RV Care Homes Limited

The Moat House

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

This inspection took place on 7 and 8 November 2018 and was unannounced.

The Moat House 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. The service accommodates 72 people in one adapted building, comprising of five suites known as Willow, Oak, Aspen, Maple and Thistle. People residing in Willow require support to manage their dementia and nursing needs. Oak provides nursing care. Aspen accommodates people living with dementia. Maple is the residential unit and Thistle is for people who require minimal support to live independently. At the time of our inspection there were 58 people using the service. This service was registered by the Care Quality Commission (CQC) on 25 August 2017 under a new provider RV Care Homes Limited. The last inspection under the previous provider, R V Moat House Limited in August 2016 was rated good. This is the first inspection under the new provider.

The service does not currently have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager resigned on the 22 June 2018. A new manager commenced in post on 11 June 2018, however, resigned on the 10 September 2018. Since this date a turnaround manager employed by the provider has been managing the service. They are making an application to be registered as the manager with CQC until a new manager is appointed.

Our inspection found the new provider had implemented their own systems to ensure performance, risks and regulatory requirements were understood and managed. However, these new systems were still being embedded and it was difficult to see how these were being used to assess and monitor the overall quality of the service. Although risks to people using the service were generally anticipated and managed well, there were occasions where risks had not been recognised. Safety concerns had not been identified and addressed quickly enough to prevent people being exposed to harm, or a significant risk of harm occurring. However, where an incident had occurred, lessons had been learned and measures taken to prevent a similar incident happening again.

People, their relatives and staff had mixed opinions about staffing levels. The provider had a dependency assessment tool they used to determine the number of staff needed. Rotas showed these numbers were being maintained, however the turnover of staff and high use of agency had added to the frustrations about staffing. The manager had taken steps to resolve this by arranging for regular agency staff to be booked to provide consistency. Ongoing issues with recruitment, largely due to the rural location, were being addressed by the provider. Recruitment processes ensured potential staff were of good character and suitable to work with people using the service.

Improvements were needed to ensure records kept about peoples' medicines and the care they received, were accurate. Changes in people's needs had not always been updated in their care plans, to ensure staff were working to the most up to date information. Staff were not using charts to monitor changes in people's behaviours correctly to ascertain, potential triggers, or reflect they had been used to action change to prevent further incidents. The manager was aware that staff training was not up to date and below the percentage the provider expected. This had been addressed at a staff meeting. They had arranged for staff to complete training where there were gaps, including syringe driver, catheter care and managing risks to people with behaviours that could be challenging.

People were supported to express their views and were involved in making decisions about their care, support and treatment. Staff understood the need to obtain consent from people before providing care and support. However, not every one deemed by staff to lack capacity had a mental capacity assessment completed. Where people were being deprived of their liberty for their safety, appropriate applications had been submitted to the local authority for approval.

People were treated with kindness, and respect by staff. Staff knew people's needs well and showed concern for their well-being in a caring way. People were supported to eat and drink enough to maintain a balanced diet, however people did not always have access to snacks, but this varied from unit to unit. People had access to a range of healthcare services, such as the dietician, Speech and Language Therapist (SALT), district nurse, continence nurse and the community mental health team. People's relatives told us they were kept informed about changes in the family member's health. Feedback from people's relatives and discussions with staff confirmed people were supported to have a comfortable, dignified and pain-free death. However, further work was needed to ensure peoples care plans reflected their wishes about their end of life care.

People's privacy, dignity and independence was respected and promoted. The provider was meeting the requirements of the Accessible Information Standards. This set of standards sets out the specific, approach for providers of health and social care to identify, record, share and meet the communication needs of people with a disability, impairment or sensory loss. People had access to a range of activities, depending on their interests, within the home and via external sources, and chose if they wanted to take part. People were supported to follow their chosen faith and religious practices.

Processes were in place to ensure people's concerns and complaints were listened and responded to and used to improve the service.

Staff felt supported by the management team, in particular the manager. The area director, manager and staff had a clear understanding of what was needed to improve the service to ensure people received high-quality care and support. The improvements being made showed that there has been a willingness to work in partnership with other agencies to improve the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The providers risk management systems had not always identified where there was a risk of harm to people, however where an incident had occurred this had been managed well and used to improve the service.

There were sufficient numbers of staff available to meet people's needs. Systems for recruiting new staff were carried out safely to ensure potential employees were suitable to work at the service.

People's medicines were managed safely, however improvements were needed to ensure accurate records were kept reflecting what medicines had been administered.

Staff had a good understanding of processes to keep people safe and how to report concerns.

Infection prevention and control policies and expected best practice guidance were in place and followed by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to eat and drink enough to maintain a balanced diet. Access to snacks was variable, depending on which unit peoples resided.

People were supported to live healthier lives, received ongoing healthcare and had good access to healthcare professionals, where required.

There has been, and continues to be improvements to the adaptation, design and decoration of premises, however, we found there were areas of the service that could be better maintained and cleaner.

Consent to care and treatment was not always managed and sought in line with legislation and current guidance.

Is the service caring?

Good

The service is caring

People were treated with kindness, and respect by staff. Staff showed concern for people's well-being in a caring way and responded to their needs quickly.

People were supported to express their views and be actively involved in making decisions about their care, and treatment, where required.

People's privacy, dignity and independence respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care that was responsive to their needs, however this was not always reflected in their daily records. Where people's needs changed, these were not always updated in their care plans to reflect their current needs.

Systems were in place to ensure people's concerns and complaints were listened and responded to.

Processes were in place to ensure people were supported to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service does not currently have a registered manager in post. The current manager is in the process of making an application to be registered with CQC until a new manager is appointed. People, their relatives and staff spoke positively about the manager. Staff felt supported by the manager.

The manager and staff had a clear understanding of what was needed to develop the service. They demonstrated a shared responsibility for improving the service and promoting people's wellbeing, safety and security.

Systems to ensure performance, risks and regulatory requirements are understood and managed, need to be fully imbedded and used to identify, themes, trends and where improvements are needed.

People who use the service, their relatives and staff were involved in making decisions about the service.

Improvements made by the manager demonstrates there has been a willingness to work in partnership with other agencies to improve the service.

The Moat House

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 November 2018 and was unannounced. On both days the team consisted of one inspector, and two bank inspectors. An assistant inspector supported the inspection on the first day.

Before the inspection we reviewed information available to us about this service. The provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports and the details of complaints, safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury.

We spoke with seven people who were able to express their views, but not everyone chose to or were able to communicate with us. Therefore, we used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three senior carers, four care staff, three agency staff, one of whom was a nurse and a kitchen assistant. We also spoke with the manager, area manager and area director, representing the provider. We looked at eight people's care records, recruitment records for three staff and reviewed records relating to the management of medicines. We also looked at records in relation to complaints, staff training, feedback in peoples, relatives and staff surveys, maintenance of the premises and equipment and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us The Moat House was a safe and secure place to live. This was confirmed in discussion with relatives visiting the service during the inspection. For example, one relative told us, "I know my [Person] is safe and well. Staff do their best to support my [Person] when their behaviour changes, they become aggressive, mostly when they try to carry out personal care, but they deal with them brilliantly, they continue to be gorgeous with them, being kind and making them feel loved." However, we found staff were not always using charts designed to record people's behaviours correctly. People's care plans contained information on the support they needed when they behaved in ways that was challenging to others. These provided guidance for staff on how to manage such situations in a positive way. One member of staff told us, "Where we have people who have complex behavioural needs, we try different ways to help them manage this aspect of their care, for example, some people respond better to certain staff, we also involve people's families and the community mental health team to find ways to support people and keep them safe." Although, staff were recording incidents, they were not always stating what had triggered the incident, the length of time this lasted and the action taken to reduce the risk of harm. This information is important to help understand what was causing the person distress and look at ways of preventing this happening again.

We received mixed feedback from people and staff about staffing levels. One person told us, "We all have our little grumbles, mine is staffing, everything else is fine. Staffing varies, but, we all like it when there is enough staff." Other comments included, "Staff are always busy" and "Needs more staff, two left recently, I would like a bath more often, but staff are not always available." However, one person commented, "I have a buzzer on the table, when I use the buzzer they do seem to come." One member of staff told us, "Staffing was crazy at times, we have been short at times, but it seems to be better now." Another member of staff commented, "Staffing levels on Aspen are okay, with two carers and a senior. Oak is the hardest unit, as all people needed nursing care. However, there are currently five empty rooms, which takes the pressure off."

Staff rotas and the providers dependency tool showed staffing hours to meet the needs of people using the service were being maintained, however agency were being used to cover staff vacancies and sickness. People, and staff were mixed about the use of agency. One person commented, "We get different staff all the time, however the new manager is great, they listen, so hopefully things will get better soon." One member of staff told us, "We are usually four on Willow unit, but it's not about quantity rather the quality of staff and teamwork. We have had staffing issues, but it's fine when we have regular staff and good agency." Another commented, "When we are short staffed, we are under a lot of pressure, when regular agency staff are used it is okay, but when new agency are used, it feels like we are continually training." A third member of staff told us, "Since the new manager has come, staffing has been better as they have arranged to use the same agency staff, for consistency." The manager told us they recognised there had been issues with staffing, and in particularly the pressure the high use of agency had had on staff morale and the impact this had on people using the service. They told us, recruitment of staff was an ongoing issue for the service largely due to the rural location, but this was being addressed by the provider. The ongoing issues with agency had been resolved by booking regular agency to cover vacancies, to provide consistency.

We reviewed the management of peoples' medicines on three of the five units, Oak, Willow and Aspen.

Overall, we found peoples' medicines were being administered, stored and disposed of safely. However, improvements were needed when recording information on peoples Medication Administration Records (MAR). Although staff had made good use of the reverse of MAR to record why a person's medicine had not been given or if they had refused, the coding used was not consistent. For example, where a person had refused their Citalopram, [A] for refused should have been recorded, however staff had entered [N], which referred to PRN medication. Another person's paracetamol was consistently coded [N] to state PRN but this was a routine prescribed medicine, four times a day. Where people were prescribed PRN (as required) medicines, such as Lorazepam, paracetamol and topical creams, protocols for when these should be administered were in place, however we found some were out of date, and needed to be reviewed to ensure they were still relevant.

Random sampling of people's medicines against their records, including controlled drugs confirmed they were receiving their medicines as prescribed by their GP. Medication Administration Record (MAR) charts provided staff with clear information about people's medicines and how they liked to be supported to take them, for example one person preferred to 'have all tablets together.' The new month's MAR charts recorded the amount of medicines carried forward and a running total of tablets were being kept at the bottom of each MAR to help audit stock. Treatment rooms contained fridges for medicines needed to be stored below certain temperatures. We saw room and fridge temperatures were checked daily to ensure medicines were stored in accordance with manufacturer guidelines so as not to lose their efficacy. Safety alerts, provided by the government for drugs and medical devices were used to form part of risk management in the service. A folder contained a recent Email alerts from the MHRA (Medicines and Healthcare Products Regulatory Agency) for a specific type of battery to be used for the syringe driver pump. The senior was aware of the alert and had arranged for the appropriate batteries to be purchased in order to minimise the risk of pump malfunction.

Although risks to people using the service were generally anticipated and managed well, there were occasions where risks had not been recognised. For example, an incident had occurred where the locks on the doors between units had failed, and a person had left the unit and assaulted another person using the service. Fortunately, although this was traumatic for the person, and their family, they were not seriously harmed. Management at the time and staff had failed to identify the risk where the door lock was not working. Lessons have since been learned following this incident and measures taken to prevent this from happening again. The Moat house, adjoins another property, Maynell House. There is a central lift that adjoins both properties, which means people have direct access to the premises, via Thistle unit. This had not been identified as a risk. The manager explained both properties used to be owned by the pervious provider as part of a retirement village. Part of the contractual agreement when the new provider purchased The Moat House, was that senior staff form Maynell House still had access to meeting rooms. The manager took immediate action to assess this risk and arranged for a key pad to be fitted in the lift, so that only those who had the key code, would be able to have access to the building.

Individual risks to people, such as choking, malnutrition, dehydration, mobility, incontinence, and the risks of developing pressure wounds had been assessed, with management plans in place to minimise the risk of harm. These provided guidance to staff to help people stay safe, including regular monitoring, repositioning and application of creams. Equipment, such as air mattresses and cushions had been provided to prevent wounds developing. A business contingency plan was in place detailing who to contact in an emergency such as a lift breakdown, gas supply failure or if residents needed to be evacuated where they would be relocated to. Staff knew who to contact if such an emergency arose. Each person had a Personal Emergency Evacuation Plan (PEEP) in place providing guidance to staff on how to support them to evacuate the building safely in the event of an emergency. Routine checks were carried out to ensure fire systems, equipment, utilities, such as gas and personal electrical appliances were in safe working order. Staff were

observed using the correct personal protective equipment such as gloves and aprons when delivering personal care, or when handling food. We saw signs around the premises reminding staff to wash their hands and observed staff following these appropriately.

Staff told us they had received updated safeguarding training and were aware of different forms of abuse and their responsibility to report concerns, record safety incidents and near misses. They demonstrated a good awareness of procedures to follow and knew who to inform if they witnessed or had an allegation of abuse reported to them. Comments included, "I would report any concerns or abuse to the manager who would in turn report it to the local safeguarding team," and "I would report any abuse straight away. No one would harm anyone here. I haven't seen anything untoward."

Safe recruitment practices were being followed to assess that staff employed were of good character, competent and had the necessary skills for the work they were employed to perform. Recruitment checks had taken place, including, proof of identity, satisfactory references and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information to establish if a potential employee has a criminal record and whether they are barred from working in adult social care settings. These had been reviewed and where concerns were identified these had been explored with the person before commencing work.

Requires Improvement

Is the service effective?

Our findings

Training was provided via different learning styles, such as computer based training, known as eLearning and face to face, classroom based learning. We received mixed feedback from staff about the training they had received. One member of staff told us, "Most training is online, that's the only downside, I would love more interactive learning." Another member of staff told us, "I like the online training, you do learn and have to complete questions at the end. We must pass 80%, otherwise we have to do the training again". Training completed by staff included, but was not limited to, safe handling of medicines, moving and handling, fire safety, health and safety and food hygiene. However, not all staff had completed training in dementia awareness, diabetes, epilepsy and managing behaviours that were challenging. Although qualified nursing staff were always on site with knowledge and experience to manage diabetes and epilepsy, we found there was a lack of syringe driver and catheter care training to ensure their knowledge was up to date. Staff told us they had completed an induction when they first started working at The Moat House. One member of staff told us they had completed two-week induction, including an introduction to the people using the service, and all mandatory training. Another told us, their induction had included orientation of the service, and being shadowed by an experienced member of staff. A regular agency member of staff told us they had completed the providers induction for bank and agency staff when they started working at The Moat House.

People told us they had enough to eat and drink. One person told us, "I like the food, I enjoyed lunch, we do have a good choice of food." Another person told us, "Food is okay, but I can't eat it all, there is two cooked meals a day, lunch and dinner, it's too much for me." Other comments included, "I chose what I like for food," and "I like the food, as far as I am concerned the food is fine. If there is anything we don't like we tell them." However, on the first day of the inspection the menu had a choice of roast pork or pasta bake. Although the food looked appetising, people told us the meat was tough and the pasta bake was dry. We observed one person being assisted to eat struggling to chew the meat, although the member of staff obtained a tissue and helped them to discreetly spit the meat into the tissue, they did not offer to get them an alternative meal.

We observed the lunch time meal on three different units, Oak, Willow, and Aspen and found there was a good ratio of staff present to ensure they received the support they needed to eat their meal. We saw nice engagement between people and staff, staff were supportive, offering help and assistance when needed and encouraging people to eat. Staff assisted people to eat at a pace that was comfortable for them. For example, we overheard a member of staff asking a person, "Are you ready for the next mouthful?" Another member of staff asked a person, "Have you had enough?" Jugs of squash, with a choice of orange, lemon or blackcurrant were provided.

People confirmed they could choose where and what they wanted to eat. One person told us, "I have to have very soft food, so today I had meat (pureed) mash and greens." Another person told us, "I prefer to stay in bed, it's my choice." Snacks were available, but this varied from unit to unit, for example, on Oak we saw fruit, chocolate, biscuits and other snacks available in lounge, however, these snacks were not available on Aspen. Staff told us this was because a person who was diabetic would eat them. There was no consideration that this prevented others from accessing snacks if they wanted them.

Regular staff and the catering staff had a good knowledge of people's specific dietary needs. They could tell us which people were on special diets and we observed these dietary requirements being adhered to. However, where, people were at risk of malnutrition and dehydration, or had specific dietary needs these were not always documented in their nutritional care plans. For example, one person's food chart had a space to indicate if they had any special dietary requirements, however this was not ticked to indicate they were diabetic. Therefore, there was a risk that agency staff, or staff unfamiliar with them would not know their dietary requirements, which placed them at risk of having a 'hypo', or 'hyper' episode. Additionally, food and fluid charts did not always state the quantity consumed or reflect if people were receiving their target fluid intake, or what action was taken if they have not consumed the target, other than 'push fluids'.

People using the service were registered at different surgeries, of their choice, and their GP's visited, when they needed them. One person told us, "I have a urine infection, I have seen the GP and they have prescribed me some antibiotics." Another person told us, "I'm not well today, I have a pain in my stomach, they [staff] are getting the doctor." Other comments included, "If can ask for my GP, if needed," and "I think I get the help I need, I have my toe nails and finger nails done regularly." People's relatives told us, they were kept informed about changes in the family member's health. One relative told us, "Any concerns are addressed, if my [Person] needs the GP, they are called, I can't fault the care. Staff 'mother' people, when they are not well, they really care, they look at the person as an individual, not just someone they are providing care too." People's records confirmed they had access to a range of healthcare services, such as the dietician, SALT, district nurses, and the mental health team. For example, people's insulin administration records showed their blood sugars levels were being monitored, twice daily, ether by a nurse, or the district nurses. Records showed their blood sugar levels were being maintained within the correct range. People at risk of malnutrition were weighed weekly and where significant weight loss was identified because of poor health, they had been referred to the dietician for advice.

Although, the overall appearance of the service looked well maintained, tidy and had no odours, some areas could have been cleaner. For example, on Willow unit we saw the carpets in the dining room were dirty, and stained in places. The carpet in the same room in the corner was wet. In Thistle artificial flowers and surfaces were dusty and paint was peeling in the dining room near the window. Parts of the premises needed updating and decorating. For example, the patio door on Maple unit which is on the first floor, led out onto a balcony, and would not close. The manager told us, the service had been without a maintenance man for several months, but had recently recruited a replacement. A maintenance person from another of the providers service arrived later in the day to repair the door. We saw a lovely bar area with seating that was not in use. The manager said there were plans to turn this into a café, as part of a Harmony program that was being introduced to improve the environment for people, especially those living with dementia. There were plans to redevelop the service to make it as conducive as possible to people, with dementia to enable them to meet their full potential and create a 'home from home'.

The Mental Capacity Act (MCA) 2005 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We looked at how the MCA was applied and managed in the service. Management and staff understood their responsibilities to ensure people were given choices about how they wished to live their lives. For example, one member of staff commented, "People's capacity can fluctuate, they can choose what they want to eat or wear, but are not able to make difficult decisions." Where decisions were being made on people's behalf their family representatives and/or professionals were involved in making decisions that were in their best interests. For example, where a person's medication was being administered covertly (disguised in food and drink) records showed this was been done in line with MCA

requirements and a multi-disciplinary team had been involved in making a 'best interest decision' to agree to the person's medicines being given in this way. However, we found not everyone deemed by staff to be lacking capacity had MCA assessments completed. Where best interest decisions were being made with the involvement of people's next of kin, and relevant professionals, information had been obtained to ensure the family members who had Lasting Power of Attorney (LPA) was documented. A LPA is a person that has been appointed by the person to help them make decisions or to make decisions on their behalf, in relation to health and welfare and finances.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager confirmed appropriate applications had been made to the local authority for people subjected to restrictions to their freedom for their own safety.

Good

Is the service caring?

Our findings

People, and their relatives were complimentary about the attitude and capability of the staff and the care provided. One person told us, "They [staff] are very approachable." Another person said, "Staff are caring, they check on me to make sure I am alright." One relative told us, "My [Person's] mental health has deteriorated in recent months. The manager and staff have gone out of their way to support them. The staff have been amazing. The care is fantastic. I have two family members here, and the manager has gone out of their way to keep them together." Another person's relative had written a book, called The Pebble and had dedicated this to the staff at The Moat House, expressing their gratitude for looking after their relative, stating 'your round the clock care is invaluable'. A supporting letter asked staff to accept the book, as they 'were so grateful for everything they do for people who can no longer manage for themselves.'

The interactions between staff and people using the service were friendly and staff showed concern for their wellbeing. For example, we saw a member of staff supporting a person, who was showing signs of anxiety, gently rubbing their shoulder whist they were eating their meal offering reassurance and this kept them calm. We overheard nice conversations between people and staff, for example, we saw a member of staff take time to sit with a person, who was complaining that their handbag was heavy. They helped the person sort through its contents discarding lots of tissues and having a laugh about why they had so many tissues. Another member of staff sat with a person talking about knitting, discussing what they were knitting and the colour of the scarf.

People received the care and support they needed from staff who knew and understood their needs well. One member of staff told us, "I work on the dementia unit, we need to have a lot of patience, and it helps to know people's needs. For example, I know [Person] doesn't sleep most nights, and this can make them a bit agitated, and sometimes aggressive. If they have had a restless night, they would not appreciate being woken up for us to provide their personal care."

People's care records reflected what they could do for themselves and how staff should encourage this to promote and maintain their independence. We saw that staff provided encouragement to people when they needed it and supported them to retain their independence wherever possible. For example, one member of staff told us, "[Person] used to be a ward sister and likes helping me to make the beds sometimes." People able to walk with the use of aids were monitored to ensure they were safe, when mobilising. For example, one person told us, "I am unable to walk, but I use the buzzer to get staff to help me when I want to go back to my room."

People were supported to express their views and be involved in making decisions about their care. Resident meetings were held to find out their thoughts and opinions about the service, including their care and the support they received. The last meeting held in February 2018 had discussed a range of issues which included a new menu, improvements being made to the service, activities, including the introduction of a non-denominational worship service. People had fedback they were happy with the food, which was in their view well cooked and nutritious.

People's privacy, dignity and independence was respected. Staff understood it is a person's human right to be treated with respect and dignity and to be able to express their views. We observed them putting this into practice during the inspection. For example, we observed staff support a person to transfer from their wheelchair to an armchair in the lounge, they described the actions during the transfer speaking with them all the time to provide reassurance. One person told us, "Staff talk to me when assisting me with my personal care and I am happy with everything."

People's communication needs had been identified and how these were to be met. Peoples care plans contained detailed information about how they communicated, and we saw staff following the guidance to effectively communicate with people. Staff respected people's decision to spend time on their own in their rooms. Staff were observed gaining people's consent to enter their rooms and provide personal care. The allocation of staff was planned so that people's preference to be attended by a female member of staff was met. Staff knocked on people's doors whether or not they were open or closed, rather than just walking in. We saw people were clean, dressed in appropriate clothing, their nails were clean, hair was tidy and their glasses were clean. One person told us, "I have my own hairdresser, and chiropodist come here to do my hair, and feet."

Requires Improvement

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs, however this was not always reflected in their daily records. For example, one person on Willow unit, was heard calling out for staff throughout the first day of the inspection. We observed that staff were attending to their needs, however when we checked the care records the following day none of these interventions had been recorded to reflect the level of care provided. We also found where required, people's charts were not completed to show they had been repositioned to minimise the risk of pressure wounds developing. Charts to monitor people's fluid output verses intake were not accurate, and information about the frequency catheters were changed was not up to date. Although, people's care records contained information staff needed to provide people's care, including managing risks, their likes, dislikes and abilities, we found changes in people's needs had not always been updated in care plans. For example, one person's care plan for communication was last completed in 2017. This stated that they could communicate some of their needs. However, monthly evaluations in 2018 showed their communication had changed and they were no longer able to communicate efficiently. All the evaluations contained information that should have been used to update the actual care plan so as to ensure this reflected their current commutation needs, as well as strategies to communicate effectively with them.

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

Thistle is a unit on the top floor and provides assisted living accommodation for people who have been discharged from hospital, who are either convalescing or do not have the confidence to return to live in their own homes. A discussion with a group of people on Thistle unit confirmed they were happy with the care and support they received. One person told us, "I came here about a year ago, it's been alright so far." However, one person said, "I had a bad fall in October, and there was no staff to help me. We need support just as much as others in the home, however since the new manager has taken over, we have a member of staff on the unit all the time." These people told us they were encouraged to be as independent as possible, and had access to the local GP, district nurses and physiotherapists to help them regain their health, confidence and a good level of movement.

People told us they were supported to retain relationships with family and friends. Staff told us, since the new manager had started they were rostered to units so that they got to know and develop relationships with people. We saw families visiting people throughout both days of the inspection. One person told us, "I have visitors mostly in the evening's." One relative told us, "The manager and staff had gone out of their way to ensure two of their family members, living at the service, maintained their relationship and spent time together." They acknowledged how difficult this had been due to the deterioration, in one family members dementia, and associated behaviours.

People's care records contained information showing they or their family members were involved in discussing and reviewing their care. One person confirmed this, stating, "I chose to come here and I was involved in the review of my care plan." One relative told us, "I was involved in the review of [Person's] care. I

am generally happy with their care, occasionally staff don't ensure their teeth are cleaned, or ensure they are wearing tights, I know these are small issues, but it means a lot. Overall, though, I feel staff are very good at ensuring [Person] is safe and comfortable." Staff had a good knowledge and understanding of people's needs and preferences, for example those who chose to stay in bed, or sit in the lounge. People told us, and we saw for ourselves, they decided how they spent their day, and were asked their opinion on what activities they wanted to take part in. One person told us, "I like to read." Another person told us, "I like watching television and when they bring the animals in."

People and staff told us about the range of activities in the community, or within the service, that were available if they wanted to take part. These included, but were not limited to, accessing an external social club monthly, coffee mornings, picnics by lake, and regular visits to the zoo. One person told us, "Once a month I join in activities down stairs, last time it was the harvest festival, we had music, and sang hymns." Another person told is, "I don't join in activities much, I like singing, and enjoy doing crosswords, I am normally quiet a quiet person, but I'm not lonely." One relative told us, "The activities are fantastic, they bring animals into the home, including dogs and Shetland ponies. My [Person] used to have dogs and really enjoys seeing the dogs when they are brought in. Staff go out of their way to include my family members in activities that are meaningful to them, they both belonged to amateur dramatics and loved singing."

A member of staff told us, ninety percent of people's families got involved in activities, and this really helped to ensure people had access to meaningful and stimulating activities. They told us, every Sunday on Willow unit, resident's and relative have a sing along. We observed people taking part in a quiz on Maple unit. This was well attended, and used as an opportunity to introduce a new resident to everyone. The activities member of staff used the TV to facilitate an interactive and stimulating session, testing people's general knowledge. Additionally, we saw an outside entertainer had been booked, impersonating Elvis. A total of 16 people engaged in this activity, singing and dancing.

Systems were in place to ensure people's concerns and complaints were listened to and responded to. The PIR and complaints file showed 12 complaints had been made about the service, under the new provider. Records showed these had been investigated in full by the manager or the head of standards and compliance and letters outlining the outcome of their investigation and an apology provided to the complainant. These concerns had been used to improve the quality of care provided. For example, concerns about poor care had been addressed by the head of standards and compliance, resulting in a best interest meeting with persons social worker to discuss arrangements moving forward to meet their care needs where they refused.

People's relatives told us the manager and staff went out of their way to ensure their family members were supported to have a dignified death. One relative told us, "When my [Person] passed away, one of the staff sat with me, they helped me get [Person] changed so they could sit with my other family member, whilst they passed away. Staff just sat with them, spent time with them and provided support throughout." We spoke with the relative of a person who was receiving end of life care. They told us, "They [staff] have been of tremendous help. We are just waiting now. They are not doing too good. It's hard to see them like this. Staff have offered us drinks and are coming in to check." This person had a detailed end of life care plan in place which had assessed their needs, including their breathing, controlling their body temperature and pain management. However, we found minimal evidence in other people's care plans to reflect advanced priorities around their end of life had been discussed. Further work was needed to ensure people's views and wishes at the end of their life were discussed, recorded and shared with the appropriate people to ensure they received a dignified, and comfortable death.

Where it had been agreed, people had a Do Not Attempt Resuscitation (DNAR) order in place. A DNAR form is

a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR).

Requires Improvement

Is the service well-led?

Our findings

Systems were in place to ensure performance, risks and regulatory requirements were understood and managed. These included but were not limited to peoples' medicines, the premises, and incidents and accidents. However, it was difficult to see how individual audits fed into the overall monitoring of the quality of the service. The manager and area director, both had a clear understanding of what was needed to develop the service, however acknowledged that the providers quality assurance systems had not yet had time to be fully imbedded to identify where improvements were needed. For example, although, detailed records were made of incidents that had occurred, and the immediate action taken, there was no analysis in place to identify trends, such as repeated falls. Records showed one person had four unwitnessed falls, in a four-week period. There had been no analysis as to why these falls occurred, or a record made of the action taken to prevent similar incidents from recurring.

Since the takeover of the service by the new provider, the previous registered manager and replacement managers have left. The interim manager confirmed they were going to make an application to become the registered manager for the service until a new manager was recruited. They told us, the provider wanted to get the right manager for the service, and people and relatives were being involved in making that decision. The manager recognised there had been issues in the service, following the change in provider and management which had led to poor outcomes for people and low staff morale. They told us they had experience of turning failing services around, and was working hard to change people's perception of the company. They told us their greatest achievement so far, had been working on the floor alongside staff, getting to know them, people and their families and rebuilding positive relationships. Working on the floor, also gave them the opportunity to monitor and influence the day to day culture and standard of care provided.

People, staff and relatives were very complimentary about the new manager. One relative told us, "The changes in managers and the provider was difficult, however the new manager is amazing, they have gone through hoops to help my [Person]. The recent residents and relatives meeting was hideous, however the issues raised, are being addressed by the provider and manager. The manager has been brilliant." Staff told us they felt well supported by the manager. One member of staff told us, "The new manager is brilliant. They, and the deputies are go to managers unlike the previous two managers who recently left." Another member of staff told us, "Management are really good, the manager is really approachable."

Staff told us they received regular supervision and annual appraisal regarding their performance. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. Staff told us, they attended regular staff meetings. The minutes of the meetings in March and October 2018, showed staff were fully briefed on the changes in management and the home improvement plan was discussed so that they were all aware of the improvements required.

Discussion's with people and their relatives and minutes of meetings reflected they were involved in making decisions about the service, and asked for their feedback. The manager told us, they were in the process of

setting up a residents committee, with the aim of having a representative from each unit to obtain the views on the planned developments, in each of their communities.

The minutes of the residents and relatives meeting in August 2018 showed there had been an open, honest and transparent meeting to discuss the failings that had occurred in the service. The meeting was attended by the managing director, assistant director and previous home manager. A range of issues had been discussed, including staffing levels, high-level use agency which had led to poor standards of care, change of provider, ongoing power cuts, lack of maintenance and complaints about the provision of food. The managing director had provided apologies and provided reassurances that they were hard to make improvements, including ongoing recruitment to resolve staffing issues.

The manager told us they used the internet to research ideas and attended area manager meetings with managers of other homes run by the provider where they were kept up to date with new legislation. They were aware of their responsibility to liaise with the local authority where safeguarding concerns had been raised and such incidents had been managed well. They had worked well with a number of specialist services, such as the Mental Health Team, the GP and district nurses.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not protected against the risks to their care and welfare due to the failure to maintain accurate, complete and contemporaneous records in respect of people using the service.