Roseville Care Homes (Melksham) Limited

The Old Parsonage

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 9 March 2018. The first day of the inspection was unannounced. The last inspection took place on 14 December 2016 and four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found. This was because the administration of medicines was not undertaken in line with best practice and the quality of person centred information was not consistent within people's care plans. In addition, risk assessments were not sufficiently detailed to ensure safe care and the decision making process for people who lacked capacity to consent, was not in line with legislation. Following the inspection, the provider submitted an action plan to show how the shortfalls would be addressed.

At this inspection, the majority of shortfalls had been addressed but further work was required in some areas. This meant the service had not been compliant with regulation since the registered manager gained their position in 2015. Other shortfalls were identified in 2014 and 2013. Whilst there was a quality auditing system in place, this had not identified all shortfalls noted at this inspection.

The Old Parsonage 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 service is registered to provide personal care and accommodation and treatment of disease, disorder or injury for up to 22 older people with dementia or other associated mental health needs. At this inspection 18 people were living at the home. The service was run by Roseville Care Homes (Melksham) Limited.

The Old Parsonage accommodates people in one building. People's bedrooms were located on the ground and first floor with communal toilets and bathrooms. A small passenger lift was available to enable easier access. There were two communal lounges and separate dining room. The kitchen and laundry room were located on the ground floor.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was available throughout the inspection. A regional manager was present on the first day.

Risks to people's safety had not always been identified and addressed. For example, one person's risk of choking had not been reassessed after a recommended action had not been successful. Other records gave conflicting information about the use of thickeners and the texture of people's food.

All care plans were being transferred to a new electronic system. However, this process was not complete and some information was insufficient in detail. The electronic system had generated some formats but these were not accurate and did not clearly inform staff of the support the person required. The lack of

person centred information was identified at the last inspection.

People were able to personalise their bedrooms but the environment was not reflective of recognised dementia care. This was because flooring and décor were similar in colour and there was limited texture or stimulation to gain people's attention as they walked around.

Some areas of the home had marks on the walls and there were stains on the stairs carpet. The windows on the first floor were fitted with restrictors to reduce the risk of people falling from height. However, the restrictors were made of thin chains, which did not meet current health and safety guidance. Staff had opened the windows in some bedrooms and on the corridor on the first floor. These were still open at 17.00, which made some areas of the home cold.

Less visible areas of the home were not always clean. This included the beading on over-bed tables and the wheels on some specialised chairs. The registered manager said they had identified this and cleaning schedules were in the process of being reviewed. Other areas including bathrooms were clean.

There were many positive interactions but staff did not always consider the reasons why some people displayed certain behaviour. For example, one person attempted to take their jumper off. Staff assisted them to put it back on again without further discussion. They did not investigate if the person was hot or if they needed the bathroom.

Improvements had been made to the management of people's medicines. A daily audit had been introduced. This ensured all medicines had been given as prescribed and staff had signed the medicine administration record appropriately. Information regarding medicines to be taken "as required" lacked detail but this had been addressed by the second day of the inspection.

There were sufficient staff to support people safely and appropriately. Staff answered call bells without delay and had time to spend with people. The home was relaxed and calm and staff went about their work without rushing. The registered manager had reviewed the admission criteria. This ensured the person's needs could be met without significant impact to those already in the home.

People had enough to eat and drink. Those people at risk of malnutrition or dehydration were encouraged to have additional intake to ensure their wellbeing. Records were consistently maintained to monitor people's intake. There was an emphasis on fresh produce and the majority of food was cooked "from scratch".

People were supported in line with the Mental Capacity Act 2015. This included gaining consent for restrictive practices such as bed rails and sensor mats. There was evidence that relatives and health care professionals were involved in decision making, where people did not have capacity to do this. Staff consistently asked people for consent when undertaking tasks.

People had good support to meet their health care needs. This included a range of specialised services related to health care conditions.

Staff felt well supported and received a range of training to help them undertake their role effectively. This included courses deemed mandatory by the provider and other topics related to older age. Emphasis was being given to training in social activity for people living with dementia.

There were many positive comments about the staff and registered manager. This included their caring,

compassionate and respectful manner. People's privacy and dignity was maintained.

There was an open culture. People, relatives and staff were encouraged to give their views about the service. This was informally on an individual basis, within meetings or by completing questionnaires. Feedback had been evaluated and action plans developed to ensure all points were addressed.

We found two repeated breaches of regulation at this inspection and made one recommendation.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks were not always properly identified and addressed.

Less visible areas of the home were not always clean.

There were sufficient staff to support people safely.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People had enough to eat and drink.

Staff were well supported and undertook a range of training.

People were supported in line with the Mental Capacity Act 2005.

People received good support to meet their health care needs.

Is the service caring?

Good

The service was caring.

There were many compliments about the caring, compassionate nature of staff.

Staff promoted people's rights to privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were being developed but not all contained the required information.

Staff did not always investigate the reasons for behaviour some people displayed.

There was an open approach to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was not a good history of compliance.

Auditing systems had not identified shortfalls we found at this inspection.

There was a clear vision, to further improve the service people received.

There were many positive comments about the registered manager.

The Old Parsonage

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 7 and 9 March 2018 and was unannounced. On the first day of the inspection, the inspection team consisted of two inspectors, a specialist advisor in dementia care 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. On the second day of the inspection there was one inspector.

Before our inspection visit we reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

We spoke to two people who used the service. Because of their complex health conditions, other people were not able to provide detailed verbal feedback about the service they received. As a result of this, much of our time was spent observing interactions and the general activity taking place. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. To gain further feedback, we spoke to ten relatives.

We spoke with the registered manager, a regional manager and seven staff. We looked at people's care records and documentation in relation to the management of the home. This included quality auditing processes and eight staff training and recruitment records. After the inspection, we contacted eight health and social care professionals for their views of the service. Two health and social care professionals responded.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in December 2016, we identified the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because information in care plans did not clearly show how potential risks were to be managed to ensure people's safety. In addition, medicines were not always given on time and the medicine policy did not reflect up to date guidance. Information about medicines to be taken "as required" was not always in place and the process for monitoring stock was not robust.

At this inspection, some improvements had been made. There were a range of assessments which identified areas of risk such as pressure ulceration, falling and malnutrition. However, other risks were not consistently identified or addressed to ensure safety. For example, one person had been admitted to hospital after a choking incident. A speech and language specialist had recommended, although not formally documented, that the person might benefit from a particular shaped cup when drinking. The registered manager told us they had purchased the cup but it was unsuccessful. Due to the risk of dehydration, they said the person reverted back to using an ordinary cup. This did not ensure the person's safety. In addition, staff had not informed the speech and language therapist or requested a reassessment of the person's needs. This was immediately arranged after it was brought to the attention of the registered manager.

Another person required a thickener in their drinks to minimise the risk of them choking. Their care plan noted and staff told us the person had two scoops of thickener in their drinks. This was confirmed in a report, written by a speech and language specialist. However, the prescription label on the tub of thickener and the instruction on the medicine administration record showed one scoop should be used. This gave staff conflicting information, which increased the risk of error. Once brought to their attention, staff and the registered manager told us the error would be discussed with the pharmacy to ensure the correct prescription was in place.

Staff told us the majority of people required pureed diets to minimise the risk of choking. On the first day of the inspection, some people were supported to play bingo. The prizes were various chocolate bars and crisps. These snacks were not conducive to people's specialised diets.

One care plan stated a person required pureed food but it was also written that they needed their food cut up. This conflict of information did not ensure the person received food of a consistency that met their needs. Another care plan showed the person liked cheese sandwiches but they too required a pureed diet. Their food chart showed they had eaten various meats but it was not documented if they had been pureed. On the second day of the inspection, improvements had been made to the recording of pureed food.

During the afternoon on the first day of the inspection, two staff helped a person to transfer from an armchair to a wheelchair. One staff member explained they were going to count to three and then help the person to stand up. They did this and the person stood up very unsteadily, whilst staff supported them by holding them under their arms. This was an unsafe technique, which increased the risk of harm to both the person and staff.

The majority of the home was clean but this was not the case with some less visible areas. This included the ledges of dining room chairs, the edges of over-bed tables and the wheels of specialised armchairs. One person's bedroom had a strong odour and the passenger lift had debris on the floor.

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

The registered manager told us they had identified some areas needed more thorough cleaning. They said they were in the process of updating cleaning schedules and addressing these with staff. They said a member of staff had been allocated the role of infection control champion. This staff member had completed additional training and were cascading this to the staff team. As part of their training, the staff member had learnt about a device which identified if hand washing had been completed effectively. The registered manager told us they were looking to purchase the device so it could be used as a training tool.

Records showed staff had received training in infection control. Personal protective clothing such as gloves and aprons were located in people's rooms and bathrooms. This reduced the risk of infection and enabled staff to access the items quickly when needed. Staff told us they washed their hands regularly and used different coloured cloths to clean various areas such as the lounges and bathrooms. There were regular checks to assess the quality of infection control practices. These had shown all areas were satisfactory although had not identified the need for more thorough cleaning of less visible areas.

At this inspection, improvements had been made to the administration of people's medicines. An audit which was completed daily, ensured medicines had been administered safely and all records were properly completed. Short shelf life medicines such as eye drops had been dated when opened and all handwritten instructions had been signed and countersigned by another member of staff. The medicine policy had been updated and a more efficient way of monitoring stock, had been implemented. Information for staff reference regarding the administration of "as required" medicines was in place. However, not all information was sufficiently detailed. For example, one record showed a medicine was to be given if a person could not sleep. It did not inform staff of other measures to be tried or the time in which the medicine was too late to be given. Another record showed a medicine had been prescribed for constipation but it did not inform staff of when it should be given. On the second day of the inspection, staff had improved the detail within the information. Records showed a picture of the food supplement each person had been prescribed. This minimised the risk of people being given the wrong one, as various different varieties were in use.

Staff followed safe procedures when administering people's medicines. They enabled people to take their medicines in a way which they preferred. They gave people time, reassurance and observed discreetly to ensure all medicines were appropriately swallowed. One member of staff told us if a person declined to take their medicines, they would try again later. If this was not successful, other measures would be tried. This included amending the time the medicines were given, which worked well for one person. Staff told us medicines were not administered covertly. This is where medicines are disguised in food or drink without the person's awareness or consent. One relative told us staff managed their family member's medicines, to reduce agitation, very well.

Systems were in place to minimise the risk of people being subject to abuse. Staff told us they were aware of their responsibility to report any concerns and knew how to do this. Staff were confident any abuse or poor care practice, would be quickly spotted and immediately addressed by any of the staff team. They said they had received training in safeguarding people. Records confirmed this.

People and relatives did not raise any concerns about safety. One person told us "I feel safe because I've got

a 'panic button' and I can get help, and the staff are alright." A relative told us "I've got no worries at all. I feel my [family member] is completely safe here and it's a weight off my shoulders. I can rest easy because we're kept fully informed, for example if the Nurse Practitioner has been or there's any other changes." Another relative told us "We're happy that [family member] is well looked after. They [the staff] are very communicative and always update us, either by phone or in person when we come in. They make a point of coming out to tell us what's happening and if the doctor has been, what treatment has been given." Another relative told us "We're extremely pleased. [Family member] is in safe hands."

There were enough staff to support people safely. On the first day of the inspection, there were four care staff and a registered nurse with a housekeeper, laundry assistant, cook and activities organiser. The home was relaxed and calm. Call bells were answered without delay and staff spent time with people, particularly in the communal areas. Staff told us there was always a member of staff allocated to the lounge, whilst it was being used by people. This minimised the risk of people falling or any altercations. Staff told us regular checks were made of people in their rooms to see if they needed anything. They said these were every hour at night, half hourly during the day or more often if needed.

Staff told us there was always sufficient staff on duty and staffing levels never fell below those set by the provider. One member of staff told us "I have never known someone that has had to wait for assistance. Staff always go to assist immediately." Staff told us they worked well as a team and covered each other at times of sickness or annual leave. They said agency staff were very rarely used, which ensured people had consistency with their care.

The registered manager told us they regularly reviewed staffing levels to ensure there were sufficient staff to meet people's needs. They said they used a dependency tool to assess the number of staff required but also regularly observed staff whilst working. They explained this was because staffing levels could look satisfactory on paper but not in practice. The registered manager told us the number of care staff during the day, would increase to five when new people were admitted and the home was full.

Relatives confirmed there were enough staff on duty. One relative told us "There is always someone around. You don't have to go looking for staff." Another relative said "They seem to carry out all the care they're supposed to do, as we look at the charts. They have time for our [family member] and us when we visit." A health/social care professional told us "I have never been concerned about staffing levels and always see familiar faces when I visit the home."

Safe recruitment practice was being followed. Records showed appropriate checks had been undertaken before new staff started work. These included the applicant's identity, previous work history and performance and their skills and qualifications. A Disclosure and Baring Service (DBS) check was undertaken. A DBS identifies if applicants are suitable to work with vulnerable people. Staff confirmed their recruitment was thorough and included a formal interview.

Good

Is the service effective?

Our findings

At the last comprehensive inspection in December 2016, we identified the service was not meeting Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because consent to care was not always sought in line with legislation and staff's knowledge of the Mental Capacity Act 2005 (MCA) was limited. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection, improvements had been made to this area. Staff understood the principles of the MCA and how to apply them in their work. One member of staff told us "We must presume capacity initially, but if someone is really struggling with their own choices, they may need DoLS. I'd check with their family first and work in people's best interests." Another member of staff told us "An authorisation would be needed where people can't make their own choices and decisions." Records showed staff had received training in the MCA and DoLS. The registered manager laughed and told us "The staff must dream about the five principles of the MCA. We're done a lot of work in that area."

Some people used bed rails or pressure mats. Pressure mats activate the nurse call bell system on movement, which alert staff to the need for potential assistance, to minimise the risk of falls. Correct documentation to show consent to this equipment was in place. This included a mental capacity assessment and best interest meetings. There was further documentation which evidenced the decision making processes for other areas. This included consent to care and treatment, sharing of personal information and any photographs which were taken of the person and their use.

Staff told us they sought consent from people before providing care and gave examples of how they did this. Throughout the inspection, staff consistently asked people for their consent. One person clearly demonstrated they did not want any assistance to change their position, whilst in bed. Staff apologised and said "don't' worry. We'll see you later." This was an agreed response and detailed within the person's care plan. Staff asked people if they could take used crockery away and one staff member asked if they could remove a person's serviette that had been tucked into their clothes.

People told us staff asked for their consent before undertaking any task. One person said "Oh yes, they certainly don't do anything if you don't want them to." Another person said, "They always ask and definitely make sure it is what I want." Relatives confirmed they had been involved in decision making. One relative told us "We've been involved in care decisions and especially so, now that [family member] is approaching the end of life and has been very poorly." Another relative said "We've been involved in discussing [family

member's] needs and feel comfortable to ask for any changes we think might be needed."

At the last comprehensive inspection in December 2016, we identified the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's fluid intake was not always monitored effectively and drinks were not always within people's reach.

At this inspection, improvements had been made to this area. People were offered and assisted to have regular drinks throughout the day. This included tea, coffee and a choice of juices, squash or water. Once finished, people were asked if they wanted anymore. Their cup or glass was regularly 'topped up'. People had a cold drink with their meal and were offered a hot or cold drink afterwards.

Records showed drinks were offered approximately every hour, particularly to those at risk of dehydration. Staff had identified that one person was not drinking their mid-morning tea. They asked the person if they were happy with their drink and if they wanted some help. The member of staff encouraged the person to hold the cup, whilst they assisted with gently and carefully tilting it. They observed to make sure the liquid was not pouring too quickly, to minimise the risk of the person choking. One person was unwell with a chest infection. Staff had assisted the person to increase their fluid intake, which was clearly evidenced in their records.

Records showed staff monitored people's fluid intake closely. They totalled amounts consumed during and at the end of the day. This enabled a person to be prompted to have additional intake later in the day, if they had declined in the morning. Information was displayed in the office regarding good hydration and what should be done to enable this.

There were positive comments about the food. One person said the meal was "beautiful". Another person said "The food is very good, I like sausage and mash and steak and kidney pie. There's plenty to eat." A relative told us "The food seems to be very good." They said staff enabled and encouraged relatives to eat with their family member. Another relative said "My [family member] has a puréed diet now and seems to be picking up after being in hospital and is gaining weight."

People had been assessed regarding their risk of poor nutrition and dehydration. Some people had supplements to maintain or enhance their weight. One member of staff told us foods such as cream were added to some foods to enable additional calories where needed. They said all food was cooked "from scratch" and there was an emphasis on fresh meat and vegetables, to ensure good nutrition.

There were monthly audits which identified and considered any weight loss people experienced. Staff told us any concerns would be reported to the GP and dietician. The registered manager told us since the introduction of supplements, people's weight had stabilised or increased and there were no concerns.

To aid orientation for those people with cognitive impairment, there was some signage around the home. This included pictures on bathroom and toilet doors and on the walls outside of communal areas. There were pictures of food on the wall outside of the dining room but these did not reflect the meals for the day. The orientation board in one of the lounges, showed the wrong date. This did not help people's memory or confusion.

The environment was not fully conducive to meeting the needs of people living with dementia. For example, the floor covering was the same throughout, which did not differentiate different rooms or areas. There was no sensory stimulation such as different textures. This did not enable people to feel and look at things as

they walked around. People had their name on their bedroom door but this was not consistent for all. Some had memory boxes, which contained memorable items such as photographs to enhance recognition.

We recommend that the suitability of the environment is considered to ensure it is further developed and more conducive to meeting people's needs.

The registered manager told us any new person to the service was fully assessed, before a place at the home was offered. As part of the assessment process, the registered manager spoke with the person, their family and any involved health or social care professionals. They said they gained as much information as possible to ensure the home would be able to meet the person's needs. Records showed areas such as the person's current situation, past and current risks and their previous medical history were explored. The registered manager told us an initial care plan was developed from the assessment and further information was gained, once the person had settled in the home. One health and social care professional told us people's transition to the service was always well managed. They told us "the manager and staff are very good at helping people to settle."

Another health care professional complimented staff on the support they gave people when moving to the home. They told us "During a very difficult and complex discharge from hospital, the manager and her team of carers took time to work with the person and build a relationship with them prior to transfer from hospital. They took time planning and preparing their room with support of their [family member] (choosing the most appropriate personal belongings and art work that they had not seen for many years). The transition and planning was so positive that the person is accepting of their treatment without restraint and now discharged from the framework of the Mental Health Act."

People received good support to meet their health care needs. This included nurse specialists in conditions such as diabetes, asthma, Parkinson's disease and tissue viability. There was also contact with community mental health teams, dieticians, psychiatrists and the speech and language team. People were able to continue seeing their own GP, unless they had recently moved to the area. This meant four local GP surgeries were used. People received regular foot care from visiting chiropodists and were able to see a dentist and optician as needed. Regular medicine reviews took place and support was given to enable people to attend hospital appointments.

The registered manager was passionate about staff training. They said it was important for staff to develop their knowledge and skills, as this had a significant impact on the quality of care provided. Records showed staff had undertaken a range of training deemed mandatory by the provider. This included fire safety, emergency first aid, moving people safely and food safety awareness. There were additional topics related to older age such as end of life care. Registered nurses had completed training in clinical care including venepuncture (taking blood samples) and male catheterization.

Staff told us they enjoyed the training they received. One member of staff told is "It is really interesting and the nursing staff will work with us on the floor to make sure we do things correctly." Staff told us they could ask for training in subjects that interested them or for areas they needed more information on. One member of staff told us "I have requested to have further training in supporting people with dementia and the registered manager has arranged this for me."

Staff completed an induction when they first started work at the service. The induction covered areas such as people's care, food and nutrition and health and safety. New staff worked alongside more experienced members of staff to enable them to learn about people and their needs. Handovers were held at the start of each shift to inform staff of any information they needed to know. They were given a paper copy of the

information, which included a brief summary of people's needs, potential risks and health conditions.

Staff felt well supported by each other and the registered manager. They said they received informal support on a day to day basis and more formally, through meetings with their supervisor. There was a written schedule, to ensure these meetings took place at the required frequency set by the provider. Records showed subjects discussed included the staff member's wellbeing and their training and development needs. Staff told us they had an annual appraisal. This enabled each member of staff to reflect on their performance over the past year and set objectives for the year ahead. The registered nurses were supported appropriately to maintain their nursing registration.

Good

Is the service caring?

Our findings

People and relatives were very complimentary about the staff. One person told us "they're lovely. All of them, very nice." They pointed to the registered manager and said "They have a place in my heart. I love her." Other people were comfortable and relaxed with staff and responded to them well. Relatives told us "they are amazing, so patient", "I can't speak highly of them" and "they do a really hard job but do it so well. They have an abundance of patience and are always friendly and cheerful." One relative told us "The staff are friendly, approachable and welcoming. As soon as we came here we knew it was the one. You can see they truly care for [family member] and [family member] responds to them." Another relative told us "The staff are very, very caring, not just of [family member] but the whole family. They go the extra mile. They've supported all of us. They have a good understanding of the illness [dementia] and how it impacts on the whole family." Another relative told us "The staff are caring and welcoming, they're kind. You can tell by the way they speak to my [family member] and other people." One relative pointed to a member of staff and said "they're my [family member's] favourite."

Staff told us they were proud of their colleagues and the care and compassion they showed towards people. The registered manager told us staff were naturally caring, respectful and compassionate. They explained staff really cared about people and were committed to their wellbeing. The registered manager told us they had recently undertaken research regarding the connection between emotion, positivity and wellbeing. This was being discussed with staff to further promote their approach and the way in which they supported people. Records showed staff had received training in dignity, privacy and respect.

There were many positive, caring interactions. This included one member of staff who gave a person their medicines. They bent down to the person's level and very quietly but clearly, explained what the medicines were for. They asked the person if they were in any pain and empathised with them. The member of staff said they would get the person some pain relief and later asked if they felt better. Another member of staff assisted a person to eat. They informed the person what they were eating and went at their pace. They talked to the person and regularly checked out if the person was enjoying their meal. Another person was served their meal and asked "would you like some parsley sauce? Whereabouts? There or there? How's that?" They ensured the person had what they needed before they left them. Staff often answered people by saying "You're very welcome."

Staff spoke to people clearly and used good eye contact. They generally knelt down with people to ensure they were on the same level and gave people time to answer any questions. They repeated instructions or questions as necessary. Staff touched some people gently on the arm to convey empathy and warmth. A health and social care professional confirmed this. They told us "I have witnessed (many times) the care staff being proactive in working with residents who are presenting in a highly anxious state and distressed – working with them to calm them and direct them to another area of the home with the resident's safety and the safety of others paramount". One member of staff entered a person's room to assist them with their personal care. The person did not want this and told the staff member to "get out." The member of staff quietly left the room and apologised saying, "I'm really sorry I disturbed you." They told us they would try again later.

During the inspection, staff respected people's privacy and dignity. Staff knocked on doors and called out before entering people's rooms. One person sat on the stairs in their nightwear, showing their bare legs. Staff encouraged the person to move from the stairs but this was unsuccessful. To promote dignity, they covered the person's legs with a towel. Staff discreetly monitored what the person was doing and repeatedly offered assistance in a calm manner. They respected the person's refusal of help and used various techniques to de-escalate their agitation. Staff waited until the person held out their hands to be assisted and then supported the person to a different area. Another person's clothing needed adjusting, as they were showing the middle part of their body. A member of staff noticed and asked "Can I pull your top down [person's name]. That looks better." Another member of staff said they ensured dignity by making sure people's clothes were well cared for. They said this included the clothing being well ironed and fresh looking, so people could feel good about themselves.

Staff told us they respected people's choices. This included the time people wanted to get up, what they wanted to wear and whether they wanted company or to remain in their room. Staff offered one person a choice of two pieces of clothing, made in different materials. The person chose which one they wanted and was happy with this. Another person told us "They help me have a wash and I can decide if I want a shave or not and whether I want to go downstairs or stay here." One member of staff told us they encouraged people to remain as independent as possible. Information about choices and people's preferences were detailed in their care plan. This included one person who liked to choose their daily clothes from a selection in their wardrobe.

Relatives told us they were able to visit their family member at any time and could 'come and go' as they pleased. During the inspection, all relatives were warmly welcomed. A health/social care professional confirmed the welcoming approach from staff. They told us "The home is welcoming and the staff make themselves available. The staff are always supportive and welcoming not only to me as a professional but more importantly to residents and family."

Relatives complimented the homely atmosphere. One relative told us "there is a real feeling that this is a home, not a care home. It's really homely." Another relative told us "it's genuinely the person's home and staff recognise this. We are able to bring things in to make it more homely." Staff agreed with these views. One member of staff said "Some people are happy in their rooms. This is their home and if that is what they want, we all respect that. They have all their things around them, like their photos and personal bits. If they want to change their mind and go down to sit in the lounge and join in the activities, they are always more than welcome."

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection in December 2016, we identified the service was not meeting Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the quality of people's care plans was not consistent. There was some conflicting information and not all plans were person centred. The provider sent us an action plan stating these shortfalls would be addressed by the end of April 2017.

At this inspection, the registered manager told us improvements had been made to the content of people's care plans. An electronic care planning system was then introduced, which meant all information needed to be transferred. The registered manager told us they were in the process of doing this and had added information about people's basic care needs. Once completed they said further detail was to be added to make the plans more person centred. The registered manager told us they had not had chance to do this in all cases, so were aware not all care plans were as they wanted them to be. However, they said staff knew people well so this did not impact of their care. A senior manager confirmed they had recently introduced the new electronic system, when appointed to their role. They explained staff were working hard to ensure all plans contained the required information, but they were aware there was more to do. A recent audit had identified more detail was needed in some care plans and more meaningful evaluations were required.

As the registered manager and regional manager confirmed, some information within care plans was not specific. For example, one care plan stated "[the person] would like to have introduced a repositioning schedule that is tailored to [the person's] current needs." Other information stated "[Person's name] needs physical support to use the toilet" and "Requires assistance with all aspects of daily living." These statements did not inform staff of the specific support each person required. Other care plans showed a number of options, which required staff to consider what was most relevant to the person. This did not ensure appropriate, consistent care was given.

People's wishes about their end of life care were not clearly stated. There were some information about whether people wanted to stay at the home or go into hospital and if they preferred burial or cremation. There was also a transfer plan in the event of a person needing a hospital admission. This detailed the person's physical and mental health needs and areas such as communication, allergies, mobility and nutrition. However, other information about the person's preferred care towards the end of their life was not stated. For example, the care plan did not detail whether the person wanted someone with them and if so who, or if they wanted to listen to their favourite music or radio station. Whilst people's views were not fully recorded, one relative told us they had been involved in planning their family member's end of life care. They were appreciative of staff keeping them updated and said "We realise that [family member] is getting very frail now and it's closer to that point. We've discussed keeping [family member] comfortable and we know we can come in any time."

Other care plans were more detailed. For example, one person had a pressure ulcer. Their care plan showed how staff were to promote healing and what treatment was required. There was a clear description of the wound, the action taken and regular monitoring. Further information showed the daily checking of all

pressure areas, the application of topical creams and antibiotic medication. Staff had contacted the specialist tissue viability nurse for advice and their recommendations were incorporated into the care plan. Other people at risk of developing pressure ulcers had preventative measures in place. Records showed repositioning regimes had been consistently followed. Pressure relieving mattresses were checked during the day and twice at night to ensure they were in good working order.

There was clear guidance for staff to follow when supporting people with anxiety or behaviour that challenged. The information had been developed using recognised assessment tools, such as the Cornell Scale for depression in people living with dementia. The information was clearly written and person centred. For example, after lunch one person became withdrawn and looked upset and worried. A member of staff noticed this change of mood and sat with the person. They tried to find out what was wrong and asked if they could help, whilst showing empathy and concern. The person said they were in pain and pain relief was promptly given. Another person did not appear sure of what they were to do next. The registered manager asked the person if they wanted one of their favourite biscuits. The person smiled and became animated whilst choosing and eating their snacks.

Whilst there were positive interactions, staff did not always investigate the behaviour a person displayed. For example, one person tried to stand from their chair and was told to sit back down. They did this a second time and staff asked them if they wanted to do a puzzle. Staff did not explore other reasons for the person wanting to get up such as needing the bathroom. Another person became agitated and attempted to take off their jumper. Staff assisted the person to put it back on, without finding out why they wanted it removed. Records showed the person had been seated in the lounge all day. They had not been assisted to change their position or go to the bathroom. One person identified there was food debris on a chair they were going to sit on. They tried to get staff's attention by calling out and pointing to the chair but staff did not respond. The person removed the debris and dropped it on the floor.

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

There was a designated activity coordinator, who arranged group activities and undertook one to one work with people who were nursed in bed. They said activities were generally arranged in the morning when people were more alert. In the afternoon, a film was usually chosen on the television.

Activities arranged included chair exercises, board games and arts and crafts. On the first day of the inspection, one person went out for a walk with a member of staff. Staff supported others to play bingo although not all appeared to be fully engaged or understood the game. Other people had various activity items on their tables. One had a simple jigsaw, which was partially completed and another had a jigsaw with lift out wooden shapes. One person had a musical toy. Another person had a craft set to make items from coloured wire. A member of staff made a wire flower, which the person was very pleased with. Staff told us people were encouraged to join in with the activities although could watch if preferred. On the second day of the inspection, there was less activity taking place. Some people did puzzles. Staff brushed one person's hair and gave them a head massage. The local priest had visited them earlier in the day.

The registered manager told us they were looking to develop social activity provision and links with the local community. They said they had introduced an initiative called Teapot Tuesday. This encouraged members of the community, particularly those living alone, to visit the home for tea, cake and social interaction. The registered manager told us the initiative had been successful and was working well.

On the second day of the inspection, staff were completing a social activity training course. The registered

manager said the course was comprehensive and arranged to provide staff with ideas and greater knowledge of activities, specifically for people living with dementia. The registered manager said they had also searched the Intranet for new social activity ideas. They said would purchase any equipment required to enable staff to apply their learning in practice.

Relatives were happy with the opportunities available to their family member in terms of social activity. They said external entertainers often visited and people were supported to go to local places of interest. One relative told us their family member had enjoyed a trip to the local garden centre.

Relatives told us they knew how to make a complaint and would feel comfortable doing so, if needed. One relative told us "Although we've had to raise a few matters, it's always been responded to well and we'd feel comfortable to discuss any issues in the future." Another relative told us "we did have a small problem when we first came because my [family member's] shirts weren't ironed and they were sometimes unshaven but we told the manager and I think the responsible staff were told off. It's much better now." Other comments were "I've never made a complaint. There have never been any worries but I would feel totally comfortable if I needed to bring something up" and "We've no complaints. There are no issues at all. The staff are all very approachable."

There was a complaint procedure in the entrance hall. The information stated the service wanted people to be happy. The format used pictures as well as text to assist people's understanding. However, the information encouraged people to raise a concern by telling the manager, making a phone call or writing a letter. This was not fully conducive to people's needs, as the majority were not able to do this. The format used animated pictures to inform people they could approach staff, if they were unhappy. The registered manager told us they would replace these pictures with actual photographs of the staff team to aid recognition. The procedure gave contact details of other agencies who could be contacted, if a complaint was not satisfactorily resolved.

A record of complaints was maintained. The information showed a clear culture of wanting to resolve any concerns and learn from them. As part of their feedback, a health and social care professional told us "The office door is always open and in fact on one of my visits, one of the residents was sat in the office talking to [the registered manager], drinking a cup of tea which was nice to see."

Alongside the complaint log, there were a high number of compliments from people who had previously used the service or their relatives. Such comments included "My sister and I would like to express our gratitude and respect to everyone involved in our [family member's] care", "Thank you for all the kindness and care given to our [family member]. We couldn't have wished for anything better" and "I feel I would like to sincerely express my gratitude and respect to everyone involved in my [family member's] care. We can only say thank you for letting my [family member] live life to the full."

The registered manager had received many compliments about the care staff provided at the end of a person's life. These included "'From the depths of my heart, I thank you for all the love and kindness you gave to our mum. I know mum passed with dignity and we couldn't have wished for anything better" and "A massive thanks for the care, love and support you gave to [person] and the family in her final hours." Another relative told us they gained comfort from a member of staff being with their family member "at the very end." They said the care during their family member's deterioration was "fabulous." They explained this was because staff were caring and attentive and talked to their family member, whilst constantly being at their side.

Staff told us they worked hard to ensure the end of a person's life was comfortable, dignified and pain free.

One member of staff said "we always try to make sure family are called so they can be with the person and we support them as well if needed." The registered manager told us "it's important to get it [end of life] right, as you only get one chance." They said this was an area staff did well.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection in December 2016, the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the emergency contingency plan for the service was incomplete. At this inspection, this had been addressed but further shortfalls found, had not been identified. This particularly applied to the management of risk. In addition, the decoration and furnishing of the home looked tired in places and there was some staining to the carpet on the stairs. Staff had opened some people's bedroom windows on the first floor and on the corridor. At 17.00, the windows had not been closed. This meant the first floor was cold, which did not ensure people's comfort. Windows had been fitted with restrictors to reduce people falling from a height. Whilst these had been regularly checked, the chains did not meet current health and safety guidance.

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

The shortfalls identified at this inspection, meant the service had not been compliant with regulation since the registered manager gained their position in June 2015. Shortfalls were also identified during inspections in 2014 and 2013.

The registered manager recognised there had not been a good history but felt staff had worked hard to improve the quality of the service. They said they were aware more was to be done as they wanted continual improvement but were pleased of the work undertaken so far. The registered manager told us they had reviewed the admission criteria and were admitting those, with less complex needs who would not significantly impact on others. This had enabled the home to become calmer and more relaxed, which enhanced people's wellbeing.

There was a programme of audits to assess the quality and safety of the service. The programme showed how often the audits needed to be completed and who was responsible. Areas such as infection control, staff training, personnel files and various areas of health and safety were addressed. Regular checks were made on the registration status of the registered nurses and there was an audit to ensure the auditing programme was being completed as required. In addition to the internal audits, a senior manager completed a monthly overview of the service. They observed a medicine round and spoke to people and staff, as well as reviewing people's records and management systems. Action plans were devised and signed off when completed.

The registered manager reviewed any accident or incident as it occurred. This was to identify if there was any particular cause, enabling action to be taken to minimise further occurrences. There were also monthly reviews of accidents and incidents. These identified potential trends or new areas of risk. Records showed risk assessments were regularly reviewed, with further action taken as required. Staff had documented details of any falls people had experienced and a monthly falls analysis was completed. This showed actions taken such as contacting the Falls Clinic or notifying the local safeguarding team. Discussions had taken place regarding one person's recent fall. As a result, a sensory mat was placed by the person's chair or bed,

to alert staff of their movement.

There were many positive comments about the registered manager and the management of the home. One relative told us "[the registered manager] is a dream. She is so committed and has the most wonderful way with her. I think she's great." Another relative told us "I think she is absolutely lovely with the residents and the staff too. Very warm. She surrounds you with love. It's like having a big hug, it embraces you totally. I think she's great." Other comments included "[the registered manager's] passion and commitment for the residents, families and staff at The Old Parsonage is paramount," "She is a good communicator and will always ask for advice if she needs it" and "her passion and loyalty to the residents and their families is outstanding." One relative told us "the manager keeps them [staff] on their toes. She leads through kindness. There's no messing. I think she's top notch."

A regional manager told us the registered manager was an asset to the service and a valued member of the company. They said if they made any suggestions to improve practice, the registered manager addressed these immediately. They said the registered manager had made a considerable difference to the home since being employed, as the registered manager. They said they had the whole staff team "on board" and was working really hard to benefit the lives of the people supported.

There was a strong desire to further improve the service and take on board any advice that was received. A health and social care professional told us "I have always found the manager professional and accepting of any feedback that I provide. Overall the management of the home is of a high standard – the manager is welcoming, knowledgeable and skilled." Another health and social care professional told us "I visit The Old Parsonage regularly and actively consider the home for the more complex of individuals whom we represent and support." Records showed there had been a recent fire safety inspection by the Fire and Rescue Service. All recommendations had been promptly addressed.

There was an open culture within the home. Relatives and staff told us they were encouraged to share their views and suggest improvements. Records showed regular meetings were held. The information detailed areas of discussion and agreed actions. The registered manager confirmed group settings were generally not conducive to people's needs. They said because of this, they spent time with people on an individual basis and gauged wellbeing, as an indicator of satisfaction. The registered manager told us in addition to meetings and individual discussions, annual questionnaires were used. Records showed the registered manager had analysed the feedback and there was a clear action plan to ensure all views were addressed. A monthly newsletter was completed to keep people and relatives up to date with forthcoming events and general information about the home.

People and their relatives had limited ideas for ways in which the home could be developed. One person told us "I'm alright here. If anything could be better it's the parking. There's not much parking for my visitors." A relative told us "We're happy overall. A bigger garden would be nice, although that's probably not really possible. It's a shame there's not much space for people to be outside in the summer." Another relative told us "I'm happy and there's nothing I can think of that could be improved. We've never regretted our decision for a moment and I'd happily recommend the home to others and have reviewed it on the website." There were cards in the entrance hall which enabled feedback to be posted on the Internet.

The registered manager had a clear vision for the development of the service. This involved enabling people to go out a lot more to experience day to day 'normal' living. In addition, they said they wanted to further develop person centred care and help staff look at emotion and how this impacted on wellbeing. The registered manager told us to do this they would be working with staff regarding approaches and how to say things, as they said this was integral to good communication. The registered manager told us "if a person

sees you smile, this demeanour automatically promotes a positive feeling, which affects wellbeing. I want to make this a starting point for all staff."

The registered manager worked alongside staff to familiarise themselves with people's needs and ensure care was of a good standard. They gave an example of a member of staff asking "Shall I get [person's name] up now?" The registered manager responded by saying "I don't know. Why are you asking me? Go and ask [person's name]." They said through discussions and training, staff were giving the person their focus, which was improving the care provided.

The registered manager told us they were developing the initiative of champions. They said those staff who wanted this responsibility, were completing additional training in areas such as tissue viability and nutrition and hydration. The registered manager told us they were encouraging staff to cascade their knowledge to the rest of the team and observe practice, to ensure further improvement.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not always been properly identified and addressed. Less visible areas of the home were not always clean. People's care plans were not sufficiently detailed and staff did not always investigate the reasons for behaviour some people displayed. Regulation 12 (1) (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The auditing systems had not identified all shortfalls found during the inspection. Not all previous breaches in regulation had been addressed. Not all areas of the environment had been well maintained. Regulation (1) (2) (a) (b).