Festival Care Homes Ltd

Barleycroft Care Home

Inspection report

Spring Garden
Romford
Essex
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08 March 2018
09 March 2018

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

Summary of findings

Overall summary

This unannounced inspection took place on 7, 8 and 9 March 2018.

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

Barleycroft is a purpose built 80 bed service providing accommodation and nursing care for older people, including those living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. 54 people were using the service when we visited.

The service did not have a registered manager but a new manager had been in post since February 2018 and had started the process to register with CQC. 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.

At the last inspection on 22 and 23 February 2017, we found two breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The lack of consistent and specific information about people's needs placed them at risk of not receiving the care they required and wanted. The registered person had not adequately monitored, assessed and improved the quality of the services provided. Following the last inspection, the provider completed an action plan to show what they would do to improve the service and meet the requirements.

At this inspection, we found that action had been taken. Care plans had been reviewed and improved to better reflect the care people needed. Some further development was needed to make them clearer and to support further consistent practice and this formed part of the services future action plan.

Systems to monitor the service provided had been changed and strengthened. However, further work was needed to ensure people received a good quality of service and legal requirements met.

Staffing levels and deployment were not sufficient to meet people's needs and to enable them to be supported in a way that they wished. Staff training was not always up to date and therefore did not ensure staff the necessary skills and knowledge to meet people's assessed needs.

The provider's recruitment process was not always operated effectively to ensure staff were suitable to work with people who need support.

Staff were aware of their responsibilities to ensure people were safe and action was taken if there were any concerns or possible abuse. People told us they felt safe at Barleycroft and were supported by kind and caring staff. Systems were in place to minimise risk and to ensure that people were supported as safely as possible.

People were encouraged to do things for themselves and staff provided care in a way that respected people's privacy and dignity.

Systems in place supported people to receive their prescribed medicines safely and they were supported to receive the healthcare they needed. If there were concerns about their eating, drinking or weight, this was discussed with the GP and support and advice were sought from the relevant healthcare professional.

Staff supported people to make choices about their care and systems were in place to ensure they were not unlawfully deprived of their liberty. Systems were in place to ensure that decisions made in people's best interest protected their human and legal rights.

Staff and relatives were positive about the changes implemented by the new management team.

We saw that staff supported people patiently, with care and encouraged them to do things for themselves.

People's nutritional needs were met and they were happy with the food provided. We recommend that catering arrangements be reviewed with a view to facilitating people receiving meals that meet their cultural preferences.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

Staff felt the management team were and supportive and gave them clear guidance.

Systems were in place to ensure that equipment was safe to use and fit for purpose. People lived in an environment that was suitable for their needs. Ongoing work was taking place to improve the environment and make it more homely and dementia friendly.

A complaints procedure was in place and relatives knew how and who to complain to when needed.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Staffing levels and deployment were not sufficient to meet people's needs and the provider's recruitment process was not always robust.

People were supported to receive their medicines safely. .

Risks were identified and systems were in place to minimise risk in order to ensure that people were supported as safely as possible.

Action was taken if there were concerns about abuse and neglect.

The premises and equipment were maintained to ensure that they were safe and ready for use when needed.

Is the service effective?

Requires Improvement

The service was not consistently effective. Not all staff training was up to date and there were some staff whose training was very overdue or had not been completed.

People's nutritional needs were met.

Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's healthcare needs were identified and monitored. They were supported to receive the healthcare they needed.

Work was in progress to improve the environment.

Is the service caring?

Good

The service was caring. People told us, and we saw, that they were treated with kindness by a caring staff team. People's privacy and dignity was respected.

People were encouraged to remain as independent as possible

and to do as much as they could for themselves.

People's cultural and religious needs were identified and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Care plans had improved and were more detailed. Some changes were still needed for clarity and to highlight important areas and further support consistent practice.

An activity programme was in place but some people felt that stimulation and activity was not adequate.

People were encouraged to make choices and to have a say in what they did and how they were cared for.

Staff provided caring support to people at the end of their life and to their families.

Complaints were listened to and action was taken to address concerns or issues.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Although systems in place to monitor and improve the quality of service provided had improved, there were still breaches in regulations.

Staff told us the manager was approachable and they felt well supported.

Staff were positive about the changes the management team had made in the short time they had been in post.

Barleycroft 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.

This unannounced inspection took place on 7, 8 and 9 March 2018. The inspection team consisted of two inspectors, a specialist nurse advisor 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 service.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we also reviewed the information we held about the service. This included notifications of incidents that the provider had sent us since the last inspection. We contacted the commissioners of the service and the local safeguarding team to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with 12 people who used the service, five relatives, the manager, the area manager, the regional director, the deputy manager, two nurses, ten care staff, and the chef. We looked at 12 people's care records and other records relating to the management of the home. This included five sets of staff recruitment records, duty rosters, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Requires Improvement

Our findings

People told us they felt safe at Barleycroft. One person said, "Yes I do feel safe and this is because there is always someone on call." Another person commented, "Yes I do feel safe. I feel secure with the staff that support me." A relative said, "I feel that it is the best place for my [family member]."

However, the arrangements for ensuring that staffing levels met people's individual needs were not robust. For example, we saw that there were 16 people in the residential unit, four of whom had very high support needs. They were cared for in bed and needed the support of two staff for moving and handling and personal care. A dependency assessment tool was used to calculate staffing levels and based on this staffing levels for that unit were two carers and one senior during the daytime shift. However, the reality of the staffing situation was that if any of the people with high support needs were receiving care there was only one member of staff available to support other people. There were times when people in communal areas were left without staff support and this placed them at risk, as there was not staff available to provide assistance. For example, with mobilising. In addition, people requiring high levels of support for moving and handling or personal care had to wait until two staff were available.

Feedback from people was that they were concerned about staffing levels. One person said, "No there is definitely not enough staff. It makes me careful how I ask for help. We are short staffed across the board especially in the morning and it affects me because of [person's specific need]." Another person told us, "The staff are coping but they all seem very busy. At busy times they take about ten minutes [to respond] at quiet times they take about five minutes." Feedback from staff also indicated that they were concerned about staffing levels. They told us they needed more staff, as they did not have the time to engage with people and to sit and talk to them. One member of staff said, "Staffing levels are not enough especially in the morning. When the senior is doing the medication, a carer is doing food and that only leaves one person to get up the residents." Another commented, "We need more staff so that we can spend more time with them and so we don't need to rush." A third member of staff added, "Staff are always on the go. We don't have any breaks and have coffee on the go if we have time. We don't have time to speak to residents." Staffing levels were not sufficient to effectively meet people's needs in a timely manner and this placed people at risk of not receiving the care they needed.

This evidences a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the regional director informed us that those with higher dependency levels on the

residential unit had been reviewed and assessments indicated their care needs were better suited to the nursing unit. This had been discussed with those concerned and their relatives and dates for transfer planned. Therefore, staffing levels on that unit were being reviewed.

The provider's recruitment process did not ensure that fit and proper persons were employed. At the last inspection on 22 and 23 February 2017, we found the provider's recruitment process ensured staff were suitable to work with people who needed support. However, in two of the four files we looked at there were missing copies of references. The office manager had audited staff files to ensure they contained the necessary information and had been following up on missing paperwork. We saw evidence of this at the time.

At this inspection, we looked at five staff recruitment files. We found prospective staff had completed an application form and attended an interview. Interview notes had been recorded, identification checks had been carried out and confirmation was received that staff were not on any list that barred them from working with people who need support. However, application forms were not always fully completed with full work history or reference information. Gaps in employment history had not been followed up. References were taken from people's last employer but for one person they had only worked for that employer for a few weeks and good practice would indicate obtaining a reference from the employer before that. This had not happened. Recruitment procedures were not operated effectively and therefore did not ensure that people were supported by suitably skilled, experienced staff of good character.

This evidences a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were managed and administered safely and they received these as prescribed. Medicines were administered by nursing staff and senior care staff who had received appropriate training and been assessed as competent to do this. People were happy with the support they received with their medicines. One person said, "Yes I do get my medication okay." Another told us, "The staff also help me with my medication and they make sure I take it. They bring it to me."

On the first day of inspection, a person told us about a serious medicines issue that had occurred earlier in the day. This was immediately and thoroughly addressed by the management team and the necessary action taken to ensure people's wellbeing and prevent this happening again.

Medicines were kept safely and securely in locked medicine trolleys and cupboards kept within locked 'treatment' rooms on each unit. Controlled drugs were stored safely in a separate controlled drugs cupboard and a controlled drugs record was kept. Medicines requiring cold storage were kept within a locked fridge. Minimum and maximum temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were also kept at safe temperatures to remain effective. Any unwanted or unused medicines were recorded, safely stored and disposed of. The person responsible for the administration of medicines kept the keys with them during their shift and only authorised people had access to medicines.

Medicines Administration Record (MAR) charts were completed accurately and were up to date. They included people's photographs to check that medicines were given to the correct person. People's allergies were also recorded. In line with good practice, opening dates were recorded on liquid medicines, drops and creams to ensure that they were not used after the expiry once opened period. A system of monthly medicine audits were in place and these were monitored by the manager. Any issues were followed up and action taken to ensure medicines continued to be safely managed.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual guidelines were in place to inform staff when these medicines should be given. This enabled staff to make decisions as to when to give these medicines, to ensure people were given these when needed and in a way that was both safe and consistent.

People who received their medicines without their knowledge (covertly) were appropriately managed. The covert administration of medicine had been approved following best interest meetings held with relatives and the necessary professionals, as it was deemed necessary for the person's health and wellbeing.

People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening. Staff had received safeguarding training and were aware of the safeguarding policies and procedure in order to protect people from abuse. They were aware of different types of abuse and knew what to do if they suspected or saw any signs of abuse or neglect. Staff were clear they would report anything of concern to the manager and confident that action would be taken. The provider had notified us about potential safeguarding incidents. They had worked with the local authority and taken action to make sure people living at the service were protected from risk of harm or abuse.

Risks were identified and systems put in place to minimise risk and to ensure people were supported as safely as possible. People's files contained risk assessments relevant to their individual needs and this gave guidance to staff on how to support people safely. For example, some people had been identified as being at risk of choking and others from dehydration. Accidents and incidents were recorded and reviewed by a member of the management team. Action was taken to minimise the possibility of reoccurrence. For example, after a fall one person's falls risk assessment was updated and they were reviewed by the GP. Accidents and incidents were audited to include where they happened, the time of the day and to identify any patterns. Any patterns identified were actioned.

Systems were in place to maintain a safe environment. Health and safety related audits were completed every three months. We saw that for the most recent audit an action plan was in place for areas for improvement. The handyperson told us the manager promptly took the necessary action to rectify any concerns.

Systems were in place to ensure that equipment was safe to use and fit for purpose. The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were maintained and checked to ensure that they were functioning appropriately and safely. The records also confirmed that appropriate checks were carried out on hoists and pressure relieving mattresses to ensure that they were safe to use and in good working order. One person told us, "The staff are very good, they will check if everything is working all right."

Staff had received emergency training. There was a fire risk assessment and they were aware of the evacuation process and the procedure to follow in an emergency. The fire safety system and equipment were serviced and checked in line with legal requirements. Each person had a personal emergency evacuation plan, which provided information about their needs to assist the emergency services in the event of an emergency evacuation being necessary. Therefore emergency information was readily available should the need arise. Systems were in place to keep people as safe as possible in the event of an emergency arising.

Appropriate infection control systems were in place. Staff had received infection control training and

protective equipment such as gloves and aprons were readily available and used when necessary. We saw a member of staff removing gloves and using the correct infection control protocol.

However, we found that there was a strong smell of urine in some areas of the building. We discussed this with the regional manager and they undertook to investigate and address the problem. We saw that cleaning schedules were in place and carpets had been steam cleaned.

Requires Improvement

Our findings

People told us they felt staff were competent. One person said, "Yes I do think the staff are competent. Yes they seem adequate to do what you ask." Another person told us, "Yes they are competent when you get up they give you a wash, change you and give you breakfast." A third person commented, "All the staff are nice. I think they do know what they are doing. I suppose they must have had the necessary skills and training because I haven't had a problem." However, staff did not always have up to date or sufficient training to effectively meet people's needs.

At the last inspection on 22 and 23 February 2017, we found staff received training to carry out their duties and felt that this was the right training for the job they did. Not all staff training was up to date and there were some staff whose training was very overdue or had not been completed. The manager was formally addressing this with those concerned. At this inspection, we found the situation remained the same. Although a lot of staff training had taken place and further training was booked, there were still staff whose training was not up to date. In particular, there was a member of staff whose training was only 59.9% up to date. Some of their training had not been updated since 2013. The new management team had started to performance manage the person concerned to deal with the issues. During our discussions with the new management team, the regional director stated that the person would not be able to work until they had completed the necessary training updates. The regional director also said that they would do a "big blitz" on training and they would be supporting manager with this.

The local authority safeguarding team felt that staff did not have specialist knowledge to work with people with advanced or high levels of dementia. This was particularly in relation to behaviours that challenge. The regional manager told us that although they had a dementia nursing unit this was not a specialist unit for people with behaviours that challenge. However, we found that some people on this unit did have advanced dementia and behaviours that challenge. Staff had not received training to enable them to effectively meet such complex needs.

This evidences a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were monitored and addressed to support them to be as healthy as possible. We saw that appropriate requests were made for input from specialists such as a speech and language therapist, dietitian and palliative care practitioners. Staff referred people with pressure area problems to a tissue viability nurse for assessment when required. Staff worked with external health and social care

agencies to ensure people received the care, treatment and support they needed. Guidance and recommendations from healthcare professionals was followed. For example, for a person living with epilepsy there was a care plan on how to meet their care needs. The information was in keeping with good practice guidelines. For another person, who received nutrition and medicines via a tube into their stomach, their care plan gave clear instructions on how to meet their needs. We observed a nurse administering medicines via the tube and saw that the care plans were followed.

We found that some records relating to people's specific health and care needs were not always fully completed or in line with best practice guidance. For example, although photographs were taken of pressure ulcers, these were not always dated or have measurements included. This full information is necessary to accurately identify if the wound is showing improvement or deteriorating. Some people had food or fluid charts in place to monitor their intake. These were not always being fully or appropriately completed. However, the management team had identified this issue and were addressing it. A nurse told us that the manager had spoken to staff about some of and the lack of adequate recording. The manager confirmed that they were meeting with staff later that week to discuss this further.

The GP service visited for a weekly surgery and was called in if necessary. Staff confirmed that any concerns about a person's health were communicated to them during the handover between shifts and in daily notes. People's care plans included information about their healthcare needs and how to meet these. People's files contained details of medical appointments and the outcomes. One person told us, "I would tell them [staff] if I felt unwell. I see all of the health professionals." Another said, "I usually tell the carers if I am unwell and one of the doctors or nurses will come round." A third commented, "I would tell the carers if I was unwell. They take your temperature."

People were cared for by staff who received support and guidance to enable them to meet their assessed needs. Staff confirmed they received supervision (one-to-one meetings with a line manager to discuss work practice and any issues affecting people who used the service). One member of staff said, "I had supervision in February 2018. [Line manager] is very supportive. Another member of staff told us, "[Line manager] is a brilliant manager. They develop us."

People's needs were assessed before they started to use the service. Assessments considered issues in relation to equality and diversity, such as religion, ethnicity and sexuality. From the assessments, care plans were developed, outlining the areas of support people needed and how this should be carried out. Information was obtained from other care professionals, social workers, relatives and as far as possible, the person. A relative told us, "When [family member] first came in there was a care plan set up. I was involved in this, explaining their childhood, what they liked and disliked, what their interests were, their life story etc."

The Mental Capacity Act (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.

Staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training and understood the importance of seeking consent when supporting people. One person told us, "Yes they do ask before they

help me. For example, to come in or wash me or to change me." For people with DoLS in place these had been agreed, by the relevant supervisory body. The manager was aware of when to make a referral to the supervisory body in order to obtain a Deprivation of Liberty Safeguard (DoLS). This meant that systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

People's human rights were protected. People who received their medicines without their knowing (covertly) were appropriately managed with best interest assessments completed and signed consents in place. The GP had been involved in the decisions and when appropriate relatives had been consulted.

People were provided with a choice of suitable nutritious food and drink and were happy with the food provided. People told us the food was nutritious and they had choices. Comments included, "The food is good and nutritious. Yes I get a choice, usually two choices," "The food is okay. If you wanted something they will get it for you" and, "Yes it is good and healthy food. We get a choice."

There was a menu for the day displayed on each floor and the chef was in the process of compiling a pictorial menu using photographs to help people make their choices. In one unit we saw staff take the two choices to people to enable them to make their choice.

The chef confirmed that most food was homemade and that the service was able to cater for a variety of dietary or religious needs. For example, diabetic, gluten free and Halal food. We saw that some people required a pureed diet and each food was pureed and served separately to enable them to enjoy the different tastes. For a person who was vegetarian we saw that vegetarian substitutes were provided. For people living with advanced dementia finger foods such as, chips, fish fingers, fish cakes, scampi and sandwiches were provided. Therefore, people were able to have meals that met their religious and health needs. However, we noted that although people's religious and health needs were met people's cultural preferences were not always met. For example, no African Caribbean or Indian meals were provided and there were some people from those cultures using the service. We recommend that catering arrangements be reviewed with a view to facilitating people receiving meals that meet their cultural preferences.

People were supported to be able to eat and drink sufficient amounts to meet their needs. Each unit had their own kitchenette where staff could prepare and provide sandwiches, biscuits or cereals for anyone at any time of the day or night. One person told us, "Yes I get enough to drink." We saw that there were drinks available in the lounge throughout the day and also available in people's rooms. Two choices of lunch were offered each day and people could have something different if they wished. When there were concerns about a person's weight or dietary intake, we saw that advice was sought from the relevant healthcare professionals such as a dietician.

At lunchtime we observed that staff gave people the support they needed. Some people ate independently and others needed assistance from staff. People were not hurried and staff gently encouraged people to eat. For example, we heard a member of staff ask a person if they had finished their meal. They said no and the staff replied that was okay and that the person should take their time.

People chose whether to have their meals in their room or the dining or lounge area. One person who had eaten in their room told us, "I have had lunch and I am quite happy to eat in my room. My TV is the attraction."

The environment met people's needs but further work was needed to make the environment more homely and dementia friendly. There was a lift and the building was accessible for those with mobility difficulties. There were adapted baths and showers and specialised equipment such as hoists were available and used

when needed. Since the last inspection some improvements had been made to the building including decorating, furniture, carpets and curtains. The regional manager told us that part of the improvements would be to make the environment more dementia friendly and the small kitchenettes in each unit were going to be refurbished shortly after the inspection.

Good

Our findings

People told us staff were kind and caring. One person said, "The staff are caring. For example, this morning the carer who was on night shift searched and brought to my bedroom some of my favourite biscuits when I asked." Another told us, "The staff treat me well. They are very attentive. They ask what your needs are and if there is anything you want. A carer just brought me the phone so I could talk to my [relative] in private in my bedroom." We saw that staff supported people in a kind and gentle manner and responded to them in a friendly and patient way. They took time to reassure people and explain things so they knew what was happening.

People's cultural and religious needs were identified and respected. To support those who wished to follow their faith a visiting church service took place. One person told us, "We have a fully trained preacher who comes in." Another person said, "I don't mind any religious service. There is no difference to me. Every Saturday there is a service and I get them to take me in the wheelchair." Staff were aware of equality and diversity issues and told us they would treat people equally regardless of race, gender, sexual status or sexuality.

People's privacy and dignity were maintained. One person said, "Yes they respect my privacy and dignity, for example they knock before they come in." Another person told us, "They respect and understand that I only want female carers to help with my personal care." Staff said they respected people's privacy and dignity by knocking on doors before entering rooms. When supporting people with personal care staff ensured people were not too exposed and that doors and curtains were closed.

People were encouraged to remain as independent as possible and to do as much as they could for themselves. For example, at lunchtime we saw that a person was asked if they wanted help to eat or if they would do it on their own. The person responded, "I will give it a try." One person told us, "Yes they do support me to be independent. For example, I do clean my teeth and face myself." Another person said, "Yes they encourage me to be independent by asking if I need help with this and that. They look at what you can do and if you want help." A third person commented, "Of course they encourage me to be independent."

We saw that staff explained what they were about to do to support people and checked that it was okay for them to help. For example, a member of staff offered a person a serviette to wipe their face and asked if they wanted them to do it for them. The person replied, "Yes please."

People were provided with information and were involved in decisions about their care and about what was

happening at the service. One person told us, "[Previous manager] would come and explain why they wanted me do something. I did not want a photograph of my face blasted on the door and they did respect that." One relative told us, "I find that the staff are very friendly and follow things through. They keep in touch and they do ring me back. They do what they say."

People were supported to maintain contact with family and friends. Relatives told us they could visit when they wanted and were made to feel welcome. They were invited to social events held at the service and some relatives had lunch with their family member.

Systems were in place to ensure that people and their relatives knew what was happening at the service and why. Residents and relatives' meetings had taken place. The new manager had held a relatives meeting to update people about management changes and to talk about the service. One person told us, "Yes I go to the residents meeting. If there is anything not right they put it right."

People's confidentiality was maintained. Their personal information was kept securely in a separate office on each unit.

Requires Improvement

Our findings

At the last inspection in February 2017, we found the lack of consistent and specific information about people's needs placed them at risk of not receiving the care they required and wanted. Whilst care plans contained varying degrees of information about individual backgrounds and preferences, they were not always sufficiently personalised or detailed. At this inspection we found care plans had improved, were more detailed, had been reviewed and updated. Some changes were still needed for clarity and to highlight important areas and support consistent practice. The management team audited care plans and ongoing care plan development was part of the service improvement plan.

People's care plans were reviewed each month and updated when needed. A person and their relative told us they felt fully involved in their care and care plan. The relative said, "Fairly recently they sat down with us and reviewed the care plan. There were a lot of mistakes in it, which I corrected 6 months ago. Generally they have it 80% right. I made alterations."

Staff knew the people they cared for. For example, a member of staff was going to support a person in their room with lunch. They said the person did not like vegetables and liked their food extra hot and this was sorted out. People told us staff were aware of their needs and preferences. One person said, "I think the staff do know and understand my needs." Another commented, "Yes I feel the staff do know and understand my needs. I have not had any problems."

People were encouraged to make choices about what they did and how they were cared for. For example, their food, clothing and where they spent their time. One person told us, "Yes we do get choices you can just call them and ask them to put you to bed. You can watch the TV as long as you don't disturb anyone." Another said, "Yes you do get choices, you can more or less do what you want. For example, getting up and bed time."

Activities were provided and two activity workers were in post to support this. We saw photographs of activities and celebrations displayed around the service. However, feedback about activities was mixed with some people saying that there were enough activities and others saying there were not.

There was an activities timetable in place. We noted that the timetable stated that on the first day of the inspection bingo was scheduled, which we did not see take place. One activity worker informed that us they did start the bingo but were unable to finish the game as they had to take a person to the dentist. We did not observe any activities taking place. However, some people told us about activities and said they enjoyed

them. They said they had played musical bingo during the afternoon. A person said, "The activities coordinator helps us make cards, about two or three of us joined in this morning on this floor. They had events in here for Valentine's Day and for the Chinese New Year. A couple of weeks ago I went upstairs for a singsong. Sometimes they [staff] come and sit with me. I get my nails done and my arms massaged." Another person said, "I like a quiz. If a word reminds you of a song we all join in and sing along." A third said, "Occasionally I join in the activities mainly sit and talk about the old times or watch an old film but I am not a very sociable person. A relative said, "[Activity worker] works very hard at trying to involve [family member].

We saw that some trips were organised. For example, to local shopping centres for Christmas shopping and visits to the seaside. Fundraising events were held such as afternoon teas and Christmas and summer fete. During the summer fete, there was a barbecue, drinks and entertainment. An activity worker told us some one-to-one activities took place. For example, pampering or reading books to people in their rooms. There was also a 'resident' of the day where an activity worker goes round on a rota to spend one to one time with a specific individual.

However, some staff and other people felt that there were not sufficient activities. One person told us, "I do get bored, sometimes the carer stays but it depends on how busy they are." A member of staff said, "There are not enough activities. Residents are lonely and bored. Us spending 15 minutes with them would make all the difference." Same staff also felt that the lack of activity and boredom contributed to people displaying behaviours that challenge. We discussed this with the management team who will look at activities as part of the overall plans to improve the service provided.

The management team were aware of the need to provide accessible information that met people's different needs. Action in this area formed part of the overall service improvement plan and the regional manager told us that this was an area that would be addressed as part of service development.

The service provided care and support to people at the end of their life and to their families. This was in conjunction with the local hospice and the GP. The service had made links with the local end of life care coordinator and they had visited the service to advise and assist on practice issues. A relative of a person receiving end of life care told us, "They [staff] have been so kind and look after [family member] well.

People used a service where their concerns or complaints were listened to. The service's complaints procedure was displayed on notice boards in communal areas. A record was kept of any complaints and what had been done in response to these. We saw that there were two recorded complaints for 2018. Both had been investigated and a written response sent to the complainant. People knew how and who to complain to and told us they would raise any complaints they had. One person said, "Yes they do listen. I would complain if there was something really bad but I have no reason to complain at the moment. I haven't made a complaint before either." Another told us, "I have no complaint. I am happy to raise one. If there was anything wrong I would talk to [relative]. We would tell the sister and they would see to it." A relative indicated that they had not always felt happy to complain but added, "Now I feel confident to make a complaint."

Requires Improvement

Our findings

At the last inspection on 22 and 23 February 2017, we found two breaches of regulations. At this inspection we found one of the breaches had been met but other issues and two further breaches were identified. Further work was needed to ensure that legal requirements were met and that people received a good quality service in all areas. Therefore, the provider had not adequately assessed, monitored and improved the quality and safety of the services provided.

Therefore there remains a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager. The new manager came into post in February 2018 and was previously the deputy manager of the service and this provided some management continuity and allowed for a handover from the previous manager. The new manager had started the process for registration with CQC. A new deputy manager had been recruited and had also been in post since February 2018.

We met with the new regional director who explained the organisational changes made to strengthen the management and governance of this and the providers other services. The post of regional director had been created and filled in December 2017. This was in addition to the regional manager. The regional director was also the nominated individual for eight of the provider's services and was only taking responsibility for these services as opposed to all of the provider's services.

New quality assurance tools had been introduced from 1 January 2018. The manager was required to complete a weekly risk management return. This included information about falls, safeguarding, pressure ulcers, complaints and the environment. We saw that the regional director had responded to the most recent return with points requiring action or asking for clarification. In addition, there was a system of monthly audits including infection, control, medicines and care plans. There was a service action plan in place to address the shortfalls and the regional manager and director monitored this. A relative told us, "Yesterday we had a talk with [staff member]. We had a good chat and sorted everything out. They are trying to help now."

The regional director, regional manager, manager and deputy were all open and honest about the issues and were clear about what they needed to do to rectify the situation. Some staff had raised issues about staffing levels and were concerned that this had not been addressed. However, relatives and staff were positive about the new manager and deputy and their commitment to improve services. As part of the

monitoring the manager and deputy manager had identified that accident and incident forms were not always comprehensively completed. They had therefore put additional prompts on the form to support staff with this. Some of the issues we fed back at the end of the first day were dealt with straightaway. For example, additions to a diabetes care plan and dealing with the medicines issue.

There were clear management and reporting structures. There was a manager in overall charge of the service. In addition to care staff and nurses, there was a deputy manager, unit leaders and senior care staff. People and their relatives were positive about the new management team. One relative told us, "We are very happy with the new manager they are approachable and polite. I go to the meetings and I feel I can speak freely now and they do listen. Things have much improved in the last month, the management in particular and there is a different atmosphere." Another relative said, "The new manager is a nice person, more caring and interested." One person said, "The new deputy manager is very nice and talkative. You can ask them anything. They are very approachable. They have been here for two weeks. Every morning they walk round and shake hands with you." Another person told us, "Since the new management are in place it has improved, they are keeping their finger on the pulse."

The management team monitored the service on a daily basis by means of a 'manager's walk round', observational checks, discussions with people and their relatives and a system of audits. One person told us, "The manager comes to ask me if we are all right. The manager is very nice and makes sure everybody is happy and there is plenty of food and drink. My family are also very happy with the service I get and the management."

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not adequately assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) and (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively. Not all of the necessary recruitment checks were undertaken.19 (2) & (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels and deployment were not sufficient to effectively meet people's needs and staff training was not always up to date. Regulation 18 (1)(2)(a)