements to the general environment for people, stabilising the staff team and improving recording quality and efficiency. Each action had a target date and dates for progress to be reviewed. We saw that actions outlined were in progress and some had been completed. For example, people had asked about the introduction of a shed in the outside space. This was being actioned and consideration given to what to set up in the shed which related to peoples previous occupations and hobbies. The registered manager said that they had a person who used to be an engineer and would enjoy being able to use the space if there were engineering parts and tools available. The PIR we received told us that the service had a dementia development team and the registered manager explained that this was made up of staff who had volunteered. The purpose was for staff to work together to consider ways of improving the service for people who were living with dementia and there was a dementia action plan in place which had been developed following discussions with staff. Again actions had target dates and review dates and included improvements to furniture, signage and pictorial menus. We saw that some of these actions were completed and others were in progress. This told us that the management was taking steps to improve the quality of service delivery.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	How the regulation was not being met.
Treatment of disease, disorder or injury	<p>The service did not have systems that effectively and consistently assessed and monitored the quality and safety of people using the service and therefore they did not have an effective system to identify areas for improvement</p> <p>The service did not always maintain accurate records about people or record the risks people faced.</p> <p>Regulation 17 (1)(2)(a)(b)(c)</p>