Care Quality Commission

Henson Healthcare (Whitby) Limited

Whitby Court 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**

Overall summary

This inspection took place on 1 and 4 September 2015. It was unannounced on the first day and announced at short notice on the second day. Whitby Court Care Home is registered to care for up to 50 older people with nursing needs. On the day of inspection there were forty five people living at the home. The building was recently built for purpose and presents an attractive living environment. There is a passenger lift to assist people to the upper floors and the home is located close to transport links and the local park.

The home had a registered manager in place. 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.

At the last inspection on 17 November 2014 we found three breaches of regulations. We received an action plan from the provider setting out how they would meet the relevant legal requirements.

We found that the registered person had not protected people because of shortfalls in the way they assessed and managed individual risk. This was in breach of regulation

Summary of findings

9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 1 and 4 September 2015 we found this area had improved with risk management plans in place to protect people. This meant there was no longer a breach of regulation 9.

At the last inspection on 17 November 2014 we found that the registered person had not protected people against the risks associated with the safe handling of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 1 and 4 September 2015, we looked at the management of medicines and found that this had improved. People received their medicines as prescribed and when they needed them. This meant there was no longer a breach of regulation 12.

At the last inspection on 17 November 2014 we found that the registered person had not protected people against the risks associated staff who were insufficiently trained to deliver effective care. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection 1 and 4 September 2015 we found that staff training had improved so that they had the skills to give effective care. Regulation 18 was no longer in breach with regard to staff training.

Staff were safely recruited. However, staffing levels were not always sufficient to care for people safely or to enable all people to pursue interests of their choice. This was a breach of Regulation 18 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.

We noted gaps in records which monitored people's clinical care needs, for example fluid and nutritional charts and moving and handling charts. Records of people's involvement in decisions about their care were not sufficiently detailed to ensure staff had the information they required. This meant there was a breach of Regulation 17(2) 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.

People had their clinical care needs met, however, people sometimes had to wait for staff to attend to them in terms of these needs, for example in relation to repositioning or receiving drinks. Required charts to monitor this care were not consistently completed. We have made a recommendation about this.

Staff were kind and usually offered compassionate care, including when people reached the end of their lives. People had written thank you cards and letters praising the kind and compassionate care offered by the service. However, staff were sometimes rushed which led to care being task led at times.

The environment, though attractive and well decorated was under used and its potential not fulfilled. People did not feel encouraged to use certain areas of the home. The environment was not well adapted to the needs of people with memory impairment. We have made a recommendation about this.

Staff and people who lived at the home told us that the culture of the home did not always put each person at the heart of care. Lines of communication between the providers, the registered manager, staff and the people who lived at the home and visitors were not sufficiently transparent or responsive. People and staff were not sufficiently involved in developing the service. Although surveys and meetings took place, there was insufficient evidence that people were consulted in a meaningful way over how the service was run. We have made a recommendation about this.

People were protected with regard to seeking consent before undertaking day-to-day care and treatment, however, they had not always received assessment for their mental capacity when this was needed to ensure their rights were upheld and their freedom to make decisions maximised. We have made a recommendation about this.

Summary of findings

People told us they felt safe at the home. Risks to people were assessed and acted upon. Staff were trained in safeguarding and understood how to recognise and report any abuse.

People were protected by the infection control practice within the home. The home was clean and fresh throughout.

Most staff were supervised and trained effectively to feel supported to offer good quality care. However, nurses felt that they needed more clinical supervision support.

People had access to health care support and the service was proactive in referring to specialist professionals and acting on their advice.

People received well balanced nutritious meals. They were offered freshly cooked breakfast and tea time meals. Main meals were pre- prepared frozen meals which the service re heated. People told us they enjoyed the food, however, some people told us they would have preferred a choice of a freshly cooked main meal and staff confirmed that at the time of inspection people did not have this option for main meals.

People were supported to take part in activities and daily occupations. However, some people were at risk of being under stimulated because staff did not have time to work with everyone in this way, particularly those on the nursing floor.

If people raised concerns or complaints these were usually dealt with promptly and recorded with actions.

The registered manager carried out a system of checks and monitoring audits to ensure the service was safe and that plans could be drawn up for improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People told us that they felt safe. However, there were sometimes insufficient staff to care for people safely.

People received the right medicines, and these were handled safely. However we noted a number of shortfalls in recording which meant there was a risk people would not always receive their medicines safely.

People were protected by the infection control practices of the service.

People were protected by staff who were safely recruited.

Staff had received safeguarding training and understood how to act if they suspected abuse.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff were trained and supported to meet people's needs and some staff were supported to develop professionally. However, nurses clinical support and leadership could be improved.

The registered manager was aware of the principles of the Mental Capacity Act 2005 and how to make an application to request authorisation for a person's deprivation of liberty. However, people had not received mental capacity assessments when needed.

People had access to healthcare services when they needed them.

People received well balanced nutritious meals.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some staff had positive relationships with people and were reassuring and kind in their approach. However, staff were sometimes rushed and did not always give people the time or attention they needed.

People were not involved in decisions about their care as much as they could be.

People told us that they were treated with regard for their privacy and dignity.

People received kind and considerate care at the end of their lives.

Is the service responsive?

Requires improvement

The service was not consistently responsive to people's needs.

Summary of findings

There was insufficient evidence that care had been discussed and planned with people. People's needs were usually met but their preferences were not sufficiently understood.

The environment had the potential for being stimulating and interesting to people, however some areas were under used and people did not feel welcome or encouraged to use it all. There were insufficient items and decoration of interest to people with memory impairment. Also signage was insufficient to assist people with memory impairment to orientate around the home.

Concerns and complaints were listened to and usually acted upon.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Communication between the providers and the registered manager and staff team did not always create a culture which placed people at the heart of care.

People were consulted about their views, but this did not always result in action which people agreed with.

The registered manager was visible about the home and staff told us they listened to them and did what they could to improve the care for everyone in the home.

Staff had regular meetings and the opportunity to consult with the registered manager.

The registered manager had made statutory notifications to the Care Quality Commission where appropriate.

People were protected by a range of checks and monitoring audits carried out by the registered manager and designated staff.

Whitby Court 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 was planned to check 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 1 and 4 September 2015. It was unannounced on the first day and announced at short notice on the second. It was carried out by one adult social care inspector, and a specialist nurse advisor.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We did not request a Provider Information Return (PIR). Requests for a PIR are not always made to coincide with inspection visits.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. However we gathered all the information we required on the day of inspection.

On the day of the inspection we spoke with six people who lived at the home, three visitors, the registered manager, and eight members of staff including two nurses. After the inspection we spoke with two social care professionals about the service and two health care professionals

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We also spent time looking at records, which included the care records for nine people. We looked at the recruitment, supervision and appraisal records of three members of staff, a full staff training matrix, rotas for the past two months, nine care plans with associated documentation, a number of audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

At the last inspection on 17 November 2014 we found that the registered person had not protected people because of shortfalls in the way they assessed individual risk. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 1 and 4 September 2015 we found this area had improved. Care plans identified a person's level of risk. People who lived at the home and visitors told us that staff had discussed areas of risk with them. We saw risk assessments where appropriate which included such areas as nutrition, pressure care, mental capacity, infection control, falls, behaviour which may challenge others and moving and handling. Risk assessments were proportionate and included information for staff on how to reduce identified risks whilst avoiding undue restriction.

The registered manager told us that people's behaviour which others might find challenging was managed alongside advice from the community mental health team and records confirmed this on care files we saw. This meant that regulation 9 was no longer in breach.

At the last inspection on 17 November 2014 we found that the registered person had not protected people against the risks associated with the safe handling of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 1 and 4 September 2015, we looked at the management of medicines and found that this had improved. We found that the service had a 'Croner care home management medication policy' that had been updated on 17.02.15, to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. This included a section on self administration. However, at the time of inspection no people administered their own medicines.

The home operated a monitored dosage system (MDS) for medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. Some medicines were stored in people's private rooms in lockable cabinets. A risk assessment had been carried out for each person who had their medicines stored in this way and the registered provider informed us that all self medication storage was kept locked when people were not directly using them.

We saw medicines were stored securely in a locked medicine trolley within a medicine treatment room which was kept locked at all times when not in use. Medicines requiring cool storage were kept in a fridge appropriately. Within the first floor treatment room we saw that fridge temperatures had been recorded daily. However, within the second medicines room we found there were gaps in the fridge temperature records which meant the registered manager could not assure themselves that the fridge temperature was safe at all times.

The temperature for the treatment room, where medicines were stored was sometimes recorded at more than 25 degrees centigrade. This is higher than the recommended safe storage temperature for some medicines. For example during August, the temperature was recorded at this high level for 27 days. During July the temperature was recorded above 25 degrees centigrade on 10 days, which meant some medicines may not have been safe for use. The nurse on duty told us that this had been reported to the manager on a number of occasions, but that the remedy of turning off the light in the room had not been effective.

The registered manager agreed to check the safety of medicines stored at higher temperatures with the pharmacist. The registered manager also agreed to order an air conditioning unit on the day of inspection.

We found that there was no signage on the door of a medicines room which stored medical gases as required. We found that not all people who received nursing care had photographs on their medical records which is recommended as a protection against administering medicines to the wrong person. The registered manager gave assurance that these shortfalls would be addressed.

When we examined a sample of the medicines administration records (MAR) charts we noted that staff had recorded administration correctly most of the time. However, we saw no signatures on a transdermal patch form for the day of inspection and administration signatures were also missing for some other medicines

which were administered by applying to the skin. This meant the registered manager could not be sure that people always received their prescribed medicines or creams at the correct time.

However, when we observed a medicines administration round we saw people received their prescribed medication at the time they needed them and that this was done in a safe way. We saw staff explain to people what medicine they were taking and why. Staff also supported people to take their medicines and provided them with drinks, as appropriate, to ensure they were comfortable in taking their medication.

We saw that people received medicines which were as required, (PRN) safely and in accordance with written guidance.

The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example mixed with food or drink. We were told that no-one received their medicines covertly.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their potential for misuse. We saw that controlled drugs were managed appropriately.

The registered manager told us that they conducted annual observations to assess staff's competency when dealing with medication. These measures gave assurance that staff received support to manage medicines in a safe way, making sure that people who used the service received their medicines as prescribed.

We noted that although medicines audits were completed, one audit had shown some errors, gaps and omissions in recording. There was no record to show when the recommendations of this audit had been implemented. This meant the registered manager could not be sure that people always received their medicines correctly.

An external pharmacy had carried out an audit on 16/07/2015 and had made recommendations. The registered manager explained to us that they were working through addressing these recommendations. This meant that regulation 13 was no longer in breach, however, there were areas around medicine handling which continued to require improvement.

Before the inspection we received an anonymous concern that there were insufficient staff on the nursing floor to ensure people received safe care. We found that the home placed enough staff on rota to care for people safely. However, we heard from staff that the rota was not always followed. This was either because of staff sickness or due to staff leaving their employment which left some shifts understaffed. This happened despite having arrangements with an agency. For example, on the first day of inspection there were five care workers and one nurse on duty on the upper floor which specialised in care for people with nursing needs. This appeared sufficient to care for those people's needs and staff confirmed that it was. On the second day of inspection there was a nurse, with one experienced carer, one new carer and another carer who usually worked on the residential floor and so was not very familiar with the care needs of the people with nursing needs. We spoke with the nurse and one of the care workers on the nursing floor who told us that they had struggled to complete all the care tasks required that morning in a timely way, such as assisting people with washing and dressing and having breakfast. At twelve o'clock the nurse was still assisting someone to get up and dressed.

Staff told us that when they were short of staff people sometimes had to wait for drinks or to be made comfortable regarding continence care. One member of staff told us, "It is very frustrating and stressful. Because there is quite a turnover of staff, we are having to assist inexperienced care workers who through no fault of their own are placed in a difficult position. They shadow staff who are rushing. They are trying to learn from staff who haven't time to show them properly." Another member of staff told us, "We don't always have time to do things the way we know we should such as using correct moving and handling techniques. We sometimes have to manage with one member of staff to assist when the care plan says two. People have not been hurt so far, but there is a risk they will be." The registered manager told us there was a difficulty in recruiting to all the positions which were vacant and that

Is the service safe?

there was also a difficulty in retaining staff. They organised the rota so that there were a range of skills and experience but in practice this did not always work out. This meant there was a risk that people would not be cared for safely.

People on both the nursing and the residential floors told us that staff came quickly if they used their call bells, although we noted that on the nursing floor, bells were sometimes sounding for a long time before they were answered. In one case we noted this was ten minutes, in another case twenty. On both days of the inspection visit we observed that staff on the nursing floor were rushed and sometimes walked past rooms where people were asking for support. The people and visitors we spoke with told us they thought there were usually enough staff but one person told us that they were sometimes, " Under pressure and rushing about with no time for a chat or a sit down."

Failing to ensure sufficient staff were on duty to care for people safely was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the residential floor, staffing levels were safe. One senior member of staff and three carer workers were on rota for this floor, staff told us this floor was usually fully staffed and the floor was fully staffed on both the days we visited. On this floor staff told us that they did not feel unduly rushed, and that they had time to carry out their tasks safely. The home employed other staff such as an activities organiser, a maintenance worker and cleaners.

We noted that staff were safely recruited. Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received. A DBS check is a way of ensuring that people who are known to be unsuitable to work with vulnerable people are not employed. Staff told us that they had been interviewed with a panel of at least two, and that they had been asked to provide information about previous employment and account for any gaps in employment history. This minimised the risk of employing people who were unsuitable for their role.

People told us that they felt safe. One person said that staff and management responded to concerns they may have, for example by approaching people's behaviour which may challenge in a way which made them feel secure. They told us about an incident, "They were really good about it, and made me a cup of tea to calm down." Another person said, "I never feel anything but safe here." Everyone we spoke with told us that if they ever felt unsure about their safety, staff would reassure them and deal with what was troubling them. People told us that the home was clean and always smelled fresh. One person said, "It's is beautifully clean in here and it's always the same, day or night."

Safeguarding training for staff was up to date with a clear timescale in place for when updates were required. Staff were able to describe different types of abuse and what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the registered manager. This meant that staff had the knowledge to protect people appropriately.

The home had a policy on whistle blowing. Staff told us that they understood the whistle blowing procedure and two said they were confident to raise any whistle blowing concerns. However, four staff said that although they would be confident to raise concerns with the manager they were not confident to do so with the owners. This meant that people may not always be sufficiently protected if staff wished to whistle blow.

We saw that the home regularly reviewed environmental risks and carried out regular safety audits. We noticed that the environment was clear of obstructions and that wheelchairs and moving and handling equipment was stored safely away. The home was purpose built, which meant that doors into rooms were wide to allow for wheelchair access. Risks to people due to the environment were minimised.

We noted that the home was very clean throughout. We saw that the home employed cleaners who worked to schedules and that they adhered to good practice guidelines regarding the use of colour coordinated cleaning equipment to reduce the risk of cross infection. Cleaning products and equipment was stored correctly and safely. Staff told us and we saw records to confirm that they had received up to date infection control training. Staff could correctly tell us about good infection control practice and procedures and assured us that they followed these.

Requires improvement

Is the service effective?

Our findings

At the last inspection on 17 November 2014 we found that the registered person had not protected people against the risks associated staff who were insufficiently trained to deliver effective care. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection 1 and 4 September 2015 we found that staff training had improved. We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed. However, staff also told us that they were often rushed on the nursing floor, and that shadowing did not always take place in the way it was intended. This meant that staff sometimes were unsure of their role until they had worked on this floor for a time and this meant at times they felt they did not have the experience to carry out tasks they were asked to do.

In addition to mandatory training, which was all completed as required, staff received specially sourced training in areas of care that were specific to the needs of people at the home. For example, a number of staff had received training in dementia care, and specialist advice on end of life care through the hospice.

People told us that staff were skilled in caring for them. One person told us, "They are really good at understanding what care I need. They are very knowledgeable." Another person told us, "They are very quick to get the doctor or to get a consultant involved." People said that staff explained things clearly to them. We saw that staff communicated with people at a pace and in a manner which helped them to respond.

Staff told us that they received regular supervision and appraisals and we saw evidence of this in the staff records we reviewed. Some staff told us this supported them to develop professionally and to give people the care they needed. However, nurses told us that while they had regular meetings with the manager they did not feel well supported in their clinical care and decision making. They told us that their supervisions which were group discussions did not address individual concerns they may have and they felt they lacked support and direction. We noted that the service did not have a clinical lead in place and that the manager was working to address this. We spoke with the nurse in charge of the shift on both days of inspection and both nurses told us they had no clinical lead to support them. The registered provider told us following the inspection that there was a clinical lead in place on the days of inspection but that the role was called 'Head of Care'.

The home had links with specialists, for example in diabetic care, nutrition, sight and hearing, pressure care, end of life care and the speech and language therapy team (SALT).This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person where this was possible. A heath care professional told us, "They are proactive about referring to us and they follow our advice."

Care plans included details of people's needs around nutrition and hydration. People's nutritional needs were assessed and the Malnutrition Universal Screening Tool (MUST) was used. MUST is a five step screening tool which is used to identify adults who are at risk of malnutrition. When people were assessed to be at risk, strategies to address this were written into care plans, such as providing fortified foods or pureed diets. A health care professional told us that the home consulted with them around people's nutritional needs and their advice was followed. Reviews and decisions made about nutritional care were clearly recorded. Staff used charts when people required their nutrition and fluid intake to be monitored. We saw surveys asking for people's view about their meals and the registered manager told us about changes which had been made following people's comments.

The home provided home cooked breakfast and tea, and each midday main meal was provided by a frozen foods company. These pre-prepared nutritionally balanced meals were delivered and reheated by the service. People had a

Requires improvement

Is the service effective?

choice of main course and desert. All pureed foods were also provided through the frozen food company. This ensured that people who required a softened diet also received nutritionally balanced meals. A number of people told us they enjoyed the meals, for example one person told us," The meals are fine, no complaints." A visitor told us, "The meals are beautiful, I could sit down and eat any one of them myself." However, some people we asked about food told us that they did not always enjoy the main meals and would have preferred the option of having a freshly prepared meal. One person told us, "It seems such a shame that they don't do home cooked food. That's what I really miss."

We noted that there were gaps in the recording of four out of the six nutritional and fluid chart records we looked at, so it was unclear if people's needs had been addressed at these times.

On the second day, we observed a morning drink time, with a choice of hot and cold drinks and snacks. Staff showed that they understood people's preferences and they listened and acted on what people asked for. We noted that people who asked for drinks also received them between these set times.

People's needs in relation to pressure care were recorded, and specialists had been involved to assess people's skin condition and what was needed in terms of care and pressure relieving equipment to minimise the risk involved. However, we noted that when moving and turning charts were in use to monitor people's care in this area, there were a number of gaps in recording. This meant it was unclear whether people had received their care in line with their care plan.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager understood the implications of the recent Supreme Court ruling which had clarified the notion of deprivation of liberty for people in a care home setting. A small number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place, and one DoLS was in place for a period of one year.

Training records showed that staff had received detailed up to date training on DoLS and the MCA. Care staff were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting power of attorney. This meant that people could be protected regarding their mental capacity.

People told us they were regularly asked for their consent to care. For example, one person told us, "They are absolutely marvellous, so polite, always respectful and keen to be sure that what they are doing is okay with you." We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. Care records showed that people's consent to care and treatment was sought. Staff told us that reviews took place with each person involved.

However, people's views were not well recorded and it was not always apparent whether their views and expressed preferences had influenced the way their care was given. Care plans did not include an assessment of mental capacity when we would expect this due to a person's level of cognitive functioning. This meant that it was not always clear how the home supported people to make decisions about their care.

We recommend that the provider consults best practice guidance to ensure people are protected under the Mental Capacity Act 2005 around making decisions about their care.

We recommend that the provider consults best practice guidance around monitoring clinical care delivery to protect people's welfare.

Requires improvement

Is the service caring?

Our findings

Most people told us that the staff and the registered manager showed them concern, gave them time and listened to them. For example, one person who lived on the lower floor told us, "They are all absolutely lovely staff." People told us that staff responded when they asked for help. One person told us, "Yes they help when I need it," A visitor to the nursing floor told us, "Staff are caring and very kind." However another visitor told us, "I hear people ringing the bell and nurses just don't have time to see to them. I hear people shouting for help and getting distressed."

The registered provider told us that a number of people had sent thank you letter and cards and these reflected that staff had treated them with kindness and concern for their wellbeing.

We spent time with people in the communal areas of the lower non nursing floor and the upper nursing floor both in the morning and again later in the day on both days of our inspection. We noted that staff interactions were more relaxed and attentive on the lower floor at all times. Staff appeared to understand people well and there was laughter and chatter between staff and people who lived at the home. We heard people say things such as, "You are a nice lady," and "I am feeling better and all because of you."

On the nursing floor staff did not often ask how people were or stop to engage people in conversation during the mornings and this was because they were attending to personal care tasks and administering medicines. In the afternoons, staff did sit with people and chat for short periods of time, but they were often called away by bells ringing or other staff asking for assistance. When we overheard staff talking they were always polite with people who lived at the home but they often gave the impression of rushing and people sometimes made comments to this effect, such as, " She's running off again."

The home worked closely with the local hospice who was supporting them to offer compassionate and attentive end of life care. The registered manager acknowledged that this approach was hampered by not being fully staffed at all times particularly on the nursing needs floor. We found this led to care sometimes being task led and that people did not always experience the level of compassionate care the registered manager and staff aimed to deliver.

Staff told us they wished they had more time to spend with people once they had completed their personal care tasks in the morning, however, all the staff we spoke with on the nursing floor felt they did not offer a sufficiently caring approach because they were too rushed to do so. They expressed concerns that they could not give people the full time they needed to make sure they always understood what they wanted and needed.

Staff told us that they respected people's privacy and dignity. They spoke about knocking on doors before entering private rooms and about how to offer personal care in a respectful way.

Some people had Do Not Attempt Resuscitation (DNAR) forms in place, and we saw these were mainly completed correctly and regularly reviewed, though one form recorded a person's home address which made the form invalid for the nursing home. We brought this to the attention of the registered manager who told us they would address this. People's wishes for the end of their lives were also recorded for some people, and where this had happened the level of recording was detailed and gave guidance for staff so that people's wishes could be followed.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with end of life care professionals and attentive monitoring to ensure people did not suffer pain. We saw that people's needs in relation to pain were addressed in their care plans and that nursing staff had attended syringe driver pain relief training, so that this type of pain relief was available to people who needed it.

We spoke with a health care professional who specialised in care for people who were reaching the last days of their lives. They told us that the home had recently begun to follow the Gold Framework which was an approach to good quality end of life care. They told us that while this was a positive initiative, they were still in the early stages of working with this model and so it was too early to judge whether this was having a positive impact on people's wellbeing.

Requires improvement

Is the service responsive?

Our findings

Some people told us that the staff supported them to have choice in their lives. For example one person without nursing needs said, “They are first class, I love it, I can help myself to drinks at any time I like.” Another person who also lived on this lower floor said, “I have my own routines, and they let me get on with it. Sometimes I listen to the reading group which I like.”

On the upper floor, a visitor said, “They do not always respond quickly, but I understand why. They have so many people to see to it’s difficult for them,” and “The staff don’t have much time to do anything nice with people really, they spend all their time trying to make sure they get up and dressed, things like that.”

The staff and most people we spoke with told us that the home welcomed visitors. During the day of our inspection we noticed that there were a number of visitors who were welcomed by staff. People told us that the staff supported people to maintain their relationships. For example, they would assist people to make visits into the local community and invite relatives for meals at the home. Two visitors told us that they called every day and that they were always made welcome and offered refreshments.

Each person’s care plan contained information about their history, their likes, dislikes and people who were significant to them. People’s interests and preferences around their care were recorded and the plans focused on the whole of the person’s life, including their strengths and any goals they may have. Care plans were regularly updated to reflect changing needs. However,we found that care plans did not always include details of how people had been involved in decisions about their care. Although some people had signed their plans, it was unclear how people were supported to express their preferences for example when they had difficulty signing their name, or had memory impairment.

People’s control over their lives was improved through staff offering choices in relation to meals, clothing and outings. A hairdressing salon was well used, and people were supported to use their chosen hairdresser, and they also enjoyed nail care from staff. The home had a number of rooms containing interesting objects for people to enjoy. For example one room contained a train set which the registered manager told us was used for people's amusement. However, this was locked when not in use to prevent damage to the train set.

However, although the home had a number of good resources in terms of space, we found that these were not all made welcoming to people and some were rarely used. For example, the service had a ‘beach’ room. This room was at below the main living area level with a rather closed outlook, seating was in deck chairs which were unsuitable for people with mobility problems, the sand was at floor level and so was not accessible for people who found difficulty in bending. The registered providers told us that the room was sometimes used by families with young children for the enjoyment of those people who had such visitors. However, over the two days of our inspection we did not see anyone using this space. When we asked people if they had used the beach room they said they never had. One visitor told us, “When we saw the beach room, we thought, well, who can use this?” One visitor told us that sometimes the children of visitors might use the room, but that the people who lived at the home did not. This meant that the potential of the room to be used by people who lived at the home was not fulfilled.

Other areas of the home were also underused. On the floor which specialised in care for people with non- nursing needs, there was a room containing a large chess set which we did not see anybody use on either day. Staff and people who lived at the home told us that people rarely used this room. The lounge area on this floor was set out with bright pleasant furniture arranged around tables. On entering the building this appeared attractive. However, during the two days we spent in the home we found that this space was only occasionally used, and people told us they did not want to spend time in it. Most of the time people chose to sit in the dining area of the home in a row of chairs which were arranged along one wall. This was because, as one person told us, “All the staff are in this area, we’d never see them if we sat in the lounge.”

The home had discrete signs for toilets and bathrooms, however, these were not clear for people who had sight or memory impairment. Objects which would assist with orientation in time such as clearly visible clocks, day of the week or season signage were not available for people who would benefit from these aids.

Requires improvement

Is the service responsive?

On the upstairs floor, staff told us people almost never used the upper lounge. We found the doors to this were always closed, that there were no interesting objects for people to engage with; no radio or television for people to enjoy in a companionable way and no staff encouraging them in for a chat. Most activity took place either in people's individual rooms or in the dining area.

A number of people remained in their rooms for most of the day when they were unwell or if they preferred this. All rooms were fitted with TVs, however, while we were observing care, we noted that some people were isolated in their rooms, with staff only visiting to carry out care tasks.

The service employed a member of staff who had responsibility for organising activities and for engaging with people in the home to provide interest and stimulation. The person was employed for 20 hours a week and had devised their own programme of work with people. This included reading aloud, taking people on trips to the local shops, a garden centre or out for a walk. They encouraged hand and eye coordination games such as catching a ball with a self-adhesive glove. They had devised a box into which they placed familiar objects for people to feel and describe which they told us people enjoyed. The activities organiser had taken a portrait style photograph of each person if they agreed, and this was used for their private room door. Each photograph portrayed an image which was sensitive, respectful and reflected each person's character. The activities organiser had been responsible for introducing dominoes and had obtained a braille set of dominoes for a person who was partially sighted so that they could be involved. The registered manager told us that the activities organiser was to have training in work with people living with dementia so that they could better meet people's needs relating to this. Staff and other people living at the home told us they liked what the activities organiser did but that there was not enough time to give everyone the attention they needed. Other entertainment was brought into the home, for example, a music entertainer regularly called. However, we did observe that some people were not being engaged by staff at all, sometimes for long periods and particularly on the upper, nursing floor. During these times some people appeared bored and under stimulated.

Some people told us that they would feel confident to raise a concern. One person told us they had never needed to raise anything, but that they would speak with the manager if they did. Another person told us that they sometimes raised concerns but that they were not always resolved to their satisfaction. The service had a complaints policy and procedures and we saw records of complaints, with a log of actions taken with timescales of response. This meant that there was as system in place to gather and act on people's complaints and that for most people the home responded in a way which resolved the concern.

We recommend that the registered manager consult best practice guidance on signage and provision of objects of interest for those people who may have memory impairment.

Requires improvement

Is the service well-led?

Our findings

We noted gaps in records which monitored people's clinical care needs, for example fluid and nutritional charts, moving and handling charts. Records of people's involvement in decisions about their care were not sufficiently detailed to ensure staff had the information they required. **This meant that the registered provider could not be sure that people's needs and preferences would be met and was a breach of Regulation 17(2)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People told us that they liked the registered manager and found her approachable. One person said, "[They] are often asking about how things are going. I make suggestions and [they] always listen and do something about it." Another person told us, "[They] always come back to me and tell me what they have done about anything I mention." People had mixed views about the leadership offered by the people who owned the service. One person told us, "I did speak with one of the owners who told me why they couldn't do something I suggested and I understood why." Another person told us, "When they visit it is as though they care more about how the chairs and cushions are arranged than the people, they hardly ever speak with us." Two further visitors echoed this latter comment in separate conversations. However, the registered provider told us that people were at the forefront of everything they did and whilst they liked to see the environment clean and tidy, this was only for the benefit of the people who lived at the home.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. However they also added that they were sometimes asked to do things which were outside of their role and which they did not feel confident about because they were short of staff. They knew who to go to for support and when to refer to the registered manager, though sometimes pressure of work meant that the manager was not able to respond or support them in the way they wished.

Nurses told us that they felt left out of decision making because they were not in charge of any shifts despite their role. There was no clinical lead and they said the manager was unable to give them the clinical support they needed. They felt that the lines of communication between them and the manager were sometimes unsupportive. They added they felt this was at least partly due to a conflict between what the manager saw as good personalised care, and what the owners wanted in terms of the way the building looked.

However, communication with relatives and other interested parties was promoted through informal and formal meetings and questionnaire surveys. The results of these were analysed and a plan drawn up. People told us that they had been consulted and that they had seen some positive changes as a result of what they had said, for example, in the variety of meals and suggested activities.

The registered manager actively sought the views of specialist health and social care professionals and we had positive feedback from these professionals, telling us that their advice was acted on and that this was in a timely way for the benefit of people who lived at the home.

Staff told us that the registered manager sought their views both in meetings and informally, and that suggestions were appreciated and sometimes acted upon. The registered manager and staff spoke about looking for ways improve the quality of life for the people who lived at the home and gave an example of when a person had gained in independence following staff discussion, medical professional involvement and a change in the person's prescribed medicines and care plan.

The registered manager told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. For example, They had begun to use the Gold Standard Framework, for quality care at the end of life. The registered manager had also begun to use the framework provided by St. Catherine's Hospice around, "supporting high quality palliative and end of life care." Staff told us this was a good initiative, but that it was still in early stages. A health care professional who specialised in care for people who were reaching the end of their lives commented that the manager was keen to offer good personalised care to people who had complex and life limiting conditions. They told us they were working well with them to improve the care given to people.

The service sent notifications to CQC as required.

The registered manager carried out a range of safety and quality audits which were clear and easy to understand. Actions plans had been drawn up in relation to any

Requires improvement

Is the service well-led?

identified improvements and staff had been informed of these in staff meetings. We saw records of improvements made as a result of the actions plans, for example in medicine administration.

We recommend that the provider consults best practice advice to improve the culture and the quality and inclusiveness of communication in the service for people's benefit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured that sufficient staff were on duty to care for people safely.**

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 had not ensured that accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided were properly maintained.**