R Sons (Homes) Limited

Church Farm Residential Care Home

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?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Church Farm on the 20 and 28 March and 6 April 2018.

During our previous inspection on 30 and 31 August 2017, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to, safe care and treatment, person centred care, consent, and good governance. We also found a breach of Regulation 18 of the Registration Regulations 2009. The overall rating for this service was 'Inadequate' and the service was placed in 'special measures'. Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are to be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Following the inspection, we undertook enforcement action placing positive conditions on the provider's registration. This meant the provider had to submit to CQC a monthly report of the actions taken to improve the quality of the service.

During this inspection in March and April 2018, we found some positive improvements had been made which meant the provider was no longer in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, or Regulation 18 of the Registration Regulations 2009. We did however find repeated breaches of Regulation 17, 9, and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have already taken enforcement action in relation to Regulation 17 and 9 following our last inspection, by imposing conditions on the providers registration. These conditions will remain in place, and the provider will continue to send us reports on their progress.

Church Farm 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.

Church Farm accommodates up to 40 people in one adapted building. At the time of the inspection there were 35 people living in the service.

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

We found that the provider had not made all the improvements required since our last inspection. However, auditing and quality assurance systems had improved and were in place. We found at this inspection that whilst they identified some concerns, they did not pick up all of the shortfalls we found, and therefore are

not yet fully effective.

There were improvements in the management of risk, and we saw that assessment of risk in relation to choking, weight loss, and risk of developing pressure sores, was accurate and reviewed regularly. Further improvements were needed with moving and handling risk assessments to ensure staff had clear instructions on how to move people safely.

People who used the service received appropriate support to eat and drink sufficient amounts to maintain a healthy and balanced diet. Meals we observed looked appetising and well presented. However, recording of people's food and fluid intake was not always consistent or accurate.

Records showed people living at the service received their medicines as prescribed. However, some improvements were still required to ensure documentation was clear, and reflected people's most up to date medicines.

The registered manager had applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. However, we did not see that a capacity assessment had been carried out in advance to determine that this was required, or how any restrictions would be managed. Decisions made where people lacked capacity did not always follow best practice and did not evidence decisions were made in a person's best interest. This did not meet the requirements of the Mental Capacity Act 2005.

Staffing levels were now being calculated using a dependency tool, which helped the management team to determine the correct number of staff. We observed that staff were visible and responded to people's request for assistance in a timely manner. However, some feedback indicated that at particular times of the day staff were more stretched and sometimes people had to wait. We have made a recommendation about this.

Staff received training in areas relevant to their role, however, we found two staff were overdue training in moving and handling. Not all staff had received training in end of life care, but the registered manager had booked training sessions for this. The software system in place for monitoring staff training did not support the management team to have effective oversight of when refresher training was due.

People who used the service had access to health care professionals as required, and advice given by health care professionals was followed appropriately.

The activity co-ordinator had increased their working hours which helped to ensure people had the opportunity to take part in activities of their choosing. However, this was still not meeting the individual and specialist needs of all the people using the service.

Staff interacted well with people who used the service and were caring in nature. The service had a calm and relaxed atmosphere and staff and people had a good relationship. Staff respected people's privacy and dignity, however, we found some practices needed to be improved to ensure people's dignity was always respected.

Infection prevention and control systems were much improved. We found the service to be clean and staff followed procedures to reduce the risk of infection.

The service had developed their practice to ensure that lessons were learned and improvements made when things had gone wrong. Accidents and incidents were now being monitored closely and analysed for

trends.

The provider had given some thought to maximising the suitability of the premises for the benefit of people living with dementia. However, we felt this could be improved further, and we have made a recommendation about this.

People we spoke with knew how to raise a complaint and said they felt comfortable speaking with the registered manager or any of the staff.

We found staff were recruited safely. Suitable checks were made to ensure people recruited were of good character. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

The overall rating for this service is 'Requires Improvement'. The rating for 'well-led' in this service is 'Inadequate' and the service therefore remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 consistently safe.

The likelihood of harm had been reduced because risks had been assessed and guidance provided to staff on how to manage risks and keep people safe. However, improvements were still required in relation to some risks.

People received their medicines in a safe and timely manner. However, improvements were still needed to ensure documentation was accurate and up to date.

Staff knew how to protect people from abuse, and who to report concerns to. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found the registered provider did not always work within the guidelines of the Mental Capacity Act 2005. We found consent to care was not always sought in line with the law and relevant guidance.

We received positive feedback about the food provided. Kitchen staff were aware of people's dietary requirements. However, people's food and fluid intake was not always monitored effectively or accurately.

The meal time experience was relaxed and staff were available to meet people's needs.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Good

The service was caring

The atmosphere in the service was relaxed and people were listened to.

People were supported to see their relatives and friends.

People using the service told us they liked the staff and found them helpful, friendly and kind. We saw staff treating people in a patient and compassionate way. However, some practices were not always respectful of people's dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The service was not following a specific end of life care model, and care plans did not always specify people's wishes in relation to this.

We saw improvements in the provision of activity in the service. However, this was still not at a level which would meet the individual and specialist needs of all people using the service.

Is the service well-led?

Inadequate

The service was not consistently well led.

The provider had not made all of the required improvements in a timely manner following the last inspection, and remained in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst systems had been implemented to monitor quality and to drive
improvements within the service, these were not yet fully effective and needed to be embedded into the service.

The management team demonstrated a committed approach to improving standards further, and were aware of where further improvement was needed.

Church Farm Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 20 and 28 March and 6 April 2018 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the monthly reports the provider had to complete and submit to us as part of the positive conditions placed on their registration. We reviewed information we held about the service including feedback sent to us from other stakeholders, for example the local authority and members of the public.

Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us prior to the inspection.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with five people living at the service, five relatives, and one health professional. We spoke with the registered provider, registered manager, deputy manager, and four members of care and catering staff. We also observed the interactions between staff and

people.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 30 and 31 August 2017, we found that people were at risk of harm, because risks had not been accurately assessed or mitigated. These failings resulted in a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and we rated this key question as 'Inadequate'.

At this inspection we found that improvements had been made in relation to assessment of risk, medicines, and infection control. Though some further improvements were still required, the service was no longer in breach of Regulation 12, and we have rated this key question as 'Requires Improvement'.

People living in the service told us they felt safe. One person said, "I feel safe, you are tucked up in bed at night, the staff come in and check me at night, you have your buzzer to press if you need anything and I see people." Another said, "I definitely feel safe all the girls [staff] are helpful." A relative told us, "[Relative] is the safest she has ever been here, my sister and I have peace of mind."

The service was using the MUST (Malnutrition Universal Screening Tool) to assess people's risk of becoming malnourished. Our previous inspection in August 2017 found that these assessments were not being completed correctly. At this inspection we found that people were being assessed accurately. For example, they were being weighed regularly and a nutrition plan was in place alongside this to describe how any weight loss was to be managed.

We still found some areas for improvement. For example, one person had lost weight, and their nutritional plan said they were to have cream shots twice daily. A food diary had been implemented to monitor their food intake. However, when we looked at their food diary, we saw staff had not recorded whether the person had received the cream shots. We did see that the person had recently been seen by the GP, and had gained weight, however, their nutritional intake was not being recorded fully. This was important to identify any reasons for future weight loss.

At our inspection in August 2017, we found that moving and handling assessments were not being completed accurately. At this inspection we found improvements had been made, but could still improve further to ensure information was clearer. For example, one person's records said they sometimes needed a hoist if they were unable to weight bear. The risk assessment did not describe what size of sling should be used or which hoist. It did not explain different transfer techniques or instruction of colour coded leg loops, which ensure correct positioning of the sling. On day two of our inspection, the registered manager informed us they had booked 'sling' training with the company who provide the slings as a result of our concerns. Following this training, they informed us that all people had been re-assessed, and that each person now had their own sling. A label had also been attached explaining which loops should be used and this was updated in the care plans accordingly.

Three people had slings which could remain 'in situ' whilst seated. Although the slings were designed for this purpose, it could potentially alter the effectiveness of pressure relieving equipment. The registered manager

had spoken to the community nurses about this, and was planning to discuss this further with them and the GP. Following the inspection, the registered manager sent us information for one person which showed that a best interest meeting had taken place with relevant people/professionals to determine that it was in the person's best interests to have the in-situ sling in place whilst seated. This also included a discussion with the person about the risks and benefits involved with using the sling.

Risk associated with the development of pressure ulcers were risk assessed, and appropriate equipment, such as pressure mattresses and cushions had been supplied where needed.

At our inspection in August 2017, people at risk of choking did not have a risk assessment in place to guide staff on how to minimise the risks associated with choking. At this inspection we found that choking risk assessments were in place which held relevant detail on actions to take, and how to prevent choking.

At our previous inspection in August 2017, we found that Infection control procedures were not effective and cleanliness in the service was poor. At this inspection we found that improvements had been made. Cleaning audits were now in place, and had been checked to ensure staff were cleaning areas fully and with the correct cleaning products.

Records showed people living at the service received their medicines as prescribed. Medicines were stored securely for the protection of people who used the service. However, there were some gaps in recent refrigerator temperature records, which meant that staff could not confirm medicines needing refrigeration had always been stored within the accepted range. Following the inspection, the registered manager informed us that a new thermometer was put in place (as the old one was faulty) and staff have been instructed to record the reading regularly.

When people were prescribed medicines on a when-required basis, there was information available for most but not all medicines prescribed in this way to show staff how and when to give them to people. Some people were having their medicines placed on top of food so it was easier to swallow. Though this was not being given covertly, we advised staff to ensure medicines administration charts clearly state that staff must inform the person that their medicines were being given with their food on each occasion, and if necessary a best interests decision should be considered.

One person was prescribed paracetamol before going into hospital, but this was changed to liquid form on discharge. It was not clear from the documentation, which approach was to be used. Further information was also needed when people were prescribed more complex pain-relief strategies with more than one pain-relief medicine.

Staff handling and giving people their medicines had received training. However, four members of staff working at night times had not had their competence assessed regularly to ensure they managed people's medicines safely. The registered manager told us they would make this a priority, and confirmed following the inspection that this had been completed.

At our last inspection in August 2017, we found that the registered manager was not using a formal system to calculate staffing levels. At this inspection we found that they had implemented a dependency tool which helped the service to determine more accurately how many staff were needed.

We received mixed feedback from people when we asked them if there were enough staff. One person said, "They [staff] are very very good, they are always kind and they will help you, I don't mind a man or woman. The only thing is and it's not their fault when they are short staffed they can't get you from the table quick

enough at breakfast or lunch, they can only move one person at a time and if someone needs the toilet that is more important." Another said, "I think the staff have the right skills, there are enough staff now as well, but the senior staff come out of the office and help if needed too, at the beginning of the year staff left and they were short but it was soon rectified, there are new staff now."

During the day we saw that staff were visible and supporting people in a timely manner. After the last inspection in August 2017, the registered manager increased staffing levels during the day, and we saw this had been sustained. The registered manager told us that the call alarm system did not allow the buzzer to sound longer than six minutes before it changed to an emergency call tone, and that they had undertaken regular monitoring to see how long people had to wait. The average taken on three random days was 3.2 minutes. They also explained that they had a procedure in place for staff to prioritise calls. For example, one person had medical needs and staff would be expected to prioritise their calls first.

However, some staff told us that evening shifts were still difficult if people called in sick. One staff member said, "If staffing levels are stable it runs like clockwork, but if one carer calls in sick at short notice it is hard to meet everyone's needs." The registered manager told us that they were considering adding an extra staff member for a few hours in the evening to help with the busier times.

We recommend that the service routinely asks people for their views and experiences of staffing levels and the availability of staff at different times of the day. This could also include the views of staff members and visitors to the service.

Staff received safeguarding adults training. Staff were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member told us, "We [staff] can come across different types of abuse in our work such as verbal, physical or financial abuse. I would always report this to my manager, and the number for the safeguarding team is on the wall in the office. If I saw staff being abusive I would have no qualms about reporting that at all." Another said, "If I saw any kind of neglect or abuse I would report this to a senior member of staff."

People were protected by procedures for the recruitment of new staff. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions.

The service had ensured that hoists and other equipment used to assist people had been serviced to confirm their continued safe use. Personal evacuation plans were in place which outlined the support people would need in an emergency situation. Fire safety checks had been carried out, and staff had received training in this area. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

The service had developed their practice to ensure that lessons were learned and improvements made when things had gone wrong. For example, the manager was having 'de-briefing' sessions when things occurred in the service which raised concerns. For example, one person had injured their leg on a bed rail as the bumper (protective attachment used to cover the bed rail) had not been secured correctly. Following this the registered manager had arranged a practical competency session for staff around the correct use and fitting of bed rail bumpers. Incidents and accidents which occurred in the service were now being analysed more thoroughly to identify themes and trends. This included outcomes, and any other improvements which could be made as a result.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 30 and 31 August 2017, we rated this key question as 'Requires Improvement' as the service was not ensuring that people's ability to make decisions for themselves was maximised. This resulted in a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that although people's mental capacity had been considered more fully when planning people's care, the provider still remained in breach of this regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

Our previous inspection in August 2017, found that where a DoLS had been applied for, there was not an associated mental capacity assessment showing that the person lacked capacity, to support the application. At this inspection we found this was still the case, and there were no mental capacity assessments or best interests decisions in relation to DoLS which had been applied for.

Where some people were deemed to have mental capacity, their care plans included a best interests decision in relation to the use of CCTV in the home, and the fact there were locked and coded doors. However, where people had capacity there was no need for a best interests decision to be made on their behalf. Others who were deemed to lack capacity also had this best interests decision included in their care records, however, there was no information in relation to any best interests meetings having taken place or who was involved in making the decision.

Another person deemed to have capacity had refused to have bed rail bumpers in place (a soft covering which attaches to the rail to reduce the risk of injury). The service had ensured the person had signed to say that this was their choice. However, there was no information to show that risks (such as entrapment and injury), complications and any alternatives had been discussed fully with the person..

Management's knowledge about MCA and DoLS was still lacking in some areas. They had attempted to improve this by liaising with another service, who shared documentation in relation to assessing mental capacity and best interests decisions. However, this documentation was still not being used in people's care records. The registered manager told us they had tried to improve their records and had re-written all care plans to include a question in relation to whether people needed a best interests decision made for each related task, however, where these were in place, we did not see that a capacity assessment had been

undertaken to determine that the person lacked capacity.

This constitutes a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following the inspection, the registered manager sent us information which showed that mental capacity assessments and best interests decisions were now being completed in line with the MCA. We saw good practice within these, such as discussing decisions with people at different times of the day to determine when they were most able to give their views.

Other areas of good practice included one person who was deemed to have mental capacity, and had been assessed by a specialist falls team. The person had declined equipment suggested by the falls team to reduce the risk of further falls. This was written up in their care plan and signed by the person to show they understood the risks involved.

We saw staff asking people for their consent before assisting with tasks such as eating, moving position or assistance to use the toilet. One staff member said, "Residents are given freedom to make their own choices. If they refuse, we [staff] accept that and come back later. "

At our previous inspection In August 2017, we found that not all staff had completed training in MCA and dementia awareness. At this inspection we found that most staff had now received training in this area. Where areas of staff training were still required, we found the registered manager had compiled a list to ensure this was monitored. Practical moving and handling training and first aid had been booked, but this was cancelled due to poor weather conditions, however both training sessions had been re-booked to take place in May 2018.

We did however find that two staff who were working in the service had not recently completed moving and handling training. We advised that these staff should not be providing assistance to people until they were properly trained. They subsequently sent us evidence to show both had completed online training until the practical session was held in May 2018. The computer software the service was using to monitor training did not enable the service to have effective oversight of who had completed their training, and was a time consuming task to ascertain this. The registered manager told us that they were going to implement their own tool to improve this.

Staff received training in safeguarding, first aid, medicines, moving and handling, and nutrition and hydration. Financial incentives had been given to staff to complete online training to ensure better compliance, and this had proven beneficial.

We found at the last inspection in August 2017, the staff member responsible for completing risk assessments had not been completing these accurately and this area of their work was not being checked by a senior member of staff. At this inspection we found that the staff member undertaking the risk assessments had completed training to do so, and risks were now more accurately assessed.

For staff working in the service who did not have formal qualifications in care, they were expected to complete the Care Certificate, which is a set of standards that care workers are assessed on to ensure they are providing good quality care. Staff we spoke with told us their induction training met their needs. One staff member told us, "I hadn't worked in care previously, but I had a good induction, I was able to shadow experienced staff, and I did not feel under pressure to work independently until I was ready."

Staff were receiving supervision on a more frequent basis, and we saw records were completed which included training requirements, and observations of staff. The registered manager told us that they were planning staff supervisions every three months. We also saw that prior to supervisions, staff were given service policies to read, such as safeguarding, and were then tested on their knowledge of the subject during supervisions. This approach helped the management team to ensure staff understood and applied their learning correctly.

Assessments of people's needs were completed before they moved into the service. This was done to ensure that the service could meet their needs. One relative told us, "Before coming in to the home, staff came out to see my [relative] at home and assessed what care they needed, they told us everything we needed to know they were very good I couldn't fault them."

However, we found that some improvements were required when people were transferred to a different care setting, or on return to the service. For example, it is good practice to have in place a 'hospital passport' or similar system, which contains key information about people's needs. Though the service had 'summary information' contained on one sheet which could be handed over, the information could be more detailed so other professionals not familiar with the person know important information about them. Additionally, when one person was transferred back to the service from hospital, we found that some information (such as moving and handling guidance) was limited, and there had been a change in their mobility status.

Nutritional and hydration needs were not always recorded accurately or consistently. For example, one care plan said that care staff were to monitor the person's food intake closely, but did not describe how or where to record this information. Another person had been prescribed drinks that were high calorie to increase weight, but we were told the person was no longer having these as they were eating and drinking well and had gained weight.

The chef was able to confirm the person was receiving a high calorie diet which was being fortified, and we saw they had gained weight, however, more accurate recording of people's intake was required. The registered manager told us they would continue to monitor this and remind staff of the importance of recording in team meetings and during supervision.

The chef was aware of people's dietary needs, and we saw that this information was displayed in the kitchen area. This included those on a soft or pureed diet, foods which should be avoided, allergies, diabetic diets, and where breakfasts should be given later due to certain medicines.

We observed the lunchtime meal. The dining area was large which enabled people to socialise and we saw that friendship groups sat together. The tables were set with tablecloths and fresh flowers. There were two choices of main meal and the food looked appetising and nicely presented. A sweet trolley came round with four choices of dessert. We asked people what they thought of the food. One person told us, "You have two choices at lunch, if you want to you can just have soup, or ham and chips. The sweets are nice you have about four or five choices. You get plenty cups of tea and biscuits too". A relative said, "The food is remarkable, the quality is good and they have plenty."

Records showed that people had access to healthcare services and received on-going healthcare support. This included specialist falls teams, GP's, community nurses, and podiatrists. One person told us, If you want to see a doctor they [staff] see to all of that, I have my feet done on a Monday." A relative said, "They [staff] are very swift to take tests if [relative] is not well, they have a clinic here with a doctor every week. [Relative] gets a lot of water infections and they [staff] are straight on it, taking a sample to the doctors." A health professional told us, "Very pro-active service. Timely referrals, good communication, and good at following

advice. I have also noted improvements in the paperwork here."

The provider had given some thought to maximising the suitability of the premises for the benefit of people living with dementia. For example, the entrance hall was bright, corridors were well lit with handrails on the walls. Picture signage was on toilets and bathrooms, and photographs were displayed on some people's bedrooms so they could recognise their room more easily. However, we felt some additional improvements would benefit people further, such as additional directional signage which would help people to navigate around the service more independently.

We recommend that the service explores current guidance from a reputable source on improving the design and decoration of accommodation for people living with dementia.

Good

Is the service caring?

Our findings

At our previous inspection in August 2017, we found that the provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture. While we observed that individual staff were kind and caring towards people, the provider's systems and processes did not always ensure that people were cared for safely. Additionally, we could not be assured that people's views had been consistently listened to in relation to how they preferred their care to be delivered. There was no evidence that people were consulted about their care. As a result we rated this key question as 'Requires Improvement'.

At this inspection in March and April 2018, we found the service was improving the involvement of people and their families in making decisions and choices about their care, where appropriate, and have rated this key question as 'Good'.

The registered manager had taken steps to support and involve people in planning and making decisions about their care. We saw that where they were able to, people had been involved in the development of their care plans, however we found these had not always been signed by the person. The registered manager told us that the majority of care plans had been signed, but there were still a few outstanding.

People were now also able to take part in monthly 'residents meetings' which included them in decisions about the way the service was run and provided an opportunity for people to give their views on any aspects of their care. We looked at the minutes from these and found that relevant items were discussed, for example, staffing levels, menu, activity schedules, and ideas for trips out. People requested that meetings were held every two months rather than monthly as they felt this was too often. We saw that the previous actions were discussed at each meeting to ensure actions had been met. We noted that the minutes of the meetings had not been displayed in the service, which would enable people who weren't able to attend to see what was discussed. The registered manager told us that they would arrange this.

It was apparent that staff had developed positive relationships with people living at the service. Staff were able to talk to us in detail about people's likes, dislikes, interests and preferences. We observed that staff spent time talking with people when they were not engaged in care tasks. People living at the service were comfortable approaching staff to ask for assistance or to start a conversation. When asked if they thought staff were kind and caring one person said, "I find the staff very caring, very kind and helpful. They do know me, I like my water on the table and my feet up, all my little traits." Another said, "The staff are kind, they help me wash and get dressed, and they hold my clothes up out of the wardrobe and say do you like that. They bring me in presents, I have had pop socks, and sewing kits. The staff are very good to me." A relative told us, "The girls [staff] are lovely, [relative] always looks clean, before they came in here they weren't eating, now [relative] is tucking into food, and has put on weight, [relative] looks well. [Relative] is still smiling, likes a laugh and a joke with people and the staff know that." Another said, "They [staff] are so accommodating, on Mother's Day and Christmas there is standing room only, and you can visit any time you want to. [Relatives] room always looks nice, tidy and clean.

People's care plans made reference to tasks they could still attend to independently, such as aspects of their personal care, and choices about what they wanted to wear, and how they wanted to be presented. These details were very person centred, for example, one person liked a particular routine in the morning assisted by staff, but then liked to be left alone to apply their make up. These routines were important to people and were acknowledged within their care plans.

Although we observed that staff were respectful when interacting with people, we observed that some practices' could be improved in relation to ensuring people's dignity. We observed that staff were hoisting people in the main lounge where most people were gathered. We noted that privacy screens were available in the same room, but staff had not thought to use these to ensure people's privacy and dignity during these times. We raised this with the registered manager who told us they would remind staff to use the privacy screens provided.

People told us they felt their privacy and dignity was respected. One person said, "Oh yes, always respectful when they [staff] help you to the toilet or things like that. I never feel embarrassed". A relative said, "They [staff] look after [relative] as a person, they give that personal touch. [Relative] can be fussy and demanding and they all do things the way [relative] likes them doing. [Relative's] room is lovely the bed is changed regularly."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in August 2017, we rated this key question as 'Requires improvement'. This was because we found two people did not have a care plan in place, which meant people did not always receive individualised and safe care. Where there were care plans in place, some details were not comprehensive or accurate. Additionally, people were not routinely involved in the development or review of their care plans. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in March and April 2018, we found some improvements in relation to people being more involved in developing their care plans. This was evident from the person centred detail within them, which included individual preferences. However, further improvement was still needed in some areas, such the recording of people's dietary and fluid intake, people's ability to consent to their care, and in relation to end of life care planning. We also noted that for three people there was no information on their life history. Having this information supports staff to have meaningful conversations with people about their lives and what is important to them. This is particularly important for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness. This meant the service remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and we have rated this key question as 'requires improvement'.

The service needed to develop their practice in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life. Some care plans made reference to people's end of life wishes, such as who they wanted involved, and where they wanted to die. Others just listed that there was a Will in place and their chosen funeral director.

The end of life care plans in place were not always holistic, and did not always reflect the scope of people's individual wishes and needs. For example, if they preferred to go into hospital or remain in the service, which people they wanted to be with them (and those they did not) and how they wished to spend their last days. There was no additional information on how staff could provide comfort during these last days such as music the person liked or calming aromas.

We asked if there was a specific approach or model of end of life care the staff would follow should anyone be approaching the end of their life. The registered manager provided evidence that end of life training had been planned, but acknowledged no specific approach or model of end of life care was in place, such as the Six Steps end of life programme which is a nationally recognised programme for supporting people and their families about making advanced decisions about the care they want at the end of their lives and their wishes after death.

The registered manager told us that they were improving systems and processes in relation to people's end of life care, and gave us an example where a person returned from hospital on end of life care. The discharge

information did not provide sufficient detail on the person's pain control, which meant they had to source this information from the hospital promptly. They told us that lessons had been learnt, and now they request a full summary of the person's care needs, including their pain control, prior to accepting a person back to the service.

People's care plans included information on how they liked their personal care delivered, their mental health, falls, communication, nutrition and hydration, spiritual, mobility, and social activity. Care plans contained person centred details which provided guidance to staff on how people liked their care to be delivered. This included whether they had a preference for a male or female carer.

One person had a very rare medical condition which most of the staff had not come across before. The registered manager sourced information on the condition and had linked this to the person's care plan. They then asked all staff to read this and make any comments. They had also sourced information for staff on Alzheimer's disease, and how this affects people's dietary intake. This meant that staff had access to information which would help them to understand how people living with specific conditions were affected in their day to day lives.

At our last inspection in August 2017, we were concerned that people were not receiving sufficient opportunity to take part in activities. There was an activity co-ordinator who worked Monday to Friday, 8am -2pm. We observed that the activity co-ordinator was at times assisting care staff, and this impacted on their time to provide activity.

At this inspection we found that the activity co-ordinator was still working five days per week, but had extended their hours to 8am to 4pm. Care staff delivered activity to people during the weekend if there was time. There were themed parties held in the service every other month, and outside entertainers on an ad hoc basis, such as singers. The activity co-ordinator told us that they were now able to dedicate their time to providing activity to people, and rarely assisted with care tasks. They told us they had tried to introduce a planned activity schedule, but this wasn't liked by people, who preferred to make a decision on the day.

The activity co-ordinator had set up a diary showing what activities had been carried out and who attended. Activities included quoits, board games, bingo, quiz, singing and ball games. The activity co-ordinator said, "The most popular activity is music and singing and bingo. We also have an outside entertainer who comes in and the residents love it. I ask people what they want to do now, they choose. It's not perfect yet, but it's getting better." The registered manager also told us, "We are not quite there with the provision of activity, particularly for those people living with dementia, but we are working on it." The majority of people (apart from two people) came to the main lounge daily to join in activity. The activity co-ordinator said they sourced ideas from a dementia and memory group in the local area, and was planning to undertake training in activity provision, which the registered manager supported.

We asked people their views on the activity in the service. One person said, "I would join in if things like bingo was going on. I do feel my brain has died; we have a singer come in sometimes." Another said, "I get very bored, I can't do crafty things because my hands don't work like they used to. I do word searches. The past few months we have had more entertainers." And a third person said, "I do like reading, and going to the sing songs, they make a circle of chairs round and then the bloke comes in and sings I enjoy that."

The provision of activity had improved since our last inspection, and people were having a say in what activities were provided, however, it was clear this was still not meeting the individual and specialist needs of all people living in the service. The activity co-ordinator had lots of ideas about providing the right activity for people with more specialist needs, such as those living with dementia. They said that they intended to

look into sensory items, lighting and reminiscence activities which would be more suited to some people.

The service had a complaints procedure in place should people or relatives want to raise concerns. The service had not received any recent complaints. We asked people about raising concerns and if they felt comfortable doing so. One person said, "I find [registered manager] very good, if there were any complaints she would soon have them in the office and sort them out if things were not right. I can always go and talk to her if I need to." Another said, "If I was worried or concerned I would talk to a carer first, if I didn't get results I would talk to [registered manager]."

A relative told us, "[Relative] is able to speak up and say what they want, we are kept informed of any changes from the office and by text messages. My sister and I visit every day between us, we are always made so welcome."

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2017, we found there were no quality assurance systems in place to continually monitor the service provided to ensure people received safe and effective care. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014, and we rated this key question as 'Inadequate'.

Following the inspection in August 2017, we took enforcement action to impose conditions on the providers registration. We asked the provider to demonstrate what action was being taken to improve the quality of the service in relation to the assessment and monitoring of risk, and the implementation of quality and monitoring audits. These conditions remain in place, and we continue to receive monthly reports.

At this inspection on 28 March and 6 April 2018, we found that a programme of audits had been implemented by the management team which included infection control, falls and analysis, medicines, care plans, and monitoring of weights. These had enabled the service to monitor more closely when shortfalls were found, and as a result people's care records were more accurate and up to date.

However, the programme of audits had not identified some of the shortfalls we found, and are therefore not yet fully effective. Additionally, the provider still remains in breach of two regulations of the Health and Social Care Act 2008, in relation to consent and person-centred care. This means the service continues to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014, and we have rated this key question as 'Inadequate'.

At our previous inspection we found that the service had not notified us of injuries which had occurred in the service, and as a result were in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found that serious injuries had been reported to us, meaning the service was no longer in breach of this regulation.

The registered manager was supported in their role by a deputy manager, assistant manager, and an administrative manager. The management team now had more defined roles and responsibilities which helped to improve the monitoring of systems and processes. However, improvements were still needed in some areas. For example, two staff had not completed moving and handling training which had not been identified independently by the registered manager or by the governance processes in place. This meant that systems were not fully established to ensure areas such as training were monitored effectively and that staff had the necessary skills to provide safe care.

We found some environmental risks that the provider had not identified independently. For example, we found cleaning fluids in an unlocked room, laundry cupboards unlocked, a room where a boiler was housed with exposed hot pipes, and a window restrictor that was not in place on an upstairs room, which could pose a risk of a fall from height. Following the inspection, the registered manager confirmed that they had mitigated these risks immediately. However, the provider did not have an audit in place which took account of risks to the environment and building, and which would support the service to identify such risks. The

provider told us they would implement one promptly.

The registered manager had sought advice from relevant professionals on the Mental Capacity Act 2005 and had obtained appropriate documentation to add into people's care plans, however, this had still not been implemented when we inspected in March and April 2018.

We observed that staff worked well as a team, and that communication with them by the management team had improved. One staff member said, "It's not perfect, but I can see things are getting better." Another said, "I feel valued in my role a bit more now. If staffing levels fall below the usual number, it brings staff morale down, but it is better most of the time now. Communication from 'the top' is better." We saw that regular monthly staff meetings were being held in the service, and relevant topics were discussed such as, infection control, new roles in the service, moving and handling observations, training, and documentation. We also saw that some areas needing improvement, such as accurate recording of food and fluid charts, had been discussed with staff including different options for how to improve this.

People living in the service knew who the registered manager was. One person said, [Registered manager] fits in well and does anything that they need to do." A relative said, "We see [registered manager] and they are very approachable. We have had questionnaires sent to us to fill in my sister and I do it between us." We also saw recent written feedback from relatives who praised the care their relative received. They said, "We are extremely grateful for the day to day care, love, support, kindness, patience, compassion and professionalism you gave our [relative] throughout their stay. Thank you is not enough."

The service worked in partnership with various organisations, including the local authority, community nurses and GP's to ensure they were following correct practice. Following the inspection the registered manager informed us of several actions they had already taken in response to our inspection findings, this included devising a spreadsheet to record all training which will also alert them when staff training is due again.

The service was also working with a company to further improve systems and quality of care within the service. We saw the registered manager had implemented an improvement plan which linked directly with the CQC key lines of enquiry, and had begun to add evidence of compliance with each area. This will support the management team to focus on what is required to meet the regulations and provide safe and effective care.

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 11 HSCA RA Regulations 2014 Need for consent The service did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent in line with MCA 2005 DoLS safeguards. 11 (1) (3)