# WCS Care Group Limited

# Castle Brook

## Inspection report

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15 November 2018

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection visit took place on 13 and 15 November 2018. The first day of our inspection visit was unannounced.

Castle Brook is a care home. People in care homes receive accommodation, and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The maximum number of people the home can accommodate is 86. The service was delivered over three floors, which were subdivided into six individual households for up to 14 people. One household is a 're-enablement' unit for people who have been discharged from hospital but need further therapeutic input to build up their strength and mobility. Each household had their own communal lounge, kitchen and dining areas and people had access to the shared facilities in communal areas throughout the home. There were 55 people living at the home at the time of our inspection visit, some of whom were living with dementia.

At our last inspection in September 2017, the home was rated as 'Requires Improvement' in the key questions of 'safe,' 'effective' 'caring' 'responsive' and 'well-led'. There were five breaches of the Regulations. After that inspection the provider provided us with an action plan. This showed what they would do and by when, to improve all areas of the service we had concerns with to at least 'good'.

During this visit the provider had made a promising start to improving the service and the home was no longer in breach of the regulations, and had improved their rating to good in the three key areas of 'safe', 'caring' and 'responsive'. However, we found further requirements were still required in 'effective' and 'well-led'. The rating therefore remains 'Requires Improvement' overall.

Following our visit in September 2017 the provider put a management 'task force' into the home to understand the issues, develop staff and look at the systems and processes to support good service delivery.

In April 2018 they appointed a new manager who has subsequently become registered with us. 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 new registered manager had a track record of managing an outstanding service and consistently demonstrated the provider's values.

Staff and relatives told us the improvements instigated by the provider and new registered manager had resulted in improvements in the home and the culture of the service. However, because it had only been six months since the appointment of the new registered manager, there had not been sufficient time to be sure the improvements were embedded into every day practice and would be sustained. The registered manager and other members of the provider's senior management team acknowledged that improvements were

required to be sustained over a period once further people were admitted to the home.

People's care plans identified whether they had the capacity to consent to living at the home. Where people required restrictions on their liberty to keep them safe from harm, Deprivation of Liberty Safeguards had been applied for. However, the provider was not always acting in accordance with their responsibility to provide care in the least restrictive way possible.

The provider had recruited more permanent staff and the staffing rota was now organised around individual households, to ensure people were supported by a consistent team of staff. Although there was still a high use of agency staff, the registered manager had made improvements to how staff were managed with more clarity about individual responsibilities. Staff said they now worked on the same household regularly, which meant they knew people well and could build effective relationships with them. Staff told us the supervision and appraisal process had improved, which gave them a renewed confidence in their abilities and the encouragement to continue to develop their skills.

Communication between staff and the registered manager, and between relatives and the registered manager, had improved. People, relatives and staff were now more confident issues raised would be taken seriously and action taken to improve the service provided.

The management of medicines in the home had improved. There were robust processes in place for the prescribing, ordering, checking, storing and disposal of medicines. Staff told us improvements in medicines management gave them more confidence people received their medicines safely.

People's individual risks were assessed and their care plans were written to minimise the identified risks. Staff followed people's care plans to keep people safe.

Staff understood their duty of care to keep people safe and report any concerns they had that people were at risk of potential or actual abuse, neglect or discrimination. The registered manager followed the local procedure for referring people at risk to the safeguarding authority.
People's care plans included their medical history, which ensured staff understood risks to their health and the signs of ill-health. Records showed people were referred to other health professionals when a need was identified. People were encouraged to eat and drink enough to maintain their health.

Staff demonstrated an enthusiasm for providing a warm, friendly environment where people were made to feel they mattered. Staff's behaviour and approach was in keeping with the provider's aim, to ensure, 'Every day is well-lived'. People were encouraged to maintain their interests, socialise and to create their own activity spontaneously.

People's care plans included personal information, which recorded what was important to the person and how they preferred their care and support to be provided. Staff shared information at a handover between shifts so they could respond to people's changing needs or abilities.

The provider had a system of checks and audits to identify where improvements were needed. Audits had led to actions which had improved people's health and well-being. However, the audits had not identified the provider was not working within the principles of the Mental Capacity Act 2005.

The registered manager was committed to building on the improvements made in the last six months to ensure people received a standard of care that supported them to live a fulfilling and meaningful life.

The registered manager and provider understood their legal responsibilities to inform us of significant events that occurred in the service and to display the ratings from our last inspection visit.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

The provider had recruited more permanent staff so people were supported by a more consistent staff team, who knew and understood people's needs and abilities. People's individual risks were assessed and their care plans were written to minimise the identified risks. The registered manager understood their responsibility to protect people from the risks of harm and report any safeguarding concerns to the local authority. Medicines were managed in accordance with good practice.

### Is the service effective?

Requires Improvement

The service was not consistently effective.

The registered manager had made improvements to how staff were managed, with more clarity about individual responsibilities. The supervision and appraisal process had improved so staff had a renewed confidence in their own skills and abilities. However, care was not always provided in the least restrictive way possible. People were supported to maintain their health with a choice of meals, drinks and snacks and referred to other healthcare professionals when a change in their health or abilities was identified.

### Is the service caring?

Good

The service was caring.

Staff were enthusiastic about providing a warm, friendly environment where people felt they mattered. Staff's behaviour and approach was in keeping with the provider's aim, to ensure, 'Every day is well-lived'. Staff understood people's right to privacy and were respectful of them.

### Is the service responsive?

Good

The service was responsive.

Improvements in the number and deployment of staff meant staff worked with people regularly so they knew them well and

could be responsive to their needs. People's needs and abilities were regularly reviewed, to make sure any changes were reflected in their care plans and known to staff. People were encouraged to maintain their interests and to socialise. The management of complaints and concerns had improved to ensure people felt listened to.

## Is the service well-led?

**Requires Improvement** 

The service was mostly well-led.

Since our last inspection in September 2017 a new registered manager had been appointed who had a track record of managing an outstanding service and consistently demonstrated the provider's values. The provider had provided more effective support to the registered manager and staff to make improvements to the service. Staff and relatives told us improvements had been made in the culture of the service and concerns were now being addressed. Quality systems had been implemented more robustly and this had improved the responses of the service in dealing with issues which arose. The improvements were relatively recent, and had not been tested over a longer period and with a home at full capacity to ensure sustainability.

# Castle Brook

**Detailed findings**

## Background to this inspection

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

This comprehensive inspection visit took place on 13 November 2018 and was unannounced. The inspection was undertaken by one inspector, a bank inspector, a specialist advisor and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had similar care needs. A specialist advisor is a qualified health professional. One inspector returned announced on 15 November 2018 to look at the provider's quality assurance systems.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team also included a dental inspector and an inspection manager who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Prior to our inspection visit, we reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The commissioners did not share any major concerns about the service.

Before the inspection visit, the provider completed a 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. The PIR was detailed and we could review the information in the PIR during our inspection visit. Overall, we found the information in the PIR was an accurate assessment of how the service operated.

During our inspection visit we spoke with the registered manager, a service manager and the provider's Director of Quality and Compliance about their management of the home. We spoke with a care co-ordinator, five deputy care co-ordinators, four care staff, the lifestyle coach, two housekeeping staff and a cook/hostess about what it was like to work at Castle Brook. We also spoke with a healthcare professional who regularly visited the home and a visiting lay reader from the local church.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Some people could tell us what it was like living at Castle Brook. We spoke with seven people who lived at the home and four relatives/visitors. We observed care and support being delivered in communal areas and how people were supported to eat and drink at lunch time. Following our inspection visit, we spoke with a further three relatives by telephone.

We reviewed five people's care plans and daily records in detail to see how their care and treatment was planned and delivered. We also looked at specific areas of seven other care plans. We looked at staff training records, records of complaints and reviewed the checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Good

# Is the service safe?

## Our findings

At the last inspection we rated safe as Requires Improvement. This was because medicines were not managed safely, there were not enough staff with the appropriate qualifications and experience to meet people's needs and allegations of abuse had not been reported to the local safeguarding authority as required. We identified three breaches of the regulations. At this inspection we found improvements had been made and rated safe as Good.

At our previous inspection in September 2017 we found improvements were required in medicines' management. At this inspection we found the required improvements had been made.

Our specialist advisor checked medicines were managed in accordance with good practice. They confirmed there were robust processes in place for the prescribing, ordering, checking, storing and disposal of medicines. Medicines that required extra checks because of the potential for misuse, were stored and recorded in accordance with legal requirements. When staff gave people their medicines, they carried out all the necessary checks to ensure they were given to the right person and in accordance with the person's prescription.

In five households staff completed electronic medicines administration records (MARs) when they had given people their medicines. Electronic MARs we looked at indicated people had received their medicines as prescribed. On the re-enablement household, as people were constantly being admitted and discharged from the household, staff used paper MARs. Overall, the paper records confirmed people had received their medicines. However, we did identify three gaps when staff had not signed to confirm a medicine had been given or had not recorded a reason why it had not been given. The care co-ordinator on that household told us they had already identified this as an area of concern, and was introducing a daily medicine count so they could quickly identify any issues in record keeping.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important patches are rotated around the body in line with the prescribing instructions, to avoid people experiencing unnecessary side effects and ensure the medicine delivery is effective through the skin. Staff generally completed records of where patches had been applied to ensure people were protected from these risks. However, these records were not routinely completed on the 're-enablement' household. On the second day of our visit the care co-ordinator showed us the documents they had introduced to record the placement of patches and the checks they intended to carry out to ensure the patches were still in place. This would ensure people did not experience unnecessary pain because the patches had fallen off and they were no longer receiving their medicine.

Staff told us improvements in medicines management gave them more confidence people received their medicines safely. They said improvements included weekly medicines' audits by deputy care coordinators, to check the amount of medicines available matched the records staff made when they gave people their medicines. A member of staff told us managers still ordered people's medicines and booked them in, and said, "The process has improved massively." Staff told us there were always enough medicines-trained staff

on duty to ensure people had their medicines at the prescribed times. A deputy care coordinator told us it was their responsibility to make sure people were supported with medicines at the 'right time', in accordance with people's prescriptions to minimise the risk of under or over-dosing a person. Another deputy care coordinator told us they used calming medicines appropriately, that is, only if other methods, such as distraction techniques, failed to reduce a person's agitation.

During our previous inspection, we identified improvements were needed to ensure there were enough suitably skilled and qualified staff on duty. At this inspection, we found the required improvements had been made. People were supported by a more consistent staff team, who knew and understood people's needs and abilities.

Staff told us improvements had been made in recruiting permanent staff, and some agency staff who had worked at the home for a long time, had been offered permanent roles because they knew people well and understood the company's values and ways of working. Staff told us they now worked in the same household most of the time, and there were always permanent staff on duty on every shift. Comments included: "It is much better. We have our own staff and less agency" and, "Before we only had two staff on each household doing everything and call bells weren't being answered. Now the new management make sure we have a cook and a cleaner and enough care staff and they are a lot more supportive as well. They are constantly checking we answer the call bells."

People's assessed needs and dependencies were 'scored' to enable the provider to ensure there were enough staff on duty to support everyone safely. Staff told us staffing levels enabled them to provide effective care, and to spend time with people, ensuring their emotional and social needs were also met. They told us they worked well as a team, because the new role of 'deputy care coordinators' in each household had resulted in effective local leadership and clarified everyone's responsibilities.

Overall, people and their relatives expressed satisfaction with a more consistent staff team and the time staff took to respond to any requests for assistance. Typical comments were: "I have a bell in my room and they come immediately", "It's the same staff here mostly", "When I require the staff I very seldom use the call bell because I am near them all the time" and, "They answer my bell in three or four minutes." One person told us, "I am happy here and could not be in safer hands, there are always staff around and they ensure that I have my bath, food and medicine on time. This is my home." However, some people felt staff were more rushed at weekends. One relative commented, "There's always someone around, always someone to help, but I came the other morning (Sunday) at 10.30am and [name] was still in bed."

The registered manager told us the provider continued to recruit permanent staff to further reduce the need for agency, but acknowledged more agency staff were used at weekends. They said, "We know that is a grey area which we are working on now."

During our previous inspection, we found the previous registered manager had not always referred safeguarding concerns to the local authority promptly, which was a breach of the regulations. At this inspection we found the new registered manager understood their responsibility to protect people from the risks of harm and followed the local procedure for referring people at risk to the safeguarding authority. For example, when one person living with dementia had presented behaviour-that-challenged-others towards another person, the registered manager had made the appropriate referral. The person who had presented behaviour that challenged others had moved to a different household and had been referred to the mental health team to identify additional actions for staff to minimise the risks of a re-occurrence.

The provider's Director of Quality and Compliance told us they planned to enhance their safeguarding

procedures by setting up a 'Safeguarding Committee'. They explained the purpose of the Committee was to ensure their safeguarding policies and procedures remained in line with current statutory requirements and should abuse or neglect occur, that their response was timely and proportionate. They were confident the Committee would ensure the provider's safeguarding practices were continually improving.

Staff understood their duty of care to keep people safe and report any concerns they had that people were at risk of potential or actual abuse, neglect or discrimination. One staff member told us they would be concerned, "If there were bruises on a resident or if someone was being sharp talking to a resident. I would go and report it." Other comments included: "At the end of the day we are here to protect our residents" and, "I'm responsible for their wellbeing."

People's individual risks were assessed and their care plans were written to minimise the identified risks. Risks to people's communication, memory, mobility, continence, fluid and nutrition, sleeping, health and skin were assessed. People's care plans were regularly reviewed and their risk assessment scores were updated when their needs and abilities changed.

Staff followed people's care plans to keep people safe. One person was at risk of falls. Staff had ensured the person had their call bell and walking frame within reach. Another person on the re-enablement unit was learning to walk again following a fall. The person was supported by the therapist to use their walking frame, with a member of care staff following close behind with a wheelchair. This gave the person confidence, allowed them to rest and minimised any risk of falling. For one person who was at risk of sore skin due to their immobility, they were supported with a pressure-relieving mattress and cushion. A deputy care coordinator told us the person always had a lie down after lunch, to relieve pressure on vulnerable areas of their body, which minimised the risks of sore skin.

One person could demonstrate unpredictable behaviours that could case distress to them or others. Staff used supportive observation by keeping a discrete distance to ensure the person did not feel they were being followed, but at the same time staff were aware of the person's whereabouts to ensure everybody was safe. Staff also monitored the person's mood for signs of anxiety or agitation so they could engage them in activities as a calming strategy to reduce the risks of their behaviours escalating.

The provider had assessed and mitigated the risks of fire. Staff received training in fire safety and attended monthly fire drills. The fire alarm and fire-fighting equipment were regularly tested and serviced. People had personal emergency evacuation plans to ensure their individual risks were known and they could be supported safely in the event of an emergency evacuation.

The provider's safety policy included lockable cleaning trolleys, to make sure cleaning products were kept safely, and finger-print recognition on the doors to stairwells and areas which presented risks to people's safety. Only staff could access the whole home. The provider's safety policy included regular checks by trained staff of equipment, such as hoists, slings and wheelchairs to minimise the risks of unsafe use

People were protected by the prevention and control of infection because the provider had policies for cleaning and maintaining the premises. The home was very clean, tidy and well maintained throughout. Housekeeping staff told us they had the appropriate equipment to maintain high standards of cleanliness and were told if anybody had an infection so they could take extra precautions to prevent the infection spreading. In the rooms that were not currently in use, staff regularly ran the water, to minimise the risks of infection in the water system.

People were happy with the cleanliness of the home and told us staff followed good hygiene practices. A

typical comment was, "They always wear gloves and wash their hands."

The provider had a process for ensuring lessons were learned when things went wrong. Managers reviewed reported accidents and incidents and recorded actions taken to reduce risks of reoccurrence. Records showed actions had been taken to address any injuries that had occurred. Accidents and incidents were also reported by the manager on the provider's electronic 'dashboard'. This meant the provider had daily oversight and could assure themselves appropriate action had been taken to minimise risks within the home.

Requires Improvement

# Is the service effective?

## Our findings

At our previous inspection in September 2017, we found people were not always supported by trained and effective staff, which was a breach of the Regulations. Improvements were required in how staff were trained and supported to be effective. At this inspection, we found improvements had been made.

Staff told us the registered manager had made improvements to how staff were managed, with more clarity about individual responsibilities. A new deputy care co-ordinator role had been created, which meant there was always a senior member of staff on each household for other staff and relatives to speak with. Handover records showed how the care co-ordinators managed the staff team, by allocating specific responsibilities to care staff. Staff said they now worked on the same household regularly, which meant they knew people well and could build effective relationships with them. A relative told us they thought communication with staff had improved.

Staff told us a decrease in the ratio of agency to permanent staff had relieved them of the pressure of feeling responsible for agency staff's actions and behaviours. Staff told us there were always the agreed number of staff on duty and the supervision and appraisal process had improved. Staff had a renewed confidence in their own skills and abilities and felt enabled to spend more time focused on supporting people instead of worrying about staffing.

The registered manager told us the completion of training had improved in the last six months so staff felt more "empowered" in their roles. Staff confirmed training opportunities had improved. They told us they had training when they started at the service, and regular refresher training and were supported to develop their skills and obtain nationally recognised qualifications. Staff told us they were encouraged with their personal development and the recently implemented posts of deputy care coordinators had given them the opportunity to take on more responsibility and develop their skills. The registered manager told us, "There is nothing more exciting than watching staff grow.  We need to build staff confidence by asking 'what is it we can do to develop staff in a particular area'." The registered manager was confident they would be able to provide more effective care once they had a full team of permanent staff who had all been trained in accordance with the provider's values.

People felt staff had the skills and competencies to provide them with effective care. Comments included: "The staff are great, I can't fault them in anything" and, "The staff are very good."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the provider was working within the principles of the MCA and whether they had the appropriate legal authority.

People's care plans identified whether they had the capacity to consent to living at the home. Where people

required restrictions on their liberty to keep them safe from harm, for example, to prevent them leaving the home alone, Deprivation of Liberty Safeguards (DoLS) had been applied for.

However, the provider was not always acting within their responsibility to provide care in the least restrictive way possible. For example, the door to one household was locked due to a person's unpredictable behaviours. Whilst this meant the risks presented by this person were minimised, the other people living on that unit were having their freedom to move freely around their home restricted. Staff were not happy about this restriction and one staff member commented, "We always used to have an open home policy where residents can go wherever they want to. When that door was locked, I wasn't happy about it. By locking that door, we were preventing people from going to the shop or the coffee shop." We were told some relatives had raised concerns and although we were assured this was only a temporary measure, records showed the door had been locked for around six weeks. On the first day of our inspection visit we shared our concerns with the management team. The registered manager told us they would stop locking the door to this household, because they understood people were at risk of being unlawfully deprived of their liberty if they continued with this practice. They re-assessed how they supported the person with unpredictable behaviours and put measures in place to manage risks in communal areas. On the second day of our visit the door to the household was unlocked and one person had already accessed the communal areas to collect their daily newspaper.

Staff demonstrated they understood the principles of the MCA, and knew they should assume people had the capacity to make their own decisions. Staff knew the importance of obtaining people's consent before providing care and support. Staff routinely asked people for their consent before they carried out any tasks or care. However, we found decisions were being made on behalf of two people which we could not be sure were in their best interests. One person's care plan said, "[Name] is to be offered a choice with every day decisions" but, we found they were not being offered the opportunity to join some activities. We discussed this with the registered manager. They assured us they would review these people's care with their relatives to ensure they were given maximum support to make their own decisions and live their lives as they wished to without any unnecessary restrictions.

People were supported to maintain their health with a choice of meals and snacks, which met their dietary requirements and preferences. Lunch was served at 12 noon and at 1:00pm, so people could choose when to eat. People were encouraged and supported to eat at dining room tables, to make lunchtime a social occasion, or could eat in the lounge or their own rooms, to suit their preferences. People were asked during the morning for their main meal preferences, but those people living with dementia were not given any visual aids such as a pictorial menu to help them make their choices. Whilst one staff member agreed this did not help people living with dementia to choose what they wanted to eat, they assured us people were able to change their minds at the time of serving when they saw the meals. People who needed special diets and assistance to eat, were supported effectively by staff who understood and cared about the individual's specific needs for support. The cook told us staff understood the importance of ensuring people had a good 'mealtime experience'. For example, staff did not start washing up, making a noise, until after the meal was over.

People were asked about their dietary needs, preferences and any allergies before they moved into the home, and these were included in their written care plans. People's dietary requirements, such as soft or diabetic meals, were known to the cooks, to make sure the menus catered safely for each person. One cook told us they had conversations with people about the meals and observed whether they ate well. The cook prepared a special 'mid-week roast', which they said people really enjoyed. A member of staff told us, "We do a mid-week roast meal. People like it, they talk about it now".

People were mostly positive about the food and we saw snacks, fruit and drinks were available in various areas of the home to encourage people to eat and drink. Comments included: "The food is excellent, you get a menu in the morning. You get as much tea and coffee as you like", "The food is quite good, I would give it five out of ten. There's several choices, they ask in the morning what I would like" and, "The food is very good, I get lots of choices. There are lots of drinks available."

People were regularly weighed to make sure they ate enough to maintain a healthy weight. Where people lost weight, staff monitored their food and fluid intake and weighed them weekly, to make sure any further weight loss would be identified quickly and action taken. Where people were identified as being at risk of poor nutrition, they were referred to dieticians and the speech and language teams, to make sure appropriate amendments were made to their diet. The staff were proactive at supporting people to drink enough. Every drink was recorded electronically, so staff could check at each shift handover meeting whether the next staff shift needed to encourage anyone to drink more before bed time.

People were assessed before they moved to the home to ensure their needs could be met and they received effective care. This included their physical, mental and social needs. Care plans had been developed from people's assessments. During the shift handover meeting, staff shared information about how people were, any particular needs, health issues and appointments for the next staff shift to manage.

People's care plans included their medical history, which ensured staff understood risks to their health and the signs of ill-health. Records showed people were referred to their GP and other health professionals, such as a district nurse, when needed. However, the registered manager acknowledged there had previously been issues with some healthcare professionals because of poor communication. They told us relationships had improved, but they still needed to make further improvements to ensure communication with other healthcare professionals was consistently managed effectively.

If a person was admitted to hospital, the electronic care records included the facility to download an extract or 'hospital pack' with the most important information about the person's needs and abilities and recent shift handover care notes. This ensured essential information was shared with the hospital.

On the re-enablement household, staff worked with a range of other healthcare professionals to ensure people received support they needed to regain their strength, mobility and life skills so they could return to their own homes. This included an occupational therapist, physiotherapist and nurses. A visiting healthcare professional told us, "As a team we have developed our knowledge and skills to meet the needs of the people admitted here. It is a fantastic environment for rehabilitation and has great potential. We have all the equipment we require and make sure people have the right gear before going home such as the correct wheel chair, walking frame and other equipment." This healthcare professional only worked Monday to Friday but told us, "I know the staff continue with the work that we carry out during the week because the people tell me and I know it from the level of functioning of the people."

The premises were purpose built to deliver the practical needs for people and staff. The environment was decorated with pictures and artefacts throughout the home, to encourage people to converse and reminisce independently or with their visitors and staff. On the ground floor people made use of a café, shop, launderette, cinema, spa, table tennis room and a garden, which people could access independently or with the support of staff if needed.

Good

# Is the service caring?

## Our findings

During our previous inspection in September 2017, we found improvements were required in caring. At this inspection, we found the provider had acted to make the required improvements. They had made changes to the management structure and recruited more permanent staff so staff had time to spend with people and develop relationships. This had a positive impact on staff's ability to deliver person-centred care. Staff told us, "A lot has changed. We fought hard to get continuity per household. Now there is always a deputy care coordinator on shift and permanent staff" and, "We have the same staff, we all know what to do. It works really well here. It's very good."

People commented positively about the staff and their caring approach. One person told us, "My carers are nice and kind. I have got to know them." Another said, "The staff all speak quite caringly." A relative told us, "We see the same faces when we visit. They are so attached to people. There's a lot of laughter."

Staff received training in dementia awareness and dignity and respect, which enabled them to understand people's complex needs and to support them with empathy and compassion. Staff's behaviour and approach was in keeping with the provider's aim, to ensure, 'Every day is well-lived'. Staff were cheerful and they smiled and sang while they were supporting people, which had a positive effect on people's moods. Staff initiated conversations between a group of people who had been sitting silently before staff approached them. When a member of staff woke a person who had been snoozing in their chair, they used a low, soft voice and gave the person a kiss when they woke.

All the staff we spoke with demonstrated an enthusiasm for providing a warm, friendly environment where people were made to feel they mattered. One staff member explained, "I get a buzz out of helping my residents and making them smile. It makes my day."

People's care plans included personal information, which recorded what was important to the person, their preferences for how they spent their time and how staff should support, reassure and comfort the person. Since our previous inspection, the registered manager had started to introduce named 'keyworkers' for people. A keyworker is a member of staff responsible for making sure the person's needs are met and who has time to get to know them well. They are also the named person for relatives to share information with and ask questions of about their relation. People's bedrooms had the name and photo of their keyworker on the back of their door, with information about the keyworker, which explained their shared interests with the person. A member of staff told us, "They are like family. We develop a bond with people."

People's care plans were written in way that promoted a caring response from staff. For one person with complex needs, staff were guided to, 'use short, clear sentences' and to ensure, 'there is no loud noise', when communicating with the person. Another person's care plan explained which kind of music the person preferred to listen to, which could reduce their anxiety. During the day of our inspection visit, the person was listening to the kind of music described in their care plan, with a relaxed facial expression.

The provider had recently introduced doll therapy and robotic pet therapy into the home as this has been

proven to have a calming and therapeutic effect on some people, especially those living with dementia. Robotic pets look like and mimic the characteristics of a real animal. Staff told us how the introduction of the pets had a really positive impact on one person who was mostly cared for in bed. One staff member explained, "It was life changing for [name] because she is a cat lover. Before they rarely spoke, but to hear her chatting to the cat and asking us to give it milk. Now she has something to wake up for." This person was sleeping when we looked in their room, but staff had positioned the cat so it would be the first thing the person saw when they woke up.

People were respected and their dignity was promoted through staff's behaviour and attitude towards them. Staff spoke to people by name and listened to their views. Staff responded with courtesy and kindness towards a person when their anxiety caused them to display behaviour that challenged others. A member of staff distracted the person by inviting them to go and play table tennis. Another member of staff demonstrated a very empathetic approach to this person and explained some of their behaviours were because they were unable to express their feelings. They went on to say, "They want to tell you, but it is just finding the right words. I will sit and listen. I drop my voice so they know I'm approachable and friendly and I am there for them." One person told us, "The staff couldn't be more respectful."

Staff understood people's right to privacy and their own space within the home. At lunch time, when a member of staff took a person's lunch to their room, staff knocked on their door and called out, "Knock, knock, knock," before going in. We heard the person and staff laughing together in the room, before staff came out with their plate. The cook was proud to tell us the person had now put on some 'needed' weight, due to the extra care and attention from staff.

Staff and the registered manager understood the importance of promoting equality and human rights as part of a caring approach. The registered manager had created an inclusive environment where people's diversity and spirituality was respected. During our inspection visit, staff immediately provided the facilities and a quiet room to enable a member of the inspection team to pray in accordance with their faith.

The registered manager told us that one of the main issues they faced when they joined the home was low morale within the staff team. In order to show staff they were appreciated, 'Castle Brooks Rising Stars' had been introduced. This was a way of recognising when staff had made a difference to people and had a positive impact on their day. The registered manager told us this demonstrated to staff that their caring attitudes were recognised and valued by the provider and senior management team.

Good

# Is the service responsive?

## Our findings

During our inspection in September 2017, we found improvements were required in responsiveness. Several relatives had told us they had raised concerns with staff, which were not followed up and said they had not received a satisfactory answer or response. They were not confident their concerns had been escalated appropriately, because there were no identifiable improvements. At this inspection we found improvements had been made in how people's concerns were managed. The registered manager explained that a failure to respond to people's concerns had resulted in a breakdown of trust which they had focussed on rebuilding.

The provider's PIR told us the service had received 68 complaints in the 12 months prior to our inspection visit. The service manager explained this was because they not only recorded formal written complaints, but also informal verbal concerns so people who raised them could be assured they had been listened to and action taken in response. Records we looked at confirmed the investigation and management of people's concerns was more robust and actions taken had improved outcomes for people.

People told us they had more confidence any concerns they raised would be dealt with. Comments included: "I am sure they would take any concerns responsibly. I have no concerns or complaints, nothing" and, "I raised the getting up problem which was not really a complaint. I don't have a problem talking to them if needed, they responded quickly." One staff member told us, "Problems are sorted out rather than just being pushed to one side and dealt with another day. Now when a problem arises, it is dealt with and sorted out."

We saw how the actions the provider had taken had improved outcomes for people. For example, improvements in staffing had resulted in improvements in staff's confidence and ability to be responsive to people's needs. All the staff we spoke with knew people's needs and dependencies well, because they worked with them regularly. Staff told us they could be responsive and proactive to people's needs because the staffing levels were 'right' and because they regularly worked with the same people. A member of staff explained, "We need the staff level due to people's complex needs. [Name] is snoozing now, but when they wake, they might want a drink or to go for a walk. When they wake, they need to see a familiar face to minimise the risk of anxiety."

Each person had an electronic care plan which was detailed and easy to follow. Care plans on the re-enablement household were clear about what goals people wanted to achieve to maximise their independence. Where one person was at risk of presenting challenging behaviour, their care plan gave staff clear guidance for supporting the person. Their interests, preferences and habits were described in their care plan, to enable staff to engage them in conversations and activities that captured their interest and distracted them from their agitation. During our inspection visit, we saw staff understood the person well and continuously intervened to engage the person in activities they enjoyed, which minimised the risk of them becoming agitated. A member of staff told us, "You know people's needs when you work in the same one place."

Staff used handsets to record the support they had provided to people and their interactions with them. The

provider's duty manager could check the care management system and identify when care was due or overdue.

People's needs and abilities were regularly reviewed, to make sure any changes were reflected in their care plans and known to staff. A member of staff told us, "We review people's needs with their relatives, GP and staff, depending on their presenting symptoms. It maybe they are ill, or we need to (take action to) prevent falls." A relative told us their relation had been living at the home for more than a year, and they had attended review-of-care meetings. They were confident that care plan reviews were a continuous process and told us, "We will go through [Name's] care plan shortly."

Staff shared information at a handover between shifts so they could respond to people's changing needs or abilities. Our specialist advisor attended the 'handover' and was impressed with the level of information shared. All the information had been checked and analysed prior to the handover, was clear and concise and covered all the people in each household. The care people had received during the morning, reflected the care planned within their care plans. The care co-ordinator managing the handover was aware of people's objectives and when the fluid target of one person was short, they brought it to the attention of staff, together with a plan of action.

People were encouraged to maintain their interests and to socialise and to create their own activity spontaneously. When one person woke from a snooze in an armchair, staff played the person's preferred music and sang and danced with them. Staff had been trained to understand the benefits of access to natural light, and followed the provider's advice to ensure everyone who was able and willing to spend time outdoors, was encouraged and supported to do so. Staff fetched people's coats and blanket wraps for those people who used wheelchairs, and went out for a walk in the garden before lunch. A member of staff encouraged people to want to go out by saying, "'We will go outside shortly, for some fresh air and to see the changing colour in the garden."

We spoke with the lifestyle coach who arranged activities for people. They told us activities offered included exercise classes, walking club, knitting and crochet club and arts and crafts. People could also enjoy playing bowls or croquet on the bowling green or cycling on the 'bike made for two' on the cycle track around the home. Every week people could go on a trip out to local museums and places of interest or shopping trips. People were also offered support with their spiritual needs and to follow their faith. During our visit some people enjoyed a service with a visiting lay reader from the local church who delivered a service responsive to the needs of people living with dementia.

However, at the time of our inspection visit there was only one lifestyle coach to co-ordinate the activities throughout the home. The registered manager told us they had recently recruited another lifestyle coach who they were confident would provide additional support for people to engage in activities that were meaningful to them.

The home provided end of life care for people in their final days. There was some information in people's care plans about their wishes for end of life care. Guest rooms were available where people's relatives could stay if they wished to be near their family members when their health declined. People's care plans included the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form. This plan provides clinicians with information about whether attempts at resuscitation should be undertaken for the person.

Requires Improvement

# Is the service well-led?

## Our findings

During our previous inspection in September 2017, we found improvements were required in how the provider monitored the quality of the service and there was a breach of the regulations. At this inspection we found improvements had been made. The provider had acted to improve day to day management and implemented systems to ensure they had better oversight of the service. However, whilst the provider had provided good resources to support the registered manager and staff to make improvements at the home, the improvements were recent and made at a time when the home was not full and there was still a high use of agency staff. There had not been sufficient time to be sure that the improvements were embedded into the culture of the home and would be sustained. The service is no longer in breach of the regulations but remains requires improvement in this key area.

Following our visit in September 2017 the provider put a management 'task force' into the home to understand the issues, develop staff and look at the systems and processes to support good service delivery.

A new registered manager had been recruited, who started working at the home in April 2018. The new registered manager had a track record of managing an outstanding service and consistently demonstrated the provider's values. Changes to the staffing structure had resulted in opportunities for promotion for staff and some external recruitment to the posts of care coordinators and deputy care coordinators, with specific responsibilities to lead each household. The staffing rota was now organised around individual households, to ensure, as far as possible people were supported by a consistent team of staff. An increase in the proportion of permanent staff, instead of agency staff, meant care staff could focus on delivering person-centred care, instead of being concerned about how people were being supported by agency staff. Staff told us the supervision and appraisal process had improved, which gave them a renewed confidence in their abilities and the encouragement to continue to develop their skills.

Staff told us the improvements instigated by the provider and new registered manager had resulted in improvements in the home. One staff member told us, "It's a completely different home. Things weren't working and weren't being dealt with. They are now and we are less stressed and have time for the residents."

Staff and relatives told us improvements had been made in the culture of the service and were now more confident concerns were being addressed. One staff member told us, "I used to think, who can I write to, who can I ring. I would complain but nothing was done. They act on things now when you have a problem." Another said, "I think we are a lot better than where we were. There are more staff, there are more care managers and there is more help and the residents themselves look happier." A relative told us, "They have been working really hard (at improving). There are regular staff now. We feel welcome. The staff and manager are accessible when we want to know anything. I think they've done okay." However, some relatives still felt senior members of the management team needed to be more visible in the home and there were some areas of communication that still needed to improve. For example, one relative told us, "There are no managers after 4.30pm and not at the weekends." The provider assured us there was a duty manager in the home until 10.00pm each day, and that they would remind people of this management availability.

Staff told us they believed in the organisation's values and aims, and now felt empowered to work within the framework, that is, 'to play, make someone's day, be there, choose your attitude'. We saw staff made the values a reality in their behaviour and approach. Staff told us, "I have seen a lot of improvements. They have made communication (between staff) better with two deputy care coordinators to take responsibility."

Not only did staff feel more supported in their day to day practice, but also in taking on the responsibilities of new roles within the home. One newly promoted member of staff explained, "They have been there to support me, but they have let me take the reins and try out new ideas." This attitude was demonstrated through the inspection visit. Staff were eager to engage with us and took immediate action when we identified any areas that required improvement.

Staff particularly spoke of how the provider was constantly looking forward to develop ways of improving the lives of people who lived in the home. For example, with people's consent, the provider used acoustic monitoring at night to identify if people were at risk of falling or required support. One member of staff said, "I love the company, their technology, the way they look forward." Staff told us the use of technology had improved people's experience of the service, in particular the acoustic monitoring, because it was, "Better than night checks and disrupting their sleep." One staff member told us how the provider had recently taken some senior staff to visit an outstanding dementia care service in Amsterdam. They told us how the provider's senior managers had shared the results of the visit with staff and were keen to implement the good practice seen in that home at Castle Brook.

At our inspection in September 2017, we found people's and relatives' views had not been actively sought or heard by the home registered manager. The registered manager told us one of their first tasks on taking over the management of the home was to improve engagement and communication with relatives and other visitors to the home. People were now invited to attend meetings, the minutes of which showed the provider was beginning to listen to people and their relations and taking on board the comments made. Following the results of a quality survey in May 2018, more housekeepers had been recruited to maintain the cleanliness of the home, an improved system for monitoring the progress for repairs had been implemented and trips outside the home had increased. Complaints were now analysed to identify any patterns and ensure appropriate action had been taken to respond to the complaint and drive improvement within the home.

The registered manager had also started to produce 'case studies' to identify and celebrate where the actions of staff had made a positive impact on people's wellbeing. These were shared with staff so they could learn how their behaviours and interactions could improve the lives of people who lived in the home.

The provider had a system of checks and audits to identify where improvements were needed. Audits had led to actions which had improved people's health and well-being. For example, the medicine audits showed medicines had been looked at in detail, and actions were being taken in response to the outcome of the audit. Infection control audits showed action had been taken to improve infection management in the home and the service had recently been awarded a five-star food hygiene rating. However, we found the audits had not identified the provider was not working within the principles of the Mental Capacity Act 2005 and the support some people received was not in the least restrictive way possible.

Despite all these improvements, the registered manager was open and transparent as to where the service was, and where they planned to be in the future. They told us one of the main challenges was to continue to recruit more permanent staff as agency usage remained at around 30%. They told us the provider continued to recruit and was providing more opportunities and incentives to retain the existing staff team.

The registered manager told us that once they had a full permanent staff team and policies and procedures had become embedded in staff practice, they would be able to start building on those foundations. For example, they acknowledged work needed to be done on care plans to ensure all aspects of the plans were updated at the same time to remove conflicting information. The registered manager told us they needed to do more work to ensure every person living with dementia had a memory box or emblem outside their room which represented them as they wished to be thought of and helped them identify their rooms. They also wanted to ensure that everyone's care plans included their life stories to help staff understand people's interests, motivation and anxieties. The registered manager explained they were enthusiastic to take Castle Brook to the next level and said, "I would say we are half way there. We are still only in second gear and to me, how exciting is it to move up a gear." They went on to say, "The day I know I have done my job is when I see all the concepts and facilities that have been built into Castle Brook being used at the same time by all the staff and the residents."

The registered manager and provider understood the responsibilities of being a registered person. They had sent statutory notifications to us and displayed the ratings from our last inspection visit in the entrance to the home. The display of the rating is a legal requirement, to inform people who live at the home, those seeking information about the service and visitors, of our judgments.