Avens Care Homes Limited

Camplehaye Residential 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Camplehaye Residential Home provides accommodation with personal care to a maximum of 44 people. The home provides care for older people, some of whom are living with dementia. 43 people lived at the home when we visited, four of whom were there short term for respite, and one person was in hospital.

This unannounced comprehensive inspection took place on 31 August and 4 September 2017. It was carried out in response to concerning information received anonymously about low staffing levels at the home, poor moving and handling by some staff, and people's medicines not always being managed in a safe way. Since the end of July 2017 at Campelhaye, there had been an increase in incidents of verbal and physical abuse between people reported by service to the local authority safeguarding team and the Care Quality Commission (CQC).

On 26 and 27 September 2016 we carried out a comprehensive inspection at the service. This was to check that improvements had been made following our previous inspection on 22 and 29 April and 7 May 2015. At that inspection the service was rated requires improvement overall and in the safe, effective, responsive and well led domains, with caring rated as good. This was because four breaches of regulations were found relating to people's safe care and treatment, safeguarding, staffing and good governance. CQC took enforcement action in relation to ineffective quality monitoring and a warning notice was served. In September 2016 we found improvements had been made with no breaches of regulations. The service was rated good overall and in the safe, effective, caring and well led domains, and requires improvement in responsive. This was because some people's care plans needed updating and because activities needed to be more personalised to people's hobbies and interests. Improvements were found in these areas at this inspection.

The service did not currently have a registered manager. The previous registered manager left in April 2017, and has deregistered. A new manager was appointed in May 2017, who had planned to register with the Care Quality Commission. However following organisational changes, this manager was taking up a newly created quality monitoring role within the company. The new role was to support managers in Campelhaye and a second home in the group with monitoring the quality of care and continuous improvement. A replacement manager had been recruited who was undergoing a period of induction, they were due to take day to day charge of the home the week we visited. For clarity, the manager referred to in this report is the manager who has been in charge of the home since May 2017.

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.

People were happy and relaxed around staff and said they felt safe living there. The manager had identified a number of safety risks within the service, such as increased falls and verbal and physical aggression

incidents which they were working to manage and reduce. However some risks had not been identified in relation to fire safety risks, a lack of detailed instruction for staff about managing a person's challenging behaviours and incorrectly set pressure relieving equipment. The service had increased staffing levels during the day and at night to provide people with additional support and supervision and staff were undertaking falls management training.

People's rights and choices were promoted and respected. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards; they involved the person, family members and other professionals in 'best interest' decision making. We followed up whether gates were used to restrict people's movements; following concerns raised with us about their use and found they were not.

People, relatives and visiting professionals were happy with the quality of care provided at Campelhaye. Feedback was positive about improvements made at the home over the past few months to improve staffing levels and reduce risks for people. Staffing levels had further increased the previous week, although it was too early to judge the impact of these changes. However, three changes of managers over the last six months was unsettling for people, relatives and staff. The manager reported safeguarding incidents regularly to the local authority and CQC, and outlined measures taken to further protect people. Although we identified one incident which should have been notified but had not been.

The service had a range of quality monitoring systems in place and made continuous improvements in response to the findings of audits and other checks. The manager was working with staff to improve staff awareness and improve the level of detail in incidents reported, to help identify the most appropriate ways to further reduce risk. Care records had improved and further improvements were being made as had activities, which were more tailored to meet people's individual needs and interests.

Several people were at increased risk because reasons they were having modified soft or pureed food were not always clear to staff or in their care records. The manager had identified this and sought advice from speech and language therapy services to check any choking risks were being appropriately managed.

Staff understood the signs of abuse and knew how to report concerns, including reporting to external agencies. They had completed safeguarding training and had regular updates. A detailed recruitment process was in place to ensure people were cared for by suitable staff. People received their medicines safely from staff that were trained and assessed to manage medicines safely. The concerns raised with the Care Quality Commission about medicines management were not substantiated.

Staff developed positive, kind and compassionate relationships with people. People appeared happy and content in their surroundings and were relaxed and comfortable with staff who were attuned to their needs. People and relatives knew how to raise concerns and complaints, and were provided with information about how to do so. Any concerns raised were robustly dealt and further improvements made.

People experienced effective care that promoted their health and wellbeing. Staff practice was in accordance with moving and handling regulations with one exception, which we made the manager aware of. People praised the quality of food and were supported to improve their health through good nutrition. People had access to healthcare services, staff recognised when a person's health deteriorated and sought medical advice promptly.

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

Some aspects of the service were not safe.

The manager had identified a number of safety risks within the service, which they were working on managing and reducing. During the inspection we identified other risks related to fire safety, incorrectly set pressure relieving equipment and lack of detailed care plan about managing challenging behaviours.

Arrangements were in place to protect and safeguard people. Staff knew about their safeguarding responsibilities and how to report suspected abuse.

People's individual risk assessments identified actions taken to reduce them.

People received their medicines on time and in a safe way.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Good

The service was effective.

People were well cared for by staff that had regular training to gain the knowledge and skills to support their care and treatment needs.

Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and acted in accordance with them.

People were supported to access healthcare services. Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were positive about the choices and quality of food. Staff supported people to improve their health through good nutrition and hydration.

Is the service caring?

Good

The service was caring.

People and relatives said staff were caring and compassionate and treated them with dignity and respect.

Staff knew people well and developed positive relationships with them.

People were able to express their views and were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their needs.

People were engaged in activities that were meaningful to them.

People's care records reflected their support needs and were regularly updated.

People knew how to raise concerns and complaints. Any concerns raised were dealt with and improvements made.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People, relatives and staff were concerned about leadership following frequent changes of manager in the past year, which was unsettling for them. The service did not have a registered manager.

The service had a variety of quality monitoring systems in place to monitor the quality of care and had made changes and improvements in response to their findings. However, some safety concerns had not been identified through quality monitoring.

A management decision to further increase staffing levels and change how staff were deployed within the service had recently been made. Staff were positive about these changes, although it was too early to judge their impact on people's quality of care.

People, relatives' and staff views were sought and taken into account in how the service was run.

Camplehaye Residential 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 unannounced comprehensive inspection took place on 31 August and 4 September 2017. The inspection team comprised of two inspectors on first day and one inspector on the second day. Prior to the inspection, we reviewed the information we held about the home, including previous inspection reports, and notifications we received from the service. We also reviewed information we received from the manager in response to specific safeguarding incidents reported to the Care Quality Commission (CQC) such as about staffing levels, rotas and staff training.

We met most of the people using the service, who talked with us about their experiences of living at the home, and spoke with 11 visitors and relatives. We looked at four people's care including their care plans and medicine records. A number of people living at the service were unable to communicate their experience of living at the home in detail with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with both directors of the company, the current and new manager and 17 staff which included a care manager, team leaders, care staff, an activity co-ordinator, housekeeping and kitchen staff. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and at five staff files, which included recruitment and training records. We also looked at quality monitoring systems used such as audits, checklists and monthly provider visit reports. We sought feedback from commissioners, and health and social care professionals who regularly visited the home and received a response from six of them.

Requires Improvement

Is the service safe?

Our findings

People were protected from potential abuse and avoidable harm by staff that had the knowledge and confidence to identify safeguarding concerns. All staff had regular safeguarding training and were knowledgeable about the different types of abuse. Safeguarding and whistleblowing policies provided information for staff about how to report concerns, to the local authority safeguarding team, police and CQC. Staff were confident concerns reported were responded to positively. The manager reported any safeguarding concerns regularly to the local authority and CQC, and outlined actions taken in response. These showed they worked proactively with local professionals to make plans to protect people.

We followed up how incidents of behaviours such as verbal and physical aggression were managed. The manager identified three people living at the home who sometimes displayed behaviours which staff and others found challenging. For example, for one person mealtimes were a source of conflict. We spent time in the lounge, where this person ate their meal. After lunch, we saw staff had to intervene on two occasions in an altercation between the person and another person sitting beside them. Staff diffused the situation quickly. A staff member said after lunch there were often altercations between this person and others. For example, they described having to intervene the day before our inspection to protect two people from physical abuse and a third person from verbal abuse.

Over the previous 14 weeks, there had been six reported incidents involving this person and two other people living at the home, and two incidents towards a staff member. The manager had already identified incident reports lacked detail and was working with staff to improve them. This was so they had more information to identify most appropriate measures to minimise the risk of recurrence.

When we looked at this persons care plan, we found it did not provide enough clear detailed instructions for staff about how to reduce those risks, apart from encouraging the person to eat their meals in the lounge to reduce conflict in the dining room. However, the manager said the person had recently been reviewed by their GP, who changed their prescribed medicines. They had also requested commissioners visit and review the person to consider whether the home was the most appropriate place for the person to live. In contrast, another person's care plan had good details for staff about how to manage the person's tendency to try and go in other people's rooms, especially at night. Staff were instructed to redirect and reassure the person in a calm and patient manner.

Staff had undertaken training on managing challenging behaviours. They were aware of any 'triggers' and which people posed the most risk and who were most vulnerable to outbursts of verbal or physical aggression by others. Staff explained the ways in which they managed this, for example engaging with those people in meaningful activities and by trying to avoid having certain people in close proximity with one another in communal areas. One person lacked awareness and tended to put themselves at risk by getting in other people's way. Staff steered the person out of harm's way on several occasions. Local professionals praised how staff managed any conflict between people. They described how staff recognised and intervened to minimise risks for people before situations escalated.

Following a notification we received on 31 July 2017, we followed up security concerns about a person, who had left the home, without staff knowledge, when it was unsafe for them to do so. During the inspection we saw an incident report which showed another person had also briefly left the home a few weeks earlier, when visitors were leaving, which CQC were not notified about. Staff identified both people were missing very quickly, instigated a search and contacted the police for help in one instance. Both people were returned to the home safe and unhurt. The manager said both people have since moved to other services, as they recognised the service could no longer meet their changing needs. Since then, outside security had been improved with additional fencing, which made a large patio area more secure for people to access. A notice on the door requested all visitors to let staff know they were leaving, so staff could monitor who left and close the door. Keypads were fitted to external doors and some corridor areas to protect people who needed to be accompanied for their safety and protection. The codes were on display for people with capacity to use them, so their freedom of movement wasn't restricted.

Seven people living at the service were on modified food, such as soft and pureed diets, although care and kitchen staff did not have clear information about the reasons for this. This could mean people were at increased risk because their dietary modifications may not be meeting their individual risk needs, or could be unnecessarily restricting their food and drink choices. None of the care records we looked at had a speech and language therapist (SALT) assessment for the person; although staff said some people had previously been assessed. The manager thought these records may have been archived when the home implemented electronic records. The manager had already identified this as a concern and had referred several people to the SALT services for assessment.

One person's care records identified they had a choking risk, their care plan included good information about how to reduce this risk, for example, by sitting the person upright for their meal and using pureed food and thickened drinks they could swallow more easily. However, two other people's care records we checked who were on soft and pureed diets were unclear about the reasons for dietary modifications. Minutes of staff meetings on 17 July 2017 showed staff were made aware that people with swallowing difficulties/choking risks must be referred to SALT team for assessment. Also, that staff could not make decisions on modifying people's diet because of the safety risks. We spoke with a SALT who confirmed they had received a number of referrals, and were working with staff at the home to address these concerns and clarify people's individual needs.

Staff protected people from avoidable skin damage. For example, people who needed them had pressure relieving mattresses and cushions to reduce the likelihood of skin damage. Where people were at high risk of pressure damage, care plans were comprehensive about how staff should manage those risks. For example, through regular repositioning, personal care and application of skin creams. However, people's care plan lacked information about pressure relieving mattress settings and when we checked one person's mattress setting, it was not set correctly for their weight, which could increase their risk of skin breakdown. We brought this to the attention of a senior member of staff, and asked them to contact the community nurses to check and review people's pressure mattresses were correctly set. When we returned on the second day, the manager informed us the person's mattress setting had been changed and all other mattresses checked. They had also implemented a weekly check, so staff could monitor people's mattresses were maintained on the correct settings.

A fire risk assessment completed in 2016 and identified fire safety improvements needed in the home. A number of fire doors had been replaced and repairs had been done to other doors. However, the service improvement plan showed less urgent recommended improvements such as installing additional smoke detectors and improving outside paths for wheelchair access had not yet been completed. We spoke with a director by telephone who confirmed the contractors were due to attend the following week to complete

the remaining work required. Since then the manager has contacted us to confirm this work is underway.

Staff received regular fire update training and fire drills were carried out, so staff were familiar with actions to take to protect people in the event of a fire. Regular checks of the fire alarm, emergency lighting and fire doors were carried out. However, we found ladders propped against a wall in a staircase area and at the top of stairs of a fire escape, which could increase the risk of injury to people and staff and impede their escape in the event of a fire. We brought this to the attention of the manager who arranged for them to be removed and stored elsewhere.

These risks were a breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 safe care and treatment.

Each person had a personal emergency evacuation plan which showed the support they needed to safely evacuate the building in the event of a fire. Environmental risk assessments were completed which showed measures taken to reduce risks. For example, the passenger lift had recent had new flooring. Equipment such as hoists and electric beds were serviced regularly and safety checks of hot water temperatures and window restrictors were carried out.

Risk assessments identified people's individual risks and care plans showed how these were managed. For example, in relation to falls, skin damage and risks of malnutrition/dehydration. These were reviewed regularly with evidence of action taken. For example, in relation to increases in falls, several people had pressure mats in their rooms to alert staff when they may need assistance. Where a person was at high risk of falling from their bed, they were provided with a 'hi-lo' bed. This lowered almost to floor level at night, with a large padded mat beside the bed to prevent injury. Others at risk of falling out of bed, had bedrails where it was assessed as safe to do so. At a staff meeting on 17 July 2017 minutes showed staff discussed people at high risk of falling to raise staff awareness, so staff could take proactive action.

On 29 July 2017, anonymous concerns were raised with the Care Quality Commission (CQC) that staffing levels during the day and at night were too low to support the needs of the people living at Camplehaye. We contacted the service for further information and any steps being taken to address this. The manager responded and confirmed staff had raised concerns with them about low staffing levels when they first started working at the home in May 2017. They outlined the actions they took in response. This included using a dependency assessment tool to calculate people's staff support needs, which took account of people's mobility, continence needs, and the help they needed with personal care, eating and drinking. From this they identified more staff were needed early in morning when people were starting to wake up. They increased staffing levels from seven to eight staff care staff between 7.30 and 13.30, so people had more support and supervision.

When we first arrived, we checked most people's bedrooms and all communal areas of the home. We found people were safe and looked well cared for. People had call bells nearby, so they could request help from staff, who they said usually responded within a few minutes. Where people were unable to use a call bell, staff checked on them every 30-60 mins, according to their level of need. Regular checks have been proven effective to reduce people's risks of falls, by anticipating people's needs, such as by offering assistance to use the toilet. Where people were confined to bed, staff ensured they were appropriately cared for and repositioned regularly to prevent their risk of developing pressure ulcers, also known as bedsores.

People showed through their body language they were happy and relaxed around staff and said they felt safe living at Camplehaye. Staff were busy around the home helping people to get washed and dressed for the day ahead. They assisted people who needed help to eat and drink. Relatives and visitors were positive

about safety at home, although one relative expressed concern about staffing levels, particularly about a lack of staff in the lounge in the mornings. They felt this put people at increased risk as some people's behaviour impacted on others and caused friction between them. Community nursing staff visited the service several times each week, they said staff worked well with them, and they had no concerns about people's safety and welfare. They said staff reported any concerns and followed their advice about people's care and any equipment needs.

When we visited, the manager had further increased staffing levels the previous week, by having an additional member of staff on duty in the afternoon and at night. This was because the number of people living at the home had increased. Also, because the analysis of incidents reported showed an increase in falls and challenging behaviours between people. From this data the manager identified that people needed an increased level of staff supervision in communal areas of the home. This showed accident and incident data was used to monitor people's safe care and staffing levels increased in response to people's changing needs. Care staff were supported by housekeeping, kitchen and laundry staff and a full time activity co-ordinator.

The numbers of staff were on duty were in accordance with the staff rota, although the manager said they had not been able to book an extra member of agency staff on two nights shifts that week. The manager also said, on occasions, over the past two months there had been shortfalls in the recommended staffing levels, mostly due to staff sickness. To manage this, existing staff worked extra hours and management staff also provided people's care. On ten occasions in September 2017, agency staff were used to ensure people were cared for safely, when permanent staff were unable to provide cover.

The manager had also just introduced changes in the way they deployed staff to work around the home to improve safety and efficiency. Staff were working together in teams in designated areas of the home. A meeting with senior staff had been held the previous evening to explain the reason for these changes. The activity co-ordinator had been asked to remain in the lounge area during the morning, with named staff staying there during the afternoon and evening. This increased the support and supervision of people in communal areas.

Staff were positive about the recent increases in staffing, which they said improved the support and supervision for people. One said, "It makes such a difference, it really does. It's nice for the residents and means there is a staff member around to diffuse situations." One member of staff expressed concern that the additional staffing numbers needed might not be filled by current staff group, as a number of staff had recently left. They said evening shifts were particularly difficult if they were not fully staffed, as 14 people needed two staff to help them with moving and personal care. The manager confirmed three extra staff were being recruited to meet the increased staffing levels needed. This showed positive action was being taken in response to changing levels of risk to improve safety.

People's walking aids were placed nearby so they could access them. All staff had received moving and handling training; and a new staff member confirmed they had not used equipment until they had completed the training. Staff practice seen was in accordance with moving and handling regulations with one exception, which we made the manager aware of. Staff confirmed there was plenty of moving and handling equipment in the home, such as hoists, hoist slings and slide sheets which are used for safe repositioning. Staff took time to assist people to move and did not rush them.

On the first day we visited staff raised concerns with us about the hand held electronic tablets they used to record day to day information about people's care. Three of the seven tablets weren't working that day, and those that were kept losing signal, which made it difficult for staff to keep their documentation up to date.

The tablets were sent for repair and the manager said more tablets were due to arrive from another service. The company were contacted to find further solutions. On the second day, more tablets had arrived and the signal had improved. If the problem persists, the manager planned to reintroduce some paper records as a backup.

People received their medicines safely by staff who were trained and assessed to make sure they had the required skills and knowledge. Staff explained to people what their medication was for and stayed with them to ensure they took it. Medicines administered were well documented in people's Medicine Administration Records (MAR), as were any allergies or sensitivities. Senior staff checked prescription charts daily so any issues could be followed up and addressed. A health professional praised recent improvements in medicines at the home in improving people's safety. For example, the manager prompted local GPs to review and reduce the number of medicines prescribed for some people. Improvements had been made to obtain newly prescribed medicines such as antibiotics more quickly, so people started treatment early.

Room temperature monitoring had highlighted one of two medicine storage rooms was sometimes hotter than recommended for storing medicines. To address this manager had obtained quotes to install an air conditioner. Once installed, this will ensure all medicines are maintained at manufacturers recommended temperatures.

There was a robust recruitment and selection processes for employing new staff. Appropriate pre-employment checks were done, which included obtaining references from previous employers, health screening, and completing Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The home was clean and odour free in all bedroom, bathroom and communal areas. Housekeeping staff followed a daily cleaning schedule, and there were plentiful supplies of gloves and aprons were available for staff providing personal care. The most recent environmental health visit to the kitchen had awarded the service the top rating of five out of five for food hygiene.

Good

Is the service effective?

Our findings

People, relatives and professionals reported positively on the knowledge and skills of staff. One person said, "I'm very well looked after here." Visitors agreed and health professionals praised staff and the knowledge and skills of the manager.

People received effective care, from staff who received regular training, support, and professional development to ensure they had the knowledge and skills to meet their needs. Most staff had completed health and social care diplomas at level two or above. Staff undertook regular update training such as fire safety, moving and handling, safeguarding adults, understanding the Mental Capacity Act 2005 (MCA) and infection control. They also completed training relevant to people's individual needs, for example, dementia awareness and challenging behaviour, which included dealing with confrontational situations.

To offer a more flexible range of training options in addition to face to face training, the manager had recently arranged a new external training provider. This included e-learning and self-assessment booklets which checked staff members understanding and learning. This meant it was easier for staff to undertake training at times suitable for them. Currently, the manager was ensuring all staff undertook and prioritised the falls training and had completed the related self-assessment booklets. A training matrix showed staff attendance at training was monitored and action taken to prompt individual staff members who were overdue for training. Staff received support through regular supervision, individual meetings and practice observation. These provided an opportunity for staff to discuss their practice and receive constructive feedback.

When staff first came to work at the home, they undertook a period of induction, and worked alongside more experienced staff to get to know people. Several staff had recently started working at the home and were still learning and said they felt well supported. New staff were undertaking the Care Certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life.

Each person had a comprehensive assessment of their individual needs and care plans gave staff guidance about how to meet those needs. For example, for a person at increased risk of skin breakdown. Community health care professionals particularly praised staff about people's skin care. They said they had worked closely with the manager and staff at the home to improve staff knowledge and skills in pressure area care.

People had access to healthcare services through regular GP and community nurse visits. Health professionals confirmed staff contacted them appropriately and followed their advice. Regular dental appointments, eye tests and visits from a chiropodist were arranged for people living at the home. One visitor commented that their relative's teeth did not always look clean but appreciated they could be reluctant to have assistance. We followed this up with the manager who confirmed oral hygiene care plans were used to identify people's individual needs. Visitors said staff involved and kept them informed about any changes in their relative's health. They could contact the home and speak to a staff member who knew their relative who could respond to their queries.

Most staff checked with people before they assisted them. For example, whether they needed help with their food, if they could provide them with protective clothing to eat their meal or needed their food cut up to help them eat independently. Staff also gained people's consent before they assisted them with personal care.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and DoLS and found they were.

People's rights and choices were promoted and respected. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Where a person lacked capacity; staff involved the person, family members and other professionals in 'best interest' decision making. For example, in relation to use of a lap strap for their safety when they were using their wheelchair.

People's legal rights were protected because staff understood the MCA and what constitutes restrictive practices. For example, the use of key pads on exit doors to prevent some people leaving unaccompanied for their safety. The manager had made DoLS applications to the local authority DoLS assessment team for 21 people living at the home. This was because they identified those people may be deprived of their liberty due to restrictions on their freedom, and needed staff supervision for their safety and wellbeing.

Following concerns raised with us about this practice in another home within the group, we looked at whether gates were used to restrict people's movements, and found they were not. Several people had gates at the entrance of their rooms. People living at the home, staff and visitors explained the purpose of these gates was to stop uninvited people entering people's rooms, rather than preventing people leaving their rooms. For example, one person showed us how they could independently open the gate. They said it made them feel safe as it prevented uninvited people walking into their room, particularly at night. All of the seven people with gates fitted to their bedroom doors had capacity to make that decision, and they did not restrict their movements. Visitors confirmed they had been involved in the discussion with their relative about a gate being fitted, and they were happy with this, as previously the person had been frightened by another person entering their room unexpectedly.

People and visitors were happy with the standard of food. One person said, "The food is wonderful, there is lots of choice," a sentiment other people and relatives agreed with. A menu on display in the dining room included photos of the meals to help people make informed choices. Staff knew people's individual food preferences. When several people were reluctant to eat the main meal choices on offer, staff provided an alternative option. The cook recognised the importance of mealtimes and encouraged people to eat by offering them a variety of choices. For example, for pudding, people were offered yoghurt, fresh fruit salad, trifles, profiteroles and other choices. Alternatives were offered for people with dietary restrictions, such as homemade ginger cake suitable for people with diabetes.

Staff supported people to eat their meals, if needed, or sat with them to encourage them to eat independently. They shared information with each other about people's nutritional intake. For example, staff reported two people who needed encouragement to eat had eaten well at breakfast time. Where there were concerns about people's nutrition, people's care plans included information about steps being taken

to improve their food intake, which staff were aware of. For example, offering one person additional sweet snacks they liked and adding butter and cream to some people's foods to increase their calorie intake. Prescribed food supplements were used for some people. People's weight was closely monitored and action taken in response to any concerns. Recent staff meeting minutes showed the manager discussed the introduction of arm measurement, as an alternative way to monitor the weight of people unable to use weighing scales, which is good practice.

Good

Is the service caring?

Our findings

Staff demonstrated an understanding of people's individual needs, and had a caring approach towards them. One person appreciated being able to bring their beloved cats to live with them when they moved to the home, and staff assistance to help care for them. People said they were happy with their care and chatted and laughed with staff. Their comments included; "Staff are marvellous to me;" "I'm very happy here and everyone is very kind;" and "Staff are fantastic." Relatives could visit any time and were always welcomed with a drink, they described the service as being "very homely."

Most staff knew people well and how they liked to be supported. For example, one person described how staff ensured their pillows were positioned correctly to make sure they were comfortable in bed. Relatives of another person described their care as "superb," another relative said staff were "exceedingly caring". Visitors praised how staff had helped their relative celebrate their birthday by preparing a cake and making an event of the occasion. Relatives and visitors said they were always welcomed by staff whether or not they were expecting them.

People confirmed they were consulted and involved in decisions made about their care, as did relatives where this was appropriate. Care records included personalised details about people's likes, dislikes and personal preferences and how they wanted to be supported. They also included details about the person's life before they came to live at the home and about people that were important to them.

Some people living at the home were unable to comment directly on their care. We saw they looked relaxed with staff. Most staff supported people in a skilled, caring and compassionate way with a few exceptions. One staff member did not make eye contact with a person and stood over them whilst they sipped their drink, using a straw. When the person looked up at them to seek reassurance, the staff member was looking away from them. This meant they did not recognise their need for comfort. We fed this back to the manager to address. On another occasion, a staff member sat behind a person while they supported them to eat a meal in bed, which meant the person could not see them. This meant they were unable to establish a connection with them. When this happened, another staff member was with us and recognised their practice needed to improve. They said they would speak with the staff member to remind them of best practice.

Staff demonstrated through their body language they cared and wanted the people to feel safe and understood. They were attentive and recognised when people needed additional reassurance. For example, staff recognised a person was unwell and were particularly attentive, they brought them a blanket to keep them warm and encouraged them to eat. When a person was tearful, staff took time to speak with them throughout the day. They put their arm around the person and gave them good eye contact, and listened to their worries.

At lunchtime, the atmosphere in the dining room was friendly and relaxed. A staff member used a trolley to present food choices to each person so they could see the range on offer. People asked questions and the staff member took time to chat about the ingredients and what they might like. These conversations

showed they recognised people's individual preferences, and the type of cutlery or crockery most suitable for the person. Staff were sitting chatting with people at one table. On another table, people sat and chatted with one another. Where people needed more support, staff ensured the actions of other people did not negatively impact on other people's mealtime experience. For example, by gently reassuring people and sensitively explaining to a person they did not need to help others to eat. When some people were worried they had no money to pay for the meal, staff assured them that the bill had already been paid. People became more relaxed after being told this and joked with each other.

Some aspects of the mealtime experience at the home did not promote people's independence and dignity. We noticed everyone in the dining room was given a plastic beaker despite their range of abilities. One person said they did not mind having a plastic cup as long as it was full. Another person expressed frustration there was no jug on the dining room table so they could not pour their own drink, and called for a drink several times. Other people who were more independent had to ask for condiments as they were not readily available on the table. When we asked the manager why the dining room was locked sometimes, they explained it was done when the tables were set for a meal to dissuade a person from removing the crockery and cutlery.

The manager was aware of how some people's behaviour needs around mealtimes had an adverse impact on others. For example, they explained there were ongoing discussions with staff and the provider to consider whether the service might change their approach. For example, grouping people with similar needs in distinct areas of the home, so they could be cared for together in a way that better met their needs. This represents an evidence based approach, which has been used successfully in other similar services.

People chose what they wanted to wear including jewellery and how they liked their hair. A hairdresser visited each week, and several people enjoyed having their hair done. Others enjoyed having their nails manicured and wearing nail varnish. Staff treated people with dignity and respect. They asked people about whether they were happy to receive personal care from male and female staff and their preference was recorded. One person said because of the caring approach by staff, they were not embarrassed to be assisted with personal care. They described how staff maintained their dignity by supporting them with their incontinence in a timely way. Personalised care plans showed what aspects of personal care people could manage independently and which they needed staff support with. For example, that a person could walk with their walking frame and access the toilet independently, but need a member of staff to support them with bathing.

People expressed pride in their rooms, which were personalised with photographs, ornaments and furniture that made them feel more homely. A relative praised how staff kept the person's clothes "neat and tidy," which they said showed respect towards their relative's belongings. Staff who helped keep the home clean also spoke about how they gained people's trust so they could access their rooms. For example, negotiating an acceptable time with the person to clean their room. Two people's relatives said they always wore their own clothes. They praised how a system of iron on labels introduced had prevented people's clothes going missing, which had been a problem in the past.

Good

Is the service responsive?

Our findings

At the last inspection we identified some care plans needed updating. We also recommended some activities were more tailored to people as individuals, taking into account their past history and interests. Improvements have been made in both these areas.

People received personalised care that was responsive to their needs. Most staff knew people well, recognised any changes in their health or care needs and took appropriate action in response. For example, where a person was unwell, staff recognised they might be showing signs of a urine infection and arranged for their GP to visit. Another person was trying to lose weight and their care plan review showed how staff were encouraging them with this. Advice had been sought from physiotherapy staff to help address two people's deteriorating mobility and both were given new walking aids.

Before each person came to live at the home, an assessment of their needs was undertaken to make sure staff could meet them. Care records included detailed care plans about people's needs, for example, physical and mental health needs, mobility, nutrition and hydration and their emotional and psychological well-being. They also included details of people's lives, including hobbies and interests they enjoyed before they came to live at the home. People were involved in their care planning where possible, family members and people's representatives were consulted and involved where people lacked capacity.

Since the last inspection, the service had implemented electronic care records. Staff were still getting used to these changes and were working with the company to address signal difficulties which impacted on reliability of the electronic care records. They used hand held electronic tablets to keep people's care records up to date throughout the day. For example, to monitor and keep people's food and drink records updated throughout the day. Where a person had not drunk enough in the previous 24 hrs, staff were prompted to try and enourage the person to drink more the next day to prevent dehydration.

Significant improvements had been made in the variety of group and personalised activities for people living at the home. Care records had more details about people's needs relating to activities, for example, that one person needed to be prompted to participate in activities and particularly liked trips out.

The service had a full time activities co-ordinator who worked Monday to Friday. An activity programme for the forthcoming week included ten pin bowling, a light exercise class, Scottish music, a magazine reading session and flower arranging. The co-ordinator said the increased staffing levels and having a member of staff in the lounge at all times had benefitted people, who were enjoying spending more time interacting with staff. On the second day we visited, a member of staff led a karaoke sing along in the lounge, which several people joined in and enjoyed.

Where people preferred to stay in their room or were unable to leave their room for health reasons, the co-ordinator spent time with them. One person enjoyed throwing and catching a ball, another enjoyed having a book read to them, others liked to chat, listen to music, have a hand massage or a manicure. The co-ordinator described how they had experimented with a range of activities to find out what individuals most

enjoyed. Some people enjoyed participating in word games and bingo whilst others enjoyed a floor game activity using beanbags to try and hit a target. Others enjoyed music quizzes covering the period of the 1930's to 1960's. The co-ordinator described how this encouraged people to tell their stories about that period in their life.

A minibus was used for group outings and the co-ordinator said several people had recently enjoyed a trip to an aquarium and a picnic. One person told us how much they had enjoyed a recent garden fete held at the home, which included a dog show. They were pleased to have been asked to act as judge and recalled with amusement the various categories, such as, 'the dog with the most waggly tail.'

Since our last inspection, a separate Monday to Friday day service had moved from another building in the grounds to a large conservatory area of the home. A visitor was concerned that using the conservatory for day care had reduced the amount of communal space available for people living at the home. They felt this meant more people congregated in the main lounge and did not have an alternative room to go to, if there was tension between people. We asked staff about this, who were all positive about the change. This was because several people liked to attend day care and join in. Some people used the conservatory area after day care finished. People also had access to a large dining room and another smaller seating area, that looked out onto the patio.

People and visitors identified senior staff they could go to with a concern or complaint and said they were confident action would be taken. At residents' meetings and individual care plan reviews, people were asked if they had any concerns so these could be addressed. One visitor said they had contacted the new manager to ask for a meeting but had not yet heard back from them to arrange the meeting.

The service had a written complaints policy and procedure and information was given to people about how to raise a complaint. It included the details of other organisations people could contact if they were dissatisfied with how their complaint was dealt with by the home. In the past 12 months, the complaints log showed one complaint had been received. This was not directly related to any care concerns and was responded to sensitively by the manager. A letter offered apologies for any unintended upset and outlined actions about how a similar situation might be handled in future. This showed complaints were used as an opportunity to reflect and improve practice. The service had received 12 compliments in same period.

Requires Improvement

Is the service well-led?

Our findings

People and relatives said the staff team were friendly and helpful. Two relatives described people's care as "superb". Visiting professionals comments included; "All staff are lovely and friendly, it's like a family." One professional said they had "a huge amount of respect" for staff who worked at the home, who did their best for people who lived there.

The service did not currently have a registered manager. The previous registered manager left in April 2017, and had deregistered. A new manager was appointed in May 2017, who had planned to register with the Care Quality Commission. However this had not occurred because of organisational changes. A new manager had been recruited who was undergoing a period of induction. This meant the service had, so far, been without a registered manager for a period of six months.

People, staff and visitors were positive about changes and improvements the manager had introduced over the last few months. A further increase in staffing levels and a change in how staff worked around the home were made the week before the inspection. Already staff were positive about those changes, for example one staff member commented that it was "such an improvement". However, it was too early to judge whether these changes would result in sustained improvements in people's quality of care as they had not been embedded.

However, people, staff and visitors expressed concern about having another change of manager within such a short period of time. A relative said, "another change of leadership is unsettling," a sentiment others agreed with. Some people and visitors were unaware of the management changes, and did not know the current managers name. Relatives had not been sent any communication about the management changes, although a letter has since been sent informing them.

The manager was in day-to-day charge, and was supported by a care manager, deputy manager and team leaders. Senior care staff were on duty during day and night shifts to lead and monitor the staff team working in different areas of the home. This was to ensure people's care needs were met and all required tasks were completed. Daily staff handover meetings and a handover sheets were used to communicate how each person was, what care they received, and any specific information that needed to be communicated within the staff team. For example, people who needed close supervision, regular repositioning and skin care or any concerns about changes in people's health.

Staff expressed confidence in the manager, who they said was approachable, they felt their concerns were listened and responded to. Community professionals said the current manager was "excellent," liked their approach and were pleased with how well they were working with them. They praised their skill in leading the staff team who they said seemed more settled and had more support.

The manager said they were trying to promote a happy and relaxed atmosphere at the home. They were visible around the service, as were other senior staff. They interacted positively with people and provided a role model for other staff about attitudes and standards of care expected. When we asked visitors whether

they could identify further areas for improvement, suggestions included staff spending more time in the lounge with people and staff making sure they always wear their name badges. Staff photos were also displayed near the front door, which visitors also used to identify staff working at the home.

Several staff praised team work at the home, one staff said, "I'm much happier with how things are progressing." However, two staff members said the quality of team work could be variable; that staff on some shifts worked well together but less so on others, depending on which staff members were on duty. For example, that some staff did not always listen to advice or instructions, which meant they had to spend more time checking whether their work was completed. Another staff commented they felt there was pressure from a more senior member of staff to provide more "task focused" care at times. For example, by encouraging staff to get a person to go to bed earlier than they might otherwise have chosen, as they were more of a challenge to persuade to go to bed if they stayed up later.

We met with one of the directors who visited the home twice a month and had a monthly management meeting with the manager. They were pleased with the changes and improvements the manager had introduced so far. The other director visited approximately twice a week, and took a lead on managing any health and safety and environment issues. The director explained the new quality monitoring role was developed to free up the manager to spend more time working with staff.

The service used a range of quality monitoring systems such as audits of care records, health and safety and medicines management and made improvements in response to their findings. A service improvement plan showed the manager was aware of risks and showed actions being taken in response to the findings of health and safety, environmental and care record audits and through regular reviews of accidents/incidents and concerns reported. For example, completing remaining fire safety work and updating medicine policies to reflect recent changes and to improve incident reporting. However, some safety aspects had not been identified through the quality monitoring systems in place, for example, ladders unsafely stored in fire exits, a missed notification, and a lack of detail for staff in one persons' care plan about how to manage their challenging behaviour.

The provider undertook a monthly quality monitoring visit at the home which included looking at care records, the environment, accidents, incidents and complaints. Records of the last quality monitoring meeting carried out in July 2017 showed previous actions identified were followed up to monitor progress. For example, to check repairs and maintenance needed had been completed.

Regular team leader and staff meetings provided staff with an opportunity to be involved in day to day decisions about the running of the home. For example, monthly minutes of meetings seen between June and August 2017, included discussions about how staff were deployed around the home and discussions about suggested changes to improve efficiency. Also, about ways staff could improve supervision and support of people in the lounge and new training on falls management. Housekeeping staff said they had dedicated meetings and attended team meetings with other staff. This meant they felt part of the wider team and understood their role in people's well-being.

Where any concerns were raised about individual practice of a member of staff; management records showed they had been addressed positively through supervision and training. The manager confirmed there were no formal staff disciplinary or capability issues. They were taking positive action to tackle frequent staff sickness with some staff to improve their attendance.

People were consulted and involved in decisions made about the home. Monthly residents meetings were held, and minutes showed people were involved in deciding what they wanted to spend their time doing. A

residents meeting was held on the first day we visited and people discussed food choices for supper and their preferences for forthcoming activities and trips.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at increased risk because some risks had not been identified. This included fire safety risks, incorrectly set pressure relieving equipment and a lack of detail for staff in a persons' care plan about managing their challenging behaviours.