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Northleach Court Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This unannounced comprehensive inspection took place on 10 and 16 August 2016.

Northleach Court Care Home provides accommodation and personal care for up to 55 people. On the day we visited 28 people were living there. The home accommodates people living with dementia and provides nursing care and end of life care. The home is a converted 'listed' building and has a passenger lift to reach the two floors where people are accommodated. There was 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.

There were one breach of legal requirements at the last inspection in August 2015. After the focused inspection the provider wrote to us to say what they would do to meet the legal requirement in relation to the breach. We checked and the action had been completed.

People were not protected from harm when incorrect equipment was used to hoist them. People did not have individual hoist slings that were the correct size for them. Infection control guidelines were not followed and some areas of the service were not clean. Improvements were needed to the environment to ensure peoples safety and provide a pleasant home that met people's needs. .

People's care and support needs were assessed to monitor the staffing levels required but there was insufficient staff. There was no activity person to ensure people had enough activities they liked and individual engagement. Staff completed some activities with people but they were very busy. The provider agreed to employ additional care staff and recruit an activity coordinator.

People's medicines were not always managed safely to ensure people were receiving medicines correctly. Medicine management was regularly audited but improvements were not always sustained. Peoples care plans did not provide sufficient detail. There was insufficient guidance to support people living with dementia. Care plan reviews were incomplete.

People told us the food was alright and there was a choice of meals. They had home cooked cakes and snacks were always available. People at risk nutritionally were monitored and appropriate meals and drinks were provided.

People were treated with kindness and they told us staff were good when they supported them with their care. Staff knew how people liked to be supported. People told us they felt safe in the home. Staff knew how to keep people safe and were trained to report any concerns. People were supported by staff that were well trained and had access to training to develop their knowledge.

The registered manager and the providers representative monitored the quality of the service with regular checks. People and their relative's views and concerns were taken seriously. They contributed in regular meetings and were provided with a record of the meetings. Staff meetings were held and staff were able to contribute to the running of the home.

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

Inadequate

This service was not safe.

People were not protected from harm because incorrect equipment was used.

The home was not clean and people were at risk when staff did not follow infection control procedures.

People's care and support needs were assessed to monitor the staffing levels required but there was insufficient staff.

People's medicines were not always managed safely to ensure people were receiving medicines correctly.

Improvements were needed to the environment to ensure peoples safety and provide a pleasant home that respects their expectations.

People were safeguarded as staff were trained to recognise abuse and to report any abuse to the local authority safeguarding team.

People were protected from the risk of being cared for by unsuitable staff by thorough recruitment practices.

Is the service effective?

Requires Improvement

This service was not as effective as it should be.

People made most decisions and choices about their care when possible. Not all people had a Deprivation of Liberty Safeguard in place when they were unable to live without supervision.

The environment did not effectively meet people's needs when they were living with dementia.

People's dietary requirements and food preferences were met for their well-being.

People had access to social and healthcare professionals and their health and welfare was monitored by them.

Staff training was up to date. Individual supervision meetings were completed regularly to monitor staff progress and plan training.

Is the service caring?

Good

The service was caring.

People were treated with compassion and kindness.

Staff engaged with people positively and improved their wellbeing.

People were treated as individuals are their wishes were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples care plans did not provide sufficient detail. There was insufficient guidance to support people living with dementia. Care plan reviews were incomplete.

People took part in some activities but there was a lack of engagement as there was no activity coordinator and insufficient staff.

Complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not as well led as it should be.

The quality checks completed included people and their relatives views of the service but improvement were not sustained with regard to person centred care and infection control.

The registered manager was approachable with relatives, staff and people.

Regular resident/relative and staff meetings enabled everyone to have their say about how the home was run.

Northleach Court Care Home with Nursing

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 and 16 August and was unannounced. The inspection team consisted of one adult social care inspector and a specialist adviser in dementia care.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We did not ask for a Provider Information Return (PIR) this time. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had information of concern raised with us from health and social care professionals and we used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, clinical lead nurse, five care staff, a chef, the maintenance person, the housekeeper, the hairdresser, a domestic assistant, a laundry assistant, the person with the therapy dog and the service quality manager. We spoke with six people who use the service and two relatives. We spoke with a visiting social care professional. We looked at information in five people's care records, two staff recruitment records, staff training information, the duty rosters and quality assurance records. We checked some procedures which included medicines and safeguarding adults. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People that required moving and handling with a hoist were not protected against the risks associated with using incorrect size hoist slings. The staff only used the large size sling for the mechanical hoists. People had been accessed for the correct size sling but staff did not follow the care plan with regard to this. People did not have individual slings. Five people were assessed to need a medium sized sling. There were other slings available for the mechanical hoist but they were for people that required a full body hoist in bed. The one manual hoist had three slings sizes; small, medium and large which was sometimes used but staff preferred the mechanical hoist as it was easier to use.

One staff member told us they pulled the sling more tightly for small people when they used the large sling. This meant people may have been uncomfortable or harmed and were at risk from slipping out of the hoist sling. Another staff member told us a very small framed person had been hoisted using the large hoist sling. The Health and Safety Executive guidance about hoisting people and the importance of using the correct size sling was not followed therefore people were not kept safe.

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

We observed staff using the mechanical hoist and the manual hoist. People were not anxious and staff reassured them all the time. There were two staff who assisted the people hoisted. We advised the provider of the safety risk as the registered manager was on leave. The next week all people using a hoist had been measured for an individual sling which was ordered. Subsequently the registered manager told us each person had an individual hoist sling that fitted them and was safe.

People were not protected against the risks associated with infection control. One staff member told us they had not seen the sling for the mechanical hoist washed. The laundry person was unsure when the large sling was last laundered as it was used for most people who were hoisted and would need to be dried. There was no spare sling for the mechanical hoist. There were four bags of dirty laundry waiting to be dealt with. One washing machine had been out of order for three months which left one washing machine and one tumble dryer. There were plans to replace the washing machine that did not work and install another tumble dryer. The laundry person we spoke with covered five days of the week and told us they were trained in infection control at their previous job. There was washing instructions for fabric temperatures and sling washing in the laundry. There were no infection control procedure for the laundry to ensure the correct flow through the room to prevent cross infection between soiled and clean laundry. With so much dirty laundry to process there was little room in the laundry. One laundry person was currently on leave and the housekeeper told us they helped out in the laundry.

Clean linen was seen on a sink draining board. There were two trolleys for dirty linen on the ground floor but no trolley for staff to use for clean linen. Staff personal protective equipment such as gloves and aprons and wipes used for people were taken from room to room and not stored in each person room ready for personal care. Staff told us there was not enough equipment for each bedroom. There were two hand gels

for visitors and staff to use, one by the front door and one in the dining room there were none on other floors. Care staff told us they had completed infection control training.

The housekeeper told us they and the domestic assistants all had infection control training. There was domestic assistants every day but a part time domestic assistant who had left was not replaced. Domestic assistants started at seven in the morning, there were two during the week and we saw both on duty. One domestic assistant told us, "People have quite a few 'accidents' on the carpets and we can't do every room every day". The communal toilets and one person's ensuite toilet were checked every two hours for cleanliness and this was recorded as completed. The dining room was not cleaned after supper but was vacuumed by the night staff in the evening.

Areas of the service were not clean. Some of the furnishings in the main lounge areas did not look clean and were 'tired' and required replacing. We noticed one corridor upstairs used by people was not clean and there were several cobwebs. One bathroom numbered six needed to be decorated and the flooring replaced. There was a vacuum cleaner and a ladder stored in a sluice where commode pots were washed. Another sluice had soiled incontinence pads in two bags stored on the top of the washer, the floor was not washable and there was no hand cleaning facility there. One bedroom smelled and the carpet was due for replacement. Another room had very dirty walls and the person had a wheelchair and hoist stored in their ensuite toilet which may have prevented access to the wash hand basin for staff.

The hoists and slings had a maintenance check six monthly by an outside company and there were correct dates on the equipment of when they had been checked. Some hoists were dirty and one stored hoist had damaged to the cushioned area and needed repair.

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

There were insufficient staff to meet people's care needs and staff were not always deployed in a way that kept people safe. Call bells were constantly ringing all morning but much less in the afternoon. Five people had sensors in their bedroom which staff said triggered the call bell when staff entered a bedroom. One person said, "Sometimes staff chat but they are very busy, I think there is enough staff" and "I just sit here all day don't do anything." Staff commented that the dependency of people was extremely high and five staff was not enough. We found six people were cared for in bed, five people had fifteen minute checks to ensure they were safe which continued throughout the night and many people required hoisting.

The registered manager told us staffing levels were calculated on the funding level provided. People cared for in bed had been rated medium dependency by the Commissioners but the registered manager told us they were high dependency. The registered manager was in the process of trying to get additional funding for five people with high dependency. On the second day of our inspection visit the provider agreed to employ an additional member of care staff all day from 7:00 until 19:00 hours.

Activities were provided by the care staff as there was no activity coordinator. There was little individual engagement for people and the reminiscence lounge was not used by staff during the two days of the inspection. We observed a nurse who was finishing medicine administration had to stop and support people in the lounge when two staff had to hoist a person and take them to the toilet.

There were three night care staff and one nurse. When we visited most people were up and about when the night staff came on duty at 19:00 hours. The home was divided up into several different areas which meant peoples rooms were spread out in two areas on the ground floor either side of the main lounge and on the

first floor which may mean people living with dementia were not always supervised when required. On the second day of our inspection visit the provider agreed to employ an additional member of staff on a twilight shift from 16:00 to 22:00 hours to help ensure people were well supported when going to bed. The registered manager told us agency staff known to people were regularly used. Two new staff had been recently recruited and would start in September 2016. The level of staffing needs to be sustained to meet the needs of people living with dementia. One relative that visited regularly told us the staff were very busy and engaged individually with some people but there were times when other people had little engagement.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mostly safe medicine administration systems in place and people received their medicines when required. However medicines were not always safely stored; Several people's creams were stored in an open container on the linen trolley in the corridor. This was unsafe practice when people walking by could take the creams unnoticed.

Medicines received were not carried forward each month so that a total amount of how many there were was available. One bottle received had 60 tablets in but was recorded as 28, this meant meaningful audits could not be completed and acted upon.

There were generally protocols for staff to follow when medicine was prescribed 'as required'. However one person did not have a protocol for medicine to be given when they were anxious to ensure staff all made the correct decision. There was no pain assessment completed when one person was prescribed pain relief 'as required'. There were two people that had eye and ear drops instilled and there was no indication on the medicine record which eye or ear and how many drops should be instilled. The nurse corrected these errors immediately.

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

Liquid medicines were dated when opened so they could be discarded at the appropriate time. The medicine storage temperatures were regularly checked to ensure safe storage. There were no signature gaps on the medicine administration records we looked at. Staff observed demonstrated safe administration practice. There was a Patient Information Sheet available for each prescribed medicine from the supplying pharmacy. There was a photograph of each person and their allergy status. One person told us the staff gave them their eye drops on time three times a day.

Improvements were needed to the environment. The maintenance person maintained the health and safety log monthly where checks to the environment were completed including fire safety. We looked at completed records of safety checks, for example, fire bells, call bells, hoists and electrical portable equipment. Legionella disease checks of the water systems had been completed six monthly. The service quality manager completed regular fire drill training with the staff during some monthly visits of the service which were recorded in the fire log.

The house keeper and the registered manager completed environment checks and some improvements needed had been highlighted but not all to include all rotten window frames and carpets that needed replacement. There was no overall improvement plan to identify all the areas that required changes and when they would be completed. The maintenance person told us there was emails between them and the maintenance manager regarding quotation for work needed but no real plan of completion. We noted

several areas for improvement to include peeling paint on dining room doors and black dirty walls outside where people sit. Some carpets and armchairs needed to be replaced as they were worn. Two people used the lift independently but without keypads to the lift other people may not be safe.

We recommend that the service seeks advice and guidance from a reputable source about developing a comprehensive improvement plan of the environment to ensure people are safe and improvements continue.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed contingency plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

People told us they felt safe in the home and relatives also expressed the view people were safe there. One relative told us. "She is happy here", "she is safe." Staff understood their safeguarding responsibilities and completed annual safeguarding training. Staff explained what they would do to safeguard people by reporting any incidents to the registered manager or the local authority safeguarding team. There were safeguarding policies and procedures for staff to follow when abuse was witnessed or suspected. Records indicated the correct action was taken when required. The registered manager had informed CQC about all safeguarding events.

Risk assessments were in place to support people to manage any risks to their individual safety and wellbeing and for them to be as independent as possible. We found risk assessments in place for example; for people falling, their nutrition and for risk of skin breakdown. Guides to the level of risk were recorded to ensure the correct action would be taken. Risk assessments were reviewed monthly. One person at risk of falling had a sensor mat to record their movement and frequent observation by staff. Another person assessed as at high risk of falling was checked every 15 minutes and this had effectively reduced their falls.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. Accident records had detailed information and preventive measures were looked at and acted upon where required. There had been12 accidents so far in August 2016 and clear actions were recorded. A monthly review of accidents was completed to ensure all possible preventative measures were working. One person had unexplained bruising and this was reported to the local authority safeguarding team and investigated to highlight any preventative measures. The investigation had revealed a sensor mat was not working effectively to alert staff the person was moving in their bedroom. The person was subsequently checked regularly by staff as they were prone to falls when unaided. Another recent accident for one person was investigated well and the person's injury was recorded, relatives were informed and they were seen by their GP for treatment.

Safe recruitment procedures were practiced and ensured people were supported by staff with the appropriate experience and were of good character. Two references were held for each staff member which included their most recent employer in care where applicable. All relevant checks were completed and staff had induction training.

Requires Improvement

Is the service effective?

Our findings

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. 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 are called the Deprivation of Liberty Safeguards (DoLS). Three DoLS application had been approved and 11 applications were waiting to be approved. The registered manager told us there were a further 18 additional DoLS applications to complete this means the service was not meeting the requirements of the MCA. The registered manager was committed to ensure these applications would be completed as soon as possible.

A visiting social care professional who represented people that have a DoLS in place told us the DoLS for one person was appropriate and least restrictive. They said the care plan records indicated the persons choice and their independence was maximised where possible. The DoLS had recently been renewed for the person living with dementia. The representative said there was a good life history in the care plan and the person's previous preferences were recorded. A monthly journal was kept about the person and sent to the DoLS team and the DoLS assessor visited annually. There were four actions the service was required to make in the DoLS and two were currently not met. One action not met was to provide a bedroom on the ground floor but none were currently available. The second action not met was to make use of the specially adapted chair so the person could sit out of bed. The person's skin was so fragile that when the staff had previously sat the person in the chair this had caused a skin ulcer very quickly. The registered manager planned to explore the use of a protective skin spray used before the person sat in the chair again. The representative had found the person bright and alert and had no concerns about their care.

Staff had completed training on the Mental Capacity Act 2005 (MCA) which 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.

All residents had a 'choice and capacity review' which enabled staff to know what peoples choices were prior to admission and their assessed capacity to make choices. There was a list of their preferences which was a clear record for people living with dementia. However the review allowed for people to change their preference and this was recorded. One person had preferred coffee but had refused it recently and now preferred cold tap water or tea. Coffee had been crossed through on the record. There was respect for people and their changing preferences were met. One staff member told us that people choose different foods and the chef prepares what they want, for example bread and butter or yogurts.

One person was assessed not to have capacity for several specific decisions. Therefore decisions such as information sharing/care planning/safety (falls) were made in the person's 'best interest'. The decisions had been shared with a relative as a courtesy as there was no power of attorney in place.

However consent was not considered on all occasions. For example two unrelated people who did not have capacity to consent shared a double room and there was no privacy for them. The registered manager told us they would ensure people had their own bedroom when they were unable to consent to share. There were several empty bedrooms that could be used in their best interest with advice sought from relatives or friends

The environment was not dementia friendly when people living with dementia moved around the home. For example there were no areas where people could interact with day to day objects if they wanted to. The gardens were not accessible independently. Some areas needed additional colours to differentiate things or obscure areas where people were not safe to go. Access to stairs and the lift were not safe.

We recommend the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

People's dietary needs and preferences were recorded. The chef had a good understanding of people's dietary needs. They received a weekly nutrition report to ensure people had the correct diets and fortified food and drinks if they were at risk of malnutrition. Diabetic and soft or pureed diets were catered for. All food was fortified at source but some people at risk of malnutrition had additional fortification in their drinks to include milk shakes with cream and ice-cream and prescribed high calorie drinks. Finger food was available to include fruit and savoury snacks. People were offered food they could choose from on the day and were supported to eat when necessary. The dining room had sufficient staff to support people but staff did not always do this carefully enough when they stood beside people instead of sitting with them. One person told us they didn't like the meals but could choose what they liked to eat. Another person said the food was "Alright." One relative told us they often had a meal at the home and said, "I am very pleased with the food and so is my wife."

A member of staff told us they knew what people liked to eat and people at risk of malnutrition had a food chart maintained which was in the office when they were downstairs. We looked at the charts and the food people had eaten was recorded. A choice of cold drinks were available at all times for people in the communal areas and their bedrooms and all jugs had been dated to ensure they were changed every day. One person told us they chose to sit in the lounge for their meals.

People were referred to the dietitian or speech and language therapy team (SALT) when staff had concerns about their nutrition. One person nursed in bed had a nutritional assessment tool which identified they had appropriate measures to effectively maintain their nutrition. Their weight had been stable over the previous year. However the SALT advice recorded was undated and informed staff to provide a pureed diet and normal fluids. The last care plan review on 1/08/2016 stated the person had Thick and Easy - thickened to a syrupy consistency. When we asked staff they told us the person had a soft diet and thickened fluids to a syrupy consistency. The conflicting guidance may have put the person at risk from choking and was discussed with the nurse in charge to ensure the person had the correct diet. We observed staff were careful when they assisted the person to eat and drink as they knew about the risk of choking.

Another person living with dementia had lost 6kg in weight over a three month period and had seen their GP weekly. Subsequently the registered manager told us the weight loss was probably due to reduction in the swelling of the person's legs but this was not recorded. Their weight had been stable for the last month and they were eating well and had fortified meals and drinks.

People were supported by staff that had individual supervision meetings and appraisals. Nine of the twenty staff had completed regular supervision meetings this year so far. The registered manager had a colour

coded plan when staff supervisions and annual appraisal meetings were due. Some staff were new and their individual supervisions had not started. The area operations manager checked individual staff supervision records every two months as part of quality assurance. Staff meetings were also used as general supervision for all staff. A member of staff agreed we could look at their individual supervision record. There was a clear record of what the staff member said and their future goals.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist, an optician, a chiropodist and a community psychiatric nurse (CPN). One record confirmed one person had several visits from a CPN to support their wellbeing and a record of their behaviour when they were anxious was kept and reviewed with the health professional.

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff completed an induction training when they started which was in line with the Skills for Care induction programme. Staff told us their training was up to date. A programme of training to maintain and update staff knowledge and skills was in place and staff were informed when their training was due. Staff had completed a range of training to include, health and safety, moving and handling, infection control, food hygiene, dementia care and fire safety. Several new staff had been recruited and three were completing level two diploma in health and social care. The registered manager planned to enrol staff on a more in depth dementia training course in October 2016. The registered manager told us staff were up-to-date with their training and the record of training completed confirmed this. Staff told us they had completed their training and were supported to attend training course or complete computer based training. Four nurses had completed syringe driver training in the last 12 months. Staff from other countries had to pass literacy and numeracy assessments before they were able to begin more formal training for example Health and Social Care diploma.

Good

Is the service caring?

Our findings

People were usually treated with kindness and compassion. One person described a member of care staff as "A nice gentle nurse" when they bent down to their eye level to talk to them. Two people told us they liked living at the home because staff were kind to them. One relative told us, "Staff are extremely kind and look after her well and me." A person that provided a regular service to people told us they had nothing but praise for the staff and had never heard an unkind word spoken by them.

We observed several caring interactions between staff and people. A care staff member bent down to a person on their level even though they were standing and spoke to them. The person put their hand on the staffs face and the staff member smiled at the person. They spoke together for a few moments and then the staff member explained it was nearly lunchtime and showed the person to the dining room. Another member of staff reassured a person who was upset. They sat with them and put their hand on the person's arm to comfort them. Another member of staff was heard talking to a person in their bedroom, they asked them if they were alright and the person replied they felt "a bit tired", The member of staff encouraged the person to have "a little nap on the bed" and said "I'll come back in half an hour and check on you."

One observation was negative when a person admitted for respite care asked where the coach was. They were becoming distressed saying, "The coach driver shouldn't just go and leave us". The member of staff replied and said, "'No coaches here" and walked away leaving the person more puzzled and anxious. We fed back this information to the nurse in charge and the registered manager to ensure staff had sufficient training to respond to people effectively with compassion.

We saw a domestic assistant in the lounge pretending to play a drum by banging on a bowl and singing to people which they really enjoyed. The same member of staff was observed speaking with people in a kind and friendly manner while they worked in their bedrooms. They passed the time of day with them, which provided them with a positive engagement.

We completed a formal observation of interactions during a lunchtime and just afterwards. There were some good interactions between the staff and people. People were talking with each other during lunch and most people were in a positive mood. One person who had been eating alone and was very quiet had a really positive engagement when a member of staff gave them a cuddle and wheeled them out of the dining room talking to them all the time. After lunch people were sat in the lounge area and we observed staff were busy with one person who was calmly reassured while hoisted to use the toilet. There was a good engagement with a person who wanted their cigarettes and staff reassured them in a kind and thoughtful manner. One person became very anxious and was near the edge of their seat. They were asked to sit further back by a member of staff and they responded negatively as they didn't seem to like being touched, so the staff member moved away and they relaxed a bit. Staff were observed asking people how they were and they were treated with kindness and respect.

People's bedrooms were personalised and had photographs of their family and friends and some of their own treasured possessions. When people received personal care in their bedroom staff attached a notice to

inform others and kept the door closed. Peoples personal care had been recorded and a relative told us; "The staff are lovely they do a good job of keeping mother clean."

There was information in the entrance to the home for people and their relatives which included the latest CQC inspection report. We looked at some letters of compliment from relatives. One relative commented that when the person returned after two weeks at the home they had spoken warmly of the home and how they had enjoyed it there. Another relative had given their thanks for the care of their relative during the previous three years and how much they missed the staff as they had become a huge part of their lives.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved into the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Care, treatment and support plans were personalised but not always person centred. This meant the care was not led by the person. There was no specific care plan for peoples varying dementia care needs which identified there individual mental health diagnosis and the care they needed.

Care plans did not provide sufficient direction for staff to effectively meet the needs of people. The care plans did not always respond to changing needs. Dementia care needs were not recognised in sufficient detail to evidence best practice, especially in terms of behaviour or risk of deterioration due to lack of activity and engagement.

There was no care plan in place for a person recently diagnosed with epilepsy and no protocol for their emergency epilepsy medicine. The person had a planned outpatient appointment with the epilepsy nurse specialist on day of the inspection. On their return the emergency medicine had been changed and staff had been directed how this was to be managed with the GP.

One staff member told us a person had a neurological disease but there was no record of this in their care plan or how staff needed to care for them in relation to the symptoms of the disease. Another staff member told us a person had a medical device in situ when they did not. The decision had been made in their best interest not to proceed due to them living with dementia and having no problematic symptoms. The clinical lead nurse informed the care staff member about the decision which was in the care plan.

Care plans followed the activities of daily living model. The care plans were not fully person centred and not always reviewed regularly to reflect people's changing needs. For example in the care plan communication was the activity of daily living where the service looked at the needs of people living with dementia. The record told staff to give one person time to express their needs. However the person was unable to speak. Staff told us the person could speak prior to their last hospitalisation, although their speech was often muddled they could understand them but this had changed. No amendment was made to the care plan. The care plan was not sufficiently detailed to give staff clear direction in respect of their needs in terms of understanding their behaviour.

One member of staff told us the same person was "nice" and can walk but needed help with personal care. A member of staff was allocated to check the person every 15 minutes to reduce the risk of falls and this was recorded. The staff member told us the person preferred to listen to music in their bedroom and was free from pressure ulcers. Their care plan for breathing was blank as they did not have any problems breathing. This was an unnecessary record and not a person centred plan.

The care plans did not reflect changing or emerging needs for example one care plan for communication did not identify how staff were to communicate with the person and what other measures they could use like hand signals and pictorial prompts. There was no specific care plan for their mental health needs.

The nursing staff reviewed the care plans monthly or when changes occurred but it was apparent this was not always completed. There were no daily records for staff to refer to when they completed the monthly reviews.

Some staff we spoke with knew people well and what they liked to do and how they should be responded to with regard to their individual dementia care needs. However this was not always recorded in sufficient detail to enable new staff to respond appropriately.

People had their position changed in accordance with their needs to prevent skin damage. However, the charts used did not record their skin condition when they had their position changed. There was no record of peoples mouth and eye care when they were nursed in bed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at risk from dehydration had a record of their fluid intake which had been correctly completed.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Information from the handover sheets was transferred to the care records to monitor peoples progress. We observed part of a handover session when the nurse in charge deployed staff and reminded them of the importance of recording peoples personal bathing care record. This had been a shortfall but staff told us this was steadily improving. One care staff member told us the nurses provided a thorough handover but care staff did not have a handover record to work from.

One person in their bedroom upstairs was calling out for assistance twice when we passed their bedroom as their call bell had slipped to the floor and they could not reach it, Staff did not respond to the shouting and we assisted and informed staff to ensure the persons bell could be reached. The person was most anxious and told us it was "tedious" living there. On the second day of the inspection the same person was much happier downstairs in a lounge area watching television. The registered manager had arranged for the person to have a more accessible bedroom with additional space.

People had a programme of activities they could be involved in when care staff were available.. These included chair exercises, darts, ball games, a walk in the garden, pampering sessions and visits from the therapy dog. Activities were organised by the care staff as there was no activity organiser. There was little time for care staff to provide individual engagement with people. One relative told us there was not enough activities for people to join in with or individual engagement. One person told us they liked doing word search puzzles on their own but their eyesight was not good. They said sometimes they joined in with activities and the staff asked them if they would like to go out in the garden but said, "I just sit here all day." Staff took them in the wheelchair to go to their GP's local surgery.

Another person told us they joined in with throwing a ball game and sometimes went into the village with staff. We saw the 'therapy dog' who visited people every Wednesday. People were enjoying the dog and engaged with the dog and the dog handler. Previously the dog visited people in their bedrooms but without the assistance of the activity coordinator the dog was unable to access people's bedrooms. One care staff member told us they talked to people in their bedroom and played ball games with people but they needed more activities. They told us the reminiscence room was mainly used by families when they visited. People watched the television but it was sometimes on when no one was watching it. Some people had their own television or radio to listen to in their bedroom and one person had some magazines and DVD's to look at.

Activity and engagement was lacking on one day of the inspection. We were told that the member of staff providing support in the dining room was responsible for activities but this was not seen on the day. People were disengaged on many occasions. The main lounge area where most people sat had no member of staff there for 20 minutes from 10:20 to 10:40 hours. However we did not note any person required assistance during this time.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People's supporters and some people knew how to complain and would speak to the staff or the registered manager first. There had been six complaints in the last 12 months and these had been investigated thoroughly and healthcare professionals and people's relatives had received a written response. Action had been taken to monitor a person's bedroom and ensuite regularly for cleanliness and a person had been referred to the continence adviser. Minor concerns raised by people or their relatives and responded to had not been recorded but the registered manager planned to record the information in future.

Requires Improvement

Is the service well-led?

Our findings

After our last inspection in August 2015 we found the service was not always notifying CQC of safeguarding incidents. This was a breach of regulation 18 of the Health and Social Care Act (Registration) Regulations 2009. We issued a requirement notice to the provider. They gave us an action plan which outlined the action they would take. At this inspection we found appropriate action had been taken.

Quality assurance systems were in place to monitor the quality of the service being delivered and the running of the home. The monthly visit record completed by the provider's service quality managers had clear information covering different areas each month and what action the registered manager must take. We looked at an example for March 2016 where some areas identified for action still remained incomplete for example with regard to improving person centred care plans.

The registered manager completed several audits for example, four care plans were audited monthly and the results were actioned and discussed with staff. However, continual monitoring was essential to maintain progress as we had found shortfalls in the care plans. The service quality manager informed us that new care plan formats were to be implemented which should improve the records generally.

We looked at a recent audit of people's personal care and bathing in June 2016 where several actions were identified and these were implemented during the inspection. Medicine management had been audited regularly and improvements were identified and actioned.

The service quality manager had identified earlier in the year the service required additional hand cleaners for staff. However this was overlooked by the registered manager but was subsequently actioned during the inspection when 10 additional secure gel pumps were ordered.

A maintenance audit completed in January 2016 by the service quality manager had identified many areas for improvement that were completed by the maintenance person and the housekeeper before the timescale. More major improvements had not been identified in the audit for example the rotten window frames. One window was measured for replacement during the inspection. The service quality manager agreed to complete an improvement plan for the service.

Staff safety fire drill training had been audited in March 2016 to identify any staff member that had not attended. There were clear records of action taken and when staffs next fire drill was required to ensure all staff had regular fire safety training and drills.

Relatives were continually asked to complete feedback forms. The provider had sent us copies of feedback forms completed by relatives in April, May and July 2016. One feedback form completed by a relative in July 2016 told us how impressed the relatives were with the registered manager and the staff team. They said the team were professional when some people living with dementia were trying. They also said the registered manager was lovely and very approachable. They had commented the 'quiet' lounge was too noisy to listen to a person who spoke softly. Subsequently the quiet reminiscence room had been used by families when

required. Another relative had commented they had nothing but respect for the way X was treated and staff were caring and knew the person's likes and dislikes. One relative told us the service was run very well and they could speak with the registered manager anytime and they knew them by their first name. They told us they had completed a questionnaire about the service and commented their relative had a lovely bedroom and their clothes were looked after.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Meetings were held with staff, people and their relatives. We looked at the minutes for a resident and relative's meeting held in June 2016. The registered manager informed people and their relatives that the post of activity coordinator had been offered and they were waiting for an acceptance. Subsequently the post was not accepted and the post remains vacant. Relatives discussed lack of activities for people and made several suggestions to improve people's engagement. It was unclear if any of the suggestions had been taken up during the inspection. The 'Twiddle' muffs which consisted of different baubles and ornaments to touch were mentioned as an activity but were not being used when we visited. One relative had suggested more use of the gardens and although staff took people outside the gardens were not clear and safe enough for people to use independently. Garden refuse blocked one path and old furniture was seen outside. Relatives commented about the time laundry took to be returned and the registered manager apologised as there was currently only one washing machine. One relative mentioned the cleanliness of tables and the registered manager agreed to monitor this. We did not notice any unclean tables during the inspection. One relatives said it was always nice to come to Northleach as the staff were welcoming and they were offered drinks and the cakes were lovely.

Staff meeting minutes recorded in June 2016 included many topics for discussion. Staff were alerted to use correct moving and handling equipment and techniques as unsafe practice had been witnessed. The correct equipment for staff to use was unavailable as the type and size of sling for each person was not indicated. Staff were also reminded about the safety of the sluice room and infection control procedures which evidently were not all working when we visited when we found dirty pads stored inappropriately in the sluice room. Monitoring of required identified actions was incomplete.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services were not protected against the risks associated with incomplete care plans. Regulation 9 (1) (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with using incorrect equipment for hoisting. Regulation 12 (1) (2) (e) . People who use services were not protected against the risks associated with unsafe infection control procedures. Regulation12 (1) (2) (h) People who use services were not protected against the risks associated with the unsafe management of medicines. Regulation12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services were not protected against the risks associated with insufficient staff. Regulation18 (1)