Contemplation Homes Limited

Southlands 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 and 7 November 2017 and was unannounced. At our last inspection in July 2015 we found the service was not meeting the legal requirements for the safe management of medicines. Following the last inspection, we asked the provider to complete an action plan to show what they would do to address a breach of Regulation 12 that we found, and ensure they were meeting the legal requirements in relation to the management of medicines. This had improved at this inspection and was no longer a breach.

Southland's Nursing home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate up to 32 older people and some who live with a physical disability in one adapted building. There were four communal areas, including three lounges and a dining room. The provider advised us that they were keen to ensure people could have single rooms and as such they were not accommodating more than 30 people.

A registered manager was in post during the inspection. 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 associated with people's needs were not always appropriately assessed and actions taken to reduce the risk were inconsistent. Records were not clear, accurate or contemporaneous.

People told us they were always asked for their permission before personal care was provided. However people's ability to make decisions was not always assessed in line with the Mental Capacity Act, 2005 (MCA). Care staff and the registered manager had received training in respect of the MCA and were able to demonstrate an awareness of the principles. However, registered nurses understanding needed improvement.

There were systems in place to monitor quality and safety of the service provided, however, these were not robust and did not identify the concerns we identified during this inspection.

Prior to people moving into the home, assessments were undertaken to ensure the service could meet the person's needs. Policies were in place for care planning which guided staff to ensure people's diverse needs were considered and where needed support was planned. One of three nurses and and the registered manager were not able to tell us what evidence based guidance they used to support their care planning on. This meant there was a risk people would not receive care and support that was evidenced to be effective.

People told us that staff knew them well and this was apparent throughout our discussion with staff about people. Whilst some care plans were in place, these at times lacked information and guidance for staff and

were not always person centred, accurate and up to date. Activities were delivered based on individual needs at the time of the inspection.

No formal system was used by the provider to assess the level of staffing and skill mix needed and some people expressed concerns about the time it took for staff to respond to their calls for help. Observations throughout the two days showed that staff responded promptly to call alarms and people's requests and there were sufficient staff to meet people's needs. We have made a recommendation about how staffing needs are calculated.

People and their relatives provided positive feedback about staff. Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion. Their privacy and dignity was respected and they were encouraged to be involved in making decisions about their care. However, at times information was not always provided to people in a variety of ways which would give them the best opportunity to understand it and be able to contribute to those decisions.

The environment did not effectively meet the diverse needs of people as the layout and equipment in rooms meant the function of these could be confusing for people We have made a recommendation about adapting the environment to meet people's diverse needs.

The provider's recruitment process ensured appropriate checks were undertaken to check staff suitability to work in the home.

People were protected against abuse. Safeguarding policies and procedures were available to everyone who used the service. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse.

People and their relatives felt the home was always clean and well maintained. Staff received infection control training and protective personal equipment was available and in use and regular audits of the cleanliness of the environment and equipment were undertaken.
Equipment was managed in a way that supported people to stay safe.

People told us they felt permanent staff had the skills and knowledge to care for them. Staff said they felt supported by the management team and the provider. Staff said they received support in the form of supervisions, appraisals and training. Records showed that staff had received information sharing and competency based supervisions on specific subject areas. However there was little evidence of general welfare supervisions. The registered manager had a plan in place to address this.

Where people required support to eat their meals this was provided in a manner which enable them to eat at the pace they wanted and not feel rushed. They were supported to ensure they received adequate nutrition and hydration.

People and their families were encouraged to provide feedback on the service through residents meetings and an annual survey. They were also supported to raise complaints should they wish to.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

People told us that they felt the home was well led and staff were positive about the registered manager who was described as open, approachable and easy to talk to. Staff were committed to meeting the needs

of people and providing a service people wanted.

We found three 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks associated with people's needs were not always appropriately assessed and action taken to reduce the risks were inconsistent. Records were not clear, accurate or contemporaneous.

The provider and registered manager ensured that learning took place following incidents. Medicines were managed safely.

Observations throughout the two days showed that staff responded promptly to call alarms and people's requests and there were sufficient staff to meet people's needs, although no formal approach was used to identify staffing needs.

People were protected against abuse by staff who knew their responsibilities and duty of care to raise safeguarding concerns.

The provider's recruitment process ensured appropriate checks were undertaken to check staff suitability to work in the home.

The environment was clean and tidy. □

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they were always asked for their permission before personal care was provided, however their ability to make decisions was not always assessed in line with the Mental Capacity Act 2005 (MCA).

Prior to people moving into the home, assessments were undertaken to ensure the service could meet the person's needs. Not all staff were not able to tell us what evidence based guidance informed their care planning. .

The layout and equipment in rooms meant the function of these could be confusing for people.

Staff received support in the form of supervisions, appraisals and

training. The registered manager had a plan in place to ensure welfare supervisions took place.

Where people required support to eat their meals this was provided. People were supported to ensure they received adequate nutrition and hydration.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring.

People and their relatives provided positive feedback about staff.

Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion.

People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst care plans were in place these were not always up to date and did not always reflect people's needs or the changes staff had made to the support provided.

People were provided with appropriate mental and physical stimulation through a programme of activities.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain but had not needed to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were systems in place to monitor the quality and safety of the service provided, however these were not all robust and did not identify the concerns we found during the inspection. The provider was reviewing these systems.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families and staff had the opportunity to become involved in developing the service.

Southlands 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 6 and 7 November 2017 and was unannounced.

The inspection team consisted of one inspector, 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 care service. The expert by experience had experience of caring for older people living with dementia.

Before the inspection we reviewed information we held about the service. We looked at previous inspection reports, notifications and the provider information return document (PIR). The PIR 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. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern.

During the inspection we spoke with nine people and nine visitors. We observed care and support being delivered in communal areas of the home. We spoke with the registered manager, deputy manager and the quality manager. We also spoke with 13 staff including, ancillary staff, care staff, nursing staff and agency workers. We spoke to one visiting health care professional during the inspection and a further social care professional after the inspection. We spent time observing interaction between staff and people. We looked at the care records for 10 people and the medicine records for everyone.

We reviewed staff recruitment records for four staff, supervision, training and appraisal records for eight staff and sampled records for others. In addition, we looked at management records such as complaints, safeguarding, incident and accident records, staffing rota's, policies and procedures and governance records.

Requires Improvement

Is the service safe?

Our findings

Feedback from people told us they felt safe and comfortable living at Southlands. One person said "What makes me feel secure is the staff". Another person told us "I feel safe in my own little place". A relative told us how their loved one was supposed to go to hospital but refused because they feel safe at Southlands. They said "He trusts them here."

People were at times placed at risk because appropriate assessments and actions had not been completed when a risk was identified.

For example, one person's records confirmed an allergy. There was a notice on display to ensure the environment was managed to minimise the risk of this allergy presenting. Following the inspection we were sent a copy of risk assessment. This did not include the management of the environment but did include the use of an antihistamine medication if this allergy presented. The registered manager confirmed that the person should be prescribed antihistamines to help manage the allergy but we found this medicine was not recorded on their medicines administration records sheet.

Whilst there was evidence of reducing risk to people who had been identified as at risk of choking there was not a consistent approach to this and at times there was no evidence of remedial action being considered and taken to reduce risk. For example, for one person we found action had been taken to reduce the risk including, a referral to other professionals, a pureed diet was being provided and fluids were being thickened. Whereas for another person we found that despite identifying the person to be at high risk of choking, no action had been taken to reduce the risk except a referral to another professional. We observed this person was provided a normal diet and left alone in their room to eat their meal. Staff told us that this person could not use their call alarm. We discussed this with the registered manager and immediate action was taken to ensure the person was observed with all meals until they had been seen by a speech and language therapist.

A number of people were cared for using airflow mattresses to help reduce the risk of skin breakdown. For these to be effective the mattresses must be set at a specific weight for the person. Staff were able to tell us how to check the setting of the mattresses and records recorded that these were checked every time they visited people. However, for four people we found these were not set correctly and asked the registered manager to take immediate action to address this.

Records did not always provide clear and accurate information to guide staff about the mattress setting. For example, care plans did not contain the information to guide staff to the appropriate setting. Daily records contained entries which told staff what the setting should be but this was incorrect for two people. For a third person there was no record of the mattress setting having ever been checked. Staff told us they checked this but didn't record it. This person's mattress was one that was set incorrectly.

A failure to ensure that risks were appropriately assessed and action taken to mitigate risks to people's safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation

2014.

Some people were living with diabetes. Care staff had a general understanding of the signs to look for that may indicate a person was becoming unwell as a result of their diabetes. People's care plans provided no information about the person's usual range of blood sugar levels. Instead, they provided a general range of blood sugars which if followed would not ensure a hypoglycaemic (hypo) episode was identified early enough. (A hypo is an extremely low blood sugar that if not treated could have serious health implications for the person). We discussed treatment of hypos with nursing staff who were able explain the concept of treating a hypo. They were able to describe the treatment and subsequent monitoring.

One persons care records had been amended and the blood sugar levels changed. However, the range had been written over and not recorded as a new entry, a note was on the assessment to say it had been updated on 20/01/17. It was not clear who had updated the assessment and why. This made the record difficult to read.

Failure to ensure that records were clear, accurate and contemporaneous was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Other risks were assessed and managed well. Risk assessments were in place where a person was prescribed medicines that posed risk. They provided guidance to staff about the risks of these medicines and the observations they should make. Care staff told us any concerns they had about people's condition would be reported to the nurse on duty straight away. For another person who was receiving support with their nutrition via a feeding tube, we found this was managed well and care records indicated the risks associated with these tubes were managed safely. A care plan was in situ including a plan for replacing the tube should it fall out and it referenced a fall out kit being available as per best practice guidance (NHS Quality Improvement Scotland 2008). The person had a clear nil by mouth sign and evidence of appropriate mouth and tube care.

Equipment was managed in a way that supported people to stay safe. Regular maintenance checks took place of equipment, such as hoists and lifts. Window restrictors were in place where these were required. A maintenance worker was present in the home on a daily basis to attend to any repairs that were required and to carry out safety checks, including fire and water testing. Where it had been assessed that a person required the use of bed rails, staff ensured that protective bumpers were also in place to prevent any injuries. The bed rails were checked regularly by staff to ensure they were safe and working correctly.

Staff told us that the provider and manager would look to make improvements when a concern is identified. For example, information about falls for one person was used to make improvements to their care delivery. Sensor mats were implemented and the person told us how staff had spoken to them about changes to their care to prevent them from falling again. In addition, the registered manager and staff told us how information had been shared following a CQC inspection in another service. They told us that the handover sheet had been amended, information about managing choking risks for people had been displayed and it had been reinforced to staff how important this aspect of care was.

At our last inspection we found that the management of topical medicines was not always safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider sent us an action plan telling us what action they would take to address this. At this inspection this was no longer a breach but further improvements could be made. Information about the use of topical medicines that people were prescribed was stored confidentially in their rooms. This contained information about the prescribed cream, where it should be applied and how frequently. Nurses had delegated this task to care

staff. Care staff documented that creams had been applied in people's daily notes. A nurse told us carers told them when the cream was applied and then the nurse signed to say this had been administered on Medicine Administration Records (MAR). Signing for the administration of a prescribed medicine when the signatory has not administered this is not good practice.

One nurse took lead responsibility for the management of medicines. They described to us the system used for monitoring and auditing medicines, disposing of medicines and of ensuring medicines were reviewed. One relative told us "They looked into his medication when he came here because he was confused and he was sleeping all the time. They changed his medication and he takes it 3 times a day. He's bucked up, he's much brighter now. We've just had a good chat. He couldn't do that before".

Medicines audits regularly identified missed signatures and the nurse was able to tell us how they ensured this was only a missed signature and not missed medicine, although the records did not describe this process. Staff were aware of those people who were prescribed medicines on an 'as required' (PRN basis). They told us when this may be used and how they would assess if it was needed. We saw PRN medicines for the management of behaviours was not used excessively but there were no PRN protocols in place. These documents would provide guidance to staff who were unfamiliar with people about when to consider the use of this medicine. The registered manager told us they would ensure these were completed and shared with staff.

The provider had policies and procedures in place for staff to follow to ensure people received their medicines safely. This included medicines and any controlled drugs (CD). Controlled drugs were safely managed according to the legislation for the administration and storage of CDs.

Storage of medicines was safe. Medicines trolleys were held in locked storage in a locked room that only nursing staff accessed. The temperature of storage was monitored daily to ensure that this did not impact on the effectiveness of medicines and nurses knew what action to take should the temperature be outside safe parameters.

People were protected against abuse. Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. Policies and procedures were available to everyone who used the service. The registered manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. They were confident to do so and staff felt that the registered manager and provider would take prompt action to address any concerns. Records were held when referrals had been made to the local authority. The registered manager told us that all incidents were investigated once the local authority confirmed they were happy for the service to do this. No potential safeguarding incidents had occurred which required investigation.

Some people expressed concerns about the time it took for staff to respond to their calls for help. One person told us "I have to wait sometimes if I want to go to bed. It's a big place with lots of customers, they are all so busy". A second person said "you wait a long time. It all depends on what you want. It's all, 'we can't do that now, its dinner' and then it's something else". A third person told us "They come after a few minutes and then they turn off the buzzer and say, '5 minutes'. They need to go back to what they were doing." Relatives told us they felt staffing levels were OK. We did not observe any concerns about the staffing levels throughout our inspection and staff all told us that they felt the staffing levels were good. The registered manager told us they always ensured two registered nurses were on duty throughout the day and agency workers always worked alongside permanent staff. Observations throughout the two days showed that staff responded promptly to call alarms and people's requests.

No formal system was used by the provider to assess the level of staffing and skill mix needed to ensure people's needs were met and we were told that if the manager identified a need for additional staff this was always agreed to by the provider. Although a call bell system was in place, the registered manager confirmed that they did not carry out an analysis of this. Following the inspection the nominated individual for the provider confirmed the system used did not have the facility to provide any data, therefore the registered manager would not be able to carry out an analysis.

We recommend the provider review their systems to ensure a systematic approach to determining staff levels and skill mix.

New employees were appropriately checked through the provider's recruitment processes to ensure their suitability for the role. Records showed prospective staff completed an application form and had a face to face interview. Following this the provider sought references to check the person was of suitable character and applied for a Disclosure and Barring Service (DBS) check. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people. New staff did not commence their role before this information was returned. Before using agency workers the provider ensured that the service received information that the employment agency had carried out checks to ensure their suitability to work with vulnerable people.

People and their relatives felt the home was always clean and well maintained. One told us "Yes, it's always spotless. The staff are excellent. They replaced the bay window before I got here".

The premises were cleaned daily to ensure the risks of infections spreading were controlled. Cleaning records were maintained and regular audits of the cleanliness of the environment and equipment were undertaken. Hoist slings were washed after each use and most equipment was clean, although we did note one person's enteral feeding machine required cleaning and a nebuliser also needed cleaning. Staff received infection control training and protective personal equipment was available and in use. We observed the home to be clean, tidy and odour free.

Requires Improvement

Is the service effective?

Our findings

People told us they were always asked for their permission before personal care was provided. Relatives confirmed that consent was sought. One relative told us "They speak to her about it. They say, 'Can I take your photo?' This is at different parties and events. She nods". A second relative said "They ask his daughter, she has power of attorney. They do ask him and he may be able to understand, but he can't necessarily respond".

People's ability to make decisions was not always assessed in line with the Mental Capacity Act, 2005 (MCA). 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.

Care staff and the registered manager had received training in respect of the MCA and were able to demonstrate an awareness of the principles. However, registered nurse's understanding needed improvement. Two nurses told us if a person lacked capacity to make a decision they would seek consent from a next of kin. They did not appear to understand that this would need to be a person who has the legal authority to provide such consent. Consent can only be provided by a person who has been given the legal right to do so. Staff had not always ensured this. For example, we found a record in one person's notes that said the person's daughter had been called to provide consent to an immunisation. However, this person did not hold any Lasting Power of Attorney for decisions about health and welfare. No mental capacity assessment had been completed to show this person could not make this decision for themselves. We discussed this with a nurse who said "So would we sign the consent form?" demonstrating a lack of awareness of how to apply the MCA in practice.

Whilst we found that people's capacity had been assessed, we found at times the decisions to be made were not decision or time specific. For two people we found consent forms in place and signed by family members relating to decisions about clinical procedures and diagnostic tests such as blood samples and rectal medicines. Blood samples can be taken for a variety of reasons and rectal medicines are invasive. No capacity assessment had been done to determine if these people could consent to these at the time the decision was required. Although signed by family members to confirm their involvement in the assessment, in the person's best interest, this did not assess the person's ability to make these decisions at the time they may be needed, such as when a blood test may be required.

For example, for two people we found mental capacity assessments had been undertaken for the decision "consent to the care and/or treatment contained in the Safe Environment section of the care and support plan?". As the care plan file was not in order it was difficult to establish what this related to. However, further in the document it recorded whether these people were able "to demonstrate an understanding of risk assessments in place and specific care surrounding their safety". These were very wide ranging question that could cover multiple areas of care from the use of bed rails, to being observed while eating and drinking.

For one of these people we found a 'maintaining safe environment' care plan in place dated 2016 which stated that to keep this person safe they must be in an upright position when having meals and drinks, and that all risk assessments must be followed. A list of risk assessments were ticked in this care plan as being completed, including bed rails. The bed rails risk assessments was in place, stating that these should be used. However, these had not been consented to and no best interest discussion was recorded, specifically in relation to the use of bed rails.

Failure to ensure appropriate consent was sought and the Mental Capacity Act 2005 was applied in full meant people could be at risk of receiving care and treatment that they had not agreed to and that was not in their best interests. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff and the registered manager understood their role and responsibility under DoLS. The registered manager held a list of those applications which had been submitted to the supervisory body for authorisation and when DoLS were approved and due to expire. No one had any conditions imposed with their DoLS and their DoLS were referenced in their care plans to ensure staff were aware of these.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. The pre-admission assessment process identified the areas of support people needed in relation to their health, their social needs and their personal needs. People and where appropriate their relatives were involved in this process. One relative told us "There was a pre-assessment at the hospital. I was present". Another told us how they had met with a staff member to discuss their loved ones needs.

Following admission to the home care plans were developed. Relatives confirmed their involvement in these. One said "They discussed the care plan with me. They tell me what they suggest and I say if I agree or not". One person told us how staff had discussed what they needed with them.

The provider had policies in place for care planning which guided staff to ensure people's diverse needs were considered and where needed support was planned. Staff told us how for example, a chaplain regularly visited to carry out services and some people chose to attend. They told us, if they needed to make support arrangements for a person to meet a different religious belief this would be done.

Not all staff and the registered manager were not always able to tell us what evidence based guidance they used to inform their care planning, which meant there was a risk people would not receive care and support that was evidenced to be effective. For example, we asked the registered manager and three nurses what evidence they based their care planning and more specifically their end of life care planning on. Two were able to tell us whereas the registered manager and one nurse were unable to. Although two nurses described how they would ensure effective end of life care, we observed that the planning for this required improvement. The provider had a tool in place to aid the planning of end of life care but this wasn't being used. Whilst advanced and end of life care plans were in place these provided basic information about any funeral arrangements and the person's resuscitation status. People we spoke with were able to tell us about their resuscitation status and felt that this would be respected. However, care plans did not provide any

information which reflected that people and where appropriate their families had been involved in discussing, developing and reviewing a personalised approach to their end of life care which considered their physical, psychological, social, emotional, spiritual, religious needs and preferences.

Whilst some care plans were in place, these at times lacked information and guidance for staff. For example, for one person we saw could display behaviours which presented challenges due to their health condition. However, no plan of care which would guide staff to the management of their mental health condition was in place and no plan to guide staff about the management of behaviours had been implemented. We discussed this with the registered manager who agreed a plan should be implemented. Good practice recommends that the underlying cause of challenging behaviour be considered to ensure a comprehensive and proactive approach to care delivery with the aim of reducing the likelihood of the behaviours occurring in the first place. By the second day of our inspection a care plan had been developed which provided basic information about the behaviours and how this could be managed, but did not identify the potential varying causes and proactive management approaches.

People told us that how they felt permanent staff had the skills and knowledge to care for them. One said "The permanent girls are, rather than those from the agency. Some of the agency people are good, but they don't know your needs like the regular staff. They don't know you; you have to tell them what to do." Another told us "I think so, they are very good. They've got everything we need".

Staff received an induction when they started in the home which involved training and a period of shadowing other staff. Staff said they felt supported by the management team and the provider. They said they received support in the form of supervisions, appraisals and training. Records showed that staff had received information sharing and competency based supervisions on specific subject areas. However there was little evidence of general welfare supervisions. Supervisions should provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop and discuss progress and any concerns staff may have. The registered manager and deputy manager told us they were aware of this and had a plan to commence these and ensure all staff received a welfare supervision in November 2017. Records confirmed that annual appraisals had been undertaken and objective's, mainly focused on training, had been set.

Staff had undertaken training in a number of areas including those that the provider set as mandatory such as safeguarding, mental capacity and DoLS, moving and handling, infection control and first aid. In addition other areas of training had been completed by some staff including diabetes awareness, end of life care, falls management, dealing with aggression and the management of PEG's (Percutaneous endoscopic gastrostomy – a tube that is used for feeding, placed into the stomach via the abdominal wall). All staff were required to complete the care certificate, including registered nurses. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The provider used a safe to practice workbook which assessed staff knowledge and competency during this period. We looked at these for six staff and found that they were mostly completed, although we did identified some gaps. Due to concerns in another of the provider's services about the management of choking risks for people, each staff member had been assessed for their competency in this area.

One relative told us "He loves the food. He has so much choice for breakfast and for lunch. They especially look out for him because he's diabetic. They take notice of his diabetes. They cut it up for him. I was going to, but they already had". Another told us "She gets enough choice", "If she wants something else they're

amenable to tweaking". A person said "If they've got something I don't like, I would tell them and they would ask what I would like". While another said "I'm not always overly impressed with the variety, it's boring. Same old things, week after week". A five week rolling menu plan was in place which provided two options at meal times and detailed that other options were always available if people did not want what was on the menu. Staff told us people were asked each day what they wanted but if this changed they were offered an alternative. A list was then provided to the chef to prepare. Information was available to the kitchen staff which included people's likes and dislikes as well as any specific dietary requirements such as a need to fortify (add to the foods nutritional value) their food or ensure the texture was modified.

Where people required support to eat their meals this was provided in a manner which enabled them to eat at the pace they wanted and not feel rushed. Food and fluid charts were in place where these were needed. However we did observe that these were inconsistently reviewed by nursing staff and did not provide any target intake for people. Staff monitored people's weight and if this was a concern made referrals to other professionals to ensure this was managed. This included ensuring supplements were provided and their meals fortified.

Staff and the registered manager spoke with us about how they worked well as a team to ensure everyone was aware of any changes in a person's support needs. Internally they used a verbal handover system between shifts. In addition they used a significant items handover book where staff shared important events of incidents which had occurred and needed to be followed up. A diary was used each day to share messages and ensure that where a person needed something, such as a health professional appointment, this was booked and staff were aware of when they were visiting so they could ensure staff availability. A visiting professional told us a staff member was always available to discuss the needs of the person they were visiting with them. They also felt that staff understood people's needs, took action when they identified a concern to reduce any risks and made timely referrals. They were confident staff acted on their professional advice.

People were supported to maintain good health and had access to appropriate healthcare services. People and their relatives told us they were supported to access other health and social care professionals where needed. One person told us that "[Staff] would call one [GP] straight away" if they requested this. A second person said "The doctor comes every now and then. You have to let the nurses know". A third told us "I have hospital appointments and see the doctor when I need to". A relative told us staff sought support from others promptly. They said "Yes, very quickly. She gets visits from the SALT lady and the mental health team representative. They arrange her personal care and everything around their visits". People's records confirmed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs.

Signage was in place to provide guidance to people about the purpose of rooms although this tended to be in the written text with limited use of pictures to demonstrate a room's function. For those people who may find it difficult to establish a rooms function, this was not always promoted by appropriate signage, the layout and equipment stored in rooms. For example, the only dining room contained a table and chairs but also contained multiple units with varying storage in it. In addition multiple bags of empty medicines package were in here waiting to be collected. People's rooms had personalised signage outside to show the room belonged to the person. This contained photos and other items of interest specially related to the person.

Relatives told us their loved ones were able to personalise their rooms. One said "[Name], the maintenance man asked her what colour she'd like and showed her the colours and she pointed this one out. They did it a couple of months ago. She likes bright colours". A second said "[Manager] said when he first moved in, he's

quite welcome to bring in photos or put anything on his walls. They don't mind at all". The registered manager confirmed that people were able to personalise their rooms to however they wanted these. The environment was regularly checked for safety but the registered manager told us they were not aware of any audit of the environment to ensure this met the diverse needs of people, including their physical needs, any dementia related needs or other cultural needs.

We recommend the provider seek advice and guidance from a reputable source about how to ensure the environment can meet the diverse needs of people.

Good

Is the service caring?

Our findings

People and their relatives provided positive feedback about staff. One person told us "[Staff] are extremely good and kind. If you need anything, they'll get it immediately.' Another said "[Staff] are kind and humorous". A relative described staff as "The salt of the earth". Another relative told us "She knows them. They are fond of her, I can see that in the way they speak to her and smile at her". The health professionals we spoke with and that provided feedback told us they did not have any concerns about how people were cared for.

Observations reflected people were comfortable and relaxed in staff's company. Staff spoke with people with kindness and warmth and engaged positively throughout our visit, laughing and joking with them. We heard good natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. We found the atmosphere in the service was warm and friendly.

People and their relatives described staff who respected people's privacy and dignity. One relative said "We shut the door then they don't come in, they know to knock first". One person told us "I say 'Can I have 5 minutes?' Then they stay away. They are quite sensible, they understand".

Generally we observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the action they took to ensure people's privacy and dignity was respected when supporting them with personal care. Information about people was stored confidentially and only those who needed access to these records had this. Relatives told us that private space is always made available to their loved one for visitors if this is needed. One said "He sees people in his room, but when he has lots of visitors they can go into the front lounge and use that privately".

People were involved in making decisions about their care and were encouraged to express their views. One person told us "There used to be bedrails, but I wanted the bedrails down so I can get up for the toilet, so now they don't put them up".

Where necessary advocacy was sought for people and relatives were encouraged and welcomed to visit and contribute. A relative told us "I can visit any time, this is my second home. I feel very welcome", "[Staff] looked after me and brought me food and drink and made sure I was OK". Another said "[Staff] even let me have lunch here. They say I'm part of the furniture. My daughter says she comes here to feel the friendliness".

The registered manager told us that resident meetings were held regularly to seek feedback. All except one person was aware of these. One relative told us that these meetings were not always well attended saying "There were 3 of us last time. But you can ask questions, it puts your mind at rest." Other relatives gave positive feedback about these meetings. One said 'There's residents' meeting once a month. I've often been. I've never felt obliged to. I made a suggestion of a musical afternoon. A chap used to play electric guitar. They took him on and now he comes ever since". A second said "It's nice to meet other relatives. It's nice to

get together as a group. We can air our views. They make every effort to accommodate our wishes. [Manager] is in the meetings and the deputy, but it's better when there's a carer there because [manager] and [deputy] sing off the same song sheet, they're both management. When a carer is there we can ask 'Would it be possible to?', and [they] can ask the carer if it's possible".

Staff understood the importance of respecting people's choice. They told us how they ensured that people were able to retain as much independence by making their own choices while they could, including what to eat and drink, what to wear, where to sit and what activities to be involved in. We observed staff offering choices throughout the day. People told us they felt staff respected their decisions.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff knew them well and this was apparent throughout our discussion with staff about people. Staff were aware of people's histories, their likes and dislikes. They adapted the service they delivered to ensure people received care they wanted. For example, one person told us how at their requested changes had been made to their support and bed rails were no longer used.

A health care professional told us how they felt the staff at the home responded promptly to people's needs when they felt these had changed. They told us that whenever they had visited following a referral from the home they were pleased that the staff had taken initial action to respond to the change in need and keep people safe. For one person this was not always clear in their records. We found that clinical observations recorded in June 2017 indicated they were potentially unwell. This person had been unwell throughout the month before. However, we found no records which reflected that staff had followed up on the observations which were outside of the person's usual range. The monthly review recorded no GP involvement as did the health professional records and there was no record to show the observation had been checked to ensure these were accurate, or if they had returned to normal. We discussed this with the registered manager who was not able to explain what had occurred. Although we were assured the person was well at the time of our inspection, their records did not always reflect that staff responded to a potential change in need.

However, for other people it was evident that staff responded to people's needs as they changed but records did not always reflect this. For example, we found records showing an increase in falls for one person. We spoke with the person who was able to tell us how staff had discussed their mobility with them, reminded them to call for help and not to stand alone. They also told us and we saw that staff had introduced an alarm mat which would alert staff to the person's movement. In addition they told us how they had requested a change in care to ensure their needs overnight were managed in a way they felt comfortable with. They told us that although sometimes a gentle reminder to staff might be needed they received the care in a way they wanted. However, their falls assessment was not reviewed following each fall which would ensure the assessment of their needs was up to date. The care plan had not been reviewed following the falls to ensure this accurately reflected their needs and they did not reflect the support the person told us they were receiving.

We found a suction machine in a second person's room. There was no record to reflect this had been used and nothing in the person's care plans to explain what this was for. The registered manager told us this was in place following a hospital admission but was unable to tell us what it related to. However the deputy manager told us how the person had been unwell before they were admitted to hospital and on one occasion they had used the suction to support them. They said it had never been needed before or since for this person but as they had two machines they had kept one in the room, just in case it was needed in the future. We discussed the lack of this information in care plans and the risks this could pose. The deputy manager agreed to ensure a clear care plan was implemented.

Although staff responded to people's needs the lack of clear, accurate and contemporaneous records about their care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Information was not always provided to people in a variety of ways which would give them the best opportunity to understand it and be able to contribute. For example, menu and activity plans were in written small text with no use of pictures or symbols. Although a member of staff told us they had pictures to help people make decisions about their meal choices they were not able to find these. Policies on display were in written text only and although feedback from the survey contained graphs the text was written and small. Then registered manager told us they were not aware of the Accessible Information Standard and the provider policies they sent us did not include ensuring information was made available in accessible formats based on individual needs. The registered manager and quality assurance manager told us they would look into this.

People provided mixed feedback about the activities provided. One told us "I go down to the entertainment". "Some things I'm not able to do, but I'm all for joining in with it. I've always done craft things". Another told us they didn't join in because they chose not to and a third told us they have games but they felt there wasn't always much to do.

An activities coordinator was in post and worked five days a week. Although a plan of activities was in place they told us how they struggled to engage people in group activities because people mostly chose to stay in their rooms. As such they provided one to one support time to people. They visited everyone in the home, every day they worked. They spent time engaging with them in a way they chose, for example, reading the paper, playing cards and chatting about their past. We observed this one to one engagement taking place during our visit. The activities coordinator told us how they arranged external entertainers for people who enjoyed this and had at the time of our visit, made special arrangements to celebrate two people's birthdays. They said they were always looking for ideas for activities.

The provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. People had access to an independent advocate, if they needed one. All of the people we spoke with told us they knew how to complain and were confident to speak to both staff and the registered manager. The registered manager told us that when concerns were raised they dealt with them in line with the provider's policy. We saw complaints were investigated by a member of the provider's senior management team. Any learning that could be taken was clearly documented and staff told us they would be made aware of any changes that were needed as a result.

At the time of the inspection the registered manager told us no one was receiving end of life care. However one person's condition was considered as rapidly deteriorating and they may be entering a terminal phase. This person had refused to discuss their end of life needs, wants and wishes but we saw evidence of multi-disciplinary team work to ensure their needs were met. Although the planning for end of life care required improvement, staff were able to tell us about what they would need to consider and how they would engage with other health professionals to ensure the person received the appropriate support at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

People's relatives provided positive feedback about the service and they did not have any concerns. One told us "There's no problem with anything here". Another said "They communicate well. We're very happy. [Relative] is happy. We are fortunate we found this place for him" and a third said "It's perfect. There's no problem at any level. Any problem goes straight to the top, when it's needed".

Although there was a system of audits in place these were not fully effective in identifying where improvements could be made. For example, care plan audits between June 2017 and the end September 2017 identified no actions or areas for improvement. However, we had identified a need to make improvements to ensure person-centred planning and to keep records updated and accurate. An effective care plan audit would have identified these areas for improvements and made plans to act on them.

Audits were carried out by a member of the provider's management team responsible for quality assurance. Although they recorded that they had sampled care records for people, they did not provide any information about whose records they had reviewed and it therefore made it difficult to track if actions had been taken to address the issues that arose. For example, one audit identified a need to ensure service user involvement was clearly reflected in care plans. We found that this was an area that could be improved for some people. We were also concerned that the audit did not always identify the concerns we had. For example, the audit in August 2017 stated that three people's care plans were checked and contained end of life and advance care plans which evidenced that people's wishes had been considered and discussed. However, we did not find this and found that the planning for end of life care needed improvement.

The quality assurance manager told us that following a CQC inspection at another of the provider's services they, along with the provider's senior management team, were reviewing the systems used to ensure the quality assurance procedures in place were robust and effective. However, this work had yet to be completed.

A failure to ensure systems were fully effective in assessing, monitoring and improving the quality of the service provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager confirmed that they did not hold a service action plan which looked at developments to drive continuous improvement. They also said they were not aware if the provider had a plan which addressed this and which aimed to ensure sustainability. We asked the nominated individual who provided us with a presentation they had given to the senior management team. They told us this gave a summary of the prior year's performance, the current year to date, what has gone well, what not so well and plans going forward. However, this tended to focus of the finances of the company and maintenance plans. It didn't contain any plans going forward to ensure a quality service was provided based on information that the provider was gathering through their own quality assurance processes about their service. However following the inspection the nominated individual sent us a further two documents demonstrating action planning to encourage improvement. They told us they held an overall quality

improvement plan for the whole of Contemplation Homes Limited which were not fully shared with the registered manager. They advised and provided a copy of a service specific improvement plans which they said was built from the analysis of the quality assurance survey results, sent to people, relatives, staff and other professionals. The registered manager had taken action to make improvements to areas that had been identified as requiring improvement in the quality assurance survey results.

Other audits in the home appeared to work well. Regular medicines audits were in place and identified any concerns in the signing for the administration of medicines and in the stock. The audits demonstrated action needed to be taken and a nurse confirmed this was always done. Weight audits of those people who were at risk were completed to ensure that support was effective and to ensure that where needed supplements were provided. In addition we saw that a meeting had been used to provide constructive feedback of a meal time audit/observation. Staff had been instructed to ensure they used hair nets and put more effort into food presentation, which we observed taking place throughout our visit.

Staff understood their roles and responsibilities within the home and strived to ensure they delivered a service that people wanted and that met their needs. The registered manager told us how they engaged with the local care homes forum and encouraged staff attendance at these as a means to develop relationships with other professionals, share knowledge and ideas' as well as keep up to date with any changes. The registered manager described the approach they used to ensure the service was open and transparent. They told us they operated an open door policy where staff, people and their relatives could access them at any time. The registered manager told us they try to ensure a hands on approach and work alongside the staff.

Staff spoke very highly of the management team. They said the registered manager, deputy manager and senior managers were very open, easy to talk to and always approachable. They told us although they hadn't needed to ask the registered manager they were assured that if they needed their support to provide direct care, that the registered manager would do this. They said they felt comfortable and confident to discuss anything with them. They felt they would be listened to and their concerns would be acted upon. One member of staff told us of concerns they had raised and said these had been dealt with immediately and effectively.

Staff told us regular team meetings took place and they were encouraged to make suggestions and give feedback. Records confirmed these meetings took place and staff were engaged. These meetings were used as an opportunity to share learning and improve practice. For example, we saw how a concern about staff communication raised by a family member had been addressed and staff reminded of the need to ensure good, clear and appropriate communication at all times.

People and their relatives were encouraged to feel welcomed and to contribute and share any concerns they had. Two relatives identified the service as their second home and visited every day. They told us they appreciated contact with the manager and felt supported and listened to. We observed through the inspection that people and relatives were comfortable to request to speak to the manager and often chose to.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person failed to ensure appropriate consent was sought and the Mental Capacity Act 2005 was applied in full. Regulation 11(1)(2)(3)

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 person failed to ensure that risks were appropriately assessed and action taken to mitigate risks to people's safety. Regulation 12(1)(2)(a)(b)

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 registered person failed to ensure systems were fully effective in assessing; monitoring and improving the quality of the service provided and failed to ensure accurate and up to date records. Regulation 17(1)(2)(a)(c)