Elder Homes Bradford Limited

Duchess Gardens Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 29 September 2015 and was unannounced. At the time of the inspection there were 54 people who used the service.

Duchess Gardens Care Centre is a converted four floor building and is registered to provide personal care and nursing to a maximum of 131 people. The home provides care for older people, people living with dementia and people with long term mental health needs.

Since the last inspection a manager has been registered. 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 service has a history of failing to meet the regulations and at the last inspection which was carried out on 27 January and 02 February 2015 we judged the service to be inadequate. The provider was in breach of a number of regulations. These included the regulations relating to respecting and involving people who used the service, care and welfare, meeting people's nutritional needs,

Summary of findings

managing medicines, staffing and staff training and development, record keeping and quality assurance. We told the provider they had to make improvements. The regulations have changed since then; new regulations came into use on 01 April 2015. However, during this inspection we followed up the areas of concern from the last inspection to check if the provider had taken action to improve the service and make sure people were safe and receiving appropriate care. Overall, we found improvements had been made across all aspects of the service but there was still work to be done to make sure the changes were sustained.

People told us they felt safe. Staff were able to recognise abuse and told us they were confident the registered manager would take action to address any concerns they reported. Senior staff were aware of how to report abuse and were familiar with the whistle blowing procedures. However, we found junior staff were less clear about how to report concerns outside of the organisation.

Significant improvements had been made to the way people's medicines were managed and this helped to make sure people were protected.

Staffing had improved since the last inspection. A new deputy manager with qualifications and experience in caring for people with mental health needs had been appointed. The home was continuing to recruit staff and used agency staff to cover shortfalls. We found improvements had been made to the way agency staff were booked and to the induction they were given when they worked at the home for the first time. This helped to reduce the risk that people would not experience continuity of care. There was mixed feedback about whether or not there were enough staff available to meet people's needs. A system for checking people's needs had been implemented to help determine the staffing numbers and skill mix. However, there were no guidelines on how often this was to be reviewed. This created a risk that the right numbers of suitably skilled staff would not always be deployed to meet people's needs. We found this was a breach of regulation because the provider did not have a proper system in place to assess, monitor and mitigate the risk.

The provider had processes in place to make sure all the required checks were completed before new staff started work in the home. However, in two of the four staff files we found the checks had not been completed properly and this could potentially put people who used the service at risk. This had not been identified until the inspectors pointed it out. This was a breach of regulation because it showed the providers systems for assessing, monitoring and mitigating risks were not effective.

At this inspection we found the home was clean and well maintained.

There was training programme and the registered manager was in the process of making sure all staff were up to date with the training they needed to work safely and meet people's needs. Staff told us they felt supported by the registered manager. However, six of the staff we spoke with told us they had not received any one to one supervision or appraisals and we found some gaps in staff knowledge around subjects such as safeguarding and the Mental Capacity Act 2005. We judged the provider was in breach of the regulation because although improvements had been made they were not enough to ensure staff received appropriate support and training to help them carry out their duties.

Improvements had been made to the way people who were at risk of poor nutrition were supported. However, the food and drink provided to people did not always take account of their preferences and was not always appropriate to their needs, for example in the case of people with diabetes. We found this was a breach of regulation because it demonstrated the provider did not have sufficient regard to people's well-being in relation to meeting their dietary needs.

The home was working in accordance with the requirements of the Mental Capacity Act 2005 which meant people's rights were protected.

People told us staff were kind and compassionate and treated them with respect. We observed interactions between staff and people living at the home were pleasant and friendly. Staff knew about people's previous lives, family, and preferences as well as care needs. However, on occasions we observed staff missed opportunities to engage people in conversation when they were supporting them with personal care.

Some aspects of the way the services were provided helped people to stay independent. For example, we saw some people had adapted cutlery so that they could eat without help from staff. However, in some other ways people were not supported. For example, the menu was a

Summary of findings

chalk board in the dining room and it would not have been easy for everyone to read. People were given the opportunity to take part in a varied programme of planned activities.

People told us they were satisfied with the care they received. People's needs are assessed and their individual care plans and risk assessments were up to date and provided an accurate record of their care needs. The involvement of people and/or their representatives was not always evident in their care records.

A relative told us they had made a complaint and were happy with the way the registered manager had dealt with it. We saw complaints and compliments were recorded.

Staff spoke about the registered manager with respect and admiration. They said the registered manager had made changes which had improved life for people living at the home and for staff.

The provider had not sent any quality assurance questionnaires to people who used the service or their representatives since the last inspection. There were meetings for people who lived at the home and the registered manager told us they had an open door policy and encouraged people to come and speak to them if they had any concerns.

We found improvements had been made and the registered manager and staff were clearly committed to continuing to improve the service for the benefit of people who used the service. However, we found the provider was still in breach of some regulations and these issues had not adequately dealt with in their improvement plan.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People told us they felt safe. Staff were able to recognise abuse and were confident the manager would take action to deal with any concerns brought to their attention. Some junior staff were not sure about how to report concerns to agencies outside of the home.

People's medicines were managed safely and they received their medicines as prescribed.

There were generally enough staff but some concerns that a lot of staff changes could compromise continuity of care experienced by people. The home did not have a proper process for checking the numbers and skills of staff reflected people's needs which created a risk there would not always be enough staff with the right skills to meet people's needs.

The home was clean and well maintained.

Is the service effective?

Requires improvement

The service was not consistently effective.

Although improvements had been made more needed to be done to make sure all staff received the right support and training to enable them to carry out their duties.

People who were at risk of poor nutrition were receiving the right support. However, the food and drink provided to people did not always take account of their preferences and was not always appropriate to their needs, for example in the case of people with diabetes.

People's rights were protected because the home was working in accordance with the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not consistently caring.

People told us staff were kind and compassionate and treated them with respect.

We saw staff interacted with people in a pleasant and friendly way. Staff were able to tell us about people's lives and interests as well as their care needs. However, we saw staff sometimes missed opportunities to engage people in conversation when they were supporting them with personal care.

Summary of findings

There were some things in place to help people be independent, for example, we saw some people had adapted cutlery. However, the menu for the day was on a chalk board in the dining room would not have been easy for everyone to read. We did not see any alternative such as pictorial menus to help maintain people's independence.

Is the service responsive?

Requires improvement

People told us they were satisfied with the care they received. People's needs were assessed; their care plans and risk assessments were up to date and provided an accurate record of their care needs. The involvement of people and/or their representatives was not always evident in their care records.

A relative told us they had made a complaint and were happy with the way the registered manager had dealt with it. We saw complaints and compliments were recorded.

Is the service well-led?

Requires improvement

Staff spoke positively about the registered manager. They said the registered manager had made improvements which had benefitted people who lived at the home and staff.

There were meetings for people who used at the home and the manager told us they actively encouraged people to speak to them if they had any concerns.

The registered manager and staff were clearly committed to continuing to improve the service for the benefit of people who lived at the home. However, the improvement must be sustained and further improvements are needed to ensure people consistently experience care which is safe, effective, caring, responsive and well led.

Duchess Gardens Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 29 September 2015 and was unannounced.

The inspection team was made up of four inspectors, one of whom was a pharmacy inspector 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, in this case older people's services.

We spoke with nine people who used the service and three relatives. We observed the way people were cared for and supported in the communal areas on both the nursing and residential unit. We observed breakfast and lunch on the nursing unit and lunch on the residential unit. We looked at eleven people's care records, medication records and medicines for 22 people and various records relating to the running of the home which included four staff recruitment files, training records, maintenance records and quality monitoring audits. We spoke with the registered manager, two nurses, eight care workers, the chef, a housekeeper and the activities organiser. We looked around the home at a selection of people's bedrooms and the communal bathrooms, toilets and living areas.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR on this occasion as the inspection was planned at short notice due to a number of concerns we had received about the provider.

Requires improvement

Is the service safe?

Our findings

All of the people we spoke with said they felt safe living in the home, and did not feel that there was any bullying behaviour.

We spoke with two nurses and four senior care workers about safeguarding. They all had a good understanding about safeguarding and whistleblowing. They told us they were confident the registered manager would take any concerns brought to their attention seriously and act on them. The nurse we spoke with knew how and when to notify appropriate external organisations if they had concerns. However, when we spoke with two more junior care workers they were less clear about how they would raise concerns outside of the organisation.

At previous inspections in August 2013, February and April 2014 and January 2015 we identified concerns about safe handling of medicines. During this inspection we found significant improvements had been made to the way medicines were managed. This meant people were much better protected against the risks associated with the administration, handling and recording of medicines. We looked at the medicines, medication administration records (MARs) and other records for 22 people living in both residential and nursing units of the home.

Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in storage areas to ensure the medicines did not spoil or become unfit for use. Stock was being managed effectively to protect people from the risk of running out of their medicines. Medication records were clear and accurate and it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. On occasions where medicines had not been given, nurses and care workers had clearly recorded the reason why. Arrangements were in place to ensure that people received their medicines even when they were away from the home at appointments or on social leave. The use of creams, ointments and other external products was clearly recorded and staff had clear information regarding the use of these topical medicines.

Only trained nurses and care workers supported people to take their medicines. A system of competency checks had been introduced to ensure that staff had understood the training and followed best practice guidelines whilst handling medicines. Care plans were in place for people prescribed medicines that only needed to be taken "when required'. Some of these contained detailed personalised information that enabled nurses and care workers to administer each person's medicines consistently and correctly, however others needed to be reviewed and more personalised information added. The manager confirmed that these would be reviewed as soon as possible.

Both weekly and monthly audits (checks) had been introduced in all units to determine how well the service managed medicines. We saw evidence that where concerns or discrepancies had been highlighted, the manager, nurses and care workers had taken appropriate action in order to address those concerns and further improve the way medicines were managed within the home. When we checked records against stocks, we found one example where a person had not received the correct dose of one of their medicines. The manager and senior nurses on duty took this information seriously and looked into this discrepancy straightaway.

At the last inspection carried out on 27 January and 02 February 2015 we found the home did not have enough nurses employed to cover the shifts and as a result people's needs were not being met.

During this inspection the registered manager told us the usual staffing levels on the residential unit were two team leaders and five care assistants during the day and one team leader and five care assistants overnight. There was a residential unit manager who was not included in the staff numbers.

On the nursing unit there were usually two nurses between 8am and 2pm Monday to Friday and the rest of the time, (day and night), there was one nurse on duty. There were usually four care assistants on the nursing unit. The registered manager told us, that starting on the week of the inspection; they had arranged to have an extra care assistant on the nursing unit at weekends. The registered manager told us the provider had a new dependency tool which was used the help determine the numbers and skill mix of staff needed. They said it looked at people's needs for example, how many people needed two staff to provide personal care, how many people needed help to eat and drink and peoples risk of falling. We asked the registered manager how often this was reviewed and they said there was no set timescale; it was done when it was recognised that people's needs had changed. The absence of a more

Requires improvement

Is the service safe?

formalised approach to reviewing people's needs and the staffing numbers and skill mix created a risk that incremental changes in people's care needs might not be noted and staffing adjusted to meet people's needs. This demonstrated the provider did not have effective systems in place to assess, monitor and mitigate risks to the health, safety and welfare of people who used the service. **This was a breach of Regulation 17(1)(2)(b) of the Health and Social Care Act Regulations (Regulated Activities) 2014.**

The nursing unit had a deputy manager who was the clinical lead and they had 12 hours a week when they were not included in the staff numbers. The deputy manager was a Registered Mental Nurse. At the last inspection we were concerned that the service did not have any nurses with qualifications or experience in this area because we found many of the people who lived in the home had mental health care needs. The registered manager told us they were trying to recruit another RMN.

The registered manager told us and the records confirmed there were enough nurses employed to cover 168 hours a week of the 198 required. They said they were in the process of recruiting to fill the 30 hour nursing vacancy and in the interim they were using agency staff. They said they were using the same agency to help maintain continuity of care. During the last inspection we had concerns about inconsistencies in the way agency nurse were given information about the service. During this inspection we found the registered manager had introduced an agency induction book to make sure all new agency workers had a proper induction before starting work.

In addition to nursing and care staff the home employed separate staff for housekeeping, catering, maintenance and administration as well as activities organisers and a driver. The registered manager told us they had no other staff vacancies.

The registered manager told us they had made some changes, in consultation with people who used the service, to help make sure staff were deployed more effectively. For example, on the nursing unit they had closed two floors which meant staff were deployed over two floors instead of four. They had also closed the day centre and brought activities back into the home. This meant more people were able to take part and those who did not want to participate had the opportunity to engage by watching and listening to what was going on.

During this inspection all the staff we spoke with said they believed people living at the home were well cared for but had differing opinions concerning the adequacy of staff numbers. On the day we visited there were 11 people living on each nursing care floor. There was a nurse, a senior carer and a carer on each floor. Staff told us that after 5pm and at night there was only one nurse who covered both floors with two carers on each floor at all times. On the day we visited staff were visible on the units most of the time and we were always able to find a member of staff. Call bells were answered promptly and we saw documentation that one person had been checked every 15 minutes was up to date.

On one floor of the nursing unit six people needed support to eat and drink, staff there thought there should be three care staff at mealtimes. Another care staff said there was enough staff most of the time but not if, "Someone calls in sick."

One of the staff on the residential unit said there generally enough staff, however, they were concerned that there was a high staff turnover and this meant it was harder to make sure people received continuity of care.

One person who used the service said they felt it would be helpful to have more staff but did not feel this was a safety issue. They said it was more about staff having time to spend with individuals. People living on the residential unit and their relatives told us they felt the call bells were answered within an appropriate amount of time.

We looked at four staff recruitment files. In two of the files we saw all the required checks which included proof of identity, two written references, a criminal records check and in the case of nurses confirmation of a current registration with the Nursing and Midwifery Council had been completed before staff started work. However, in one person's file we saw that although a reference had been requested from their previous employer it had not been provided and this had not been followed up. In another person's file the information provided by the DBS (Disclosure and Barring Service) in relation to the person's criminal record check stated the "details do not match, try again". This had not been identified until it was brought to the attention of the registered manager by the inspector. The registered manager identified the problem as being that the person's date of birth had been entered incorrectly and the DBS check was completed. It showed the person had no convictions.

Requires improvement

Is the service safe?

The registered manager said they would put checks in place to make sure this did not happen again. However, it called into question the effectiveness of the systems the provider had in place to monitor, assess and mitigate risks to the safety of people who used the service. **This was a breach of Regulation 17(1)(2)(b) of the Health and Social Care Act Regulations (Regulated Activities) 2014**.

People living in the home told us staff were able to care for them safely and understood their needs. One visitor said their relative had recently fallen and said, "Staff are now more watchful." They added, "There is a thin mattress placed beside the bed at night in case he should roll out of bed". One person we spoke with told us they were sometimes moved using a hoist and said, "I feel safe."

In the records we looked at we saw people living at the home had risk assessments which included the risk of falls, pressure ulcers, mobility and malnutrition. These had been reviewed every month. We also saw that special risks were assessed for individuals when they arose, such as the risks involved in supporting a person to leave the home with staff.

People all had emergency evacuation plans in their care files and in a red 'grab file' located in the main reception area of the home. This would help staff to evacuate people safely and quickly in the event of an emergency.

The home was clean and smelled fresh and pleasant. Handwashing basins were equipped with soap in dispensers and paper towels. Bins in bathrooms and toilets had foot pedals which helped people to avoid contamination of the lid. All of the staff we spoke with understood how to prevent cross infection by appropriate handwashing and protective equipment such as gloves and aprons. They discussed identifying infection and when to isolate people to control infection should it arise.

In August 2015 the home was inspected by the infection control team from Bradford Metropolitan District Council and achieved 96.5% compliance.

The kitchens were clean and kitchen safety checks, including fridge temperatures had been recorded daily. There was plenty of food of different types. The chef said that a kitchen assistant checked the kitchenettes on each unit every day to ensure adequate supplies and that food was not kept longer than was safe to do so. In June 2014 the kitchens were given a food hygiene rating of 5 (Very good) by Bradford Metropolitan District Council.

We observed one of the toilets near the lounge on the residential unit had double doors which made it easier for people to get in and out. The doors could be locked from inside but there was nothing on the outside to enable staff to open the door in the event of someone inadvertently locking themselves in or needing assistance in an emergency. We made the registered manager aware of this before we left.

We looked at the maintenance records and found they were up to date. These included checks on the water systems, gas, electricity, lifts and hoists. At the time of the last inspection there was work outstanding to comply with a safety enforcement notice issued by West Yorkshire Fire & Rescue Service. We checked the fire service enforcement register and found the notice had been complied with which meant the provider had taken the action required to comply with fire safety legislation.

We found improvements had been made to help make sure people who used the service were safe. However, the changes were at an early stage and had been implemented at a time when the home was not accepting any new admissions. There was more to be done to make sure the changes were embedded and the provider could demonstrate people experienced care and treatment which was consistently safe.

Requires improvement

Is the service effective?

Our findings

We asked staff about the training they had received and their induction. They all said they had received enough training to care for people safely. Only one registered mental health nurse (RMN) was employed by the service and at least 10 people had mental health needs. Care workers said they had not had any mental health training, although they had received an introduction to caring for people living with dementia. We also found some of the junior staff lacked an understanding of the basic principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

All staff told us they had received training about managing behaviour that challenges. They backed this up by discussing individuals and how they interacted with them if they became distressed.

The training champion who was responsible for organising staff training had left since the last inspection. The registered manager said after the training champion left they had identified a problem with the way training was being recorded. The computerised system in use had not been flagging up when training was due to be updated. This had resulted in staff not being up to date with required training. For example, they said 60 staff had up to date safeguarding training but 25 staff were overdue for an update. The registered manager said they were dealing with this by allocating specific training sessions, (on line), to individual staff members with a timescale for completion. They then checked to make sure the training had been completed and if it had not been done they discussed this with the staff involved. They said persistent failure by staff to complete the required training would result in disciplinary action.

The registered manager told us appraisals should take place once a year and there was a programme of planned supervision. Responsibility for supervision was delegated to heads of departments and senior staff and the registered manager said they checked all the supervision records to identify training needs.

However, six of the staff we talked with said they had not received an appraisal or supervision. One said, "I don't think they happen here." Another said, "I think they will be introduced." One of the senior care staff said they had attended one supervision meeting with the registered manager, "A few months ago" and another said they thought they had supervisions or appraisals every three to six months but they were not really sure how often they should take place or what the difference was between supervision and appraisal.

This was a breach of Regulation 18(2) of the Health and Social Care Act Regulations (Regulated Activities) 2014.

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. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. One person had a deprivation of liberty safeguard in place (DoLS) and applications had been made for the majority of people living in the nursing unit. We saw documentation had been completed and received by the local authority several months before our visit. Most staff had a clear understanding about what a DoLS meant for people and about assessing mental capacity. Two junior staff we spoke with were unclear what it meant, apart from 'keeping people safe'. They did not know who, if anyone had a DoLS in place or applied for.

In most cases we found the mental capacity documentation for each person was clear and used appropriately for separate decisions such as the use of bed rails. However, in one person's we saw that although they had been assessed as lacking capacity they had signed a consent form to have their photograph taken.

At the last inspection we identified concerns about people being asked to choose their meals from the menu one day

in advance. This practice did not support people, particularly but not exclusively, people living with dementia to make choices. We found similar concerns during this inspection.

We observed both breakfast and lunch service on the second floor of the nursing unit. Six people sat at dining tables and one person came and went from the dining room as they preferred to keep moving even when eating. The care workers told us people ordered their food from a menu which was done the previous day. At breakfast there was a choice of cereals or porridge and a cooked breakfast if it had previously been ordered. At lunch people had sandwiches or a hot meal. One person asked for a salad and was told by a care worker it would not be possible to get one but that they could have one for their evening meal. They told us, "They can't really do it if it's not requested before."

After we discussed this with the care worker they telephoned the kitchen and a salad was supplied. Later we talked with a chef who said people could always ask for alternatives and some people often asked for salads or omelettes. We found that neither staff nor people living at the home knew, or remembered this. Fresh fruit was available in the kitchens but we did not see this offered to people. Fruit was not shown as an option on the menus. One member of staff said, "They (people living in the home) are not keen on fruit."

On the residential unit staff confirmed people also selected their meals the day before. However, they added people were given the opportunity to change their mind when the meals were being served. We observed the meal service in the residential unit dining room at lunch time. We observed staff checking the list of allocated meals, however, we did not hear anyone being offered the opportunity to change their mind and have something else.

We observed hot drinks and biscuits were served in the afternoon. We asked if there was ever anything other than biscuits and one of the staff said, "Yes, Mondays there is fruit and yogurt, and we also have cakes."

Some of the people living on the nursing unit had nutritional needs such as diabetes. They were offered the same choice as other people apart from puddings when the only option was yoghurt. Staff told us, and the chef confirmed that no other puddings were ever available for people living with diabetes. We discussed with the chef how this could be improved using sugar free products that are readily available.

On the residential unit when we asked people about the food, one person said, "Sometimes the veg is raw, the carrots are raw, the tatties are raw, they've not got that touch." Two people said their favourite meal was roast beef dinner but one added they didn't have it on Sundays.

We observed people were given different portion sizes which suggested staff were aware of people's preferences. However, one person we spoke with said, "The meals are small."

We found none of the people living in the nursing unit had a risk of malnutrition when we visited. Staff told us that when this was the case people's weights were checked weekly. On the residential unit we looked at the records of two people who had experienced recent unplanned weight loss and found appropriate action had been taken to manage the risk and monitor their weight.

We saw people had a choice of cold drinks such as milk or fruit squash and hot drinks were also served with the lunchtime meal. People who lived in the home told us they could have a drink anytime they liked. This was echoed by two relatives who said they had noticed when someone said out loud they would like a drink, "The next minute a member of staff has arrived with one, they must have overheard." They added they were always offered a drink when visiting.

We saw snacks were available in the kitchenettes on each unit and included bread for toast, biscuits, yoghurts and cakes.

Although improvements had been made we found the food and drink provided to people was not always appropriate to their needs and did not always reflect their preferences and the provider did not have sufficient regard to people's well-being in relation to meeting their nutritional and hydration needs.

This was a breach of Regulation 9(1)(3)(i) of the Health and Social Care Act Regulations (Regulated Activities) 2014.

All the people we spoke with told us they were able to see the doctor, district nurse and chiropodist when required. This was supported by information in people's care records.

Requires improvement

Is the service effective?

People's relatives said that when people had needed medical attention because of an emergency they had been informed. One of the nurses told us most people who lived at the home were registered with one of three local GP practices and a doctor or practice nurse visited the home every week.

Requires improvement

Is the service caring?

Our findings

During the day we saw interaction between staff and people living at the home was pleasant and friendly. Staff demonstrated they knew people and their needs by their behaviour and in talking with us. They all knew about people's previous lives, family, and preferences as well as people's care needs.

On the residential unit we spoke with five people who lived in the home. They all said there were treated with kindness, compassion and respect. Two relatives also told us staff treated people with dignity. One said their relative always looked clean and well shaven and was dressed in properly co-ordinated clothing whenever they or other family members visited. A relative said, "The staff know everyone by name even family members, people are not just a number." They added, "People are dealt with in an excellent manner."

One care staff said, "When I came to work here I could tell (staff) were caring by the way they spent time talking with people."

The staff we spoke with were able to tell us about people's individual needs and preferences. However, on occasions we observed staff missed opportunities to engage people in conversation when they were supporting them with personal care.

Most of our observations showed staff treated people with dignity and respect, for example we saw staff knocked on people's bedroom doors before going in. However, at lunch time we heard one of the staff ask the senior care worker if they could have the food for people eating in their rooms and she was told, "They will have to wait, they can have it after these." (Indicating the dining room) This was not a respectful way to speak about people and was particularly inappropriate from a senior care work who should be setting standards for junior staff to follow.

Over lunchtime we observed three people in the coffee lounge and there were no staff present. We noted they had been sat in the coffee lounge for several hours with music playing but no other stimulation. The people in the coffee lounge received their lunch later than the people in the dining room and none of the staff stayed to support them with their meals. We observed some of them were having difficulty and might have welcomed an offer of assistance.

We saw people were supported to maintain their independence and were able to move around the home and choose whether to take part in activities or sit quietly. We saw people were offered adapted cutlery at lunch time to help them eat without the need for staff support. We observed one person who was visually impaired being supported in an appropriate manner by staff.

However, we observed the menu for the day was on a chalk board in the dining room on the residential unit but it would not have been easy for anyone who was visually impaired or living with dementia to read. We did not see any pictorial menus to help people choose what they would like to eat. This did not help people to maintain their independence.

One person's relatives told us that there had been a problem with clothing going missing, even when labelled, but said this had improved of late. However, they added they often found their relative wearing clothing they didn't recognise and said staff had purchased clothing for them from a charity shop.

The bedroom doors on the residential unit had people's names and a personal "like", for example a cup of tea or ballroom dancing to help people identify their own rooms. We saw people had personal belongings in their bedrooms which can also help people to feel more comfortable with their surroundings. However, the communal rooms, bathrooms and toilets did not have picture signs which can help people find their way around. Doors connecting different areas of the home all had key pad locks although the lift was accessible on each floor.

Two people who lived in the home told us they had no keys to the only lockable drawer in their bedrooms. They both said they had asked for a key but it had not received one. This meant they had nowhere safe to keep valuables.

We observed none of the staff wore name badges. Badges can help people living at the home and visitors to identify staff.

There were inconsistencies in the care records with regard to evidence of involvement by people and/or their representatives in the planning and reviewing of care. We saw evidence of recent involvement in three people's records, in another person's records the most recent review

Requires improvement

Is the service caring?

involving the person's relatives was recorded in December 2013 and in other people's records there was no evidence of involvement. This created a risk people's care would not be planned in accordance with their wishes.

We saw evidence of people being supported to plan their end of life care to help make sure their wishes were taken into account in the final stages of life. We saw when people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place they had been completed properly and people and/or their representatives had been consulted.

Requires improvement

Is the service responsive?

Our findings

One person who lived in the home said, "I am looked after very well".

During our observations on the nursing unit we met four people and spoke with staff about their care needs. We then looked at their care records. We found the information in the care records which included care plans and risk assessments reflected what staff had told us about people's lives and care needs. We saw people's needs had been assessed and the information used to develop person centred care plans. The care plans were easy to read and contained all the information necessary for staff to care for people. We noted that plans were clearly individualised as opposed to following standardised formats. In particular care plans for people living with diabetes or percutaneous endoscopic gastrostomy (PEG) feeding tubes were detailed and informative. Some people had behaviour that challenged and care plans detailed how each person could be helped if a challenging situation arose.

All care plans had been reviewed every six months and we saw evidence that they had been changed sooner when people's needs or risks changed.

There were three pressure relief cushions in the lounge area on one floor. All of the staff on the floor were able to identify the people at risk of developing pressure ulcers who sat on the cushions. We saw that where risk assessment showed a high risk of pressure ulceration, plans included the use of pressure relief cushions and air flow mattresses.

We noticed that some people chose to remain in their bedrooms most of the day when we visited. Staff told us how they respected people's choice to do this while being mindful of the risk of social isolation. To minimise this people were encouraged to move into the dining room for meals and be involved in activities such as day trips and watching films. A care worker said they encouraged people to join in communal activities or took some individuals out into the garden, which they enjoyed.

On the residential unit we looked at seven people's care records. The care plans were up to date and were person centred. Risk assessments had been completed for areas of potential risk such as pressure sores and falls. Although some were written in the first person the value of this was diminished by the language used which had put people's needs into professional terminology rather than using their own words. The manager of the residential unit told us this would be addressed by the care documentation which was being put in place at the time of the inspection. We looked at some examples of the new style card records and found they provided detailed information about people's needs and the actions staff should take to support people.

We observed one person who used the service was restless and showing signs of distress during the morning. They had a care plan in place with clear information on the actions staff should take to support the person and after lunch we saw staff supported the person to go outside for a walk.

The relative of a person who lived in the home said they were concerns staff were not doing enough to support their relative to walk and were using a wheelchair too often. We looked at the person's care plan and it had clear information about staff supporting the person to walk using a walking aid and only using the wheelchair for longer distances. We discussed this with one of the senior care workers who said staff encouraged the person to walk when they wanted to but sometimes they didn't want to walk.

The home employed separate staff for activities. The registered manager had closed the day centre and brought the activities staff back into the home. They said this gave more people the opportunity to take part in, or observe, activities.

One person who lived in the home said they were lonely and another said they found it claustrophobic. Both declined to take part in planned activities, one said, "The activities are for 10 year olds."

On the day of the inspection we observed people taking part in planned activities. A group of people went out on a mini bus trip in the morning and in the afternoon a group of people went to another home where an entertainer had been booked. People were offered the opportunity to go out on regular trips, a local Donkey Sanctuary being a favourite destination.

During the morning we saw the activities co-ordinator running a craft group. There was evidence of other creative activities around the home, for example, flowers and bunting strung across pictures in the corridors, and displays on walls. We saw other people sitting quietly listening to music.

Requires improvement

Is the service responsive?

There were activity planners on display covering a period of four weeks. We also saw small areas of reminiscence displays but did not see anyone refer to them. The activities organiser told us they also spent one to one time with people who did not like to leave their rooms, for example offering people the opportunity to have a hand massage.

We saw one person sitting on their own doing wood work, staff said the person did not enjoy group activities and enjoyed having a quiet place to pursue their interest.

One person's relatives told us they had made a complaint to the manager and were happy with the way it was dealt with. One person who lived in the home told us they had nothing to complain about, they said, "It is like living in a 5* hotel, we are like a happy family."

We looked at the complaints records. They showed the service had received 10 complaints since the last inspection, five of them in March 2015 and one a month between April and August 2015. The records showed verbal complaints were dealt with in the same way as written complaints. All the complaints had been dealt with to the satisfaction of the people who had raised the concern.

Although we found significant improvements had been made to address the concerns we had previously raised the improvements now need to be sustained to ensure people receive consistently responsive care.

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager; they took up the post of manager in October 2014 and were registered by the Commission on 25 September 2015.

The staff we talked with spoke about the registered manager with respect and admiration. They said changes had been made by the registered manager which improved life for people living at the home and for staff. One member of staff said the manager was "Easy to work with, we are team and work well together." Another person said the registered manager was, "Very supportive".

The registered manager told us they held a staff surgery twice a week to provide staff with the opportunity to talk to them about any concerns they had either related to work or their personal circumstances. They staff we spoke confirmed the registered manager was always available to talk with them. They told us they had staff meetings about every two or three months and all staff were encouraged to raise any concerns or issues.

The management structure within the home was clearly defined and the registered manager and deputy manager took it in turns to provide on call cover out of hours. On the nursing unit the care staff said they well supported by the deputy manager and the other full time nurse employed by the service. On the residential unit staff said the newly appointed residential manager was very "hands on" and always available to support staff.

We spoke with one senior member of staff who was very enthusiastic about their job. We asked if they had any links to other homes, outside of the company, where they could share good practice. They said, "I've never heard of doing that but it sounds good, I wonder if we can do that."

Meetings were held every month for people who used the service to give them an opportunity to share their views. The meetings were run by the activities organiser and the agenda items included activities and events, food, housekeeping and general news about the service. The registered manager told us the housekeeper and chef had also been asked to attend these meetings to help them gain a better understanding of people's needs and preferences. The registered manager told us any individual concerns arising from these meetings were followed up with the people concerned. This was confirmed by the records which showed meetings had taken place with two people to follow up individual concerns.

At the last inspection we were concerned that the phone system on the nursing unit was not working, there was no land line phone. The registered manager confirmed this had been resolved and the landline phones on the nursing unit were working and linked to the main switchboard.

The registered manager told us they had an open door policy and encouraged people and/or their representatives to come and speak to them if they had any concerns. They said they held a coffee morning every Tuesday where people were invited to come and talk about any concerns or issues.

The registered manager told us the provider had not sent quality assurance questionnaires to people who used the service and/or their representatives since the last inspection. They told us some individuals had provided feedback using the feedback forms provided in the home. We saw one person's relatives had completed a survey in June 2015 in which they stated they were always kept up to date and always found the home "spotless". They also said, "The staff do a brilliant job."

The registered manager told us they had an improvement plan in place. They carried out a range of checks (audits) and the plan was updated weekly. The areas checked included the environment, equipment such as mattresses and hoists, care records such as care plans and medication records and the kitchen. They told us they were being supported to implement and monitor the improvement plan by a compliance team, (who worked for the provider but were not based at Duchess Gardens) and an area manager. The improvement plan included the areas of concerns identified during previous CQC inspections. The manager provided us with a copy of the improvement plan dated September 2015. The plan confirmed that the home was making progress in achieving compliance with the relevant legislation and providing people who use the service with safe and effective care.

In the course of the inspection we identified some breaches of the regulations. These were in relation to assessing, monitoring and mitigating risks, staff training and support and person centred care as detailed in the safe and effective sections of this report. We found these issues were

Requires improvement

Is the service well-led?

not addressed satisfactorily in the home's improvement plan. For example, the improvement plan showed all the required actions in relation to staff supervision had been completed but our discussions with staff indicated further improvements were needed in this area. Similarly, we found that although the service had implemented a dependency assessment to help determine the correct staffing numbers and skill mix there was no clear process in place for reviewing this in response to changes in people's needs.

Since the last inspection (27 January & 02 February 2015) we have received mixed feedback about the service. The registered manager shared with us positive feedback they had received from a visiting health care professional who had visited the home in August 2015. They said they had seen improvements on the residential unit and noted "a calm, happy atmosphere" which they had not experienced on previous visits. They described the residential unit as "homely" and also noted an improvement in the way people were supported to meet their social and recreational needs. However, we had also received some concerns from visiting health care professionals and from representatives of people who used the service. In addition, we received information that the registered manager had been deployed to provide support to another home in the area, (operated by the same management company). This meant they were not always available at Duchess Gardens to provide the leadership and direction needed to continue to improve the services provided.

Historically, the home has had a high turnover of managers and in house senior staff and this has contributed to the failings identified at previous inspections. The registered manager, deputy manager and residential services manager were all relatively new in post at the time of this inspection. It was clear they were committed to continuing to improve the service for the benefit of people who lived at the home. However, the improvements must be sustained and further improvements were needed to ensure the services provided to people are consistently safe, effective, caring, responsive and well led.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have sufficient regard to people's well-being in relation to meeting their nutritional and hydration needs. Regulation 9(1)(3)(i)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems in place to assess, monitor and mitigate risks to the health, safety and welfare of people who used the service.** **Regulation 17(1)(2)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not always receive appropriate training, support, supervision and appraisal to enable them to carry out their duties.** **Regulation 18(2)(a)**