Stretton Care Limited

Stretton Nursing Home

Inspection report

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28 August 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22, 24 and 28 August 2018. The first day of our inspection visit was unannounced.

Stretton Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Stretton Nursing Home accommodates up to 50 people within a large adapted building, and specialises in care for older people with physical disabilities and sensory impairments who may be living with dementia. At the time of our inspection, 32 people were living at the nursing home.

The provider had a registered manager of the service. However, this person had not been involved in the day-to-day management of the service for several months. 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. During our inspection visits, we met with the home's deputy manager and the newly-appointed manager who oversaw the management of the home with the support of the provider and their organisational oversight manager.

At our previous inspection in January 2018, we rated the service as 'Inadequate,' and it was therefore placed in 'special measures.' We identified eight breaches of the Regulations. These related to the provider's failure to deploy suitable numbers of staff and fully safeguard people from abuse, the management of people's medicines, a lack of clinical leadership and the ineffectiveness of quality assurance processes, the failure to assess and minimise risks to individuals, and the failure to fully promote people's rights under the Mental Capacity Act. In addition, people's care plans were not always accurate or reflective of their current needs, and they were not always protected from the risks of malnutrition or dehydration. As a result of the inspection, we imposed a condition on the provider's registration which meant they needed to tell us, on a monthly basis, how they were monitoring the quality and safety of service provided and inform us of actions taken to bring about improvement.

At this inspection, the provider demonstrated to us that sufficient improvements had been made to the service that it was no longer rated as inadequate overall or in any of the key questions. Therefore, the service is no longer in 'special measures.' However, further improvements were still required to the safety and quality of the care people received, and the provider remained in breach of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights under the Mental Capacity Act were still not consistently promoted. Procedures for assessing people's capacity and, where appropriate, making decisions on their behalf were not followed on a consistent basis. People's medicines were not always managed safely to ensure they received these as

prescribed, and that accurate and complete medicines records were maintained. People's risk assessments did not always provide clear guidance on how to minimise the risks to individuals, including the management of long-term health conditions, and were not always read by staff. New staff were sometimes permitted to provide personal care without appropriate initial training. This included training in the home's moving and handling procedures.

The plans for improving people's hydration and addressing weight loss were not always clear. Screening tools for assessing people's risk of malnutrition had not always been completed on a consistent monthly basis. The provider's staff induction programme did not reflect the requirements of the Care Certificate. The provider lacked a clear strategy for creating a dementia-friendly environment. People's personal information held on the premises was not always stored securely to prevent unauthorised access to this. People's care plans were sometimes contradictory, lacking in detail or omitted key information about the individual's current needs, and were not always read by staff. The provider's procedures for identifying people's preferences and choices for their end-of-life care were not followed on a consistent basis.

Staffing levels enabled staff to meet people's needs safely and without unreasonable delays. Staff received training in and understood their individual responsibilities to remain alert to and report abuse. Measures were in place to protect people, staff and visitors from the risk of infection.

People were supported to choose what they wanted to eat and drink, and received any physical assistance required to eat and drink safely and comfortably. Staff participated in a programme of training and received formal supervision and appraisal to support them in them in fulfilling their roles. Staff helped people seek professional medical advice and treatment when they were unwell.

Staff adopted a kind and compassionate approach towards their work and knew the people they supported well. People and their relatives were encouraged to express their opinions and participate in decision-making that affected them.

People's care plans were individual to them, and had been developed with input from their relatives and relevant health and social care professionals. People's communication needs had been assessed and recorded in their care plans. The management team understood the need assess and consider people's protected characteristics under the Equality Act. People received support to participate in recreational activities and pursue their interests. People and their relatives were clear how to raise any concerns or complaints about the service.

Staff commented on improvements in the overall management and clinical leadership of the service, and felt valued and well supported in their work. The provider took steps to invite feedback on the service from people, their relatives and staff. People's relatives benefitted from open communication with the management team, whom they felt able to approach at any time. Staff and management liaised with, and sought advice from, a wide range of community health and social care professionals to ensure people's individual needs were met.

You can see what action we have told the provider to take at the back of the full 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 always Safe.

People did not always receive their medicines as prescribed and the medicines records kept were not always accurate and complete.

The risks associated with people's care and support needs were not always effectively managed and kept under review.

Measures were in place to protect people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always Effective.

People's rights under the Mental Capacity Act were not consistently promoted.

The provider had not implemented a clear strategy to create a dementia-friendly environment.

People were supported to choose their meals and snacks, and received any physical assistance required to eat and drink safely and comfortably.

Is the service caring?

Requires Improvement

The service was not always Caring.

People's personal information was not always stored securely to prevent unauthorised access.

Staff treated people in a kind and caring manner, and showed concern for people's comfort and wellbeing.

People and their relatives were encouraged to express their views on the care and support provided.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

People's care plans were not always sufficiently clear or read by staff.

An inconsistent approach had been taken towards assessing people's wishes for their end-of-life care.

People and their relatives were clear how to raise any complaints about the care and support provided.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

The provider's quality assurance processes were not always effective.

People and their relatives had positive relationships with, and felt able to freely approach, the management team.

Staff felt well supported and valued by an approachable management team.

Stretton Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 22, 24 and 28 August 2018. The first day of the inspection visit was unannounced.

The inspection team consisted of two inspectors, an Expert by Experience, a medicines inspector and a specialist advisor who is a nurse specialist in dementia care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, the provider completed a Provider Information Return (PIR). 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 took this information into account during the planning of our inspection of the service.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority and Healthwatch for their views on the service.Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

Over the course of our inspection visits, we spoke with eight people who used the service, five people's relatives or friends, six community health and social care professionals, the provider, their organisational oversight manager, the home manager and the deputy manager. We also spoke with the provider's clinical lead, the home administrator, the moving and handling trainer, four nurses, the head housekeeper, three kitchen staff, two domestic support staff, two activities coordinators and 10 care staff.

We looked at a range of documentation, including 16 people's care and assessment records, medicines

records, incident and accident reports, six staff recruitment records, staff induction and training records, complaints records, selected policies and procedures, certification related to the safety of the premises and records associated with the provider's quality assurance.

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.

Requires Improvement

Is the service safe?

Our findings

At the time of our last comprehensive inspection in January 2018, the 'Safe' key question was rated as 'Inadequate.' At this inspection we found that whilst the provider had made some improvements to people's care, further improvements were required. We have now rated this key question as 'Requires Improvement'.

At our last inspection, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not fully assessed and managed the risks to people's health, safety and welfare, including the management of individuals' epilepsy and the prevention of pressure sores. In addition, people's medicines were not always safely managed.

At this inspection, we found that although the provider had taken further steps to keep people safe, they remained in breach of Regulation 12. The provider's procedures for managing people's medicines did not always ensure they received these as intended, or that accurate and up-to-date medicines records were maintained. Several people living at the home had been prescribed the same medicine to reduce stomach acid, and one person was taking an antibiotic for a urinary tract infection. Although the pharmacy labels clearly stated these medicines were to be given on an empty stomach, we found the nurses were administering these to people at mealtimes. We also found one person had been administered the incorrect strength of eye drops since March 2018, as staff had failed to notice the medicine delivered by the pharmacy did not match the information recorded on their medication administration record (MAR). In addition, the eye drops in use for this person had also recently passed their expiry date and should have been returned to the pharmacy for disposal.

We looked at 12 people's MARs and four people's topical medicines administration records (TMARs). Eight of these records contained unexplained gaps in recording. There was no clear evidence these missing signatures had been identified and investigated to ensure people had received their medicines as prescribed. Handwritten entries on people's MARs had not always been checked for accuracy by two trained members of staff in line with best practice guidelines. When people had been prescribed 'as required' (PRN) medicines, clear written guidance was not always available to the nurses on the expected use of these. This meant people were at risk of not receiving these medicines when they needed them, or too often. We discussed these concerns with the management team who assured us they would take prompt action to ensure people were receiving their medicines as prescribed, and would put additional measures in place to prevent similar issues from arising moving forward.

The provider had made some improvements in their procedures for identifying, assessing and managing the risks associated with people's individual care and support needs. We found people's individualised risk assessments generally reflected the known and foreseeable risks to their health, safety and wellbeing. This included assessments of the risks associated with people's pressure care needs, their mobility and risk of falls, the use of bed rails and people's access to call bells in their bedrooms.

However, people's risk assessments and associated care plans did not always provide clear guidance on how to minimise the risks to individuals. In addition, we found staff had not always responded promptly to

changes in people's health and wellbeing to mitigate risks to individuals. For example, one person's care plan regarding the management of their constipation lacked specific guidance on the expected use of their prescribed laxatives. This person's care records indicated they had become constipated, and had not had a bowel movement, for a 12-day period in August 2018. This change in their condition had not been fully reviewed by staff or treated through the administration of an additional laxative they were prescribed on an 'as required' (PRN) basis. Another person's epilepsy care plans contained incomplete and contradictory guidance on the management of their epileptic seizures. This included a lack of information on the known triggers for, and frequency and duration of, seizures, and contradictory guidance on the use of their prescribed rescue medication. Neither of the individuals in question had experienced any significant harm as a result of these issues. We discussed these concerns with the management team who took immediate action to address these during our inspection, through reviewing and updating the care plans in question.

Four staff members informed us that, upon commencing duties at the home, they had been permitted to support their work colleagues in providing people's personal care without having first completed mandatory training to enable them to them to work safely, namely moving and handling and safeguarding training. On this subject, one member of staff told us, "It would have been better if I had done [moving and handling] training before going on the floor." In addition, we were not assured staff were always prompted, and given sufficient time, to read people's risk assessments and associated care plans. The staff we spoke with did not always demonstrate clear insight into the risks to individuals. For example, one staff member told us, regarding the management of one person's epilepsy, "I do not have time to read care plans. I'm not aware of what action is required if [person] had a seizure. [I would] report to the nurse!" The identified risks to individuals and agreed plans for managing these had not always been kept under consistent monthly review by the nurses, in accordance with the provider's procedures. For example, we found the provider's screening tools for assessing people's risk of malnutrition or developing pressure sores had not always been updated on a consistent basis.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The risks to people's health, safety and welfare were not always effectively managed and minimised.

At our last inspection, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not always deployed sufficient numbers of staff to meet people's needs. At this inspection, we found the provider was now meeting the requirements of this regulation, and that staffing levels were adequate for the reduced number of people currently living at the home. However, the provider must continue to review and adapt staffing levels and staff skill mix in response to changes in occupancy levels and people's changing needs and circumstances.

Most of the people, relatives and staff we spoke with were satisfied with the staffing arrangements at the home. One person told us, "I have no concerns about day or night staffing levels. If I ring my bell, they [staff] come pretty quickly." A staff member explained, "Staffing levels are safe. We have at least two nurses on site and the management team will assist nurses and help out." Two staff members expressed some degree of concern regarding the adequacy of the service's night-time staffing levels, and one person referred to night staff becoming 'a bit tired and frayed". We discussed their concerns with the management team. Since our last inspection, the provider had introduced a dependency tool to determine and review, with the assistance of the nurses, the appropriate staffing levels, based upon people's current care needs. The provider's organisational oversight manager assured us this dependency tool was used to assess and review night-time staffing arrangements. During our inspection site visits, we found there were enough staff on duty to respond to people's individual care needs, and their requests for assistance, without unnecessary delay or putting people at risk.

'Staff handovers' were held two to three times each day, depending on staff's shift pattern, to enable the nurses leaving duty to systematically discuss each person's current care needs, and any associated changes in risk, with the nurses and care staff arriving on shift. We attended a staff handover meeting, and saw the discussions between staff were focused on promoting people's safety and the continuity of their care.

Before prospective staff started work, the provider undertook checks to confirm they were suitable to care for people. These included an Enhanced Disclosure and Barring Service (DBS) check and employment references. The DBS carries out criminal records checks to help employers make safer recruitment decisions. However, we found the provider had not always fully explored gaps in prospective staff's employment history in line with safe recruitment practices. We discussed this concern with the management team who assured they would review their recruitments procedures as a matter of priority in order to address this. We will follow this up at our next inspection.

At our last inspection, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some staff had not followed the provider's procedures for disclosing and reporting abuse, and the provider had not addressed these issues in line with their disciplinary procedures. At this inspection, we found the provider was now meeting the requirements of this regulation. People told us they felt safe living at the home. One person told us, "They [staff] look after me very well indeed." People's relatives had confidence in the overall safety of the service provided to their family members. One person's friend told us, "[Person] is always looked after. Since they have needed the hoist, staff won't do it [use the hoist] unless there are two staff there. [Person] hasn't been put at risk."

Staff received training in and understood their individual responsibilities to report abuse and the provider's procedures for doing so. Since our last inspection, the provider had produced additional staff guidance on the action to take in response to suspected or witnessed abuse and had displayed this in the staff room. One staff member told us, "I would report any safeguarding concerns to the nurse and, if there was no action, I would report it to management, the CQC or even the police." The provider had safeguarding procedures in place to ensure any abuse concerns were reported to the appropriate external agencies, such as the local authority, police and CQC and investigated. Our records showed they had made us aware of allegations of abuse in line with these procedures.

We looked at how the provider protected people from the risk of infection. At our last inspection, we found the provider had failed to carry out appropriate risk assessments and make staff aware of specific risks of infection within the home. At this inspection, we found the provider had put measures in place to better protect people, staff and visitors from the risk of infection. A care plan had been developed regarding the risk of infection associated with one person's blood-borne virus, and staff were aware of the related precautions to be taken. Staff received infection control training, and we saw they made use of personal protective equipment, namely disposable aprons and gloves, when completing people's personal care. People's laundry was handled in a hygienic manner, including the use of red alginate bags to keep soiled or infected linen separate from other items. The provider employed domestic staff to support care staff in maintaining overall standard of cleanliness throughout the home, and we found the premises and equipment to be clean and hygienic.

Requires Improvement

Is the service effective?

Our findings

At the time of our last comprehensive inspection in January 2018, the 'Effective' key question was rated as 'Inadequate.' At this inspection we found that whilst the provider had made improvements in some areas, further improvements were required. We have now rated this key question as 'Requires Improvement'.

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.

At our last inspection, we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not fully promoted people's rights under the Mental Capacity Act 2005. The best interests decision-making process had not been followed where people lacked capacity to make significant decisions about their care and support. In addition, unclear or contradictory information had been recorded about people's capacity to make decisions.

At this inspection, we found that whilst some improvements had been made, the provider was still not meeting the requirements of Regulation 11.

We saw staff sought people's permission before carrying out routine care tasks, and respected people's wishes and choices in this regard. Formal mental capacity assessments and, where people were deemed to lack capacity, best interests decisions had been carried out where significant decisions needed to be made about people's care. People's relatives and relevant health and social care professionals had been involved in these decision-making processes. This included decisions about the administration of people's medicines, the use of bed rails, the provision of nutrition and hydration and people's continence care. However, the provider's procedures for assessing people's capacity and, where necessary, making decisions on their behalf were not adhered to on a consistent basis. For example, we found that where formal mental capacity assessments had identified a person lacked capacity to make a particular decision, these were not always accompanied by a best-interests decision record. Where best-interests decisions had been recorded directly onto some people's care plans, there was no record of why, when and how these decisions had been made, or who had been involved in these processes. This included significant decisions about the use of an alarm mat in one person's bedroom and the administration of another person's epilepsy rescue medicine. In addition, formal mental capacity assessments had not always been completed in relation to the decision made to care for people in their beds.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the management team had made applications for DoLS authorisations based upon an individual assessment of people's capacity and

their care and support arrangements.

Where DoLS authorisations had been granted, the provider had procedures in place designed to ensure any associated conditions were reviewed and complied with. However, we found these procedures were not fully effective, as DoLS conditions were not consistently adhered to and staff sometimes lacked insight into these. For example, a condition on one person's DoLS authorisation required that their cultural heritage was incorporated into their activities and life at the home. However, the lead activities coordinator was unaware of this condition. We discussed our concerns regarding the promotion of people's rights under the MCA with the home's management team who assured us these would be addressed as a matter of priority.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's rights under the Mental Capacity Act were not always fully promoted.

At our last inspection, we found the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not having their hydration needs met and they did not always receive the physical assistance they needed to eat their meals. At this inspection, we found some improvements had been made and the provider was now meeting the requirements of Regulation 14. However, further improvements were needed to manage the risks of malnutrition and hydration more effectively.

People and their relatives spoke positively about the choice of food and drink available, the physical support people received to eat and drink, and the extent to which people's individual dietary needs and requirements were met. One person explained, "If it [menu option] is something that doesn't suit you or you don't like it, they [kitchen staff] will do their best to suit you." A relative told us, "They [staff] have tried very hard to get people to eat … [Person] loves tomato sauce so they [staff] brought them a big bottle. They also provide [person] with hot chocolate as they love it." Another relative described how staff catered for their family member's vegetarianism, food intolerance and their need for a texture-modified diet.

The provider had made some improvements in their procedures for identifying, recording and managing risks or complex needs associated with people's eating and drinking. We saw they had sought appropriate professional medical advice and specialist nutritional support from, for example, people's GP and the local speech and language team, on how to manage individuals' nutrition and hydration. The care plans we looked at highlighted where people were considered at risk of malnutrition or hydration, any swallowing difficulties or other dietary requirements, and reflected the advice received from external professionals. 'Fluid matrix charts" had been completed to estimate people's minimum daily fluid requirements and inform target fluid intakes. People's daily fluid intake was recorded by staff and reviewed by the clinical team monthly, along with people's monthly weights.

However, where individuals' target fluid amounts had not been achieved or there had been significant fluctuations in their weight, the plans for improving their hydration and addressing weight loss were not always clear. In addition, we found unexplained gaps in the recording of people's monthly weights, and the provider's screening tool for assessing people's risk of malnutrition had not always been completed on a consistent monthly basis. We did not identify anyone who had been significantly adversely affected by these shortcomings. We discussed these concerns with the home's management team who assured us action would be taken to address these as a matter of priority. We will follow this up at our next inspection.

Staff helped people choose between the available meal options before their meals, and confirmed they were still happy with their choices when their meals were served. The management team explained they were in the process of developing pictorial menus to enhance people's ability to make informed choices

about what they ate and drank. We saw people were provided with regular drinks and snacks between meals, and that those cared for in their bedrooms had drinks within reach. The lunchtime meal was a relaxed and social event, during which people chatted with one another and staff and they received any physical assistance required to eat and drink safely and comfortably. People's meals looked fresh and inviting and they had a choice of drinks to accompany these. Plate guards were used, where needed, to help people eat independently.

Before people moved into the home, the management team met with them, their relatives and the health and social care professionals involved in their care to assess their individual care and support needs and ensure these could be safely and effectively met by the service. This enabled the provider to develop individualised care plans aimed at promoting positive outcomes for people. The management team assured us they understood the need to assess and consider people's protected characteristics under the Equality Act to avoid any form of discrimination in the planning or delivery of their care.

At our last inspection, staff expressed concerns regarding the standard of their induction and training, and the lack of formal supervision. At this inspection, most staff spoke positively about their overall induction experience, which included the opportunity to work alongside, or 'shadow', more experienced staff. One staff member explained, "My induction was very good. I had to do online training beforehand, then I did four shadow shifts … It was easy to take on the role because of the good induction I had." However, we found staff had not always completed essential training before being permitted to assist with people's personal care. In addition, the provider's staff induction programme did not reflect the requirements of the Care Certificate, and staff members' induction records were sometimes incomplete or, in one case, absent. The Care Certificate is a nationally-recognised set of minimum standards that should be covered in the induction of all new care staff. We discussed these concerns with the management team, who assured us these would be addressed as a matter of priority to ensure all new staff underwent an induction programme which incorporated the requirements of the Care Certificate and fully addressed their initial training needs. We will follow this up at our next inspection.

Following induction, staff participated in a rolling programme of training, based upon the provider's assessment of their learning and development needs. Staff continued to express mixed views about the overall quality of the training they received. Two members of staff told us they would benefit from training in relation to the management of challenging behaviour. We discussed this with the manager, who assured us they were currently in the process of organising external training on the prevention and management of challenging behaviour for all staff. The provider maintained up-to-date training records to help them monitor and address staff training needs. Procedures for the formal supervision and appraisal of nurses and care staff were in place, as part which staff received constructive feedback on their work and were able to request any additional support or training required.

People's relatives were satisfied with the role staff played in ensuring their family members' health needs were met, as part of which they helped people seek professional medical advice and treatment if they were unwell. One person's friend described how staff's prompt response to a recent acute infection the individual had suffered had enabled them to avoid admission to hospital. They went on to say, "They [staff] have always called the doctor in if [person] has needed it." We saw staff and management liaised with a wide range of community healthcare professionals to ensure their health needs were monitored and addressed, and that they received joined-up care. People's care files included information about their medical history to give staff insight into this aspect of their care needs. However, the specific guidance provided on the management of long-term health conditions, including epilepsy and constipation, was not always clear or sufficiently detailed.

We looked at the extent to which the adaptation, design and decoration of the premises reflected people's individual needs. We found there were suitable arrangements in place, and appropriate space, for people to access the home's garden, participate in leisure activities, receive visitors or spend time alone. Some effort had been made to adapt the premises to the needs of the significant proportion of people who were living with dementia through, for example, the development of a reminiscence room themed around a bar and the installation of raised beds in the home's garden. However, we found the provider lacked a clear strategy for creating a dementia-friendly environment. This was reflected in, amongst other things, the lack of clear signage, incorporating pictures or photographs, on people's bedroom doors, toilets, bathrooms and other key areas of the home to help people navigate their way around the home. We discussed this issue with the management team. They acknowledged that further efforts needed to be made to create a more dementia-friendly environment and assured us this would be a key focus moving forward. They explained the activities coordinators were currently consulting with people regarding the choice of names for each of the home's corridors, following which dementia-friendly corridor signage would be installed.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in January 2018, we rated this key question as 'Requires Improvement'. At this inspection, we found that, although some improvements had been made, the provider needed to make further improvements to the service. The rating for this key question remains 'Requires Improvement'.

At our last inspection, we found people were sometimes placed in undignified situations as their personal care needs were not always attended to promptly, due to a lack of staffing. At this inspection, we did not identify any concerns of this nature. Although the provider must continue to keep staffing levels under regular review, we found there were enough staff on duty to address people's personal care needs without unreasonable delay. People and their relatives told us staff treated people with dignity and respect. One person explained, "Staff do chat with me when they are helping. They are very good and respectful … They always knock on my door before coming in." A relative told us, "They [staff] have respected [person] and have never belittled them ever." The staff we spoke with gave us examples of how they promoted people's privacy and dignity on a day-to-day basis. These included protecting people's modesty during intimate care tasks, promoting their independence, and respecting people's wishes and choices. One staff member explained, "I always seek permission and ask people what I need to do [for them]. I also encourage people to do as much as they can for themselves, such as washing their own face." During our inspection visits, we saw staff encouraging people to mobilise independently, whilst supervising their movements to ensure their safety.

However, we found the provider needed to take additional steps to prevent unauthorised access to people's personal information. Sensitive person information, including the outcomes of visits from the community health and social care professionals involved in people's care, was insecurely stored in one of the home's nurses stations located in the entrance hallway. Although this information was kept out of sight, it could be accessed by unauthorised persons. We discussed this concern with the management team, who assured us prompt action would be taken to improve the security of all information stored in the home's nurses stations. We will follow this up at our next inspection.

People and their relatives told us staff adopted a caring approach towards their work and had taken the time to get to know people well. One person explained, "The staff are very good. They're good fun – good for a laugh." One person's friend said, "They [staff] are caring. [Person] is a person in their own right to them … I've never known one staff member to have a cross word with people … I would praise every one of them [staff]." A health and social professional told us, "The carers there genuinely come from a good place; they are definitely caring … Staff know the residents really well and have been able to tell me a lot about the person [under review]." Another professional said, regarding their most recent visit to the home, "I feel the staff were caring. I could see and hear lots of things which showed me they were really caring towards people there."

We saw people were at ease in the presence of staff, and freely requested their support and assistance. We heard people laughing and chatting with staff, during their lunchtime meal for example. Staff spoke to people in a polite and professional manner, greeted them warmly upon seeing them for the first time that

day and prioritised people's needs and requests. When providing personal care, including helping people with their transfers and assisting people to eat their meals, staff did so in a patient and attentive manner, showing concern for people's safety, comfort and wellbeing. Staff responded to promptly when people were upset or distressed. For example, a member of staff offered effective reassurance to one person who had become anxious, by helping them to recall memories from their earlier life.

People and their relatives were satisfied with the support they had to express their opinions and participate in decision-making that affected them. A relative explained, "They [staff and management] have involved me as much as I want to be." Another person's friend told us they felt 'very well involved' in their friend's care at the home. People's care plans contained information about their individual communication needs, any aids worn due to sensory impairments, and guidance for staff on how to promote effective communication. One person had a cochlear implant and hearing aid due to severe hearing loss. Their care plan provided instructions for staff on how to maintain and check these devices, and guidance on the use of a whiteboard to promote this person's understanding. The service had developed links with local advocacy services and supported people to access an advocate whenever required to ensure their voices were heard in relation to any important decisions affecting them.

Requires Improvement

Is the service responsive?

Our findings

At the time of our last comprehensive inspection in January 2018, the 'Responsive' key question was rated as 'Inadequate.' At this inspection we found that, whilst the provider had made improvements in some areas, further improvements were required. We have now rated this key question as 'Requires Improvement'.

At our last inspection, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not always responsive to people's needs. People's personal care needs were not always met in a timely manner due to inadequate staffing levels. People and staff expressed concerns about the level of support provided to enable people to pursue their hobbies and interests. In addition, people's care plans were not always reflective of their current needs.

At this inspection, we found the provider had made some improvements in the overall responsiveness of the service to people's needs, and that they were now meeting the requirements of Regulation 9. However, further improvements were needed to ensure people received consistent person-centred care.

People and their relatives were satisfied with the extent to which staff and management involved them in care planning and day-to-day decision-making that affected them. Most felt the service provided reflected people's individual needs and preferences. People's care plans demonstrated an individual assessment of their care and support needs, with the input of their relatives and relevant health and social care professionals. Individual care plans had been developed in relation, for example, to people's physical and mental health needs, their mobility and risk of falls, their nutrition and hydration and their behaviour support needs. 'This is me' forms, produced by the Alzheimer's Society, had been completed for each individual to record their personal background, preferences, daily routines and valued relationships to promote person-centred care.

However, we found the content of people's care plans was sometimes contradictory, lacking in detail or omitted key information about the individual's current needs. This included our findings in relation to people's epilepsy care plans and care plans for constipation. One person had been admitted to hospital on three occasions, and had undergone various medical investigations, due to potentially serious abdominal symptoms. We found there was no mention of these symptoms, or the outcome of their medical investigations, in this person's care plans. Responsibility for reviewing and updating each person's care plans had been delegated to a specific nurse. However, we found people's care plans had not always been reviewed on a consistent monthly basis. In addition, we were not assured all staff were given appropriate time and opportunity to read people's care plans. Three of the staff we spoke with acknowledged they had not yet had time to read people's individual care plans. We discussed our concerns in relation to people's care plans with the management team who assured us they would address these as a matter of priority. We will follow this up at our next inspection.

At the time of our inspection, no one who lived at the home was receiving palliative or end-of-life care.

Whilst the provider had systems and procedures in place to identify people's preferences and choices for their end-of-life care, this process was not followed on a consistent basis. Although some people had been supported to make advance statements, which set out their wishes regarding their future care, this topic had not been discussed with other people and their relatives, without any clear explanation for this. The organisational overview manager explained they had recently written to people's relatives to invite them in for a six-monthly care review meeting, as part of which people's preferences and choices for their end-of-life care would be discussed. They assured us that, moving forward, a more proactive and consistent approach would be adopted to establishing people's wishes for their future care. We will follow this up at our next inspection.

We looked at how the provider ensured they were meeting the requirements of the Accessible Information Standard (AIS). The AIS tells organisation what they need to do make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need. We discussed the AIS with the management team who showed good insight into its requirements. We saw people's communication needs had been assessed and recorded in their care plans. The management team explained that, at the current time, no one living at the home had requested, or been assessed as requiring, information in alternative, accessible formats. They assured us people and their relatives had been made aware that key information, such as the service's 'service user guide' were available in alternative formats upon request. The management team discussed their plans to produce pictorial menus to enhance people's ability to make informed choices about their meals.

We looked at how the provider ensured the assessment and delivery of people's care and support took into account their protected characteristics under the Equality Act. The management team showed good insight into the nature of, and the need to consider, protected equality characteristics. They assured us people's protected characteristics would be identified through their pre-admission assessment process and subsequent care reviews, where people were willing to disclose this information. We saw a Holy Communion service was held at the home on a regular basis to enable people to practice their religion.

Most of the people and relatives we spoke with talked positively about the support people received to participate in recreational activities and pursue their interests. One person said, "[Am I] bored? Good lord no! - I can always amuse myself. I've got loads of puzzle books. The fact that I'm exercising my brain seems to keep my body going." A relative described the enjoyment their family member and other people had gained from singing along with the band at the home's recent summer fête. The provider employed two activities coordinators to take the lead on organising group and one-to-one activities, which included visiting musicians and interest groups; themed days and events; and arts and crafts, music, cookery and exercise-based sessions. However, some of the staff we spoke with raised concerns about the limited hours activities coordinators worked, and a resulting lack of stimulation for people on certain days. One staff member told us, "We have really good activities coordinators, but they are not in every day." The organisational oversight manager assured us they were currently actively seeking to recruit additional activities coordinators, in order to provide more flexible activities provision across the week. We will follow this up at our next inspection.

People and their relatives were clear how to raise any concerns or complaints regarding the service by speaking with staff or management. One person told us, "If I had worries, I'd talk to [staff member]. They're very good at sorting things out, but they haven't really had to sort anything out for me." The provider had a complaints procedure in place to ensure complaints were dealt with fairly and consistently. We looked at the two most recent complaints received by the service and saw they had been responded to in line with this procedure.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, the provider's registered manager had not been at work for several months. The day-to-day management of the service was being overseen by a newly-appointed manager and the home's deputy manager, with the support of the service's clinical lead and the provider's organisational oversight manager.

At our last inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's quality assurance processes were ineffective, there was a lack of clinical leadership and staff were experiencing high levels of stress and low morale.

At this inspection, we found that, whilst some improvements had been made, the provider was still not meeting the requirements of Regulation 17, due to the ineffectiveness of their quality assurance activities. The provider had a programme of quality assurance systems and processes in place which were designed to enable them to assess, monitor and improve the quality of the care and support people received. These included regular audits in relation to the home's health and safety arrangements, the management of people's medicines, the standard of care planning, catering and the prevention of infection. However, we found the provider's audits had not always been completed on a consistent basis, including their monthly accident analysis. In addition, where audits had been completed on key aspects of the service, such as the safe management of medicines or standards of care planning, they were not effective in enabling the provider to identify and address the shortfalls which we identified during our inspection. This included the failure to ensure people always received their medicines as prescribed and the unexplained gaps in people's medicines records.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's procedures for assessing, monitoring and improving the quality and safety of the service were not effective.

At our last inspection, we found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because they had failed to notify us of a safeguarding issue involving a person who used the service. At this inspection, we found the provider was now meeting the requirements of this Regulation. The management team showed good insight into the duties and responsibilities associated with their registration with CQC. This included the requirement to notify us about certain changes, events and incidents that affect their service or the people who use it. These 'statutory notifications' play a key role in our ongoing monitoring of services. Our records showed the provider had submitted statutory notifications to CQC in line with their registration with us.

Staff spoke about their work at the home with a clear sense of commitment to providing good care that promoted people's safety and wellbeing. Whilst acknowledging previous shortcomings in the management of the service, staff told us this had improved since our last inspection and were hopeful further improvements would be made by the current management team. They referred to improved clinical

leadership and management support, better communication between management and staff and a clearer sense of direction from the management team. One staff member told us, "Things are getting better … Hopefully things will still improve [further] with the new manager and clinical lead … I feel supported now, though not previously." Another staff member said, "It [management of the service] is better. [Organisational manager] is more focused on improving things." All of the staff we spoke with confirmed they felt valued and supported in their work and felt able to freely approach a member of the management team for further advice and guidance. One staff member explained, "I feel they [management team] are approachable. They pass me in the corridor and ask how I'm getting on, which is nice." They described good communication and a strong sense of teamwork between staff, and close working relationships between the care staff and nurses. One staff member explained, "The nurses really help us a lot and we work as a team … It feels like a second home."

General staff meetings and nursing staff meetings were held to update and consult with staff as a group, during which staff had the opportunity to share their ideas and suggestions. Staff expressed greater confidence in the management team's willingness to listen to and respect their views and opinions. The provider had a whistleblowing policy in place. Staff understood the role of whistleblowing and felt able to challenge any practices or decisions taken by the provider which they disagreed with. People's relatives told us they felt adequately involved in the service, and able to provide feedback to the management team on how it could be improved. The provider had systems in place designed to encourage people and relatives' feedback on the service. These included ensuring the accessibility of the management team, and the provision of feedback surveys in the home's entrance hallway for people or their relatives to complete at any time.

Most people and their relatives spoke positively about the overall service provided, and their relationship with the management team. One person told us, "The service has been terrific … I'm pretty happy and content here. They do their best for me." A relative said, "They're brilliant. I've no complaints at all, and I'm not just saying that." People's relatives felt the service had improved over recent months, although some referred to further areas for improvement. One person's relative told us, "Staffing levels have increased over the past few months and staff morale is better - you can feel it." Another relative said, "There have been some improvements, but it could be an awful lot better." One person's friend said, "I think [organisational manager] has got it all buttoned up. They are very hard working and have sorted out a lot of the paperwork." People's relatives felt adequately involved in the service, that the management team were approachable, and that communication regarding any changes in the family members' health or wellbeing was good. One person's relative explained, "Communication is good. [Person] was confused last week and they [staff] told me straightaway … I wouldn't have any qualms about going to them [management team] with anything."

Staff and management liaised with a wide range of community health and social care professionals to ensure people needs were met. The health and social care professionals we spoke with during our inspection highlighted the need for significant further improvements in the service. However, they are also spoke positively about their individual dealings with, and impressions of, the management team, and their willingness to take advice and recommendations on board. One professional explained, "They [service] are still going through a learning process and are not there yet, but they have been open to implementing new things." They went on to say, "Whenever we have had assessments and have made suggestions, they [management team] have always taken things on board." Another professional told us, "I think [deputy manager] is brilliant. They are on the ball and know all the residents here … They [management team] have definitely responded well to the recommendations that had been made by [healthcare professional]." Whilst concerned about the slow pace of improvements, a further professional explained, "[Provider] was forthcoming in trying to rectify things."

The management team had made efforts to maintain links within the local community through, for example, inviting children from local schools to visit the home over the festive period, and by organising events, such as tea parties and fetes which were open to the local community.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act were not consistently promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks associated with people's care and support needs were not always managed and minimised to keep people as safe as possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and procedures in place for assessing, monitoring and improving the safety and quality of people's care and support.