Bupa Care Homes Limited

Perry Locks Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 May 2017 and was an unannounced inspection. On 10 May 2017 we conducted an unannounced evening inspection to see how care was provided to people at night. We then returned for a full day on 11 May 2017 to complete the inspection.

Perry Locks Care home was registered under the provider name of BUPA Care Homes (CFH Care Limited) up until February 2017. We were notified in December 2016 that the provider intended to simplify its structure and applied for all of its registered locations across the UK, (which at that time were registered across 13 different legal entities) to transfer over to just two legal entities. This meant that Perry Locks Care Home became newly registered under the provider name Bupa Care Homes Limited in February 2017. Therefore, this was the provider's first inspection at this location since newly registering with us in February 2017. The inspection history for the location under the previous provider was used to inform the planning of this inspection because there had been no other changes at the location; the registered manager and the running of the service had remained consistent.

Our last comprehensive inspection of this location took place in June 2016, when the service was rated as "requires improvement". As a result of matters found on that occasion, a further inspection was undertaken in January 2017. The reports from both inspections are available in the full history of inspection reports, which can be found in the previous provider's archived records for this location on our website at www.cqc.org.uk

Some matters outstanding from these two inspections required our further attention during our inspection of 10 and 11 May 2017, and an action plan submitted by the previous provider detailing the way it would improve the care delivered and ensure compliance with relevant legal requirements was used to inform our inspection.

Perry Locks care home provides accommodation for up to 128 people who require nursing and personal care for their physical and/or dementia care needs. The home is purpose built and is separated in to four buildings. Perry Well House is for people living with dementia whilst Lawrence House, Calthorpe House and Brooklyn House provide nursing care for people with general nursing care needs. The location also provides accommodation and nursing care to people on a temporary basis whilst their on-going nursing care needs are being assessed. These are known as Enhanced Assessment Beds (EAB); most of these were situated in Brooklyn House. At the time of our inspection, there were 122 people living at the home.

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

Staffing levels had improved to a safe level and on the whole, people received the care and support they

required in a much timelier way. Medicine management systems and processes within the home had also improved and people received their medicines as prescribed. However, some of the record keeping practices with regards to medicine and risk management meant that people were potentially at risk of not receiving consistently safe care in accordance with their health and care needs.

The provider had not ensured that all staff had received training updates in accordance with their policy and procedures. However, people we spoke with were confident that most of the staff had the knowledge and the skills they required to care for people safely and effectively.

The provider had quality assurance systems and processes in place which supported them to maintain the safety and efficiency of the service. However, some of these systems and processes had not always identified the shortfalls that we found during our inspection and further improvements were required.

People were cared for with their consent, where possible, and the provider had followed the proper processes to ensure care was provided to people lawfully. However, people did not always feel involved in the planning or review of their care.

People were supported to have enough food and drinks and were complimentary of the quality and variety of their meal choices. They had access to health and social care professionals in order to ensure their health and well-being was maintained.

People were supported by staff who were kind, compassionate and caring and who protected their privacy and dignity. People were treated as individuals and their personal preferences and diverse care needs were respected.

People were supported to maintain social contact and relationships with people who were important to them and visitors were welcomed at any time. The provider employed activity coordinators who organised and facilitated a range of activities and encouraged people to participate in activities that they enjoyed.

The provider had a compliments and complaints policy in place and most of the people we spoke with were confident that any concerns they raised would be dealt with professionally and efficiently. Staff reported to feel supported in their work and we found the management team to be approachable, open and honest throughout our inspection process.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from risks associated with their care needs because risk assessments and management plans were not always sufficiently detailed or updated.

People were supported by an increased number of staff in order to keep them safe and to meet their health and care needs. However, further improvements were required to maintain the consistency of care across the home.

People were protected from the risk of abuse and avoidable harm because staff were aware of their roles and responsibilities and knew what the reporting procedures were.

People received their prescribed medicines as required because medicine management processes had improved. However, further improvements were required to the medicine administration records.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive care from staff who had received training updates as required by the providers training policies. However, people were confident that most of the staff had the knowledge and skills they required to do their job effectively.

People's rights were protected because key processes had been followed to ensure that people were not unlawfully restricted.

People received care and support with their consent, where possible.

People's dietary needs were assessed and monitored to identify any risks associated with their diet and fluid requirements and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when

necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

Some aspects of care was not always caring. People did not always receive the support they required when they required it.

People were supported by staff that were kind and caring. People received the care they wanted based on their personal preferences and dislikes because staff spent time getting to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and/or their relatives did not always feel involved in the planning and review of their care. People's care was reviewed but associated care records were not always updated to reflect any changes to their care needs. This put people at risk of receiving ineffective and/or potentially unsafe care.

It was not always evident that staff had been responsive to people's changing needs.

People were actively encouraged and supported to engage in activities that were meaningful to them and people were supported to maintain positive relationships with their friends and family.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had some systems in place to assess and monitor the quality and safety of the service. However, these

were not always effective in identifying shortfalls found during the inspection.

Improvements had been made to the leadership and management of the service and staff felt supported in their work.

The management team were approachable, open and honest throughout the inspection process and were responsive to our feedback.

Perry Locks Care Home

Detailed findings

Background to this inspection

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

On 10 May 2017 we conducted an unannounced evening inspection to see how care was provided to people living at the home at night time. We then returned for a full day on 11 May 2017 to complete the inspection. The inspection was conducted by four inspectors on 10 May 2017 and five inspectors on 11 May 2017. A Pharmacy Inspector was also present on 11 May 2017 to look at how the medicines were managed within the home alongside an Expert by Experience and a Specialist Advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience involved in this inspection had experience of caring for an older relative who used regulated services including care homes with nursing. A Specialist Advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected. They are deployed by the Care Quality Commission to support the inspection process. The specialist advisor involved in this inspection was a registered nurse with specialist knowledge and skills of nursing people with general and dementia care needs.

As part of the inspection we looked at the information that we hold about the service prior to visiting the location. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. A Provider Information Return (PIR) request had not been sent to the provider prior to the inspection and therefore was not available to inform the inspection plans. A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the service does well and any improvements they plan to make. We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

During our inspection visit, we spoke with 28 people who lived at the home and 11 relatives. We also spoke with 20 members of staff including the registered manager, a regional director, four unit managers, nursing staff, care staff, an activity co-ordinator and a visiting health professional. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called the Short Observational Framework for Inspection (SOFI) coupled with general observations across all four sites of the care home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of 16 people to see how their care was planned and looked at the medicine administration processes and associated records in detail on three out of the four units, Brooklyn House, Lawrence House and Calthorpe House. This included the medicine administration records for 23 people in total. We looked at training records for staff and at three staff files to review recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including medication administration audits, accidents and incident records, compliments and complaints, infection control audits and quality monitoring reports.

Requires Improvement

Is the service safe?

Our findings

During our night inspection visit on 10 May 2017, we found that staffing levels were safe but not completely reflective of the improvements proposed. We found that Lawrence House and Brooklyn House were fully staffed in accordance with the plan, whilst Perry Well House and Calthorpe House were not. Perry Well House had a registered nurse, two care staff (instead of three) and a member of staff deployed on a twilight shift (a member of staff who works until midnight). Calthorpe House had a registered nurse and just two care staff and no twilight shift. There was no senior carer deployed to provide leadership cover across the site as had been proposed. However, we acknowledged that the provider had recruited to the vacant senior care post and were waiting for this staff member to complete their induction in to the new role. The registered manager told us that this member of staff would be in their new post by the 31 May 2017 at which time, the provider would be able to deploy leadership cover seven nights a week.

People and staff we spoke with on Perry Well House and Calthorpe House told us that when the units were fully staffed, there were no issues or concerns. However, people and staff we spoke with and observations we made during our night inspection, showed that at times, when the staffing levels were short, people did not always get their needs met in a timely manner. One person living at Calthorpe House said, "I think the staff are a bit stretched tonight, they could do with an extra pair of hands". Another person said, "There's not always enough of them [staff]; I have been waiting to go to bed, but I have had to wait because they need two of them [staff] for the hoist". We saw that this person was supported in to bed 30 minutes later. A third person told us that they too were waiting to be supported to go to bed and that they had 'been waiting for ages'. We observed that one person was calling for assistance; after five minutes, we went to find a member of staff to support them, after which a member of staff assisted them straight away. On Perry Well House, staff we spoke with told us and observations we made showed that it was the busiest of all of the units at night time, with lots of people seen to still be up and about in the communal areas past 11pm. One member of staff said, "It is okay when there are three of us [care assistants] but tonight, our third carer leaves at midnight [twilight] and it is hard with just two of us". Following our inspection, we were informed by the provider that a third member of staff was deployed from Brooklyn House to Perry Well House at midnight to help to manage this shortfall. We were not informed of any impact that this had had on people living at Brooklyn House.

We discussed the shortfalls identified with the registered manager at the time of our inspection. They told us and records we looked at showed that new members of staff had been recruited to meet the shortfalls in staffing levels at night and that these members of staff would be in post by the end of May 2017 (following the induction process). Whilst some people's experiences on these two units were not ideal, we did not find any evidence to indicate that people were unsafe. It was clear to us that improvements had been made since our last inspection and that further improvements were being implemented.

On 11 May 2017, we found that all units were adequately staffed during the day and that staff were mostly well deployed to ensure that people's needs were met as required. This was with the exception of Calthorpe House; on this unit staff were not always sure of their roles and responsibilities. For example, records we looked at showed that one person required staff to check on their well-being and safety every hour because

they did not have access to a call assistance alarm. However, when we spoke with the person concerned they said, "It is difficult to call for help, they [staff] do check on me, but not very often". They confirmed that staff did not check on them on an hourly basis as per their care plan. Two members of staff we spoke with told us that they did not know that this person required hourly checks because it had not been handed over to them.

People and relatives we spoke with across all four units told us that the staffing levels had improved but were still changeable. They told us that most of the time there were enough members of staff, however, sometimes the provider either moved staff from one unit to another in order to cover shortfalls or deployed bank staff (non-permanent members of staff), which meant that the consistency of staff was also variable. One person said, "I am not always confident that all of the staff know what I need but I am able to instruct them; I just worry about the people who can't [tell them]". Another person said, "Sometimes we are short staffed and we have to appeal to other units to help us". A relative we spoke with said, "Most of the time there are quite a lot of staff here; there are days when people obviously go off sick and they don't seem to have much of a contingency plan in place. I think they [management] staff the units to the bare minimum and don't allow for absence". We asked the registered manager to show us how the staffing levels were determined for each of the units. We saw that that provider used a tool that they referred to as a 'skills mix'. This supported them to identify where the staffing shortfalls were and allowed them to plan in advance or at short notice, how to manage the staffing levels safely within the home. Staffing rotas we looked at showed that the minimum levels of staff required to ensure that people were cared for safely had been accommodated by either moving staff around or deploying bank (non-permanent) staff.

We looked at how medicines were managed in detail on three of the four units, including Lawrence House, Brooklyn House and Calthorpe House. We found that on the whole, people's tablets were being administered as prescribed. However discrepancies found between the liquid medicines and the administration records meant that we were unable to tell whether these particular medicines had been administered correctly. For example, we saw that one person was taking a liquid medicine for the treatment of their epilepsy. We saw 300ml was available at the start of the medication cycle and the records showed 245ml of this had been administered. We therefore expected to find 55ml remaining; however we found 95ml remaining. Since the inspection, we have been told that the clinical services manager carried out an additional audit to look in to this area of concern and found that this was due to a dispensing and recording error rather than indicative of a medicine error. The audit found that the pharmacy had over-dispensed above the amount that had been prescribed and that the nurse who had signed in the medicines had only recorded the amount required rather than the amount received from the pharmacy. The registered manager told us that this had now been addressed with the pharmacy and that all staff had been re-trained to ensure that they accurately completed the records when a medicine delivery was received.

We found that where people were prescribed to have their medicines administered covertly (for example, by disguising them in food or drink) the provider did not always have all of the necessary safeguards in place to ensure that these medicines were administered safely. For example, we found that staff were not always able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that the relevant written information was not always available to tell staff how to carry out this process safely and consistently.

We also found that where people were prescribed medicines on a 'when required' (PRN) basis and particularly when the administration process was complex, the lack of robust information and staff knowledge meant that the provider was not able to demonstrate these interventions were being carried out appropriately for the welfare of the people concerned. For example, we found that one person had been prescribed two different types of medicines for the management of epileptic seizures. There was no

information available to describe the type of epileptic seizures the person was known to experience or how many seizures or the length of a seizure before either of the two medicines were administered, which, if any should be used as a first line option or circumstances when a second dose should be administered, if required. The nurse we spoke with was unsure of the answers to these queries and advised, "I shall ring the specialist and see if I can get a protocol". We found that the staffs knowledge and awareness of epilepsy was lacking across the home and they did not always have the relevant information available to support them in caring for people with epilepsy safely and effectively. Since the inspection, we have been told that 11 people had been identified to be living with epilepsy across the home and that new epilepsy care plans and protocols had been written in line with the provider's clinical guidance policy. We were also informed that new protocols have also been written for other PRN medicines such as lorazepam.

We looked at the records for people who were having medicinal skin patches applied to their bodies. We found that these records were robust enough to demonstrate where the patches were being applied to the body. As a consequence the provider was able to demonstrate that the patches were being applied in line with the manufacturer's guidance thus reducing the risk of side effects. We also found that where people needed to have their medicines administered directly into their stomach through a tube the provider had ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely.

Medicines were being stored securely and at the correct temperature. Controlled Drugs were stored and their administration was recorded correctly. The provider had recently introduced a Medication Essentials Treatment Room Diary which set out daily, weekly and monthly tasks for the nursing staff to complete to ensure the safe management of medicines. The provider recognised that this new system was still being embedded into the daily routines but was confident that this system would support them to improve medicine management processes further. A nurse we spoke with said, "The diary is really useful in reminding us of the tasks we need to do."

We saw that people had some risk assessments in their care files which identified some of the potential risks relating to their health needs. These included risks related to their mobility needs and the potential risk of falls, as well as the associated risk management plans such as the use of bed rails. However, we saw that not all health related risks had been identified, recorded and/or updated effectively. For example, we looked at one person's care file on Lawrence unit and found that their care plans and risk assessments had been reviewed on a monthly basis. However, where there had been a change in circumstances, it had not always been transferred to the main care plan. For Instance, we saw that the person was nursed in bed and although this was evident in the day to day notes, their risk assessment and care plan made reference to the person non-weight bearing and the need for hoisting when being transferred out of bed. The unit manager said that this had been left in "just in case they were supported out of bed" but acknowledged that it could be confusing to staff and they advised us that this would be revisited. We found that a similar omission had been made on Perry Well House. We saw that there was a discrepancy regarding a person's mobility support needs within the records that were kept in their main care file in the nursing office and those that were kept in the person's bedroom. One document stated that the person was non-weight bearing whilst the other reported the person to be weight bearing with the support of two members of staff. This conflicting information has the potential to put people at risk especially if they are being supported by staff who are unfamiliar with their needs. We have since been told that this person's care records have been fully reviewed and updated.

We also saw that some people were living with dementia and often experienced behavioural and psychological symptoms associated with dementia (BPSD) which can, at times, be difficult to manage. It was not always evident from looking at people's care records that these needs had been identified and/or

recorded, nor could we see any associated risk management plans or protocols to support staff to assist a person when they were experiencing these symptoms. Whilst some of the staff we spoke with were able to tell us about some of the ways in which they would support a person who was presenting with these symptoms such as through the use of distraction, reassurance or the administration of PRN medication, the staffs accounts were often inconsistent. This meant that people were not always receiving the support they required in a person-centred and consistent way. Furthermore, with the use of agency and bank staff as well as the changes to staff covering across the home, it could not be assured that staff who were unfamiliar with people's needs, would have the information they required. We discussed this with the unit managers and the registered manager at the time. We have since been shown evidence that additional plans of care have been either updated, reviewed or implemented to ensure that staff have access to the relevant and detailed level of information. This will promote the consistency and safety of care being provided to people.

However, people and relatives we spoke with were confident that staff would know what to do in the event of a different type of emergency such as a fire, fall or choking. One relative explained "Mum has choked a couple of times and staff have been quick to dislodge the blockage, so she's safe on that front". Care staff we spoke with were aware of their roles and responsibilities in an emergency with regards to summoning assistance from a qualified nurse and nursing staff had received training in the initiation of CPR [cardiopulmonary resuscitation]. CPR is an emergency procedure that aims to manually maintain the circulation of blood and oxygen around the body until spontaneous blood circulation is restored, where possible

People and relatives we spoke with across the home also told us that the staff supported them well with their health care needs and that they felt safe living at the home. One person living on Lawrence House said, "I have never felt unsafe". A relative we spoke with said, "I have been very pleased generally with the care here and go home feeling confident that he [person] is safe and being looked after". These experiences were consistent across the other three units of the home too.

Staff we spoke with on all four units were knowledgeable about the potential risks of abuse and avoidable harm and were aware of what their roles and responsibilities were in relation to what the reporting procedures were. One member of staff working on Perry Well House told us, "If I had any [safeguarding] concerns I would speak to the manager; I can also whistle blow and call CQC if I need to". A member of staff working on Lawrence House said, "If you had of asked me three, four months ago 'were people safe?' I'd have said no, but now yes 100% absolutely". Two members of staff we spoke with gave examples of people requiring the support of two staff for personal care and they told us that historically only one member of staff had provided the care. Both staff members told us that they had reported this poor practice to the management team and they both said that it had been addressed and was no longer an issue. The registered manager confirmed this and told us that following a safeguarding incident last year, issues around safe manual handling practices and safeguarding concerns had been identified. They told us that some of these concerns had been dealt with directly by the appropriate external agency, but an internal investigation had also identified additional areas of concern which they had addressed directly. We were told that some staff had been taken through the disciplinary process and had either been given written warnings or dismissed. We were also told that all members of staff had undergone additional training in moving and handling and safeguarding practices. The management team had also made changes to the staffing teams across the home to ensure that there was an effective skill mix of staff and a wider level of supervision practices were facilitated. The registered manager said, "I am confident that we have a good staffing team on all units now and there are no concerns relating to the safety of people living here anymore. Any concerns are historic and we are moving forward and embedding the improvements that have been made".

Observations we made throughout the day showed that people were supported with their mobility needs safely and effectively. We saw that staff appeared confident and well trained in safe moving and handling practices. For example, on Lawrence House we saw that people had their walking frames to hand and no unsafe practice was seen with moving or handling. One person was supported by two staff from their lounge chair to walk with their frame to the bathroom. This person said, "I feel safe while I'm sitting down but a little frightened when I try to stand because I start to shake, so I have to wait for staff to help me now."

We found that the provider had a recruitment policy in place. Records we looked at showed that staff had been appropriately recruited via a formal interview, references, and a Disclosure and Barring check (DBS). Staff we spoke with told us they had completed a range of pre-employment checks before working unsupervised. We saw that staff were required to satisfy a number of competencies during their probation period of six months, before they were permanently employed by the organisation. We discussed the recruitment process with the registered manager and they said, "We have a very robust process and if people do not meet the standard then they will be coached further and offered additional support, but if after this they are still unsuitable, we will let them go because we have to be sure they can do the job safely and look after people properly".

Requires Improvement

Is the service effective?

Our findings

Most of the people and relatives we spoke with across the home were confident that the staff had the knowledge and the skills they required to care for people safely and effectively. One person living at Calthorpe House told us, "The staff all seem very skilled and able". A person living at Lawrence House said, "I don't have any concerns that the staff are not trained, they all seem to be very competent". Another person said, "I have a lot of confidence in the carers and they all seem to be well trained and efficient". A third person told us, "I think the care here is very effective. They have followed instructions and my pressure sores which I got in hospital and they have now nearly healed". A relative we spoke with on Perry Well House told us that the staff were 'excellent' and looked after their loved one 'brilliantly'.

However, some of the people and relatives we spoke with were not always as sure about the level of knowledge and the skills held by the staff members that were deployed by the provider on a temporary basis to cover any staffing shortfalls; the provider referred to these as 'bank' staff . One person said, "I don't have confidence that the temporary [bank] staff know what they are doing but otherwise I think the staff are well trained". A relative we spoke with told us, "I think they use agency staff too much. They don't give me the confidence that they know how to use some of the equipment properly and don't give the impression they are trained". We discussed this with the registered manager at the time of our inspection. We were told that the bank staff were all BUPA trained employees and therefore undergo the same level of training and supervision as the permanent staff. The registered manager said, "We only use agency (external to BUPA) nurses and when we do, we have regular agency nurses who are familiar with the home". They told us that the lack of familiarity of some of the care staff may have impacted upon people's confidence, but they assured us that staff were all skilled and trained to do their jobs effectively and that records are kept of staff competencies.

Staff we spoke with told us that the training they received was usually to a good standard and that they had received a thorough and robust induction programme when they first joined the service. However, many of the staff members we spoke with told us that there had been a reduction in the training that had been available recently. One member of staff said, "We usually do a lot of training and this is usually face to face learning and then we get a test paper to check our knowledge, but this year we have not had the training, just a test paper; I wasn't very impressed with that". Another member of staff told us, "We have had a lot of online learning this year". A third member of staff we spoke with said, "A lot of the in-house training has been cancelled this year and there is a lot of on-line training". We discussed this with the registered manager at the time of our inspection. They told us that unfortunately, they have not had access to an 'in-house trainer' since September 2016. In order to manage this, they have encouraged staff to undertake on-line learning and have also issued test papers to facilitate a 'knowledge check' to enable them to identify where the priorities for learning and development are. The registered manager said, "We are aware that a lot of staff are over-due their training dates and it has been escalated to the director of operations on a number of occasions. We are currently managing the compliance within the home for mandatory subjects by issuing knowledge checks. We have prioritised fire safety and moving and handling now that training is available and sessions have been booked for these". We also found that the provider had arranged for external agencies to offer training as an interim measure including safeguarding training which had been provided by

the local authority's safeguarding team and continence training provided by a specialist company. Records we looked at showed that some staff had missed the target dates for some of their learning and development needs. Whilst we did not find any impact that this lack of training had had on people using the service, the registered manager acknowledged that was an area in need of improvement and had been recognised as a priority.

Whilst staff we spoke with had a good level of knowledge about how to keep people safe and care for people effectively, there were areas that were lacking, such as their understanding and knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff we spoke with including the registered manager told us and records we looked at showed that staff received training in these areas as part of their induction and that whilst there were no requirements set by the provider for a refresher on these topics, they were discussed with staff as part of the supervision and annual appraisal processes.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

We found that most staff were able to tell us about people's capacity to consent to the care that they were receiving. One person we spoke with said, "I feel very involved and they [staff] always ask me before doing anything for me". A relative we spoke with told us, "I am kept informed and we are both involved in any decision making". Another relative said, "I am always fully involved in any decisions about care and [unit manager] keeps me fully informed". Throughout the inspection and across all four units, we saw examples of how staff gained consent from people before they provided them with care and support. For example, during a medicine round on Lawrence House, we saw the nurse informed people about their medicines and gained their consent before they administered these to them. We also saw people were given choices about day to day events, such as the clothes they wore, the care they received, the food/drinks they consumed, and how they wished to spend their time. One person said, "The carers are lovely and always look after me very well. We talk about what shirt I want to wear in a morning". Another person told us, "I am finding it a bit strange having come from hospital that I now have a choice about doing things".

Where people were deemed to lack the mental capacity to consent, applications to deprive the person of their liberty within their best interests had been sent and authorised. However, some of the documentation around mental capacity assessments and best interests' decisions were not always clear. The documents used to assess and a record a persons' mental capacity within the home were called 'Cognitive Assessment Tools'. We found that the assessments were generic and not time related or decision specific, other than having a list of tick boxes to identify what generic decisions had been assessed. For example, for medicines that were being administered covertly we saw that a cognitive assessment tool had been completed, but there was no evidence to show that a GP or an external specialist had been involved or that a multi-disciplinary team decision had been made to determine that this care was being provided within the person's best interests. The provider's independent best interests' paperwork had also not been completed. In addition to this, it was not always evident that conditions that had been imposed on the authorisation to deprive a person of their liberty were being followed. Since our inspection, we have been informed that the registered manager had modified the DoLS tracker tool to include conditions and recommendations to

ensure that these were followed up in a timely manner.

People and relatives we spoke with were complimentary about the food prepared for them at the home and reported to have a good level of choice about what they ate. One person living at Calthorpe House said, "The food is very good and they recognise what I need for my diabetic diet". A person living at Lawrence House told us, "I am very happy with the food and drinks, there is always a choice". Another person said, "The food is amazing. Always plenty of it and well presented. Can't fault the cook!". A relative we spoke with said, "The food is very good. I am here a lot so I usually eat with him [person] which makes it easier for me and it is nice for us to still be able to have a meal together". We observed a meal time on each of the four units and consistently found that meal times were a pleasant and social experience for people; the tables were laid, condiments were available and people ate whilst chatting to staff and with each other. The food looked and smelt appetising and people appeared to enjoy their meals. One person we spoke with said, "The food is always well presented, even when pureed it is still appetising". Some people chose to have a second serving because they told us the food was 'so nice'. We saw that people had a choice about where and what they wanted to eat and drink. Some people chose to eat at the dining table, others sat in the lounge to eat their meals and others were supported to eat in bed. We saw people received the right amount of support to enable them to eat their meals as independently as possible, where possible. We saw staff were deployed effectively and people received their meals and the support they required in a timely manner. People that required assistance to eat, were supported by staff in a way that was kind and encouraging. Staff sat down next to people and spoke to them throughout, informing them about what it was they were eating and checking that they were ready for the next serving. We saw that there was a good variety of food and people's cultural needs were also catered for. One member of staff we spoke with said, "We have a Caribbean menu that people can order from and we had one gentleman who wanted Asian food, so he used to have curry and chapattis'. He's not with us anymore sadly, but anything anyone wants they can have". We saw one person's family had brought them a meal in that they had prepared at home.

People we spoke with and records we looked at showed that people had care plans and risk assessments in place associated with their dietary needs. These detailed people's specific needs and risks in relation to their diet. One person said, "I have to have my food pureed or chopped very small and they always do this for me". We saw that where people were at high risk associated with their diet or fluids they were referred to the appropriate medical professionals such as Speech and Language Therapists and Dieticians. Staff we spoke with told us, "Some people have special dietary requirements; for example [person's name] has to have a soft diet because they are at risk of choking". We saw evidence of this in people's care plans.

People had access to GP's and other health and social care professionals. People we spoke with across all four units and records we looked at confirmed this. For example, one person living on Calthorpe House said, "I see all the professionals I need to. I have seen doctors, dentists and chiropodists. I also see the hairdresser every week as I like to look presentable". A person living on Brooklyn House told us that they had received medical attention whenever they needed it and that staff were quick to call the GP if they were concerned. Another person living at Brooklyn House told us and records confirmed that they had recently been seen by a dietician to review their enteral feeding (PEG) tube (a tube that is surgically placed directly in to the stomach to provide a means of feeding when a person has been assessed to be at risk of choking or aspirational pneumonia if they were to eat orally). This person told us that they missed eating and drinking 'normally' and therefore the staff had made a referral to the speech and language therapist to re-assess their eating and drinking needs. We saw detailed protocols in place for people that were living with an enteral feeding tube and that these had been informed by the relevant specialist professionals. People's weights were monitored and recorded and action was taken to support people to maintain a healthy weight where required. For example, we saw people were prescribed fortified high calorie diets if they were at risk of losing weight. On Lawrence House we saw that one person had been observed to be losing weight. The nursing

staff had formally assessed this by taking measurements of their upper arm as they were unable to access the weighing scales due to frailty. We saw that this person had been referred to the speech and language therapist for a review of their dietary needs and had gained weight when their cuff measurement was re-assessed in May 2017. Records we looked at confirmed that people's health and care needs were met by visiting GP's, Tissue Viability Nurses for wound care, Podiatrists and other community health workers. We also saw that people were regularly reviewed by a Psychiatrist or received input from the local Community Mental Health Team for their mental health needs, such as dementia. This meant that people were supported to maintain good health any health care concerns were followed up in a timely manner with referrals to the relevant services.

Requires Improvement

Is the service caring?

Our findings

Whilst individual staff members were reported and observed to be caring, we found that some aspects of the care being provided to people was not always caring. For example, we saw that people waited over 30 minutes to be assisted to bed, people and relatives told us that they were not always involved in the planning and review of their care and we also found that one person did not receive the support they required, when they required it because staff had not always been responsive to their needs. For instance, on Brooklyn House, throughout the course of our evening inspection, we saw one person repeatedly called out for help and assistance. We spent time monitoring this situation and observed staff walking past the person's room without responding to their calls for assistance. When we looked at this person's care file, we saw that they had been assessed when they first arrived at the home as being able to tell staff where they wanted to spend their time, what they needed and that they could communicate with staff when things were explained to them 'calmly and carefully'. It also stated that the person would often shout out loudly for help if they needed to use the toilet for example, and at times could become disorientated and restless. The care plan stated that at these times, staff should provide support, reassurance and re-orientate the person when required. This was not what we observed during our inspection. Since our inspection, we have received information to show us that this person's care needs had been reviewed following the inspection to ensure that they received the care they required, safely, effectively and consistently.

However, people and relatives we spoke with were complimentary about the staff and the care they received. One person living on Lawrence House told us, "The staff are lovely, very kind and considerate". Another person said, "Everyone is very friendly and have a laugh and a joke with me. I am very happy here". A relative we spoke with said, "It's nice to come and see lots of smiling happy people". This feedback was consistent across all four units. One person living at Brooklyn House told us that they were only staying there on a temporary basis but they wished they could stay. They said, "As soon as I came here a member of staff smiled at me and made me very welcome; that was all I needed". A person we spoke with who lived at Calthorpe House said, "The carers are always willing and smiling, which brightens the day and makes me feel so much better". Observations we made confirmed these reports. We saw staff interacting with people with kindness and compassion. They altered their communication style to meet the needs of individual people. For example, we saw some staff engaged with people in a humorous and jovial way and people told us that they enjoyed the 'banter', whilst other people responded well to gentle encouragement and reassurance. We saw that staff were responsive to changes in people's moods and spoke to people with empathy and consideration. One member of staff working on Perry Well House said, "This lady sometimes asks to go home, but we know how to reassure her and she loves a cup of tea". We saw people smiling and laughing with staff and when a person showed signs of distress, they were reassured by staff contact. It was clear that there were friendly relationships between the staff and the people using the service as well as with relatives and visitors. A relative we spoke with said, "The staff look after me as well".

We found that people received their care and support from staff who knew them well, most of the time. Some people we spoke with were not always sure that temporary staff knew them as well as the permanent staff, but were complimentary about their efforts to get to know them better. One relative we spoke with during our time on Calthorpe House told us that staff took the time to get to know a person and to care for

them. They said, "I see the compassion that they [staff] have for people; they take their time and they listen to people about what they want and need, that's everyone from the carers, to the nurses and management". A relative visiting a person at Perry Well House also shared a similar experience and said, "Staff make an effort to meet people's individual needs". A person living at Brooklyn House said, "When I first arrived they asked me lots of questions about how I liked things done; they took the time to listen and I think they know me very well even though I have only been here a short space of time". Another person told us, "They know me well here; I don't eat breakfast, never have! I am a biscuit dunker, they don't make me eat breakfast, they know I am happy with my biscuits". We saw that this person looked happy and content dipping their biscuits in their cup of tea.

People we spoke with and records we looked at confirmed that the staff had completed a document called 'My day, my life, my portrait'. These documents included information about a person's life experiences, interests, likes, dislikes, needs and preferences. For example, in one person's care file, we saw that this document had detailed how they preferred to use Nivea or Elizabeth Arden face cream. Another person's personal document detailed all of the people who were important to them and who they wanted to be involved in decisions about their care. A member of staff we spoke with said, "I love my job, I love getting to know people, we know people inside and out and treat them like they are our own family". Another member of staff told us, "We divide ourselves up in to teams, so we each care for seven people to make sure all of their needs are met in the way they prefer; we get to know people well this way".

Information we received from Healthwatch told us that they had received an anonymous concern from a relative about people not always being treated with dignity and respect. We followed this up as part of our inspection. Everyone we spoke with told us that people were treated with dignity and respect and we saw that people looked clean and well cared for. One person living at Calthorpe House said, "I am always treated with the utmost dignity and respect". A relative we spoke with told us, "Privacy is always maintained and I feel they are a very caring team". Another relative explained, "She is always very clean and well-presented when we visit. They are always her own clothes and they are clean and co-ordinated, which would be important to her". A third relative said, "The carers are genuinely sympathetic and understanding and treat her with dignity and respect. The comments are age appropriate and never condescending". We saw that people were addressed by their preferred names and everyone looked clean and well presented. However, we noted on our evening visit that care records and people's personal belongings were sometimes left in the corridors whilst staff supported people in their bedrooms with their personal care. We discussed this with the registered manager at the time. They told us that care records are often left in the corridors at night time to prevent as much disruption to people's sleep as possible. They told us that during night checks, staff would enter the room to check on a person and complete the records in the corridor where there is more light. They acknowledged that these records should always be returned to the person's room as soon as possible in the morning in order to protect their confidentiality. They assured us that this would be fed back to the individual units.

Requires Improvement

Is the service responsive?

Our findings

We received mixed reviews about whether or not people and/or their relatives were involved in the planning and review of their care across all four units. On Lawrence House, two people said that they were involved in the planning of their care whilst three people told us that they weren't. One relative told us that they were involved but they felt that this was only because they were actively involved in their loved ones care anyway. Another person said, "So far I feel very informed and involved in my care plan, which is very reassuring". On Calthorpe House we were told by one person that they felt very involved in their care and staff were very responsive to their needs, whilst another person told us that they had not been involved in decisions relating to their care needs, risk assessments or care plans. On the contrary, two relatives we spoke with on Calthorpe House told us that they were actively involved in the planning and review of their loved ones care and any associated decision making processes. We spoke with a person living at Brooklyn House and they also told us that they were involved in care planning. Relatives we spoke with on Perry Well House said that they knew who to speak with about the care being provided to their family member but were unsure about whether or not they were involved in any formal review processes.

Records we looked at showed that people's care was reviewed on a monthly basis, but it was not always clear from looking at these records whether or not people had been involved in the planning or review of their care across all four units. We fed this back to the registered manager. The registered manager told us that the provider operated a system called 'resident of the day' and that each month, one person on each of the units was allocated a date of the month at which time their care was reviewed. This involved staff meeting with people and/or their representatives to ensure that they were happy with the care being provided or whether they wished for anything to be done differently. Following these discussions, staff would then review and update all of their care records. The registered manager said, "People are made aware of what date of the month they have been allocated to for resident of the day. Invite letters are sent to all of the relatives inviting them to attend the resident of the day review. Copies of these letters are kept within the care files. Some relatives do take the opportunity to attend but many don't". They went on to tell us that the 'resident of the day' is a set agenda item for the residents and relatives meetings and that reminder letters had been sent out to all relatives in November 2016. The registered manager said that in order to enhance this process further, they would include the invite letter as part of the new resident information pack going forward.

We found that people's care was reviewed and changes had been made to the way people received their care in accordance with their care needs. However, it was not always clear from looking at their care records how these decisions or changes had been made, by whom and when. We saw that for some people, their care plans required updating with the most relevant information. For example, on Brooklyn House, we saw that one person had bed rails in place which we were told was for the person's safety. When we went to see the person they told us that they felt like they were 'imprisoned' and asked to be 'released'. This person was actively objecting to the bed rails as they told us they made them feel like they were 'being kept hostage'. They told us, "I didn't think I would have to wait this long for someone to come and see me, I don't understand why it seems so normal here to keep people hostage like this".

We discussed this person's care with a nurse. They told us and daily records we looked at showed that staff had noticed a deterioration in their mental state since their admission and the GP had prescribed Lorazepam for 'agitation and insomnia'. We did not see any evidence in the care file that this person's care plan had been reviewed or that their care needs had changed. Nor did we see any evidence that staff had tried any other non-pharmacological interventions to support this person during periods of distress. For example, we could not see that alternative measures had been tried in replace of the bedrails, in line with least restrictive practices, despite reports in the daily notes that this person had repeatedly complained of feeling imprisoned. The nurse told us that staff had tried to care for this person without bed rails by using a low profiling bed and a crash mat on one occasion but the person was deemed to be unsafe. Further attempts or additional measures had not been considered and the nurse was unsure whether this had had a positive impact upon how the person felt with regards to feeling imprisoned and whether a best interests' decision had been made formally. We also observed that this person appeared more settled in the lounge area and spent much of the day sleeping in a recliner chair. We discussed this with the nurse on duty and asked whether they had considered supporting the person to sleep in the lounge area at night time when they became agitated or distressed, given effective postural and pressure relieving equipment was available. We were told that the person was generally more settled during the day and usually they responded well to distraction techniques and reassurance by staff, meaning that lorazepam was not required. It was unclear why these interventions had not been deployed at night. Since our inspection, we have received confirmation that this person's care had been reviewed and updated where required.

The Provider had a compliments and complaints procedure in place and we were told that people were encouraged to raise any concerns at any time. However, one relative we spoke with told us that they had not been assured that their concerns had been taken seriously or that the provider had done all that was reasonably possible to reassure them that they would investigate the concerns and take appropriate action. They said, "Since the incident, [person] has been happy and feels safe, but at the time, I just needed reassurance that my mom was safe and neither the staff nor the manager I spoke with reassured me or gave me the confidence that this was the case". However, all other people we spoke with across all four units reported to be confident that any complaints or concerns would be dealt with professionally and efficiently. One person we spoke with on Lawrence House said, "The staff are generally pretty responsive and will try and sort out any problems immediately". They went on to say, "We have had to raise things in the past and know who to speak to. They have always listened and been conscious to try and sort things out". Another person told us, "I have had to complain on two occasions and have spoken with the nurse. She has reported it to the home manager and they have made sure things were sorted out; I am confident that if I were to raise another complaint it would be dealt with professionally". This was consistent across all four units. People and relatives we spoke with told us that they could speak to any of the staff if they were worried or concerned about anything, they were aware of who the unit managers were and felt comfortable raising any issues with them.

The provider kept a tracker report of the compliments and complaints and we saw that there had been a significant reduction in the number of complaints they had received since December 2016. The registered manager told us that improvements had definitely been made since last year and that this was reflected in the report.

People were supported to maintain personal relationships and social contact with their relatives and friends. Relatives we spoke with told us that they could visit their loved ones whenever they wanted to. One relative said, "I can get here as early as 9am and stay all day if I wanted to, it's not a problem". During our evening inspection, we saw visitors were welcomed to stay as long as they wished to and some were seen within the home until gone 10pm. On Lawrence House in particular, there was a vibrant atmosphere within the lounge area with lots of visitors and interactions. A relative on Calthorpe House said, "They [staff] are all

lovely and welcome me being here". We continued to see lots of visitors during the day throughout all four of the units. On Lawrence House we saw that the staff had arranged a birthday party for one person who lived there. We were told that the catering staff would always cook a birthday cake to help people to celebrate their birthday and visitors and relatives were all welcome. We saw that visitors made use of the kitchenette facilities on the unit and the person appeared to enjoy having their family around to celebrate with them.

The provider employed three activity co-ordinators who shared their time across the four units. At a recent residents and relatives meeting, it was recorded that people were sometimes 'bored' particularly on Lawrence House. The provider had acknowledged and responded to this by revising how the activity coordinators divided their time. People we spoke with were complimentary of the activities within the home and told us that staff encouraged them to get involved in things that they were interested in. One person said, "They [staff] do try and encourage me to go into the dayroom and socialise but I do prefer my own company, so I tend to sit here and read my book and that's okay". Another person said, "I am quite happy. They try and keep us entertained and I can watch TV or talk to others when my wife is not here". A third person said, "I do like to join in with the bingo and quizzes, we have a good laugh and it keeps my brain going". A fourth person told us, "We do have entertainment which is usually very good. Some days though it can be a bit boring so I have to make my own amusement. I like knitting and they [staff] do encourage me, always being interested in what I am making". We saw that the activity coordinators organised group activities and spent time with people on an individual basis. On the day of our inspection, they had arranged for ponies from the local pony sanctuary to visit people on all four units. Staff we spoke with told us that this was always a favourite with both staff and residents and everyone felt uplifted by the activity. One of the activity coordinators we spoke with told us that they also organised trips out of the home too as often as possible and that they had planned for people from all four units to go to the local pub for a meal the following week. People we spoke with told us that this was a regular occurrence and they were looking forward to the pub visit.

People had the opportunity to maintain their religious beliefs and associated activities. For example, we were told that the provider arranged for church services to be facilitated regularly and people's cultural and religious needs were met on a daily basis. One member of staff we spoke with said, "We support people who wish to pray and we respect people's religious dietary requirements". We also saw staff speaking to people in their preferred language which appeared to offer comfort and supported the communication between them and staff. Staff we spoke with and records we looked at confirmed that they had received training on respecting people's equality and diversity needs, which included people from the Lesbian, Gay, Bi-sexual and Transgender community (LGBT). All of the staff we spoke with were unaware if anyone living at the home were a part of the LGBT community and the registered manager acknowledged that this was an area in need of further development. They showed us an 'LGBT Age Audit Tool' that they had accessed and implemented which was designed as a guide for services and organisations working with older people to become more LGBT inclusive. The registered manager said, "As you can see from the results we still have a way to go, but we have made promising progress so far and it has helped us to identify where our areas for improvements are".

People we spoke with and records showed that the provider often asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One person we spoke with said, "We are asked what we think about things sometimes and if we can suggest any improvements". A relative said, "There are resident meetings and we go if we can. They [staff] do seem to welcome our feedback". Another relative we spoke with said, "I think they [staff] do value the opinions of the residents and their families". Records we looked at confirmed this; we saw that minutes from these meetings had been formalised and an action plan had been agreed. This meant that people and their relatives felt listened to and that the provider ensured that feedback was used to drive improvements.

Requires Improvement

Is the service well-led?

Our findings

The provider was required to have a registered manager in place as part of the conditions of their registration. There was a registered manager in post at the time of our inspection.

During this inspection, we saw that the provider had actively recruited to fulfil staff shortages and to increase the staffing levels and leadership arrangements at night. However, we found that the implementation of these improvements were changeable whilst the recruitment and staff induction processes were on-going; this meant that on 10 May 2017, we saw that these were not fully operational which had an impact upon the quality and efficiency of the care that people received. During our day inspection on 11 May 2017 we found that people were better supported and had a more positive experience of care. However, we continued to receive feedback from people and their relatives about the inconsistency of the staffing group providing care due to the use of agency nurses, temporary care staff and/or the swapping of staff from one unit to another. The registered manager acknowledged that whilst this was not ideal, their priority was to make sure staffing levels were safe and they were confident that once the newly recruited staff had completed their induction programmes, the staffing levels would be much more stable and people would be able to experience a greater level of consistency. They were assured that this would be effective by 31 May 2017.

With regards to medicine management, one of the unit managers had taken on the role of 'Clinical Services Manager' and they were responsible for overseeing medication management processes across the home. A named nurse on each of the units was also responsible for the monthly ordering and monitoring of medicines. Daily medication reviews and monthly medication audits were completed and the service was piloting a new medicines quality monitoring system. During our inspection, we saw that these actions had been implemented and improvements to the medicine management processes were observed. However, we continued to find shortfalls with some of the practices around medicine management including the lack of robust and detailed records to promote the safety and efficacy of medicine administration. Thus, further improvements were required.

We found that further improvements were required to proactively identify the issues that we identified during the inspection particularly around the record keeping and governance of the service. This was particularly relevant to the enhanced assessment placements, as we found that the on-going assessment process was not accurately reflected in people's care records or in the way in which they received care. The registered manager explained to us that people who were staying at the home on a temporary basis had fewer and less detailed care plans and that much of the information they received initially came from hospital staff (where possible) and medical records. They acknowledged that these were not always an accurate reflection of a person's care needs outside of a hospital setting and that staff were given 72 hours to update the records where necessary. We were told that it was a 'daily struggle' to maintain the records for people staying on a temporary basis with at least one admission scheduled per day and for this reason the home had reduced the number of placements available for this type of stay and that the continuation of the enhanced assessment bed system was currently under review. This demonstrated their responsiveness and awareness of the difficulties associated with this type of care.

We could see that systems and processes were in place to support the management to achieve the required improvements and that plans continued to be implemented to make further improvements. We found the management team were responsive to our feedback and since our inspection they have provided us with information and some evidence to demonstrate the actions that they have taken as a result. For example, since the inspection site visit, we have been told that handover documents (used to share information between staff during shift change-overs) have been strengthened to identify people's monitoring and support needs. We have also received examples of detailed care plans for people living with epilepsy and those experiencing behavioural and psychological symptoms in dementia to ensure staff have sufficient information to enable them to care for people safely, effectively and consistently. We were told that an additional audit on medicines had been facilitated and changes had been made to the way in which the staff now recorded medicines received from the pharmacy and how they audited liquid medicines. We have also received evidence of enhanced medicine management protocols for medicines that are prescribed on an 'as required' basis. We received a copy of a new Deprivation of Liberty Safeguards (DoLS) tracker that the registered manager has amended to enable them to monitor their compliance with any conditions implemented within the authorisations. We will check the effectiveness and sustainability of these actions and the improvements made at our next inspection.

We saw that the provider had a clearer and stronger leadership structure within the service including a registered manager, four unit managers, qualified nurses and senior carers who all supported the day to day management and running of the service. The registered manager had also introduced two new clinical service manager roles to oversee areas that had been previously identified as requires improvement, such as care planning, training, clinical risk management, audits and medicine management. Whilst further improvements were still required in these areas, it was recognised that these were new roles and continued to be in their infancy. We saw that since the introduction of these roles, some improvements had been made, particularly around medicine management. The sustainability of these improvements will be checked at our next inspection.

A range of meetings were held including a daily 'take ten' meeting where the registered manager, unit managers and departmental leads would meet to discuss daily concerns, issues and risks to people's welfare as well as good practice issues. We were invited to join the meeting and found that it was well organised and structured, with open communication between all involved. 'Resident of the day' was discussed on each of the units and a sample audit of care records were undertaken. The meeting had a clear focus on the health and well-being of people who used the service.

The provider had a full quality assurance framework called Operational Essentials which was well embedded within the home. This included daily, weekly, monthly and quarterly quality monitoring activities which were undertaken at unit/department and management level then overseen by regional management, where any trends analysis and actions arising were escalated. The registered manager and the regional manager told us that this was a robust system and that both of them had a 'good handle on the strengths and areas for development within the home'. This was evident when we spoke with them about staff training and the difficulties associated with the enhanced assessment beds and record keeping. The registered manager had also proactively identified a service gap for people of the lesbian, gay, bisexual and transgender community in older age and had been resourceful in sourcing an independent audit tool to help them to assess and identify ways in which they could work towards meeting this gap.

Feedback we have received from the clinical commissioners of the service has been positive. One commissioner said, "We carried out a quality visit to the location last week (25 May 2017) and we were very pleased with the improvements that have been made; we now need to continue to monitor the sustainability of these improvements". Results from their quality visit were reflective of the improvements

that we had found as part of our inspection and also informed us that some of the actions we have been informed of since our inspection, have been implemented. For example, the commissioner's quality monitoring visit saw evidence that further training in moving and handling and fire safety had been facilitated on 24 May 2017 and was planned for 05 June 2017.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and that there was a whistle-blowing policy in place. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal. They can also share their concerns with external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concerns properly. All of the staff we spoke with told us that they felt comfortable raising concerns with either the unit managers and/or the registered manager and knew that they could contact external agencies, such as ourselves if they needed to.

Everyone we spoke with were complimentary about the management team. A relative we spoke with said, "I have been coming here a long time now, I know [registered manager]. She has changed the place beyond recognition for the better. Since she has come, the staff are much more motivated and efficient". Another person said, "[registered manager's name] is lovely, very good. She even came in on Christmas Day to say Merry Christmas to us all; you can't get more committed than that". People we spoke with on each of the units all knew who the unit managers were too. One person on Lawrence House said, "I know [unit manager's name], she will come in most mornings and always has a chat and to see if everything is ok; the staff seem to like her too". On Calthorpe House, a person told us, "I know [unit manager's name] well. She comes around every day to see if we are okay; she will sort out any issues". A person living on Brooklyn House told us that the unit manager was always around if they needed to speak with him.

All members of the management team that we met throughout our inspection appeared to know people, their families and their staff well. Staff we spoke with also told us that the management team were approachable and supportive and that they maintained an open and honest leadership style. One member of staff working on Brooklyn House said, "It [home] is very well run and organised; our unit manager is brilliant, he will spend time with people, he is very considerate of us [staff] too and everyone including the residents are confident to speak with him, he is approachable". Staff working on Lawrence House were very complimentary about the unit manager and the registered manager. They too unitedly told us that the management team were approachable.

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us their understanding of this regulation and how they reflected this within their practice. They said, "We have an open culture here and we will be upfront and honest about everything; nowhere is perfect but we have been working extremely hard to make the required improvements. I am confident that we are making great progress. I am extremely proud of the staff and I think we have a good strong staffing and management team now; we have had a very difficult twelve months, but we are definitely coming out the other end". We found the registered manager to be open and transparent both prior to (during routine enquiries) and throughout the inspection process. Any information that we have asked for or that the provider was legally required to share with us both prior to and since the inspection was provided, reliably and efficiently.