Harpers Villas Care Centre Ltd

Harpers Villas Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook our comprehensive inspection of Harper Villas on 17 and 22 August 2018. The first day of the inspection was unannounced, the second announced. We previously inspected the service on 12 January 2017 and the rating after this inspection was 'good'. At this latest inspection we found there were areas where the provider needed to improve the service. We rated the service as 'Requires Improvement' at this inspection.

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

Harper Villas accommodates a maximum of 26 older people that may have dementia. People live in one building that was adapted to meet the needs of people living there. There were 23 people living at the home at the time of our inspection. The provider was also offering day care provision, this not an activity that is regulated by CQC. There were no additional staff employed to provide care for people attending for day-care.

The service has a registered manager who was present during our inspection. 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.

Our inspection was prompted following by concerns from local authority commissioners, which had led to several safeguarding alerts.

This is the first time the service has been rated Requires Improvement

We found areas where the provider was in breach of regulations. We found the provider's systems for governance were not always effective in identifying and addressing risks to people promptly and needed improvement. In addition, the provider had not notified us of allegations of abuse as required by the law. You can see what action we told the provider to take at the back of the full version of the report.

We have also made recommendations. We have recommended that the provider considers how they could improve the environment for people living with dementia in line with national recognised guidance. We have also recommended that the provider improves people's access to information in a way that consistently reflects their individual communication needs and in accordance with the Accessible Information Standard.

Despite the lack of notification to CQC of allegations of abuse, staff demonstrated a good understanding of safeguarding procedures. Following local authority visits, several risks to people were identified. Audits in

place had failed to identify some risks to people that had not been assessed by the provider. People were satisfied with how their medicines were managed, but there were areas were medicines management could be safer. We found there was not sufficient staff available at night to ensure the provider was able to follow their fire procedure. The provider has stated more night staff will be employed. There was an impact on staff time during day time hours due to the additional dependency levels of people attending for day-care. We saw prospective staff were subject to checks prior to their employment.

People's consent was sought consistently by staff and the registered manager had made applications to the local authority for any restrictions that may be a deprivation of a person's liberty. People were supported by staff on a day to day basis to have maximum choice and control of their and we saw staff supported them in the least restrictive way possible; the policies in the service supported this practice but some systems did not. Some care plans were agreed by people's relatives and it was not clear whether these relatives were legally able to make these decisions.

People were confident in staff who they felt were competent and trained to meet their needs. The provider did however need to consider how training input for staff was to be monitored, so that staff skills and knowledge were maintained. We were made aware by the local authority that the response to people's healthcare needs had at times been delayed, but people were confident they could access external healthcare whether on a routine or emergency basis. People had a choice of food and drinks were made available frequently, although systems to identify where people were at risk of dehydration or malnutrition needed improvement.

People received care from staff that were kind and caring and respectful. People were treated in a dignified and respectful way by staff. There was a good rapport between people and staff. People could maintain their independence and make choices about their daily living. People could maintain relationships with people important to them. Even when staff were busy we saw they made a committed effort to ensure they were caring in their approach to people.

People's care plans did not consistently reflect all their needs, wishes and preferences although staff knew what people liked, disliked and what was important for them. People had access to some leisure opportunities, although the provision of this was inconsistent as staff did not always have the time. People felt able to complain and were confident these complaints would be responded to.

People and their relatives expressed satisfied with the care provided and felt the standard of care was good and managers and staff were approachable. Staff felt well supported and liked working at the home.

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.

Risks to people, when identified were not consistently addressed.

Allegations of potential abuse had not consistently been identified and reported, this despite staff having a good understanding of safeguarding procedures.

Risks to people were not consistently identified by the provider, or when identified acted upon.

People were satisfied with how their medicines were managed, but there was scope to make medicines management safer.

The provider had not ensured staffing levels reflected their dependency tool and there was not always sufficient staff to ensure people were safe at night if there was a fire.

Checks were carried out on prospective staff before they were employed.

Is the service effective?

Requires Improvement

The service was not always effective

People living with dementia would benefit from improvement to the environment.

People's right to consent was sought by staff and any restrictions where people lacked capacity were referred to the appropriate local authority, although it was not always clear who could make decisions on behalf of people lacking capacity.

People were confident staff were trained to meet their needs.

People were confident they could access external healthcare when needed despite some concerns about delayed healthcare.

People had a choice of food and drinks were made available frequently.

Is the service caring?

Good

The service was caring

People were supported by staff who were kind, caring and respectful. People were treated with dignity and respect and staff had positive relationships with people. People's independence and privacy was promoted.

People were supported by staff to express their views and make choices regarding their daily living.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always have access to information that was accessible and considered their individual communication needs. Some people's care plans reflected their needs, wishes and preferences, although this was not consistent, despite staff having a good awareness of these.

People had access to some leisure opportunities, although this was dependent on the time staff had available to offer these.

People's needs likes, dislikes and personal preferences were understood and known to staff.

People could raise complaints and these were responded to by the provider.

Is the service well-led?

Requires Improvement

The service was not always well led

We found the systems for governance were at times overly complex and ineffective in addressing all risks to people promptly and maintaining the quality of the service.

We had not received notifications related to allegations of abuse as required by the law.

People and their relatives were satisfied with the service they received and felt the management and staff were approachable and would listen to them.

Staff told us they were well supported and liked working at the home.

Harpers Villas Care Centre

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 was prompted by concerns that we received from local authority commissioners and several safeguarding alerts that were raised prior to the inspection. The risks we were made aware of included information related to falls, poor infection control measures, unsafe medicines management, lack of staff understanding in respect of the mental capacity act and deprivation of liberties, poor record keeping, lack of food options to meet cultural needs, a lack of activities for people, concerns in respect of fire safety, delays in sourcing appropriate health care when needed and issues in respect of food hygiene.

The inspection took place on 17 and 22 August 2018. The first day of the inspection was unannounced, the second announced.

The inspection was carried out by two inspectors on the first visit date and one on the second.

We reviewed other information we held about the service such as notifications, which tell us about incidents which happened in the service that the provider is required to tell us about. We also contacted other agencies such as commissioners and safeguarding teams. We used this information to help us plan our inspection.

We spoke with four people who lived at the home. Several people living at the home were not able to clearly express their views so we spent time observing how staff provided care for people to help us better understand their experiences of the care and support they received. We carried out Short Observational Frameworks for Inspection (SOFI) to observe the people's experience of life at Harper Villas. We spoke with five visiting friends/relatives, the registered manager, the provider, the deputy manager, five care staff and the cook. We reviewed five people's care records; five medicine administration records (MARs), and three staff files. We also looked at other records relating to the management of the service, for example audits and certificates of safety for equipment. We also spoke with three visiting social care professionals and the local

fire prevention officer.

Requires Improvement

Is the service safe?

Our findings

We previously inspected the service on 12 January 2017 and the rating after this inspection for this key question was 'good'. At this latest inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

People told us they had confidence in staff team but felt there should be more staff available to support them. One person said, "I don't think there is enough staff sometimes. Staff are rushed off their feet". The person added they did not wait long for assistance when needed though. Another person told us, "I don't think they have many staff". Relatives we spoke with had no concerns about staffing although one had recently responded to the provider in a survey form, 'That maybe a few more staff' (were needed). The number of staff available each day remained the same despite the number of people being cared for increasing four days each week when people came into the home to attend day care. The local authority also visited the home with an occupational therapist on our first inspection day, and while some staff time was taken up assisting these professionals, we noted staff were very busy, with time taken to assist and monitor two people attending for day-care as well as the people who lived at the home. On the second day of inspection we saw there was no day-care provision, and staff were far more relaxed and spent more time with people living at the home, for example spending time talking to people and carrying out some activities with them. We discussed the impact of providing day-care in respect of staffing with the registered manager and provider and they acknowledged this was a matter they would need to review. We also discussed the staffing tool the provider completed where they had identified staffing hours were more than 70 hours under what they needed based on their assessment of people's current dependency levels. We asked the provider and they had not considered the impact of people attending for day-care on staff time. Staff did not raise any undue concerns about staffing levels despite what people told us and what we observed.

In addition, when we looked at the provider's fire procedure we saw this stated at night one member of staff would be deployed to the front entrance whilst other staff on duty would commence evacuation of people to a safe area. As there were only two staff on duty at night this presented a risk, as some people would need two staff to assist them to mobilise. The provider acknowledged this risk and told us they would employ a third member of night staff as soon as was possible and until this point staff who could reach the home quickly at night had been identified as emergency contacts in the case of fire.

We heard from local authority commissioners that there were several concerns as to people's safety prior to our inspection. The safety risks we were made aware of included information related to falls, poor infection control measures, unsafe medicines management, lack of staff, poor record keeping, concerns in respect of fire safety, and issues in respect of food hygiene. We looked to see what improvements the provider had, or was planning to make at the time of our inspection, to ensure people living at the home were safe. We found the provider had made some improvements in line with visiting professionals recommendations, for example making improvements to the environment to enhance good infection control.

We saw people had risk assessments in place that detailed actions staff should take to minimise risks to them, although these had not always been acted upon. For example, we saw a person was identified as

being at risk of falling when they got out of bed. A sensor mat that would have alerted staff had been identified as needed but was not available as it had malfunctioned and had not been repaired. We spoke with the registered manager who said increased monitoring was in place for this person. They also said a sensor mat may present a trip hazard. This was not identified or documented in the person's risk assessment, and no alternatives to minimise the risk to the person had been considered; for example, other types of sensors that would alert the staff to the person's movement at night, while avoiding a tripping hazard were not explored. This meant whilst identifying risks to people the registered persons had not always taken prompt action to address the risks identified. We also saw where staff identified people had lost weight, action taken in response was not always documented, for example, we could not see in some people's risk assessments the steps taken to address a person's weight loss, despite staff telling us people had seen their GP and were taking supplements. Based on the assessments we saw, for example recording of potential risk due to people's weight, we had not identified any one person at immediate risk of malnutrition at the time of our inspection.

Staff we spoke with demonstrated an awareness of how to protect people from the risk of accidents. Staff told us accidents or incidents that occurred were reported verbally and action was taken to support the person involved. Whilst staff could clearly relay what had happened in the case of some recent incidents the specific records relating to these were not consistently detailed. In some instances, some of the records failed to indicate what action had taken place. We found other records provided detail but this was not always easily identified. In two sets of records that detailed an accident that happened to one person the accident report and handover did not detail paramedics had attended the home to check the person following a fall. This additional detail was in the daily report, but was not referenced in the accident report. In nine accident/incident records we looked at we found records were at times very brief or lacked detail of the support that had been provided. Whilst audits were undertaken to look for any trends or patterns to help prevent such occurrences and keep people safe this had not always led to the appropriate actions been taken, for example provision of equipment to prevent falls. The duplication of audits impacted on the clarity of records, as it was sometimes difficult to find the relevant information. The management team could not easily monitor trends and identify where improvement was needed.

We found the provider's safeguarding and whistleblowing policies held information about reporting safeguarding matters to the local authority and contained relevant contact information. Staff demonstrated a good awareness of local safeguarding procedures and knew they needed to inform the local authority safeguarding team or police if they witnessed abuse or had an allegation of abuse reported to them. The registered manager was aware they had a responsibility to report any safeguarding matters to the local authority and could demonstrate that some past allegations of abuse had been reported to them, but told us they were unaware they had to report allegations of abuse to CQC as well. Local authority commissioners informed us when they had visited they had identified several safeguarding issues they were now investigating. This meant the provider needed to ensure that all allegations of abuse, or incidents that may indicate potential abuse were consistently reported to CQC as well as the local authority. The registered manager acknowledged this and said they would ensure this was completed from this point onwards, and has since the inspection sent us information about previous allegations of abuse they had not notified us of and some that had arisen since our inspection.

We found the provider did not always have systems in place to ensure there was a good standard of cleanliness throughout the home to ensure people were protected from cross infection. The home had received a recent visit from an infection control specialist, prior to our inspection, who had identified several areas where improvement was needed in respect of infection control. For example, pressure cushions with evidence of body fluid staining, no liquid soap and paper towels in toilet and bathrooms. The provider had responded and was working to address these issues with all pressure cushions now replaced, and liquid

soap and paper towels fitted in bathrooms and toilets. The registered manager told us they were planning to fit these in all bedrooms as well but were still awaiting delivery. We also saw the seats to bath hoists, where they had been rusty, had been replaced. The registered manager also told us other systems were to be introduced, for example mattress audits and said they would contact the infection control nurse if advice was needed on their systems for infection prevention and control. We were made aware that following a visit from the local authority Environmental Health (EHO) the service's food safety rating had been downgraded from a five to a four star. The issues identified by EHO we saw were in the process of being addressed by the provider at the time of the inspection.

People we spoke with had no concerns about the cleanliness of the home however, one person telling us, "It's very clean". A relative told us their loved ones, "Room is clean spotless, every time I go in sink clean, no marks on the floor, never unclean, I do check the bed, never found soiled". At the time of our inspection we found the premises presented as clean and smelt fresh.

We found systems were not always in place to consistently and safely manage people's medicines. The service had received an audit of their systems for the management of medicines the day before our inspection, and we saw that there had been some areas identified where improvement was needed. There was an occasion identified where one person had run out of a medicine as it had been agreed the relative would collect the medicine. The person went without their medicine for seven days before staff noticed the medicine was missing. There was also some sedative 'as required' medicines being given to people on a regular basis where the management had been advised there should be contact with the GP, as the medicine was written up as to be given 'when required' and not on a regular basis without consultation with the GP. There were also identified gaps in some medication administration records(MAR), for example, one medicine whilst prescribed was not recorded on the MAR. The registered manager was aware of these shortcomings and told us they had, or would be addressed. People told us they received their medicines as prescribed one person telling us, "Tablets on time every morning and teatime". A relative told us their relative always received their medicines after their meals. We observed medicines given by a member of staff on the day of inspection and saw this was carried out safely, with checks on the MARs prior to administration, and signature on the MARs only after the medicine was given. We saw the member of staff asked people if they wanted medicines such as pain killers and took time to ensure people took the medicine. We saw staff had received medicines training and the registered manager had introduced checks on their 'competency' in administering medicines through checks/ observation following advice from a pharmacist.

We found a recruitment and selection process was in place that specified the checks needed to confirm the staff member's suitability to work with adults; for example, exploration of their working history. We saw these checks were completed, although we did see in some instances where some of the references obtained for staff had been obtained from relatives or friends and therefore could not be regarded as robust or objective. Following discussion with the registered manager they said they would risk assess the suitability of the referees when no last employer reference was available. All staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed. Staff we spoke with confirmed these checks had been completed before they commenced employment.

People said they felt safe in the home. People looked very relaxed and comfortable with staff throughout our inspection. One person told us, "I feel safe". One relative told us how their loved one had moved to Harper Villas from another home and they felt the person was far safer now. They said the person's, "Safety is met by the girls [the staff]". Another relative said their loved one, "Is safe, never any problems, always clean,

always comfortable". A third relative told us their loved one, "Was always safe, never a problem with staff". We saw that people were encouraged and reminded by staff to wear slippers and use any walking aids that had been allocated to them. The corridors and rooms were free from any obvious hazards to health and safety; people were free to use the lift on their own which took them to the first floor. Some people needed support from staff to rise out of their chairs and move around the home. The support provided we saw was consistent and helpful. People were at ease being supported by staff and received lots of reassurance when they seemed unsure or lacking in confidence.

Requires Improvement

Is the service effective?

Our findings

We previously inspected the service on 12 January 2017 and the rating after this inspection for this key question was 'good'. At this latest inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

The home was undergoing works to provide additional living space and extra bedrooms at the time of our inspection. We saw that some steps had been taken to make the building more suitable for people living with dementia, for example boards with items of interest related to past historical events. We did note however that some information displayed was conflicting, for example pictures on the menu board did not always reflect what was for dinner, clocks around the home had different times and there were two activity boards that had conflicting information on, which could be disorientating for people living with dementia. Some areas would have benefited from redecoration, with the registered manager confirming this was planned as part of the ongoing building works and refurbishment of the home. We recommend that the provider refers to current guidance on building design for people living with dementia.

We heard from the local authority prior to our inspection that there had been allegations raised in respect of delayed access to healthcare. At the time of our inspection we were not aware of the outcome of the investigations into these allegations. The registered manager told us people living at the home on a temporary basis had not been allocated a temporary GP, even when out of their existing GP's catchment area. The registered manager said they would change people's GP when people were confirmed as a permanent resident of the home, but had not appreciated this may have led to difficulties if requesting the current GP to visit outside of their catchment area. This had been identified when a person on respite had required their GP's input. The registered manager informed us they had now arranged for a local GP to cover any temporary residents at the home. People we spoke with told us they were happy with how their healthcare needs were monitored by the home, and said they saw external healthcare professionals when needed. One person told us, "They changed my GP and do get doctor in, have seen optician and went to hospital to have ears checked". Another person said, "They [staff] get the GP quick and ambulance if needed". A relative told us, "They [staff] are very good on the ball regarding any health concerns, optician is one that comes in, they [person] are going to a clinic for chiropody". Another relative said, "If [person] needs to see the doctor they [staff] call them in. Has seen chiropodist and eyes checked every so often, dentist they would not like". We spoke with a district nurse who confirmed nurses visited the home daily, to support some of the people with healthcare needs. A visiting health care professional told us, "Staff never refuse to do something they are asked".

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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA.

We did see some people's records were signed by relatives but did not carry any evidence of whether their relatives had the legal right to make decisions on behalf of people however, for example having lasting power of attorney. This did indicate a lack of understanding about what needed to be in place for a relative to legally make decisions on behalf of a person. The registered manager told us they would address this matter following discussion. We found when staff provided care to people they promoted people's rights, and obtained their consent. People we spoke with told us they made their own decisions and staff respected these. A relative told us, "They are very good with [the person] will ask and repeat two or three times to check they agree, they [staff] are very good". Another relative said their loved one, "Is able to make day to day decisions". We saw when staff provided care to people who lacked capacity that they asked people for their consent and if they did not receive a response would stop if the person expressed dissatisfaction. Staff we spoke with understood the importance of protecting people's legal rights and liberty and had a working knowledge of the MCA. The registered manager and staff told us all people living in the home would need support if going outside whether due to physical frailty or a lack of capacity and understanding of risks. People we spoke with who had capacity told us they decided only to go out when they had support from staff or relatives. Where people had a lack of capacity the registered manager had made DoLS applications to the local authority. At the time of our inspection none of the applications had been determined, but the registered manager told us they worked to ensure people received care that reflected their best interests, and that they had learnt more about the MCA recently from the local authority DoLS assessor.

We saw there were assessments in place to detail people's needs at the point of admission and saw these were used to inform people's risk assessments and care plans. We saw the provider consulted with other professionals, the person and significant others at the point of admission. We saw some people's assessments considered important information including personal characteristics protected by law, for example age, gender and disability. While staff told us, they had no problem accessing information on people we found this was not always easy due to the amount of information, duplication or layout of people's records. Staff told us how they provided options that reflected a person's cultural heritage and specific likes and dislikes. For example, Staff told us, and we saw, staff were aware of the importance of a person's clothing and how this reflected their heritage.

People received food that was to their liking and were offered two choices at main meals. One person told us, "I like the food". Another person said, "Good meals, choice of foods ". A third person said, "I asked if I could have lamb chops, I do have choices". A relative told us "The meals are good, there is plenty to eat and plenty of drinks". Another relative said their loved one was, "Happy with the food, its lovely. Staff bring drinks down, have a jug or orange juice, on one occasion they wanted an ice cream and staff brought him one down with a cone". A third relative said people, "Have a choice, have a menu, if I'm here I know what [the person] likes, does not like pasta but staff know, not lost any weight, staff do tell me if they do not eat and has regular drinks". We saw staff either offered people a choice at the time the food was served or could offer people who were reluctant or unable to make a choice a meal that they knew would be liked. People were seen to enjoy eating their meals and those people who needed support received help from staff who focussed on them to ensure that they ate well and had time to eat at their own pace. People could eat meals where wished whether the dining room or their bedroom. People's likes and dislikes of food was known to the cook and staff and records were maintained of choices that had been made for each person. In one person's records there was general guidance as to what a person of their religion would usually prefer to eat, although this record was not personalised to reflect the person's specific choices where they differed. Staff told us the person liked a variety of foods that included traditional English meals. Staff were also aware of the person's likes and dislikes, and said when asked the person was not always clear about their choices, but if presented with a meal they did not want they would tell staff who said they would change the meal to

something they liked. This indicated that records as to food preferences needed to be clearer but the person's food choices were respected by staff.

The cook was clear in how the food was fortified in the home and provided softened food for some people. Special diets could be catered for and when people were at risk of not eating enough the cook and staff were aware of the people most at risk. Staff maintained food and fluid records for 10 people detailing how much they had eaten or drunk throughout the day. The records of fluids were not however robustly maintained and where it was recorded that the amount consumed was low it was not clear what action had been taken. The records did not indicate how much each person at risk should drink, with some people only having drunk an amount far lower than is recommended for their body weight or body mass. Staff we spoke with told us these people were encouraged to have regular drinks and this reflected what we saw, with staff providing regular drinks for people. We raised this with the registered manager, who was not able to evidence that these records were monitored by them. We did see staff encouraged people to drink on a regular basis and people and relatives we spoke with told us drinks were always available which indicated this was a recording issue, rather than people not been given regular fluids.

People felt supported by staff who they thought were competent to meet their care needs. People we spoke with expressed confidence in the staff. One person told us, "The staff are great". Another person said, "Couldn't get better care". A relative told us staff, "They are the best", another relative telling us the staff were, "Excellent, [person] really well looked after, they are happy". All staff spoken with were positive about the training they had received and were able to speak about topics and subjects that had been covered. New staff were supported to undertake training in Care Certificate Standards. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of people working in the care sector. Staff advised that they felt well supported in their work and could approach the manager or more experienced staff for support and advice at any time.

Good

Is the service caring?

Our findings

We previously inspected the service on 12 January 2017 and the rating after this inspection for this key question was 'good'. At this latest inspection we found the service remained 'good' for this key question.

People spoke positively about the confidence they had in staff. One person said, "Staff are kind and caring". They also told us in respect of a specific member of staff, "If I'm feeling down, they give me one of those smiles and I feel a lot better". Another person told us they thought staff were, "Kind and caring, I like the staff". Relatives also told us they thought staff to be caring. One relative told us, "I was talking to a member of staff when they were taking [the person] to bed and they said do you love me [to the member of staff] and they said we tell you we do every night". They said their relative was reassured and this demonstrated the warmth of the relationship between their relative and staff. Another relative told us that when their loved one attended hospital, and was worried about not returning to the home, when they returned, "It was beautiful, all the lights were on and staff came out to welcome them, [the person] recognised the staff immediately".

We saw numerous occasions where staff showed genuine affection for people living at the home, this through the way they spoke with people, use of appropriate touch and hugs with people smiling and laughing in response. We saw when staff assisted people they showed patience and understanding, and encouraged people, explained what was happening and complimented people on their appearance. People we saw were clean, well presented and dressed according to their individual preferences, gender and culture. We saw relationships and exchanges between staff and people living in the home were relaxed and comfortable. Some people were clearly at ease with some members of staff and their demeanour and facial expressions improved when they were receiving support. A visiting health professional told us, "Staff have a good rapport with people, and are usually more settled when staff are with them".

We saw people were offered choices by staff, whether at the point at which they received support, or on a more general basis. People in the home were supported by staff to keep safe but were still able to exercise choice in where they wanted to be at any time. We saw some people liked to spend time in their own bedrooms and others liked to walk around the home on their own and were free to go in all the shared spaces and rooms.

We saw dignity and respect was promoted by staff. We saw people were dressed individually and appropriately and wearing clean clothing. We saw and staff told us how they learnt key words in some people's first language to help them communicate with people. Staff were seen offering comfort and support to people who were distressed and recognised people's own way of expressing themselves.

People's privacy was respected. We saw staff close toilet doors when the had been left open by people entering and bedrooms were respected as private places, with some people having keys to their bedroom doors. One person told us, "I have my own key" at the same time showing us the key. We saw staff consistently knocked bedroom, or toilet doors before entering. One person showed us their bedroom and told us how they had brought their own possessions in so that it was a nice place for them to spend time. We

saw it was personalised to reflect the person's interests.

People were supported with their independence as far as they were able. One person told us they, "Clean my own room" and liked to keep busy, helping with the washing up and doing some paperwork for the manager which they said they enjoyed. Another person told us, "When I have a shower I wash myself down". A relative told us staff, "Have got [their relative] back on their legs" which had helped the person with their self-esteem. Staff told us how they would encourage people to be independent even if they needed a lot of support. For example, when assisting people with washing they would encourage them to wash themselves where able.

People were supported to maintain relationships, and we saw several relatives visited during our inspection. People we spoke with told us they had made friends with other people living at the home one person telling us, "I have one or two friends here, they are like family". A relative told us staff were, "Always welcoming, anything you want only have to say". Another relative said, "Staff always make me welcome, they are friendly". No one was using advocacy services at the time of the inspection. An advocate is a person independent of the service or person's family who puts a case on someone's behalf. The registered manager said if a person needed support with any issues they would use local advocacy services to gain this support for them.

Requires Improvement

Is the service responsive?

Our findings

We previously inspected the service on 12 January 2017 and the rating after this inspection for this key question was 'good'. At this latest inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

The registered manager told us they were aware of the expectations of the Accessible Information Standards (AIS) and how this should be implemented. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. We found some care plans to be overly complex and finding some information was at times difficult, as there was not always a clear audit trail. Due to the volume of information it may have been difficult to involve people living with dementia directly with their care plans, although people did tell us staff did ask them their preferences, and staff could demonstrate that they were knowledgeable about people's needs, likes, dislikes and personal preference. Information about people's needs was not always written in simple language, and whilst people's communication needs were sometimes well recorded, this was not consistent. We recommend that the registered manager and provider take steps to ensure that people receive information consistently which they can access and understand, in so far as this is possible, and in accordance with the AIS.

One person told us. "I can look at my records, the care plan staff have talked through with me, and staff know my likes and dislikes". A relative told us the, "Care plan, did have input, i.e. what kind of food, what likes to do, always give me feedback". Another relative said, "Any changes I'm informed" and a third relative commented, "Staff put information in [the care plan], their past life they [staff] know all that". The Registered manager told us that care plans had been compiled for people that were based on information and assessments available at the time of admission, which people and relatives told us they were involved in. We found staff had good knowledge of people's needs and could tell us what they needed to ensure their care needs were met, but their care records didn't always reflect this. For example, whilst we saw there were regular reviews of some care plans and evidence of updates, there were others where changes/updates known to the registered manager and staff were not reflected in people's care plans. We looked at one person's records and found there was no detail in respect of catheter care or behaviours that may result in self harm, although staff were knowledgeable about the support needed.

Staff spoke positively about the value of the care plans and despite the volume of information staff said the care plans were helpful and informative, and gave them an insight into people's backgrounds. Some staff told us it was easy to read the care plans and recognise people from what was recorded in the care plan, and that their interests and routines were accurately reflected. When asking the management team for records that supported what they told us about people's needs, likes and dislikes we found they had at times difficultly evidencing their and staff knowledge was consistently recorded. We found staff had a good understanding of people's needs and preferences including those where they needed to consider characteristics protected under the Equality Act 2010, for example people's race. We did find in some people's records there was good recording in respect of protected characteristics, such as disability, although this was not consistent.

While staff told us, they tried to adhere to planned activities they said they did not always have sufficient time to provide these. What we saw also showed staff were usually very busy providing personal care with limited capacity to provide activities, although where able they would try and stimulate people. We saw staff had more time to do so on the second day of the inspection, when there was no additional people attending the home for day-care. Some staff told us they liked to provide for example impromptu games and collective completion of crossword puzzles, which we did see take place on the second day of the inspection. These did not always reflect the activities displayed as planned however, and we saw there were two displays advertising activities. The activities displayed on these boards contradicted each other so it was not possible to know what activities were planned. The registered manager acknowledged that activities were important and should be structured, and staff consistently deployed so they could offer these to people as planned.

Two people who were more independent told us how they could occupy themselves, for example one person told us they liked cleaning and would help the registered manager with 'paperwork' while another said they liked to read and had access to books they liked. One person told us "We have singers in" and "Just going to do a game with the carers called pick a name". Another person said, "I'm not very interested in anything". A relative told us their loved one, "Watches TV, chats with others, makes friends, they do singing and entertainment" and added there was, "Plenty to look at, plenty of stimulation, plenty of entertainment". Another relative told us their loved one, "Is 95% asleep and gets tired even when entertainment is here they are asleep but are quite happy". We saw when staff had put a film on that was popular with some people they made a point of seeking out the person and letting them know about the favourite film. We saw people's personal routines were respected as we saw people could get up when they wished, or remain in their bedroom should they choose. We saw there was flexibility with when people had meals and we saw one person chose to have a later dinner.

We saw there was a complaints procedure available to people, which was on display in the home. People and their relatives told us they knew how to make a complaint. One person told us, "The manager is great, any problems I would talk to the manager who would understand". Another person told us, "Any problems [registered manager] will sort ". A relative told us, "There are no complaints, but if there were I would go to [registered manager] and tell them". Another relative, "If I had a complaint would go straight to the [registered manager] and I know they would sort it out". A third relative said, "I have no complaints". We looked at the provider complaints log and saw any complaints were documented and responded to. The registered manager told us they reviewed the complaints log monthly to look for any trends that could be readily identified. We saw that complaints received by the registered manager or provider were documented.

Requires Improvement

Is the service well-led?

Our findings

We previously inspected the service on 12 January 2017 and the rating after this inspection for this key question was 'good'. At this latest inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

We found the provider had systems in place for auditing the service to monitor, identify trends and better respond to risks to people using the service, but these were not always effective and had not consistently identified risks to people living at the home. For example, the registered manager had completed a staffing tool based on dependency levels of the people living at the home, but this showed that they had been operating 70 staff hours less than the provider's dependency tool had identified as needed per week. In addition, the dependency tool had not considered the impact of people attending for day-care which was a further impact on staff time. We saw staff were far busier and more task orientated on the day of our inspection where there were people attending for day care.

Audits took place but had not always produced any actions for learning. We found some audits were duplicated and in some instances, there had been no checks to ensure monitoring forms initiated action when required. An example of this was weight records and fluid charts, where actions were not escalated and no management guidance given to staff. The risk to people who may be at risk of dehydration and malnutrition may not have been identified as a result. We found background information related to some accidents was difficult to find as staff had not cross referenced the appropriate record when information may be incomplete in the incident report. This meant audits may draw incorrect conclusions as important information may not be identified when trends were analysed.

Audits were not effective at identifying short falls. For example, we saw there were audits in place for infection control yet issues identified when the infection control nurse visited were not identified prior to this external audit. Action to improve infection control measures only commenced after the infection control nurse made recommendations. Some of these recommendations had been actioned by the time we inspected the service, for example pressure relieving cushions had been replaced and liquid soap and paper towels were available around the home for staff to wash their hands. These are basic expectations when promoting good infection control, and it would have been reasonable to expect the provider's audits to have identified these shortcomings.

Following audits by the local authority, fire department and a pharmacist we found there were several areas where the service needed to improve that had not previously been identified by the registered persons. People had been at risk because the provider had failed to identify shortfalls in the safety and quality of the service they provided. The registered persons are required to be able to robustly audit the service, identify shortcomings, and comply with legal requirements.

The fire prevention officer had visited the service shortly before our inspection and identified areas that needed improvement, not identified by the provider's own audits. We found the provider had commenced addressing these issues, for example ensuring fire doors fully closed and staff understood how to open

doors fitted with two handles (which we saw they could do very quickly). The provider told us that the remaining works were to be addressed and the fire officer informed us they were to revisit the home after completion of the building works. We were informed by the operations manager that the home's fire risk assessment was being updated at the time of the inspection as some changes were needed.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said that it was difficult to address some of the shortcomings identified as they did not have the time to complete management tasks. The registered manager had not explicitly shared this concern with the provider. A deputy had been appointed they were new to the post so were still learning at the time of our inspection, and had a limited amount of time as allocated to deputise. We discussed this with the provider who told us they would source a social care consultant to come in and support the registered manager so they could better manage the changes needed to address the issues identified.

The registered manager was aware of their legal responsibilities regarding submitting notifications in respect of any incidents to CQC except for the legal requirement to make us aware of any allegations of abuse. While the registered manager had made us aware of all other required notifications we had not received notifications in respect of allegations of abuse that were raised recently, or indeed any since the location had been first registered with CQC.

This was a breach of Regulation 18: Notification of other incidents of the Health and Social Care Act 2008 (Registration) Regulations 2009.

People expressed satisfaction with the management of the home however. One person told us, "They look after me right". Another person said, "I'm happy near enough". A relative we spoke with said, "It's excellent [the person] is really well looked after, me and the rest of the family and [the person] is happy". Another relative said their loved one, "Is happy, I have never seen them upset".

We asked people how they could share their views with management. People told us they could talk to managers or staff if they wished to talk about something. Relatives were positive about how staff kept in touch with them, one telling us, "If problem staff phone up straight away". Another relative said, "I'm informed of everything straight away". The registered manager told us they had sent out survey forms to get people's views on the service and we saw some that had recently been completed and returned. Feedback was overall very positive with comments from relatives including, 'We are very pleased with the care that [the person] is getting. The staff are always very kind and have some wonderful ideas about bringing out the best in [the person] as I know they can be difficult when agitated. I love that you get [the person] to write about things and that you are always positive about things' and 'I am happy how you look after [the person], you are all friendly. It's like a home from home when we visit'. We saw the registered manager held meetings with people living at the home to discuss changes, and ask for people's views although they told us there was not any involvement from relatives with these. One relative did tell us they had received letters from the provider about significant changes at the home however.

Staff we spoke with told us they were well supported and were happy in their work. One member of staff told us,
"Feel well supported? Yes, I do, I love working here". One member told us how the registered manager had been very supportive and understanding when they needed additional support. Staff said that they found team work was good in the home and the duty rotas were organised so that staff worked with different people on a regular basis which they felt helped ensure that skills and knowledge were shared and

standards maintained. Staff said they felt able to raise any issues with the registered manager or person's in charge and were aware of how to 'whistle-blow'. A 'whistle-blower' is a person who informs on a person or organization who may be regarded as engaging in an unlawful or immoral activity.

The provider had a senior manager that oversaw the staff training, and provided some of the training. They were due to leave the provider's employment however and as some staff training was due update (for example moving and handling people training for some staff) or had recently expired at the time of our inspection it was not clear who would organise this training and who would monitor the training provision, as the registered manager told us it was the senior manager's responsibility. The provider told us they would resolve who was going to have responsibility for training and its overview.

The law requires the provider to display the rating for the service as detailed in CQC reports and the provider was aware of this requirement. We saw the rating from the previous inspection was clearly on display in the reception area of the home. The registered manager and provider were aware of their responsibilities in respect of their duty of candour, and we found they were open that improvements needed to be made at the service.

The registered manager was at the time of our inspection receiving support from the local authority and other agencies and had demonstrated that they had begun work to address recommendations and advice they had been given by infection control, the fire service, food safety inspectors, occupational therapy, pharmacists, DoLS assessors, social workers and the local authority commissioning officers. The registered manager did tell us that due to the number of areas identified where improvement was needed, and with regular visits from the local authority there had been some difficulty in addressing some issues promptly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC had not received notifications in respect of allegations of abuse that were raised in respect of people living at the service since the location had been first registered with CQC. We were aware that some allegations have been made during this period. The provider must inform us of any allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems of governance had not consistently identified where there were risks to people living at the service, and when it had prompt action had not always been taken. The provider must ensure that their systems for governance are operated effectively to ensure they are compliant with the law, and they are able to identify when they are not and take prompt remedial action to address any failings.