Porthaven Care Homes No 2 Limited

Savernake View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Savernake View Care Home provides accommodation which includes nursing and personal care for up to 64 older people, some of who are living with dementia. At the time of our inspection 34 people were using the service. Savernake View is one of Porthaven's Care Home's, situated in the Marlborough area.

The inspection took place on the 22 and 23 August 2017 and was unannounced. This was the service's first rated inspection since being registered with the CQC in August 2016.

The service had 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.

Medicines were not managed safely. We found gaps in the medicines administration records (MAR). Medicines had not been signed as administered and there was nothing documented to indicate that staff had either escalated this for investigation or had undertaken a stock check to ascertain whether they had been administered.

People did not always have access to on-going healthcare that was responsive to their needs. Although people were registered with a local GP practice, the GP did not regularly visit and there was nothing documented to indicate that people's heath had been regularly reviewed. Staff said that accessing the GP for advice was not easy and that communication was by fax only. This meant there were often delays in seeking GP support.

Care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs. Care plans contained risk assessments for areas such as falls, moving and handling, skin integrity and malnutrition. These had been regularly reviewed; however, when risks had been identified the care plans did not always provide staff with enough guidance on how to reduce the risks.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. However, we found that people were not always supported to stay safe.

A significant number of people, relatives, visitors and staff expressed concerns about lack of staff, the use of agency carers/nurses and the impact that this had on the quality of care.

The service did not follow the requirements set out in the Mental Capacity Act 2005 when people lacked the ability to give consent to their care and treatment.

Language used in some of the care plans we looked at was unprofessional and did not demonstrate that staff were respectful of people.

Internal audits had identified shortfalls and action had been taken. However, we found that the action taken was not sufficient to resolve the shortfalls, for example, the safe management of medicines. Records kept in respect of people using the service, were not always accurately recorded or complete.

People told us they felt safe living at Savernake View. Comments included "A nice place to live - a gentle environment to live in. Everyone nice and friendly.", "I like it here no hassle from anybody."

People told us that they mostly liked the staff and felt they worked hard to provide a good level of care. Most staff were described as kind, considerate, caring and approachable.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred.

The service followed safe recruitment practices. Records showed that checks had been made with the Disclosure and Barring Service [criminal records check] to make sure people were suitable to work with vulnerable adults.

People's preferences including their dislikes and any allergies were recorded and visible in the kitchen. We saw the chef also catered for people from different cultural backgrounds, for example would occasionally prepare polish cuisine for a person from Polish background.

Care plans had been reviewed regularly, although it did not appear as though the issues we noted had been identified during the reviews. We saw that people's relatives were invited to attend regular reviews and saw that this had happened and that their feedback was asked for.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. People told us they enjoyed the activities on offer.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Regular residents' and relatives' meetings were held.

Staff generally spoke highly of the registered manager. Speaking with relatives and people, they told us they knew who the manager was and felt the service was well managed. The registered manager was supportive and approachable.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People's medicines were not managed safely.

People's personal safety had been assessed and care plans were in place, however care plans did not always provide staff with enough guidance on how to reduce the risks.

Staff were aware of how to recognise signs of potential abuse and were clear about the action they would take to prevent people from harm.

People told us they felt safe living at Savernake View Care Home.

Is the service effective?

Requires Improvement

The service was not effective.

Consent to care was not always sought in line with the Mental Capacity Act (2005). People had not always been assessed for their capacity to consent and when people did lack capacity, decisions had not been made in line with legislation.

Systems in place for people to have access to on-going healthcare were not effective and responsive to people's needs.

Staff had the training and skills they needed to meet people's needs. However, people told us they felt concerned about agency staff's knowledge to meet their needs.

People told us they enjoyed their meals and there was plenty of variety on offer.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people told us not all carers were caring and approachable and some had concerns about the way agency staff had treated them.

Language used by some staff when recording was unprofessional and did not demonstrate that all staff were respectful of people.

We observed positive interactions between staff and people using the service. People appeared happy and generally relaxed around staff.

The home was spacious and allowed people to spend time on their own if they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs.

Handover between staff at the start of each shift did not always ensure that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

Complaints and concerns were taken seriously and used as an opportunity to improve the service.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Internal audits had identified shortfalls and action had been taken. However, we found that the action taken was not sufficient to resolve the shortfalls, for example the safe management of medicines.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received.

Staff told us they felt supported by the registered manager and had regular staff meetings.

The service had developed good community links.

Savernake View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 August 2017 and was unannounced. This was the service's first rated inspection since being registered with the CQC in August 2016.

The first day of the inspection was carried out by two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On the second day of the inspection one inspector, a specialist nurse advisor and an expert by experience returned to complete the inspection.

Before the inspection we reviewed the information we held about the service. We read the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with twelve people and six visiting relatives about their views on the quality of the care and support being provided. During two days of our inspection we observed the interactions between people using the service and staff. We looked around the premises and observed care practices.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included ten care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents.

We spoke with the registered manager, area manager, three care staff, five nurses, including an agency nurse, housekeeping staff, the chef, leisure and wellness coordinator and the maintenance person. We

received feedback from one health and social care professional.

Requires Improvement

Is the service safe?

Our findings

Medicines were not managed safely. We looked at all of the medicine administration records (MAR charts) and saw that on 35 occasions since 01/08/2017, medicines had not been signed as administered and there was nothing documented to indicate that staff had either escalated this for investigation or had undertaken a stock check to ascertain whether they had been administered.

Missing signatures had been identified as an issue during a Pharmacist Advice visit during April 2017 and additionally had been raised during internal monthly audits in May, June and July 2017. We also saw that the CQC had written to the registered manager in February 2017 after receiving information of concern about the safe management of medicines. This was investigated by the regional manager who replied that they had already identified this in an audit in February and was immediately addressing the issues. They also told the CQC there was an action plan in place and they would be monitoring the progress. Despite this, the issue had not been resolved and there was a risk that people might not always receive their medicines as prescribed because staff had not signed to indicate they had administered them.

The provider's medicine management policy stated "All medication that is administered or not administered must be recorded as such on the MAR". This meant that staff were not adhering to the provider's policy. The registered manager said they would investigate the missing signatures. They assured us during the second day of our inspection that they could account for the medicines and that people had received it as prescribed.

Although stock balance checks of medicines were carried out, this did not take place consistently which meant it was difficult to assess whether stock balances were correct. Additionally, we saw that stock management of medicines was poorly controlled. For example, one person was prescribed a steroid which had not been administered for four days and another person had been prescribed an antidepressant which had not been administered for seven days. In both of these cases staff had indicated on the MAR chart that the medicines were out of stock. Although the registered manager confirmed with us that the medicine for one person had arrived in stock on the second day of our inspection, it was not clear how the service managed stock levels to reduce the risk of people missing doses of prescribed medicines.

Stock balances of controlled medicines had been regularly carried out; however when controlled medicines had been administered there was not always two signatures recorded in the log book. The provider's policy stated "Two members of staff must be involved who both must check and sign the controlled drug register".

Medicines were generally stored safely. However, temperature monitoring records for medicine fridges and clinical rooms had not been undertaken on a daily basis. It was also not clear how frequently medicine fridges were cleaned. Although the form that was in place had a box for staff to document when the fridge was due for cleaning and the guidance was "every 3 months" there was nothing documented to show that fridges had been cleaned.

The regional manager told us that the action plan for improvements to medicines management, remained

on-going and poor practice by staff identified, was being dealt with. They said the process was closely monitored by the registered manager and safety checks have now been put in place. These included a 10 point MAR check, fridge temperatures and checks by the registered and deputy manager.

There were photographs of people using the service at the front of MAR charts. This meant that staff who were unfamiliar with people, such as agency staff or new staff were able to recognise people. People's allergies had been recorded.

Some people had been prescribed additional medicines on an "as required" basis (PRN). However, there were no PRN protocols in place. These protocols assist staff administering medicines to know when and why people might require additional medicines. For example, they provide staff with information on how to recognise when people who are unable to communicate might display signs of being in pain.

Care plans contained risk assessments for areas such as falls, moving and handling, skin integrity and malnutrition. These had been regularly reviewed; however, when risks had been identified the care plans did not always provide staff with enough guidance on how to reduce the risks. For example, in one person's plan staff had documented that the person's mobility needs had changed over time. Occupational Therapist (OT) input had been sought for advice and this had taken place. However, the latest guidance from the OT was not reflected within the care plan. The care plan dated 09/08/2017 stated "now on full hoist on all transfers with assistance of 2 care staff". But the guidance from the OT dated 16/08/2017 following their assessment was that the person's mobility was variable and that "on good days can use stand aid, poor days hoisting". The care plan had not been updated following the OT assessment which meant there was a risk that staff were not aware of changes in people's support needs.

Some people had bed rails in place to prevent them from falling out of bed. However, risk assessments were not seen in all the plans of people with bed rails in place.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. We found that people were not always supported to stay safe. We saw in a person's mobility care plan that their mobility was "challenging" at times and that the assistance and supervision of one staff was needed at all times. However, we found several accident reports regarding this person where they had an unwitnessed fall. We also observed during the first day of our inspection that this person was getting up from their chair and started walking. A nurse who was passing by the lounge had to prompt the staff member in the room to check on the person as they were unaware they had gotten up. We also found that where people fell, it wasn't always clear what observations had been completed, for example with a head injury. Recording was inconsistent.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A significant number of people, relatives, visitors and staff expressed concerns about lack of staff, the use of agency carers/nurses and the impact that this had on the quality of care. Speaking with people they said "I use a pendant to get help. They try hard, but sometimes only one person [carer] on this floor.", "Use bell - some delay because there is always someone worse off than you.", "Use a call button for staff. You have to remember that you are one of many. Very busy, not enough staff.", "Call bells - take a long time and when they come made to feel that you are a nuisance." and "I do get a cup of tea around 6.30 but they tell me not to call them after 7 because they are so busy then". A relative told us "Carers are very overstretched. On one occasion [person] left on the toilet for over half an hour, on another only one hearing aid because the carer had rushed off to help someone else. Everything all put together not what we expect for a standard of care."

We also saw that some relatives had made a formal complaint to the service regarding staffing levels. The registered manager had acknowledged and addressed these complaints.

During our first day of our inspection we were stopped by a visitor who was asking for help. He had been waiting over half an hour after lunch for carers to come and support his partner out of their chair. We tried to find a carer, but all carers were busy in other people's rooms. The visitor told us this happened frequently that they couldn't find a carer to help. Eventually two carers appeared and supported the person.

The regional manager told us they had reviewed their staffing levels over the last six weeks and had evidenced that this had been increased with new admissions into the home. They said their staffing levels were worked out carefully with their dependency tool.

Some people had behaviours which could be seen as challenging to others. Speaking with staff on the dementia unit, they felt they did not have the specialist training to deal with certain behaviours. We spoke with a health and social care professional from the care home liaison team, who said they regularly visited the home to provide support. They said any recommendations they made were followed through, however they were only involved in supporting one person at present and had not had any involvement on the dementia unit. The regional manager told us Porthaven [care provider] had already identified specialist dementia training as a training need and was due to provide this training in September 2017.

Speaking with people they told us they felt safe living at Savernake View. Comments included "A nice place to live - a gentle environment to live in. Everyone nice and friendly.", "I like it here no hassle from anybody", "Feels nice and safe here. Things safe and sound.", "Safe within reason." "Very safe, security good, outside door locked.", "Safe! The carers at all levels take good care of me." and "Quite satisfied it's safe - lovely here."

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Requires Improvement

Is the service effective?

Our findings

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). The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

Consent to care was not always sought in line with the Mental Capacity Act. People had not always been assessed for their capacity to consent and when people did lack capacity; decisions had not been made in line with legislation. For example, some people had bed rails in situ, but there were no assessments in place to indicate whether people had been assessed for their ability to consent to their use. This was discussed with the registered manager during the inspection and on the second day they said that assessments had been completed. However, the capacity assessment forms were not completed correctly because the specific decision requiring the test of mental capacity had not been documented. Although best interest documentation had been started, there was no evidence of input from other members of the multi-disciplinary team or people's representatives. Instead staff had documented "does not have capacity to make a decision. Staff to act strictly based on best interests in relation to care".

Staff knowledge about the Mental Capacity Act was variable. For example, consent forms had been signed by relatives for the consent of care plans, and on one occasion staff had documented "has LPA [lasting power of attorney] for property and affairs". However, this type of Lasting Power of Attorney does not authorise someone to consent to a person's care. One staff member said "I don't feel that confident with MCA. I did have some training but it was a while ago".

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

The regional manager told us Porthaven as the provider had already identified and were addressing the issues around the paperwork for mental capacity. They said training was now underway and updated paperwork had been sent to all Porthaven Care Homes.

People told us they liked the food and there were good choices. Comments included "Food is good, sometimes too much, small appetite. I have a reasonable breakfast and lunch, always something for me on the menu.", "Food varies, some days lovely. I have a pork allergy so have jacket potato instead.", "Food very good for such a large catering place.", "Food rather good, enjoy it - eat well.", "Good choice of meals. Chef

comes and talks to us about what we like." and "Very nice food - good range.". Relatives told us "Quality and attention to detail of the food is excellent." and "Food is excellent. I have eaten here".

We saw fruit, snacks and drinks were available during the day and observed some people using the drink dispensers to make a hot drink. We found that people who were not able to use the drink making facilities, were not offered a drink after breakfast and they had to wait until lunchtime. Mid-morning refreshments were not offered. A staff member told us the tea trolley was not part of Porthaven's vision for the service as they did not want it to appear institutionalised. They said staff did not have time to continuously be offering to make people a drink and only people who were asking, would get a hot drink. We observed that this was the case on our first day of inspection. The second day we saw people were regularly offered a drink.

People's preferences including their dislikes and any allergies were recorded and visible in the kitchen. We saw the chef also catered for people from different cultural backgrounds, for example would occasionally prepare polish cuisine for a person from Polish background. We observed during our visit that there was a menu available on display in the communal area for people to see and be reminded what the choices for lunch were. We found that on the dementia unit, there was only a written menu and people could benefit from a pictorial menu to support them in making a choice. We observed positive interactions during mealtimes. Staff discretely supported people who needed additional help, sitting at tables, explaining the meal and encouraging them to eat where necessary. People told us that they enjoyed the calmness of lunchtime.

People had been assessed for the risk of malnutrition and people's weights were monitored. When people had lost weight, support and advice had been sought. Care plans detailed when people required food supplements. However, people's preferences in relation to food and drink were not documented in much detail. For example, in one person's pre-admission assessment document, it had been written that they had a tendency to refuse food and drinks. The guidance was for staff to serve the meals without actually asking if the person wanted them. However, this information was not included within the nutrition plan.

Some people were having their food and fluid intake monitored, but the reasons for this were not always clear because it had not been written on the monitoring charts. Additionally it was not clear how consistently the charts were reviewed or whether staff knew when to escalate concerns in relation to people's intake. For example, one person had a urinary tract infection. The care plan guided staff to "ensure fluids are pushed", but there was no detail of how much fluid staff should encourage the person to drink. When we looked at the fluid charts for this person, they showed that the person's intake varied from 600 millilitres per day to 1200 millilitres per day. There was no target intake written on the forms and not all completed forms had been signed to indicate that the nurse in charge was monitoring total intake each day.

People did not always have access to on-going healthcare that was responsive to their needs. Although people were registered with a local GP practice, the GP did not regularly visit and there was nothing documented to indicate that people had their on-going health needs regularly reviewed. Staff said that accessing the GP for advice was not easy and that communication was by fax only. This meant there were often delays in seeking GP support. For example, we saw that staff had faxed the GP asking for a prescription of antibiotics for someone with a suspected infection. The GP had faxed back asking for more information, which had then been provided. However, this method of communication meant there was a four day delay in the person receiving their antibiotics. We discussed this with the registered manager who said they were trying to arrange a meeting with the GP in order to improve communication methods and ensure that people could see a GP more frequently.

We viewed the training records for staff which confirmed staff received training on a range of subjects.

Training completed by staff included, safeguarding adults, manual handling and fire safety. Nursing staff said they had access to training and development in order to meet their professional registration requirements. One said "We've had some specialist training; we had some training on Huntingdon's disease the other week which was really useful". Staff said if they identified any training needs, they were supported to attend relevant training courses.

People living with dementia were mainly supported on the first floor of the building. We found the design of the dementia floor was not consistently dementia friendly and did not always follow recommended guidance. For example walls were in a natural colour, with no contrast which is known to be beneficial to people living with dementia. There was no reminiscence or sensory objects around and no clocks or information to orientate people to time. However, we saw there was signage to orientate people to the toilet and memory boxes to help people recognise and find their bedroom. The home was also trialling specialist dementia crockery to improve people's dining experience.

The registered manager told us they had recognised that improvements had to be made to make it more "dementia friendly". The provider was currently sending a dementia specialist around the Porthaven homes to make recommendations, for example having more sensory equipment around for people to touch. The registered manager was also working with the senior management team regarding understanding dementia.

Requires Improvement

Is the service caring?

Our findings

People told us that they mostly liked the staff and felt they worked hard to provide a good level of care. Most staff were described as kind, considerate, caring and approachable. Comments included "I like the staff – very patient.", "Carers vary a bit, some you like some you don't.", "it's a friendly place, people are friendly - well looked after. All got time for you" and "Like the staff. New staff ok when they get to know you".

However language used in some of the care plans we looked at was unprofessional and did not demonstrate that staff were respectful of people. For example, we looked at one person's plan which was titled "shouting out". The plan did not explain why the person might frequently call out and the guidance for staff was limited to "spend time with [person], encourage with activities and going out in the garden". Additionally, the daily notes showed lack of respect or understanding of the person's needs because staff had documented "shouting out whole day as usual". Other terminology in daily recording included "misbehaving" and naughty behaviour". In another person's accident recording, staff wrote "[person] was so uncooperative and wouldn't bend his knee". This was following a fall when staff were trying to help the person up. We raised this with the management team during our inspection, who told us they were addressing the issues. They also said that the language used in recording was not a reflection on the caring nature of the care provided by staff.

Some people also told us not all carers were caring and approachable and some had concerns about the way agency staff had treated them. They also felt that agency staff had a lack of knowledge about people's needs. One person said "I've had some problems with care. Had a wound on my arm and was told by a certain nurse that I was a low priority. It was dressed eventually. Made to feel a nuisance if you ask for anything." A relative told us '"agency nurses do not always understand her [person] needs. One night she was having some difficulty breathing as a result of a panic attack. The agency nurse, unaware that all she needed was calming down, called in the emergency doctor". A staff member said "It depends which staff are on shift. I think there is some apathy. Sometimes the basics are being missed by some of the staff".

Speaking with relatives, they told us "When X [person] came in she was very poorly –didn't expect her to be with us. Now a different woman.","Y [person] was 100 recently and staff could not have been kinder. They gave us a special room upstairs. Chef changed the menu to salmon, which is her favourite and cooked us a joint of beef especially. Staff so caring and attentive.", "Good response from care staff who take the initiative to support her", "Carers very dedicated - take it seriously. You see that when they are very tired, professionalism takes over", "Staff so lovely, treat you as though they have known you all your life." and "She gets excellent care and they are so nice to her –speak so kindly to her".

People received care and support from staff who had got to know them well. We heard staff making caring comments such as "Don't you look lovely today" and "Would you like to watch the television?" When one person said they didn't want to watch TV, the staff member asked if they would like to sit and read a book with them.

The relationships between staff and people receiving support demonstrated dignity and respect most of the

times. We observed staff knocking on doors, waiting and introducing themselves. Doors were closed during personal care. People told us their dignity and privacy were respected. They said "They [staff] always knock on the door.", "They [staff] are very respectful when doing personal care." And "Very good with privacy. Knock on doors and wait".

We observed positive interactions between staff and people using the service. People appeared happy and generally relaxed around staff. We saw that staff responded quickly when people were upset or distressed, including members of the housekeeping staff. On one occasion we observed a member of staff crouched down to one person, talking and reassuring them. On another occasion when one person was crying, another staff member stopped what they were doing and gave them a hug.

The home was spacious and allowed people to spend time on their own if they wished. Relatives and visitors told us there were no restrictions on when they could visit. They received a warm welcome from the receptionist and staff. People told us that this helped to create a pleasant atmosphere within the home.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs. For example, wound care plans were not always clear. Although one plan we looked at detailed the wound dressing plan and there were photographs in place to enable staff to assess the improvement over time, this was not seen in all wound plans. In one plan we looked at, although there were photographs in place these had not all been dated, which meant it was difficult to assess easily if the wound was deteriorating or improving. One person had a pressure sore but the plan did not make reference to the pressure relieving aids that were being used. Another person had a medical condition that required a feeding or gastric tube to be changed every three months. It had been documented that the tube had been changed over three months previously, but there was nothing written to indicate if the tube had been changed since or if it was overdue. We asked the nursing staff about this who said they were waiting for a hospital appointment, but this had not been documented.

In another person's plan it was documented that they were having their food and fluid intake monitored. However, when we checked there were no monitoring charts in place and staff said the person had been putting weight on and so didn't need monitoring. Monitoring charts that were in place were unclear because "Turning Record" charts were being used as observation charts. Air mattress monitoring charts were used, but did not specify what the correct mattress setting was. When we asked staff how they knew if the mattresses were set correctly, they were unable to say because people's weights had not been written on the charts. Despite this, the majority of the mattresses we looked at were set correctly.

Records did not always show that referrals had been made in a timely manner. For example, in one person's plan it had been documented that following a care plan review, one person's advocate had asked for them to be reviewed by the GP because of concerns about depression. This had been written on 03/07/2017. Although there was a copy of the fax sent to the GP requesting a review, it did not specify that there were any concerns about the person's emotional wellbeing, There was nothing to indicate the person had been reviewed and nothing to indicate that this had been followed up by staff. One staff member said "Because we've been short of permanent nurses, it's hard to keep track sometimes" and another said "The staff here need to have care planning training to understand what person centred means".

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had been reviewed regularly. We saw that people's relatives were invited to attend regular reviews and saw that this had happened and that their feedback was asked for. Speaking with people they said "Know I have a care plan and what's in it. They [staff] talk to me about my care and if I need any extra." and "They [staff] have been through my care plan with me." Relatives confirmed they had been involved in care reviews. Comments included "Four weeks ago head nurse talked to her about her care plan. Spent an hour going through it with her." and "Have been to a review meeting recently."

A handover was held between staff at the start of each shift, which ensured that important information was

shared. However, we found that the information was not always acted upon to ensure people's progress was monitored. Staff told us this was mainly a concern when agency staff was on duty. People and their relatives also told us they felt communication within the home could improve.

People had a range of leisure and wellness they could be involved in. People were able to choose what they took part in and suggest other leisure and wellness they would like to complete. People told us they enjoyed what was on offer. Comments included: "I go to as much as possible. Exercise very important, so go to that. Trips out, looking forward to visiting Salisbury Cathedral soon.", "M [co-ordinator] is brilliant and has been looking after us.", "Lots to do, scrabble, trips, lovely.", "Lots of different things going on, always something for you if you want it." and "Been out on quite a few trips, brilliant activity people.". A relative told us "Feel they provide a good range of activities. Not seen people just stuck in front of the TV.".

There was a seven day a week leisure and wellness programme, organised and ran by two coordinators. We observed the coordinators visiting peoples' rooms, chatting to them and asking if they would like to do any of the activities planned for the day. There were a range of activities on offer each day, for example exercises, choir, walk outs, craft, gardening, cookery, scrabble, knitting, manicure and pampering, reminiscence, visiting entertainers, games, quizzes and visiting animal experiences, which provided people with a range of stimulating activities. In addition there were trips out and the home had their own cinema offering films, which we saw people enjoying.

People had the opportunity to follow their interests they had previously been involved in before coming to live at Savernake View. For example we saw that a keen artist was involved in a painting session. The person, now living with advanced dementia was given appropriate materials which enabled him to achieve within his capability. Keen gardeners had been involved with planting grow bags with a selection of vegetables. Cookery was available for those who wished to learn a new skill or had a previous interest. There was also a programme of one-to-one activities for people who were unable or would rather not join in with a group activity.

Complaints and concerns were taken seriously and investigated in a timely way. We saw when people or their relatives had complaint, that the s registered manager acknowledged the complaint and put in writing the outcome of the investigation. Where people were not happy with the outcome of the investigation, they were given information of where to take their complaint next.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post since January 2017. They told us it had been a challenge coming into the service as there was a negative culture within the home at the time, with demoralised staff. They said they were working towards achieving a staff team with the same passions and ideals to create the best service possible. The registered manager said "Wonderful bunch of carers. No doubt the residents are looked after and cared for." They said they liked the ethos of Porthaven [care provider], which was "To provide the best quality of everything, making it a beautiful place to stay, but also putting emphasis on quality care". The registered manager told us they felt well supported by the senior management team.

However, they acknowledged there were still worked to be done and were slowly making improvements. They explained the biggest risk for the service was the lack of nursing staff and a lack of continuity for people. It was difficult to recruit suitable nursing staff and therefore the use of agency staff had been high. They were also working to resolve the poor relationship with the local GP surgery as this had an impact on the effective health care people were receiving. The registered manager said this was work in progress, but they were hoping to resolve this and was due to arrange a meeting.

Internal audits had identified shortfalls and action had been taken. However, we found that the action taken was not sufficient to resolve the shortfalls. For example we found that action plans to resolve issues around the safe management of medicines had been in place since February 2017, but these issues still had not been resolved during our inspection. Although the provider had put actions in place to ensure the nursing staff made improvements, there were no systems in place to monitor if the nursing staff had completed these actions. We also found that records kept in respect of people using the service, were not always accurately recorded or complete.

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

Staff generally spoke highly of the registered manager. Comments included "No matter how busy she is, she will always give you time", "The most positive thing here is the manager; she will really make a difference here. She's the crème de la crème" and "The manager is very visible, but I'm not always confident that when I go to her with things that she will get them done".

Staff said they attended regular staff meetings and were aware of changes that were in the process of being implemented. One said "We knew we were due an inspection, but I think we've still got some work to do". Staff told us they felt supported by the management team.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Regular residents' and relatives' meetings were held. Speaking with relatives and people, they told us they knew who the manager was and felt the service was well managed. Comments included "A good relationship with the management.", "I get on with [manager] - very approachable - they [management] all are.", "Excellent support for me from the manager. She is an exceptional manager - subtle

changes have been made.", and "Any issues go straight to speak to the manager.". A person said "Think that it is quite well managed."

The service was pro-active in developing community links. It had close links with the adjacent supported living complex, inviting people to events, and encouraging people to join residents for lunch. A memory café is due to open in the autumn and the local Alzheimer's society used the building and facilities for their meetings.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always person centred and did not provide enough detailed guidance for staff on how to meet people's needs. Some records were contradictory and not a true reflection of people's current care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care was not always sought in line with the Mental Capacity Act. People had not always been assessed for their capacity to consent and when people did lack capacity, decisions had not been made in line with legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. We found gaps in the medicines administration records (MAR). Medicines had not been signed as administered and there was nothing documented to indicate that staff had either escalated this for investigation or had undertaken a stock check to ascertain whether they had been administered. People did not always have access to on-going healthcare that was responsive to their needs. Where risks to people's health and safety had been identified, the service did not do all

reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Internal audits had identified shortfalls and action had been taken. However, we found that the action taken was not sufficient to resolve the shortfalls, for example the safe management of medicines. Records kept in respect of people using the service, were not always accurately recorded or complete.