London & West Investments Limited

Brooklands Nursing & Residential 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?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 and 16 November 2016. The first day was unannounced.

Brooklands Nursing and Residential Home is a service that provides accommodation, personal and nursing care for up to 70 people. The home is split over three floors, one of which is dedicated to providing care to people living with dementia. During the inspection visit, there were 67 people living within the home.

There was a registered manager employed at the home. 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 and associated Regulations about how the home is run. The registered manager was not present during our inspection.

At the last inspection on 14 May 2015, we asked the provider to take action to make improvements in respect of the quality of care that was provided to people. At this inspection, we found that the necessary improvements had not been made. People's medicines were still not being managed safely and risks to people's safety in the event of a fire had not been managed effectively. The systems in place to assess, monitor and reduce the risk of people receiving poor care were not always effective. You can see what action we have told the provider to take at the back of our report.

There were enough staff to meet people's care needs. However, they were often very busy and therefore did not always have time to spend with people interacting with them or providing them with stimulation to enhance their wellbeing.

Systems were in place to protect people from the risk of abuse. Staff had received training and this was monitored to make sure it was up to date. Most staff were kind, caring and compassionate. However, some staff demonstrated poor practice which resulted in some people not being treated with dignity and respect.

Staff provided people with choice so they could make decisions about how they wanted to be cared for. People's individual care needs had been assessed and were being met.

People had access to a good choice of freshly prepared meals and snacks. Staff sought advice from other healthcare professionals and acted in a timely manner when they identified any concerns about people's health.

The staff requested people's consent before they provided them with care. Where people were not able to give consent, the staff made sure that they took any decisions they made on their behalf in the person's best interests.

There was an open culture where people and staff could raise concerns if they wanted to. Staff were happy

working in the home.

The provider had identified that they wanted to improve the quality of care being provided to people living in the home, the ultimate aim of which was to improve people's quality of life and wellbeing. The chefs had received external training in how to improve the food people were offered. Improvements were planned which involved staff receiving further training regarding supporting people living with dementia and making changes to the environment.

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 had not always received their medicines when they needed them.

Risks in relation to fire safety had not been managed well.

The majority of the home was clean however, some equipment people used was not.

There were enough staff to meet people's care needs.

Systems were in place to protect people from the risk of abuse.

Is the service effective?

Good

The service was effective.

Staff had received enough training to enable them to provide people with effective care.

Staff sought consent in line with the necessary legislation.

People received enough to eat and drink to meet their needs.

People were supported with their healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff were kind and compassionate but some did not always treat people with dignity and respect.

People and their relatives were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff did not always have time to interact with people in a meaningful way.

People's care needs had been assessed but their care records did not always contain enough information to guide staff on the care they required.

People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The improvements that were required following our last inspection had not all been made.

Not all of the systems in place to assess and monitor the quality of care provided were effective.

Staff were happy working at the home and there was an open culture where staff and people were listened to.

Brooklands Nursing & Residential 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 home under the Care Act 2014.

This inspection took place on 15 and 16 November 2016. The first day was unannounced. The inspection team consisted of three inspectors, one of whom specialised in the management of medicines 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We also reviewed other information that we held about the home. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

During the inspection visit we spoke with three people living at the home and seven visiting relatives. We also spoke with ten care staff, the chef, the deputy manager, a regional business manager who represented the provider and a social care professional. We also observed how care and support was provided to people.

The records we looked at included six people's care records, people's medicine records and other records relating to people's care, four staff recruitment files and staff training records. We also looked at records relating to how the provider monitored the quality of the service.

After the inspection visit, we requested further information from the deputy manager in relation to how the provider monitored the quality of care provided and staffing levels in the home. This information was sent to us promptly.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2015, we found that people's medicines had not been managed safely. This resulted in a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by August 2015. At this inspection, we found that the necessary improvements had not been made.

People had not always received their medicines when they needed them. We looked at how information in medication administration records and care notes for people living in the home supported the safe handling of their medicines. Records showed that six people had not always received their medicines as prescribed for short periods of time because they had not been promptly obtained by the staff. For example, one person had not received six doses of their pain medication over a two day period. Another person had not received a steroid cream for 11 days and a further person had not received two of their prescribed medicines for two days in November 2016. This placed some people at risk.

This was a breach of regulation 12, parts 1 and 2 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Further improvements were required to the management of people's medicines. Written information was not always in place to guide staff on how to give people their medicines safely where they had been prescribed for occasional use. In addition, more detail was required in respect of medicines that were used to support people when they became distressed to ensure they were used appropriately and consistently. For one person who was unable to verbally tell staff they were in pain, there was no guidance in place to help staff determine how the person expressed they were in pain. Additional charts with body maps were in place to record the application of prescribed skin patches and to ensure the sites of application were rotated. However, the charts in use did not record the removal of the previous patch to show that it had been removed before the new one had been applied. This is important as it gives a clear record that only one patch is in use at any one time.

Where people were being given their medicines covertly (hidden in food or drink), we saw that the relevant healthcare professionals had been consulted for advice on how to do this safely. However, some records were no longer accurate where people's medicines had been changed. In addition, the records gave no indication of review dates to ensure it remained appropriate to give people their medicines in this way.

Actions had not always been taken to reduce the risk of harm to people in the event of a fire. In June 2016, the provider had commissioned a private fire safety company to undertake an audit of their premises. A number of actions had been identified as being required to reduce the risk of the spread of fire if one occurred. Some of these actions were in relation to a number of fire doors not closing correctly, therefore exposing people to potential harm. We randomly checked four of these identified doors. We found that two of them still did not close properly. Another action required was to remove an obstruction that was hanging over the top of a person's door which was preventing it from closing properly. This obstruction was still in

place. The deputy manager told us they would have to discuss this with the person and their family. They said this was because the obstruction was a hanger that the person used regularly. There was no risk assessment in place regarding the use of this hanger. A further action required was that a fire detector was needed within a cupboard that contained electrics but this had not yet been installed.

In the event of a fire at the premises, the registered manager had an emergency 'grab bag' in place. The purpose of this was to provide the relevant authorities and the staff with information about the people within the home, including what assistance they required if they needed to be evacuated (personal evacuation plan or PEEP). We checked the information for all fifteen people living on the top floor of the home. We found that four people did not have a PEEP in this bag. For another person, the information on the PEEP about their current mobility status and therefore what assistance they required in an evacuation was incorrect. We noted that the PEEP was dated November 2015. The deputy manager told us that the bag should contain PEEPS for each individual within the home. They also said they should have been reviewed each month to ensure they contained the correct information. We referred these matters to the local authority fire and rescue service for their consideration.

This was a breach of Regulation 12 parts 1 and 2 (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During the inspection, one of the fire doors we had identified as an issue was repaired. The day after our inspection visit, the deputy manager told us they had audited the emergency grab bag and ensured it contained the relevant information. A smoke alarm had also been ordered for the electrics room.

Some equipment people used was not clean. We observed that most areas of the home were clean. This included people's bedrooms and the communal areas. Staff were observed wearing appropriate protective equipment when assisting people with personal care. However, we found that some equipment that people used was not clean. This included the underside of a bath hoist and a commode in a bathroom and two hoists. All of these were on the top floor of the home. This increased the risk of the spread of infection. Improvements are therefore required within this area.

At our last inspection in May 2015, we found that there were not always enough staff to keep people safe or to meet their needs. This resulted in a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by August 2015. At this inspection, we found that some improvements had been made and that the provider was no longer in breach of this regulation.

Two people we spoke with gave us positive views about the staffing levels within the home. One person told us, "Definitely enough staff although I don't need much help I do it all myself but I do need help having a bath, they are excellent." Another person said, "They are always here to help." The third person we spoke with told us, "It varies. Sometimes they never arrive but on the whole it is pretty good."

The relatives we spoke with told us there were usually enough staff but that they were sometimes very busy. One relative told us, "There are no issues with staffing levels although they are sometimes very busy." Another relative said, "There are usually enough staff around. Sometimes they are very busy but they are always there." A further relative said, "Staff can be thin on the ground at weekends. They use a lot of agency staff at the weekends. I haven't known them not try to get staff."

All of the staff we spoke with told us there were enough of them to keep people safe and to meet their

needs. However, three staff who worked on different floors told us that the staffing levels could be variable with some days more staff working than on others. Three staff members told us that when they had more staff, they could spend more time with people performing activities or chatting.

During our inspection visit, we observed that there were enough staff to meet people's care needs. However, during the morning the staff were very busy assisting people with personal care. Therefore they did not always have time to spend with people unless they were supporting them with their care needs.

The deputy manager told us that the number of staff required to work on each shift had been calculated based on people's individual needs and was reviewed on a regular basis. Any unplanned absence was covered by existing staff or agency staff. We asked them why on occasions, there was a variation in the number of staff working during the week particularly on the top floor. They told us that a better level of care could be provided when more staff were working and that they endeavoured to provide this number. However, they said that the tool used to calculate the required number of staff specified the lower number was sufficient to meet people's needs and that therefore, some daily shifts were implemented using this figure.

Systems were in place to reduce the risk of people experiencing abuse. All of the people we spoke with told us they felt safe living in the home. One person told us, "I feel safe living here, if I didn't I would speak to somebody from the office." Another person said, "I feel safe here." Six of the seven relatives we spoke with agreed with this. One relative told us, "Yes I feel [family member] is safe being here, if I didn't I would speak to the manager, or a team leader." Another relative said, "I feel my [family member] is safe living here. If I had any worries I would talk to the manager." One relative disagreed with this telling us they felt their family member was not safe. We spoke to the deputy manager about this who told us they were aware of the family member's concerns and said they were working with them to resolve these.

Staff had received training in safeguarding adults. They were able to demonstrate to us that they understood what constituted abuse. They were clear on the correct reporting procedures if they suspected that any abuse had taken place. This included who to report concerns to outside of the home if this was needed. Any safeguarding concerns raised in the home had been reported to the relevant authorities by the registered manager and fully investigated by them, with action taken as appropriate.

The staff told us that some people could become distressed which could pose a risk to themselves, the staff and others living in the home. Some of the relatives we spoke with told us they had witnessed some people becoming upset. They said that the actions staff had taken during these circumstances had resulted in people becoming calm and much happier. There was clear information within people's care records to guide staff on what action they could take to calm the person in this situation. The staff were able to demonstrate to us they clearly understood these strategies and that they took action to reduce any risks to people's safety in these circumstances.

During our walk around the home, we saw that the emergency exits were well sign posted and kept clear. The staff we spoke with confirmed that testing of the fire alarm had taken place to make sure it worked correctly. Lifting equipment used to assist people to move such as hoists, had been regularly serviced to make sure they were safe to use.

Risks to some areas of people's individual safety had been assessed and had been managed well. These included risks in respect of people developing a pressure ulcer, not eating and falls. We saw that actions had been taken to reduce the risk to people experiencing harm within these areas. For example, people who were at risk of falling out of bed had bed rails to help prevent this from happening. Another person who had

been assessed as being at risk of choking on their food, was receiving a pureed diet to reduce this risk. We also saw that staff made sure the person was sitting upright when they received their food.

For those people who were at risk of developing a pressure ulcer, equipment was in place to help reduce this risk such as a specialist mattress on their bed. Regular checks were made on these mattresses to make sure they were working correctly. We observed some people sitting on specialist cushions when they were sitting in chairs. The staff told us they regularly supported people where needed, to change their position to also help reduce this risk.

Medicines were being stored securely for the protection of people who lived in the home and at the correct temperatures to make sure they were safe to give to people. Written information was available for staff to tell them how people liked to have their medicines given to them.

The required checks had been completed when recruiting new staff to the home. These included checking with the Disclosure and Barring Service that the staff member was deemed safe to work with people living in the home and obtaining references about the staff member's character. There was a system in place to ensure that nursing staff had the appropriate qualifications and were registered with the necessary regulatory body. These measures all reduced the risk of employing staff who were unsuitable to work within care.

Good

Is the service effective?

Our findings

All of the people spoken with told us they felt the staff were well trained. One person said, "Yes I think so. They all seem very good. They go ahead and do what is needed." Another person told us, "Definitely well trained." Six of the seven relatives we spoke with agreed with this. One relative told us, "Yes, because if there is a problem it gets scaled up, and there is a procedure. If one carer doesn't know they will get someone else. They are seldom out of their depth because they are experienced." Another relative told us, "Staff know what they are doing."

All of the staff we spoke with told us they felt they had received enough training to provide people with effective care and that they felt supported in their role. They said that their training consisted of e-learning and also some practical hands on training which they found useful. They were able to tell us about various aspects of their training such as what steps they took to reduce the risk of people developing a pressure ulcer.

We looked at the overall record of staff training and saw that staff had been trained in a number of different subjects such as but not limited to, dementia care, supporting people to move safely, infection control, first aid and fire safety. The nurses training file that we also checked showed they had received training in a number of different areas in relation to nursing care.

Staff new to the home were completing the care certificate. This is a recognised qualification in health and social care that is completed over a 12 week period. It aims to provide staff with the skills they require to give people good quality care. We saw evidence that these new staff had their competency regularly assessed by a senior person before they were able to provide people with care.

On occasions, staff did not demonstrate good care practice in relation to treating people with dignity and respect. We therefore asked the deputy and regional business manager how the provider checked that the training they had provided was effective. The deputy manager told us that care staff had recently started to have their care practice monitored to make sure it was safe and effective. However, they were unable to provide us with any records in relation to this and the three care staff records we checked did not have any evidence in them to show these had taken place. The regional business manager told us that the nurse's competency in relation to the administration of medicines was checked but that the provider did not have a programme in place to check the competency of the nurse's practice. The day after our inspection, the deputy manager told us that plans to implement a programme had been put in place.

The people and relatives we spoke with told us staff always sought consent before supporting the person with a task. One relative told us, "The difference in the staff here is they are human here. They will come in and ask do you mind if I give [family member] a hug."

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular

decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

All of the staff we spoke with had a good understanding of the principles of the MCA. They were clear that they needed to offer people choice and support them to make decisions for themselves. They knew that if they had to make a decision for someone that it had to be in their best interests. We observed this during the inspection. Staff always asked people for their consent before they performed a task. Where the person could not consent, the staff were seen supporting people to make day to day decisions about their care. For example, people were shown different meals to help them make a choice. Staff respected people's decision not to have personal care at a certain time and regularly returned to them at a time when they were happy to consent to this.

People's care records contained information about what decisions people could make for themselves and for those staff needed to support them with. The staff had involved the appropriate individuals in making best interest decisions for people. For example, GPs, pharmacists and those close to the person had all been consulted when making a decision to give people their medicines covertly (medicines hidden in food or drink).

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had assessed people living in the home to see if they were depriving them of the liberty. Where it was felt they were, applications had been made to the local authority for authorisation to deprive some people of their liberty in their best interests. We checked two applications that had been approved and found that the registered manager was working within any conditions that had been set. Therefore, the provider had acted in accordance with relevant legal requirements.

Two of the three people we spoke with told us the food was to their liking, that they received adequate for their needs and that they had a choice of food. One person said, "The food is excellent. I think I have put weight on since being here. At breakfast you can have prunes with your cereal, apple juice, yogurt then toast and marmalade." Another person told us, "The food is good. A good choice and snacks are available." However one person said, "It is not my kind of food, I don't enjoy the food. I like spicy food and things like that and I don't get anything like that. My friends bring a curry in for me occasionally and the staff will reheat it for me." We asked the person if they had raised this issue with the staff but they told us they had not.

The relatives we spoke with told us the food was good and that there was choice for people. One relative said, "The food is good. [Family member] has the soft option." Another relative told us, "The food is nice."

People had a choice of eating their meals in either the dining room, their own room or within a communal lounge. There were a number of different choices of meal for people at breakfast including a cooked breakfast. At lunchtime there were two choices of main meal. The chef told us that they made alternative dishes for people who didn't like the choice of main meal. They demonstrated a good understanding about people's individual dietary requirements and these were catered for.

We saw that people had access to a choice of drinks throughout the inspection. This included an alcoholic beverage if people wished to have one. Staff prompted people to drink regularly and those that required assistance to eat their meals received this in a timely manner.

The chef took actions to increase the calorific intake of people who were at risk of not eating enough. They told us they fortified these people's food with extra calories. The staff we spoke with told us they offered these people regular snacks to encourage them to eat more. When concerned about people not eating and drinking enough, staff had made a referral to a GP or other healthcare professional for specialist advice. People's weight was also monitored to make sure they were receiving enough food to meet their needs.

The provider had sent a number of chefs who worked within their care homes for extra training with Michelin chefs. The chef told us this training had been very helpful to give them ideas about being creative with food. One idea that had been implemented was a fortnightly afternoon tea for which the home had won an award from the company who provided the training.

All of the people we spoke with confirmed that staff supported them with access to healthcare. One person told us, "I think I could see the doctor if I was ill or I wanted to. I have my hearing aid through the NHS and I have had the optician and had new spectacles." Another person said, "I have seen a doctor every week." The relatives agreed with this and said that staff had responded well when there had been concerns about their family member's health. One relative said, "[Family member] had a cold. The staff were concerned about their chest so they got the doctor to check. I was very pleased with the way the staff responded. The chiropodist has visited as well." Another relative told us, "[Family member] has seen the dentist on occasions. The doctor visits weekly and if there is a problem the staff refer it to the doctor if they need to."

The staff told us that the GP visited often and the records we saw confirmed this. We also saw that other healthcare professionals such as dentists, chiropodists and district nurses provided care to people when needed. We were therefore satisfied that the staff supported people with their healthcare needs.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. Improvements are required within this area. One person was observed to be sitting on a continence pad within a communal area. This did not promote this person's dignity. On another occasion, a staff member was heard referring to people who required support to eat their meals as 'feeds'. Another staff member who worked in a different area of the home also referred to people using this term. One staff member was observed talking about a person in a communal area. This may have breached this person's confidentiality. We observed the lunchtime meal in one area of the home. The staff assisting people to eat rarely spoke with them. There was very little conversation or interaction during this meal and it mostly took place in silence.

All of the people living in the home that we spoke with told us the staff were kind and caring. One person told us, "All the staff are very caring and helpful." Another person said, "The staff are kind and caring. They can't do enough to help you. There is nothing you can ask that they won't do. Everyone I have met here are superb." Six of the seven relatives we spoke with agreed with this. One relative said, "Yes the staff are very caring they look after [family member]." Another relative told us, "They (staff) are very genuine, kind people. I think they are all amazing. The staff are very considerate." However, one relative disagreed. They told us, "The staff are not caring. The voice and body language of the staff are unsympathetic. There are one or two that are the exception."

When staff did interact with people, this was done in a kind, compassionate and polite way. Good eye contact was made and the staff were encouraging. A visiting social care professional told us how a staff member had fostered one person's dog when they moved into the home. The staff member took the dog into the home on a regular basis which the social care professional said, made the person very happy. This demonstrated consideration and kindness.

The staff we spoke with demonstrated they knew people well. People's life history had been explored and staff told us this helped them facilitate conversations with people and helped them get to know them as a person. Staff celebrated people's birthdays with them if they wished for this to happen. Plans were in place to celebrate one person's birthday in the near future.

People and/or their family were involved in making decisions about the care that was received. Before people moved into the home, they and/or their family member had been asked for their opinion on what care they needed and how they wanted it to be provided. On-going reviews of people's care needs had taken place that involved them and their family member if necessary. One person told us, "I more or less live as I want to." A relative said, "[Family member] was included in their care planning we all spent three hours in the office doing it." Another relative told us how they and their family member had been involved in making a decision about the person's medical care. They told us, "We were both fully consulted and given the information so [family member] could make a choice."

People had been able to decorate and personalise their rooms as they wanted to. We observed staff offering people choice throughout the inspection. This included whether people wanted to be in their own rooms or

within a communal area, what food and drink they wanted to receive and whether they wanted to join in with activities. The staff we spoke with demonstrated they understood the importance of offering people choice and supporting them to make decisions for themselves.

Requires Improvement

Is the service responsive?

Our findings

The staff did not always have time to spend with people to enhance their wellbeing. The people we spoke with gave us mixed views at the levels of stimulation they received to enhance their wellbeing. This was echoed by the relatives. One person proudly showed us their nails and said, "The staff did these for me the other day, they are lovely." Another person said, "I just sit round all day, I can't read or anything now, I have my television even though I can't see it the sound is company." One relative told us, "They don't do activities at the weekends. [Family member] likes the singing and they appreciate the music. There is a mini bus but the same people go out in it all the time. I would like [family member] to go out more. They have only been out on five trips in three years." Another relative said, "The activities are fantastic, but I would like to see things going on in the morning other than sitting in their rooms." A further relative said, "There are activities to do, like games and colouring."

We also received mixed views from the staff. Some of the staff we spoke with told us they felt people received enough stimulation to enhance their wellbeing. They said that they were able to take people outside the home for walks. They said the home had a mini bus that often took people out for trips to the coast or other areas of interest. However, three told us that they found it more difficult to spend time with people in the mornings due to being busy supporting people with personal care.

During the inspection, there was a group keep fit class that was well attended and also a coffee morning. We saw some people colouring in books and reading books and newspapers in their rooms. On the top floor, there were a number of sensory items that people who were living with dementia could touch, look at and feel. This included different types of materials, dolls and toys. We observed one person walking around the communal areas accessing some of these items. However, for people who did not wish to join in the group activities, there was a lack of stimulation during the morning of the inspection visit. Staff did not have much time to spend with people and only engaged with them when they were performing a task. This improved on all floors in the afternoon. Staff were observed to spend more time sitting chatting with people and engaging with them. A PAT also visited at this time which some people were observed to enjoy.

There was a programme of group activities that took place each day on the lower floor of the home. These included but were not restricted to, a gentleman's club, pampering sessions, arts and crafts and baking. Garden parties had been held in the summer and remembrance day had recently been commemorated. The deputy manager told us that the provider had recently recruited another staff member to the activities team with the aim of improving people's access to individualised activities.

People's care records did not always contain all of the relevant information about the person's needs and preferences to guide staff on the care they wished to receive. Before people went to live in the home, the registered manager carried out an assessment of their individual needs to make sure that these could be met. The information took into account the care that people wanted to receive and some preferences about how they wanted their care to be given. For example, whether they wanted their care from a male or female carer. Spiritual and cultural information was also captured.

There was information documented within people's care records about what actions staff needed to take to meet people's needs and preferences. Some people's care records contained clear and thorough information about these areas however, others needed improving. This was important as the home regularly used agency staff who may not know the person's needs and preferences well. For example, care plans in respect of supporting people who had diabetes required improvement. These lacked information in relation to what the person's safe blood sugar range was, how being hyper or hypoglycaemic could affect them and what staff should do in those circumstances. Also, where one person had an oxygen concentrator in place, there was no information detailed how often this equipment needed to be cleaned, changed or how to dispose of it safely. Another person's care record said they liked to have a bath but did not state how often they wanted to have one. Nothing was recorded in another person's care plan in relation to whether they were an early or late riser or if they had no preference in relation to this matter. The deputy manager told us that they were aware that some people's care records required improving and that this was currently being worked on.

Both of the people we spoke with and the visiting relatives told us they knew how to complain if they felt they needed to. One person said, "I would speak to any of the girls [staff]." Another person told us, "If I was troubled with anything I would speak to [staff member]. She is the one I saw in hospital she seems to be the main one." A relative told us, "I would speak to [registered manager], or if not any of the staff." Another relative said, "I find all of the staff are approachable the regional manager, manager and deputy manager if I had any concerns I would speak to any of them." One relative told us they had made several complaints to the registered manager and that these had not always been resolved to their satisfaction. We spoke to the deputy manager about this. They told us they were aware of the relative's complaints and said that several discussions had taken place in relation to the concerns raised. They confirmed that these were on-going.

We looked at the records of complaints. Most complaints had been investigated and appropriate responses had been sent back to the person who had complained. However, although written complaints and some verbal ones had been recorded, the verbal complaints made by the relative we spoke with had not. There was no record of any investigation into these concerns or discussions that had taken place. We were therefore unable to verify whether these complaints had been dealt with in line with the provider's policy.

All of the people we spoke with told us that they received care that met their individual needs and preferences. One person said, "I go to bed around eight o'clock and I get up at eight o'clock you have whoever is available to help get you up." Another person told us how they could have a bath when they wanted one. Six of the relatives we spoke with agreed with this. One relative said, "[Family member] likes to socialise and although they can't communicate verbally, they like to people watch and see what is going on. So I asked the staff if [family member] could sit at reception when I am not here watching what is going on and people coming and going. They sorted that out and [family member] loves it. The staff are very considerate."

All of the staff we spoke with told us they were able to provide people with care that met their individual needs and preferences. Two staff told us that when they had less staff than planned this could be difficult but confirmed that people received the care they required. They told us that they respected people's preferences of what time they wanted to get up in the morning and go to bed at night. They also said they supported people with a bath or shower at a frequency of their choosing. One staff member told us how they supported one person to go outside each day as this enhanced their wellbeing.

During the inspection, we saw that although the staff had monitored people's wellbeing earlier in the day, four people did not receive support with a wash until after 11am. We spoke with the staff about this. They told us they had offered to support people with washing and dressing earlier in the day but that they had

declined. They said they respected the person's preference and continued to offer as they understood how important personal hygiene was for people.

Figures who represented various faiths visited the home to assist some people who wished to continue to practice their religion or for whom this was important. One person told us, "I do have communion at the home." Another person said, "I have been to a religious service since I have been here."

People told us that their relationships with family and friends were encouraged to enhance their wellbeing. One person told us, "My daughter comes nearly every day and my son comes every week." A relative said, "You can come and go as you please, day or night."

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager had not taken sufficient action to make sure all of the improvements required since our last inspection had taken place. The current systems in place were not effective at making sure people received safe, good quality care and that any actions identified to improve these areas had been implemented in a timely manner.

The audit in respect of checking the safety of people's rooms was not effective. This audit had been conducted in November 2016 but had not identified the issues we found in relation to people's doors not closing properly in the event of a fire. Five months after a specialist fire safety company had identified that a detector needed to be fitted within an electrical cupboard, this had still not been fitted.

Adequate systems were not in place to ensure that people received their medicines when they needed them. Although the balance of people's medicines had been checked each day, timely action had not been taken to obtain new stock to prevent the medicine running out. This had resulted in some people not receiving their medicines.

The registered manager had a service improvement plan in place (SIP). This document was used to track the completion of actions that needed to be taken to improve the quality of care people received. However, we found that the monitoring and implementation of these required actions was not effective. The improvements required following the local authority, CCG and external auditor visits in September and October 2016 had not been added to the provider's SIP for follow up. The deputy manager told us they thought the local authorities actions had been added on there so they could be tracked. The SIP had last been reviewed on 1 October 2016.

The local clinical commissioning group (CCG) conducted an inspection of the home in June 16. They found that there was not enough information detailed on people's personal evacuation plans (PEEPs) that were kept within the emergency grab bag. This action had been recorded on the SIP which stated that it had been completed in August 2016. At the CCG's subsequent visit on 6 October 2016 they found the same issue. They also found during this visit that the information within the emergency grab bag was inconsistent and needed improving. We found the same issue at this inspection nearly six weeks after the CCG's last visit.

The CCG had identified in June 2016 that there was no system in place to assess the competency of nurses in specific clinical tasks. Again, this action had been added to the provider's SIP following this visit with a date of completion in September 2016. On 1 October 2016 when the SIP was last reviewed, it was noted that this action needed to be completed as a priority. At the CCG's visit on 6 October 2016, they repeated this recommendation as little progress had been made. We found that this had still not been implemented at this inspection.

We were told by the deputy manager that a system was in place to monitor and assess care staff competency and that these had commenced but was not fully embedded. We observed staff on occasions, demonstrating poor practice. We noted that in October 2016, the external company who conducted an audit

on behalf of the provider had noted that some staff referred to people who required assistance to eat their meals as 'feeds'. They stated on their audit that this was disrespectful. We found the same issue during our inspection which indicated that staff practice had not been addressed in a timely manner.

In September 2016, the local authority infection control specialists visited the home. They had some concerns in relation the systems in place to monitor and control the risk of the spread of infection. One of these concerns was in relation to some equipment they had identified that was unclean. The registered manager had completed a thorough audit in relation to infection control in September 2016 and had found no issues within this area. In October 2016, an external company who conducted an audit on behalf of the provider found some equipment was unclean. We also found this an issue during this inspection. No other audits within this area had been completed by the registered manager since September 2016.

Some people's care records continued to not contain enough information in relation to the care people required. This issue had been identified at our last inspection in May 2015. This had also been identified in the audit conducted for the provider by an external company in July 2016 and again in October 2016. It had been recorded on the SIP in October 2016 that care records were still being reviewed.

The complaints that people had made had not all been recorded. No analysis of complaints had taken place to enable the provider to learn from them.

The deputy manager told us that the number of staff working on each shift was monitored regularly to ensure the provider met people's needs. However, we found during the morning of the inspection that there were not always enough staff to engage with some people in a meaningful way. The deputy manager told us that the calculation made to establish the number of staffing hours required by the provider did not taken into account non-care tasks completed by senior staff. Examples of these are completing paperwork, providing leadership and guidance to staff and assisting visiting healthcare professionals. Staff breaks had also not been factored into the calculation. Therefore, the systems used to determine the number of staff required were not wholly effective.

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

The registered manager regularly analysed accidents and incidents. Action had been taken to reduce the risk of the incident or accident happening again. For example, we saw that one person had been referred to a specialist falls team for advice following a number of falls they had experienced.

Feedback from people and their relatives about the care being provided had been regularly sought. This was in the form of meetings or formal questionnaires. We saw that suggested improvements from people had been made.

All of the people we spoke with and six of the visiting relatives told us they were happy with the support and care that was provided, that the management team were open and that they felt that the home was well-led. One person told us, "I would recommend the home. All of the staff are absolutely wonderful, if I need to speak to someone it would be any of the staff." Another said, "I am happy here and I would recommend it, I have been in one or two homes over the years this is the best one I have been in for food, caring and help given to me. The manager has spoken to me several times." A relative told us, "I am happy with [family member] being here I wouldn't let her be here if I wasn't, I think it is well led it is pretty good now, the manager is about round the home." Another relative said, "The running of the home is done exceptionally well, the manager and the deputy manager wander around the home popping into people's rooms to say hello and see how they are getting on. I would absolutely recommend it."

The management team had an open door policy. All of the staff we spoke with were happy working within the home. They said they all worked well as a team to provide people with care and support. All of the staff said they received good leadership and direction and that they could raise any concerns without hesitation. The provider recognised staff for their work through the 'Hearts of Gold' scheme. This was where staff, people who lived in the home and relatives could nominate a staff member to receive an award and recognition for their hard work. The deputy manager told us a party was held each year to celebrate this.

During the inspection visit, we regularly saw the deputy manager within the home, talking to staff, the people living there and their visitors. People were seen going to the manager's office to discuss any concerns they had.

Links with the local community had been established. This included with the local school who visited the home to chat with people. A monthly coffee morning was also held to support the carers of people living within the local community. The registered manager had set up regular seminars that relatives attended. Here, they discussed dementia and provided support to the relatives to help them understand the condition.

The regional business manager told us the provider was implementing a new dementia strategy within their care homes. This strategy called 'living well with dementia' aimed to improve the care people living with dementia received. Plans were in place for staff to receive further training in dementia care to improve their skills in this area and also improvements were to be made to the environment. A lifestyle co-ordinator had also recently been employed to support improvement in relation to activities for people living with dementia.

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 The provider had not done everything practicable to mitigate risks to people's safety. Regulation 12, 1, 2 (a) (b) and (d).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not made sure there were sufficient supplies of medicines to ensure the safety of service users. Regulation 12, 1, 2 (f) and (g).

The enforcement action we took:

We have issued a warning notice and have said it has to be complied with by 30 December 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Not all current systems in place were effective at assessing and monitoring the quality of care provided or to reduce the risk of people receiving poor quality care. Some records in relation to people's care were not accurate. Timely action had not always been taken in response to feedback from other relevant bodies. Regulation 17, 1, 2 (a), (b) (c) (e) and (f).

The enforcement action we took:

We have issued a warning notice and have said it has to be complied with by 1 February 2017.