Rushcliffe Care Limited

Normanton Village View Nursing 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive, unannounced inspection on 22 March 2018. The previous comprehensive was undertaken in September 2017. At this inspection the provider had breached six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches related to staffing, safe care, consent, dignity and respect, person centred care and good governance. The service was rated as 'Inadequate'. At the present inspection we found the provider had made some improvements against breaches. However, we found further improvements were required to ensure the provider was able to consistently deliver good care for people. You can read the report from our last comprehensive inspection and our focused inspection, by selecting the 'all reports' link for Normanton Village View Nursing Home on our website at www.cqc.org.uk.

Following the last inspection in September 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Caring, Responsive and Well-led to at least good.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this time frame. At this inspection the service demonstrated to us that some improvements had been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Normanton Village View Nursing home is a 'care home' with nursing and is registered to provide accommodation to people who require personal or nursing care for up to 72 people. 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.

The service is provided across two floors which are split into four separate units. At the time of our inspection there were 38 people living in the service, many of whom were living with dementia.

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.

Risks to people had been assessed and staff demonstrated they understood how to support people safely. However, we found inconsistencies in people's care records. Some records lacked clarity in providing guidance for staff on the measures they needed to take to keep people safe. People's care records did not always reflect people received care to meet their assessed needs and keep them safe. Records lacked the detail and guidance staff needed to intervene when people became distressed or anxious in order to keep them safe.

People did not always receive medicines administered covertly (disguised in food and drink) as prescribed. Other aspects of medicines were, in the main, managed safely.

The provider had made improvements to systems and processes to monitor the quality of the care provided. However, these systems were not always effective in bringing about improvements that were embedded into staff working practices to ensure people received consistently good care.

People did not always receive the support they needed to eat their meals. Further improvements were needed to ensure people experienced a positive dining experience.

Staff did not always demonstrate the awareness they needed to ensure people's right to be treated in a dignified manner was protected.

Staff had completed training to enable them to recognise the signs and symptoms of abuse and felt confident in how to report concerns.

People were protected from the risk of unsuitable staff because the provider followed safe recruitment procedures. There were enough staff available to meet people's needs as assessed in their care plans.

Systems were in place to support staff to follow safe infection control procedures and staff were observed adhering to these in practice.

There were arrangements in place for staff to make sure that action was taken and lessons learned when accidents or incidents occurred, to improve safety across the service.

Staff completed an induction process when they first stated working in the service. They received on-going development training and supervision for their role. The registered manager reviewed and evaluated training to ensure it was effective.

People were supported to access a range of health professionals to maintain their health and well-being. The service worked collaboratively with other agencies to ensure people had the care and treatment they needed in line with best practice guidance.

The provider was in the process of upgrading the décor of the premises. This included appropriate directional signage to enable people to move around the premises safely and independently.

People's needs were assessed before they began to use the service. People were supported to make decisions and choices about their care. Staff understood the principles of the Mental Capacity Act 2005 and sought consent before providing care and respected people's right to decline care and support.

Staff had developed caring relationships with staff and people and relatives were positive about the staff who provided care and support. Staff understood the importance of maintaining people's independence where possible.

Staff supported people to express their views and be involved in decisions about their care as far as possible. This included consulting relatives and providing access to independent advocates if necessary.

People and their relatives were involved in planning their care and were able to make changes to how their care was provided. The registered manager was in the process of reviewing and updating all care records to

ensure they reflected people's current needs.

People had access to a varied activities programme, either individually or as small groups. People maintained contact with those important to them and were therefore not isolated from those people closest to them.

People's concerns and complaints were listened to and responded to. The registered manager had an open approach to listening and responding to people's concerns and taking action to bring about improvements.

People, those important to them and staff were able to share their views about the service and the quality of care they received. These were used to critically review the service and drive improvements to develop the service.

People, relatives and staff spoke positively about the registered manager. The registered manager was promoting a positive culture in the service that was focussed upon achieving good outcomes for people. They had identified where improvements were required and had taken steps to make changes and develop the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessment records did not always reflect the care people needed or provide sufficient guidance for staff to keep people safe. Staff did not respond to challenging situation consistently and records did not always provide the information staff needed to support people safely.

Medicines were in the main managed safely but the administration of some medicines required further improvement.

Staff had an understanding of what abuse was and their responsibilities to act on concerns. The provider followed safe recruitment procedures and ensured there were sufficient numbers of staff to meet people's needs.

There were systems and procedures to prevent the risk of infection and these were followed by staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Further improvements were needed to ensure people received the support they needed to eat their meals and experienced a positive dining experience.

Staff received training and support to develop in their roles. Staff worked in partnership with a range of healthcare professionals to ensure people were supported to maintain their health and well-being.

People's consent to care and treatment was sought in line with legislation and guidance, although further improvements were needed to records to demonstrate this.

Is the service caring?

Requires Improvement

The service was mostly caring.

Staff had developed positive, caring relationships with people. However, people's dignity needs were not always protected. People and relatives were involved in their care and supported to make decisions and choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were inconsistencies in some people's care records and care plans did not always included the information staff needed to provide personalised care, although improvements had been made to records overall.

People and their relatives were supported to make decisions and choices about how their care was provided.

People had access to an activity programme. The provider had a system in place to receive and monitor any complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had improved systems and processes for identifying and assessing risks to the health, safety and welfare of people. Some areas required further improvements.

The registered manager encouraged an open line of communication with their staff team. Staff enjoyed working at the service and spoke highly of the registered manager and senior staff.

People and their relatives were encouraged to provide feedback on their experience of the service.

Normanton Village View Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 22 March 2018 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor and an expert-by-experience. A specialist advisor is someone who has professional expertise in care or nursing. 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 looked at information we held about the service. This included notifications about changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with commissioners, responsible for funding and monitoring the care for some of the people using the service, to gain their views about the care provided. Our review of this information enabled us to ensure we were aware of, and could address, any potential areas of concern.

During our inspection we spoke with five people who used the service and two relatives. We also spoke with the registered manager, a senior manager, a nurse, five care staff, a staff member responsible for activities and an office administrator. We observed care and support provided in communal areas and the lunchtime and evening meals. This helped us to evaluate the quality of interactions and support that took place between people and staff who supported them.

We reviewed information including care plans and records for eight people. We sampled medicine records and reviewed four staff recruitment files. We also reviewed records relating the day-to-day management of the service, including records of meetings, complaints and staff rotas, and the provider's internal audits and

quality management systems.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2017, we rated the service as inadequate in the safe domain. This was because staff did not follow safe medicines management and infection control practices, sufficient numbers of staff were not always on duty to meet people's needs, risks were not always managed so people were protected from avoidable harm. These were breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breaches. At this inspection we found that improvements had been made but further improvements were needed to rectify all the breaches and to ensure people received safe care.

Care plans included risk assessments for areas such as falls, mobility, skin integrity and risks associated with people's health conditions. In most cases these were detailed and included guidance for staff on how to reduce the risks of harm to people. When staff needed to use equipment to move people, the type of hoist and sling required was listed. Where people were at risk of developing pressure sores, specialist equipment was identified, such as air mattress and pressure relieving cushions. Since our last inspection, the provider had purchased new pressure relief cushions for people. We looked at four people's pressure relief mattresses to ensure they were set at the correct setting detailed in their care plans. We found three mattresses were set at the correct level but one mattress was not at the correct setting for the person's current weight and needs. We raised this with the registered manager who told us they would review all pressure mattress settings to ensure they were set correctly.

When people needed assistance to change their positions to reduce the risk of pressures areas developing, the required frequency was not consistently recorded. We sampled three people's positioning change charts for March 2018, to review if people were receiving support to change their positions regularly in line with guidance in their care plan. We found gaps in records which indicated that people were not receiving support to change position as frequently as they required. For example, one person's care plan identified they required support to change their position every three hours to reduce the risk of pressure areas developing. Records showed for the 21st March 2018, they were supported to change position at 18.35, 03.28 and 10.30. Records did not provide an explanation as to why there were gaps in the level of support provided.

In some cases, risks assessments did not reflect the care people needed to keep them safe. For instance, one person was identified as requiring staff support to move to reduce the risk of falling. Reviews of their risk assessments contained contradictory information in the level of staff support required. Some records referred to one staff member and others as two staff members were required. We discussed these concerns with the registered manager who told us staff were working through care plans and records to ensure they were up to date and reflected people's needs. However, this work was in progress and some people's records had yet to be updated. The registered manager had identified target dates to complete this work through their action plan. We reviewed records which had been updated and saw these were detailed and reflected people's current needs.

We looked at how risks associated with behaviour that challenges the service were managed. Records

showed risks had been assessed but care plans did not always included clear instructions on how staff should manage challenging situations. For instance, one person was identified as using 'verbal or physical actions' towards others to demonstrate they were angry or unsettled. Guidance in records advised staff to, 'continue to distract or reassure.' However, records lacked information as to how staff should distract or provide reassurance in order to reduce the person's distress.

We observed staff did not always intervene in a timely manner in challenging situations. For example, one person was agitated by the presence of another person walking around nearby. The person became verbally aggressive, with comments such as, "Why don't you go away?" One staff member intervened and calmed the person; removed a plate that the person had in their hands and distracted the other person with a task. However, on another occasion, a staff member did not intervene when the person repeated their verbal aggression to the other person, with the result that the person threw a drink of juice over the other person, who quickly retreated from the area. The staff member told us this was not unusual behaviour for the person and continued to support a third person. They did not check if the person who had juice thrown at them had been adversely affected or required support. This demonstrated that staff did not consistently respond to challenging situations. The registered manager told us plans were in the process of being updated to include the detailed information staff needed to support people safely. They had prioritised more complex care plans as requiring immediate updates.

Medicines were in the main managed safely but there were areas which required further improvement. People who required their medicines to be administered covertly (hidden in food or drink) had a care plan and protocol in place. This detailed the reason for the covert medicines, how it was to be administered and appropriate authorisation, for example from a GP. However, we observed staff did not always follow these protocols. For example, one person required their medicines to be administered in cornflakes in the morning. However, records showed on one day the person had eaten porridge for breakfast and on another day they had only consumed half of their cornflakes. It was not possible to determine if the person had received all their medicines.

We observed nursing staff administered covert medicine to another person in their cup of tea. The staff member provided the person with a full cup of tea to drink. However, they did not consult with care staff as to what the person had already drank (they had just consumed a full cup of tea). The person was no longer thirsty and did not want the drink. The person's protocol stated medicines were to be administered in a small amount of juice. This meant people were not always receiving their covert medicines in line with the guidance in their protocol. We raised these concerns with the registered manager who told us they would undertake a full review of the administration of covert medicines with nursing staff to ensure protocols were followed correctly.

These were continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely. The temperature of the medicines fridge and medicines room was monitored. Records showed these were maintained within recommended temperatures. We looked at a sample of medicine stocks and records for five people and found records had been fully completed and reflected the quantity of medicines in stock. Where people were prescribed medicines to be taken as and when (PRN), for example pain relief, these were supported by protocols which guided staff on the purpose of the medicine and when the person may require it. Suitable processes were in place to ensure people's medicines were kept in sufficient quantities. Out of date or medicines no longer required were safely disposed of in line with the Misuse of Drugs Act 2001.

Care plans guided staff on the correct area of application for topical medicines such as creams and lotions. We saw these medicines were clearly marked with the date of opening to ensure they were not used after any recommended expiry date. Transdermal patches (medicines applied through patches directly onto the skin) were supported by body maps which guided staff on the position of current patches. This helped to reduce the risk of additional patches being applied or patches being applied to the same area of skin.

Staff who were responsible for administering medicines told us they had completed training in this which had recently been refreshed. This was supported by information from the provider's training centre in changes to best practice, in particular National Institute for Health and Care Excellence (NICE) guidance. This was confirmed in training records we reviewed.

Staff demonstrated they knew how to people safe when moving around the premises. We saw staff supported people to move around the service using equipment such as hoists and walking frames. Staff supported people safely, using best practice guidance. For example, one person required a hoist to move from a wheelchair to an armchair. Staff explained what they were going to do and checked the person was happy with this before they provided support. Staff worked together to ensure the correct fitting and position of slings and provided reassurance to the person throughout the transfer. The person responded positively to this support. Another person required staff support to walk around the premises. Staff ensured the person was safe by walking alongside them and providing a guiding arm which supported the person to maintain their balance.

Staffing levels were regular assessed by the registered manager by using the provider's staffing dependency tool. The service was currently supporting reduced numbers of people who used the service. The registered manager had adjusted staffing levels to reflect this whilst ensuring sufficient staffing was available to meet people's current needs. Where people required one-to-one support and supervision from staff, we saw there were enough staff to provide this throughout our inspection visit.

People, relatives and staff told us there were generally enough staff available to meet people's needs. One person told us,"Staff change but I think there is enough staff." A relative told us, "There is enough staff at the moment but they are down on numbers (of people). Mostly, it's the same staff." Staff told us that there were generally enough staff, although it was hard when staff rang in absent. Although people were safe, they felt they had less time to spend chatting with people and providing activities at these times. The registered manager told us they had recognised a high level of short-notice staff absence within the service and the impact this had on day-to-day activities. As a result, they told us they had introduced a new system for staff to report absence which had reduced the level of absence and improved staff consistency. We observed there were sufficient staff available during our inspection visit to meet people's needs. This included ensuring staff presence within communal areas which helped to keep people safe.

Staff had attended safeguarding training to protect people from harm and abuse. Staff we spoke with knew how to recognise signs of abuse and how to report concerns. Staff were also familiar with the term whistleblowing, which is a process for staff to raise concerns about potential malpractice at work. Staff told us they would feel confident to discuss any concerns that they may have about poor care with the registered manager and they would be listened to.

The registered manager had ensured displays of safeguarding information and advice was available in communal corridors. This supported people, their relatives and staff to understand what abuse was and how they could raise concerns. Information included contact details of external agencies who could provide advice and support for people. When safeguarding incidents had occurred, staff discussed with the appropriate local authorities and made relevant notifications. This helped external agencies decide on the

level of intervention required to keep people safe.

Recruitment checks had been consistently carried out in accordance with the provider's policy. Records showed a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with adults using care services.

People were cared for in a clean environment. People and relatives told us, "There are always plenty of cleaners and washing always comes back nice and clean. It's a very good standard. They [staff] put gloves and aprons on for personal care," "It is nice and clean," and "They [staff] wipe everything and come in [to my room] with the hoover." Staff knew how to protect people from the risk of infection. We saw staff had access to personal protective equipment (PEE) such as aprons and gloves. Rooms we saw were well maintained, hygienic and odour free. A domestic staff member was able to describe how they protected people from the risk of infection through following safe laundry procedures; colour coded cleaning equipment, spillage kits and specific cleaning products. The kitchen had a five star rating awarded by the Food Standards Agency.

Regular maintenance and equipment audits relating to fire safety records, maintenance of safety equipment, gas safety and portable appliance testing (PAT) were undertaken. Contingency plans were in place in case the service needed to be evacuated and each person had a Personal Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation. Where maintenance actions were required, they were recorded with timescales for actions to be completed.

There were arrangements in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the events leading up to the incident, steps taken to avoid the incident, behaviour, intervention and follow up action. For example, where a person had fallen out of bed, measures were introduced in a timely manner to reduce the risk of further incidents. This included guidance for staff to follow such as ensuring the bed was in the lowest position from the floor and the use of crash mats. We saw these were in place in the person's room and there had been no further incidents since these measures had been introduced.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2017, we rated the service as requires improvement in the effective domain. This was because people's rights were not always protected under the Mental Capacity Act 2005 and not all staff received appropriate induction, training and supervision. These were breaches of Regulation 11 and Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breaches. At this inspection we found that improvements had been made to rectify the breaches but further improvements were needed to ensure people received effective care.

People and relatives were generally positive about the meals and drinks provided. Comments included, "It's [food] excellent, nothing fancy. The food is really good. [Name of family member] is eating things they would never before. [Name] needs a soft meal and this provided," "The food is alright, I've got no complaints about it. I enjoy my breakfast and have the same every day, as I like it," "The food is good, very good," and "I have a choice of food." One person told us and we saw they had a supply of fresh fruit within reach and sweets which they enjoyed.

We observed the lunchtime and evening meals and the support people required to have sufficient to eat and drink. We saw meal-times were not always a positive dining experience for people. In one unit people received support and time to eat their meals. People were supported to choose where they sat according to their preferences. Staff engaged with people, providing conversation and encouragement throughout the meal. For example, where one person required support to eat, a staff member sat next to them and asked them what they would like to eat first. They then supported the person to eat at their own pace. A second person declined to sit down for their meal, preferring to walk around. We saw a staff member accompanied them and provided them with finger foods to enable them to have sufficient to eat. People were supported to have a choice of hot or cold drinks. Where people required nutritional supplements or fortified foods, staff provided this. The mood was calm and relaxed and people enjoyed their meals.

However, in a second unit, the dining experience was chaotic and people did not receive the support they needed to eat their meals. Three members of staff were available to support ten people in the dining room. The meal was served to people by staff in accordance with their choices and needs. Staff proceeded to sit with people who required support and encouragement to eat and drink. During the meal, we observed two people eating with their fingers and one person began to throw their meal at others in the room. Staff did not intervene or distract the person. Two staff were required to support a person to re-position which resulted in a delay in them eating their meal. A person who was waiting for them wouldn't eat their meal until the other person was ready. A staff member called across the room, "I'm waiting to feed [name]. [Name] won't eat until [name] has theirs, so if you can give me both of them, I'll feed them both." This did not demonstrate that people received personalised support to eat their meals.

During this meal-time, we saw another person struggling to eat their meal, pushing the plate away from them until they couldn't reach it. They then tried to drink from their cup using a fork. Staff did not assist, merely took the meal, which was out of reach, away from the table. A second person was calling for staff

assistance to help them to eat their meal but staff did not assist. The person did not eat their meal. Dessert was delayed by nearly an hour after the main meal with the result most people did not have a dessert. The registered manager told us there had been a problem with the dessert which had resulted in the unusual delay.

Staff from another dining room entered the room and approached the cook, asking for, "two soft, two puree and one normal" meals. The staff members did not state who these meals were for. However, the cook did question this and served the meals accordingly once they were happy with the information they had asked for.

We discussed the meal time concerns with the registered manager. They told us the standard of support we observed in the second unit was not usual and they would address this with staff to ensure people experienced a positive dining experience in all units.

The evening meal, by contrast, was calm and positive across all dining areas. People were able to choose the food they had ordered and alternatives were available. People were supported to choose their portion sizes and to eat their meals and have sufficient to drink. During the day, snacks and drinks were regularly provided, although people were not always supported to make choices. For example, one person was asked by a staff member if they would like [brand name] crisps or biscuits with their drink. The person was unable to choose so the staff member provided both. They did not take the food over to the person to support them to make a choice based on what they had seen. This demonstrated staff were not always familiar with the nutritional needs of people living with dementia.

Staff told us they were given training that gave them the knowledge and skills they needed in their role. One staff member told us, "We go to the training centre and have a trainer come to us which is really good. I've completed basic training, such as assisting and moving, health and safety, dietary needs and protection training. I am on my NVQ too." Staff who were new to the service told us they had a level of induction into the service. This included working alongside more experienced staff. A staff member told us, "I had never worked in care before. The training is really good. The initial training was over three days and included a 'taster' session where you could spend two hours talking with people to make a decision if it was the kind of job you wanted to do. The theory training included safeguarding and manual handling which also included a practical session." Another staff member told us, "To learn about people's needs, we shadow [experienced] staff who know them well. We can watch and ask questions. Then we start to do the work and other staff watch and step in if they need to."

We reviewed the provider's training records which showed staff were provided with a range of training to meet people's needs, including specialist training such as behaviours that challenge and dementia. Two members of staff who were new to the service demonstrated a good understanding of the needs of people living with dementia. Comments included, "How people are might depend on their level of capacity at the time. Consistency is the key, them getting to know you and you them. Dementia or no dementia, people are individuals," "People need routine, constant reassurance. They may be resistant to care, for example personal care, because they cannot understand why you are taking their clothes off. We need to make them feel safe and be aware of the different stages of dementia and how this affects people." The registered manager kept training under review to provide opportunities for staff to keep their knowledge and skills up to date.

Staff told us they received support and supervision which helped them develop in their roles. Supervision is a process where staff meet one to one with their line manager. Conducting regular supervisions ensured that staff competence levels were maintained to the expected standard and training needs are acted upon.

Staff told us, "I get regular supervision and my appraisal is due soon. If I am unsure about anything, I can openly go and ask for advice and support from managers," "There is regular supervision. I know I get watched when I am working to make sure I am doing everything right and this is okay. I get feedback so I know what I need to do different," and "The managers are really supportive with issues at work and at home."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records showed people's mental capacity to understand and consent to their care and treatment had been assessed. When people lacked mental capacity, best interests decisions had been made. However, it was not always clear how these best interest decisions had been reached because there was, in some care plans, limited information recorded. For example, one person had been assessed as lacking mental capacity to consent to medicines and to understand how to summon assistance. Staff had documented this in the person's consent plan but the actual decision making process was unclear. The registered manager told us they were in the process of updating care plans. Where people had capacity to do so, they had consented to their care.

Some people were subject to DoLS authorisations, for example, because they were unable to consent to treatment or choice of home or required constant supervision. Care plans included appropriate paperwork and details of any conditions to be complied with, for example one-to-one staffing. In our previous inspection, we found the provider had not kept all authorisations under review which meant that some authorisations had expired. At this inspection administration staff provided us with records which demonstrated applications had been made for all expired applications and systems had been implemented to ensure authorisations were kept under review and new applications made in a timely manner. This helped to ensure that any restrictions on a person's liberty were being lawfully applied.

People's care plans showed staff worked in partnership with other agencies to ensure people's health and wellbeing was maintained. Staff supported people to attend routine appointments, such as opticians and chiropody in addition to specialist appointments. These included memory clinics and mental health services. One person told us, "I've recently seen the doctor but it was more of a check-up than anything else." A relative told us, "[Name of family member] has recently been to an optician and has new glasses. There was a problem getting a chiropodist but there is a new one now. The doctor [GP] comes in every Wednesday and will come in if needed and there is dentist as well. They are all there as needed." Where people required support to manage their health needs, such as monitoring wounds or blood sugar levels, records showed they received the support they needed. People's care plans had been updated to reflect advice and guidance from health professionals, for instance where a tissue viability nurse had recommended a change in dressing due to wounds improving.

Wound care plans were very detailed. They contained photographs of people's wounds and the wound dressing plans were documented. This meant it was easy for staff to identify when wounds improved or deteriorated and take appropriate action.

Nursing staff were aware of National Institute for Clinical Excellence [NICE] guidelines in clinical care, such as medicines and health conditions. They told us they followed best practice through reading up to date research and this was something they intended to develop further with the registered manager. The provider and registered manager ensured systems were in place to check nurse's registration and identify when these were due for renewal. Registered nurses competency updates are managed by the lead clinical nurse through NMC and revalidation processes. This helped to ensure nurses had the up to date knowledge and competency required to support people with their health needs.

The provider had improved the décor in some areas of the premises which were clean, light and bright. People and relatives were positive about the changes. One relative told us, "They [provider] have done a lot of work [on premises] recently to get everything that needs to be done. It does need more work done." A second relative was able to describe the positive impact that the premises had on their family member. They told us they liked to walk around the premises and could do so safely. The registered manager told us further work was planned to ensure appropriate signage, guidance and stimulation for people within communal areas and corridors.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in September 2017, we rated the service as requires improvement in the caring domain. This was because staff did not always protect people's right to privacy and dignity. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breach. At this inspection we found that improvements had been made to rectify the breach but further improvements were needed to ensure people's right to dignity was respected.

Staff addressed people respectfully and used their preferred term of address. However, we observed that staff did not always take action to protect people's dignity. For example, one member of staff identified that a person, who was sat in a lounge, was not wearing their dentures. The staff member collected the dentures from the person's room. They then proceeded to attempt to fit the dentures into the person's mouth in full view of people, staff and visitors. The person showed signs of distress, pushing the staff member's hands away. It was only at this stage that another staff intervened and said the person had refused to wear them this morning. Staff did not demonstrate awareness that these actions had not protected the person's right to be treated in a dignified manner.

We saw one person had juice thrown over them by another person in an altercation. This was observed by a staff member. However, they made no attempt to check if the person required support to change their clothing after the incident or check they were okay.

People and their relatives told us staff usually treated them with dignity and respect. One person told us, "I've no complaint about this whatsoever, they just do it." A relative told us, "If they [staff] are going to help [name] get dressed, they always pull the curtains and shut the door." The relative explained staff had been 'kind and gentle' when supporting their family member with their personal care.

Relatives told us they were always made to feel welcome by staff when they visited and could visit at any time. One relative told us, "I feel quite comfortable staying with [family member]. They [staff] ask if I want anything." We observed visitors arriving throughout the day and without exception, they were greeted by staff in a friendly and warm manner.

We observed some caring relationships between people and staff. Where people became anxious or distressed, staff were quick to intervene and offer reassurance and support. For instance, one person became distressed after an altercation with another person. A staff member intervened, spoke calmly to the person at eye level and offered to take them to a quieter area to talk, which the person accepted. We later saw the person sleeping with her head on the staff member's shoulders, having received the reassurance they needed.

Staff were knowledgeable about people's needs and interests. We observed staff communicating effectively with people, using different ways of enhancing communication. For instance, by touch, ensuing they were at eye level with people who were seated and altering the tone of their voice appropriately. Where a person did

not respond positively to one staff member, they moved away and another staff member took over. Staff told us they found this approach of a 'different face' worked for many people who declined or rejected care or support initially.

Staff told us they usually had time to provide the care people needed and enjoyed their work. One staff member told us, "The best part of the job is helping the residents; giving them the support they need and seeing them happy. Not everyone needs everything doing. You look for the signs; maybe their body movements, or ask people how you can help them." Another staff member told us, "People need to be given choice around everything in the home. I support the same people everyday day and get to know what they like and how to help them make choices. For instance, one person likes to have a jug of juice always available. We ask them what flavour and give different flavours during the day. They also like coffee too and need to be asked if they want this as well." Staff told us although there were days when the home was busy, there was enough time to care and meet people's needs.

People were supported to maintain their independence as far as possible. One person told us, "I asked for my TV remote to be put on the bed trolley so I can change channel myself and they did this. I can eat some things myself and staff know I enjoy this." A relative told us, "[Name of family member] couldn't walk when they first came here and now they are on a walking frame." We saw, where required, staff supported people to walk around the premises safely.

Care plans included some references to how much people were able to do for themselves. People and, where appropriate relatives, told us they had been involved in the planning of their care and were consulted about how they wanted their care to be provided. Care plans and records were held electronically and accessed by staff through mobile telephones. These were secure and password protected for each staff member. We saw staff kept the mobile phones on their person throughout our inspection visit. Paper records were kept securely in designated offices. This helped to assure people that their information was stored and managed in line with legal requirements to protect their right to confidentiality.

The registered manager provided details of advocacy services in communal areas which were accessible by people, visitors and staff. An advocate is an independent person who seeks to ensure the people, particularly those who are most vulnerable in society, are able to have their voices heard on issues that are important to them and defends and safeguards their rights.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2017, we rated the service as requires improvement in the responsive domain. This was because we found inconsistencies in people's care records and care plans did not provide the information staff needed to provide personalised care. There was a lack of activities and stimulation for people. These were breaches of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breach. At this inspection we found that improvements had been made to rectify the breach and these were on-going.

Care plans had been developed through assessments involving people and, where appropriate, their relatives or representatives. The registered manager was in the process of updating care plans and records and this was confirmed in the records we reviewed. Care plans included details about people's life history, people who were important to them and their needs, wishes and preferences. However, some care plans we looked at did not provide enough detail for staff on how to meet people's specific needs, or records were contradictory. In one person's care plan it was documented for staff to 'distract or reassure' if the person became anxious or unsettled. There was no detail of how to provide reassurance or what type of distraction worked best. In another person's care plan, one record stated the person identified with their beliefs and religious practices, whilst another record stated the person had no beliefs. The registered manager told us these care plans were in the process of being reviewed and updated.

Other care plans we looked at included detailed information for staff to follow. For example, one person's care plan included details of what was important to them. This included staff support to maintain a well-presented appearance. We saw staff had supported the person to maintain their appearance in line with their wishes. A second care plan including clear information on the person's 'expressive behaviours' and actions staff needed to take to manage any potential distress or risks. A third care plan detailed the importance of staff supporting the person to maintain their relationship with a family member. Records showed staff had supported and encouraged this by involving the relative in all aspects of the persons' care.

One person's care plan included guidance for staff that they should encourage the person to eat, which included providing prompts and supervision at mealtimes. We saw that staff did not provide any support or supervision during the lunchtime meal, despite the person being distracted and eating little of their meal. This demonstrated that staff did not always follow the guidance in people's care plans to provide personalised care.

People had access to an activities programme, which was mainly provided in small groups or individually. One person told us, "I am quite happy here. I read the newspaper and I like the television - sport." A relative told us, "[Name of family member] will go to the concerts. They have made cards, decorated cakes. One of the staff plays cards with them. [Name] likes music but is mainly stimulated by watching people."

There was a member of staff responsible for activities who had recently started in the post. They told us, "We have an activity cupboard and I put my monthly plan on the [notice] board. I try to change it every day. We

do themes, like Mother's day, St David's Day, sports relief. We also do summer fete and we have a party next week for Easter with a karaoke. We celebrate key festivals and people's birthdays to give them a sense of pride and dignity." The staff member told us they recorded outcomes of activities in a daily log which included what people did and didn't like. This helped them to provide activities which people liked or enjoyed. The staff member told us they ensured people who spent time in their rooms were provided with suitable stimulation. For example, one person liked to read the bible. Their activity plan ensured staff spent time reading the bible to the person.

During our inspection visit we observed the activity for the day was 'pampering'. This involved head messages. Where people declined this, they were offered with an alternative of hand massage and we saw some people accept this and responded positively to it. Other people were supported to join in a group game of skittles. Where people declined to get involved in activities, we saw they were supported to read newspapers and staff spent time chatting with them.

Where people had sensory losses, such as poor hearing or eyesight, or cognitive impairment, care plans detailed how staff should communicate with people. This included details such as 'give information step by step,' 'give me time to respond' and 'use short sentences and maintain eye contact.' This helped to ensure people were provided with information in a format they could understand. The provider was aware of their responsibilities to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given.

We looked at how the provider handled and responded to complaints and concerns and saw there was a policy and procedure in place which was displayed in communal areas for people and visitors. This provided people with details of how their complaint would be managed and included details of external agencies should the complaint not be resolved to their satisfaction. People and relatives told us they were confident to raise concerns and felt these would be responded to. One person told us, "I would go to the head one (registered manager)". A second person told us, "I would speak to one of the staff." A relative told us, "I have had things where I've gone to see the [registered] manager when I have not been happy about something. Not a complaint, and it was sorted. On a day-to-day basis I talk to the care staff."

Records showed complaints received since our last inspection were related to care issues. Complaints had been acknowledged and investigated; with a response and outcome given to the individual complainant. Complaints were used to bring about improvements, For example, a meeting had been arranged between a complainant and the registered manager to resolve concerns and establish more effective communication.

People were supported at the end of their life to have a comfortable and pain-free death. Where possible, people were able to remain at the service and not be admitted to hospital. People's wishes had been sought and recorded in advanced care plans which included resuscitation wishes and any prescribed anticipatory medicines to ensure people were not in pain.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2017, we rated the service as inadequate in the well-led domain. This was because we found the leadership and governance of the service was not effective, there were insufficient systems to monitor and the quality of the care provided and people's views were not acted upon. These were breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breach.

At our previous inspection the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. At this inspection some improvements had been made but this area required further development. Some shortfalls identified during this inspection had not been identified through the provider's systems. For example, the completion of care records and the administration of covert medicines. Improvements were not always embedded into staff working practices and therefore the provider was unable to demonstrate that improvements had been sustained at the time of our inspection.

This was a continued breach of Regulation 17, Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager provided assurances that the shortfalls identified at this inspection would be addressed as a matter of priority.

In most cases, the quality assurance process was more detailed and actions were usually taken in a timely manner. Regular performance and compliance reviews were conducted and they reviewed areas such as health and safety, infection control, wounds, staffing, premises and equipment. For example, audits conducted in December 2017 and January 2018 recognised care plans did not always reflect people's current needs and lacked detail and guidance for staff to follow. The registered manager had put in place an action plan which identified issues that needed to be taken forward within stated timelines and was working towards completing action points at the time of our inspection.

People and relatives told us things had improved since the new registered manager had been in post. One person told us, "I would always recommend it here." A relative told us, "The atmosphere is good; warm and inviting. It's getting better now. She [registered manager] is getting there, it's been a transition." People and relatives commented on improvements in the service, such as the arrangement of furniture in communal areas which helped create a 'friendlier, more inclusive' atmosphere and better paperwork. One relative told us there had been improvements in staff. They said, "There were one or two [staff] who were task orientated. They did not have a connection with people. They [staff] are not like that anymore." Another relative told us, "I think the only problem with this home is that they lost control. The new manager is quite proficient and had made quite an impact so far."

All the staff we spoke with said they enjoyed working at the service and were positive about improvements that had been made. Their comments included, "We love this home and we're glad it's improving. Things were bad and they get better and better," "Staff here work for the service users and colleagues are quite

nice. The [registered] manager is good and supportive and can be approached with anything" and "We have good leadership here and caring staff, with good team leaders. There is always someone to ask if you are not sure or who will help you out. The management are new and it takes time to build trust and relationships, but I would be happy to approach them no matter what."

Staff were supported to share their views and contribute to decision making through regular staff meetings. We reviewed records of meetings held in January, February and March 2018. These showed staff were supported to reflect on best practice, for example in dementia care, and involved in 'problem solving.' For example, how improvements could be made to working practices, such as mealtimes and the environment. Meetings were used as an opportunity for the registered manager to support staff to reflect on their knowledge in areas such as safeguarding.

People and relatives were encouraged to provide feedback on their experience of the service through meetings and surveys. The registered manager held an open clinic once a week where people and relatives could 'drop-in' and see her, share views or ask questions. This was advertised in communal areas to ensure people and visitors were aware of this. People and relatives were invited to meetings where information was shared and people were consulted about proposed changes. We reviewed minutes of a meeting held in December 2017. Records showed the provider had been open and transparent about where improvements were needed and how they intended to make these. People were consulted about proposals, such as improvements to directional signage and care planning. We saw overall people and relatives shared positive views and had no concerns.

In the short time they had been working in the service, the registered manager had brought about changes to improve the culture of the service. This included working with staff to provide a more person-centred approach and support staff to work across roles so the care provided was 'seamless' and staff had a better understanding of different roles. Staff told us this had improved teamwork and helped to recognise the diversity within the staff team and ensure staff were treated equally. The registered manager was working towards action plans to develop further improvements. These included a memory room for people to relax in and improving the décor on the first floor.

The registered manager was supported by the provider to work with other agencies in an open, honest and transparent way. Working in partnership with other agencies who commissioned services and local authority safeguarding and community health teams ensured that people received a joined up approach to their care and support. Commissioners, responsible for funding some of the people who used the service, told us they had found improvements had been made in the service and these were being closely monitored under their contractual responsibilities.

All health and social services registered with the Care Quality Commission (CQC) must notify the CQC about certain changes, events an incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events had been handled. We found the registered manager had sent appropriate notifications to us. The provider had ensured their displayed their current ratings on their website and at the registered location.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not always ensured that risk assessments were completed in order to meet the needs and safety of people using the service. They had not ensured that medicines were always administered safely.

The enforcement action we took:

simple caution

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had systems and processes in place to monitor the quality of the service but these were not always effective in improving the quality of the service provided.

The enforcement action we took:

simple caution