

# Kingsley Care Homes Limited

## Branksome Heights

### Inspection report

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18 January 2018

06 February 2018

07 February 2018

09 February 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?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

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

Branksome Heights was registered for 46 people. There were 31 older people living in the home at the start of our inspection. People had a variety of care and support needs related to their physical and mental health.

This unannounced inspection took place on the 18 January and the 6 February 2018. We made further calls to gather evidence on the 7 and 9 February 2018. This was our first inspection of the service.

There was a registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service and had applied to deregister at the time of our inspection. A new manager had been appointed.

People told us they saw health care professionals when necessary. However, people's needs related to their healthcare and health emergencies were not always shared and recorded. This put people at risk of not receiving the treatment they needed. People did not always receive their medicines as they were prescribed. The provider put robust plans into action to respond to these concerns.

Staff encouraged people to make decisions about their lives. However care plans did not always reflected that care was being delivered within the framework of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been applied for when necessary. People were at risk of receiving care that was not in their best interests or was overly restrictive. The provider started a review of all relevant care plans during our inspection.

Quality assurance systems had not been effective in identifying the issues identified during our inspection. Auditing processes were updated to ensure they would be more effective.

People and relatives felt that they were listened to and their views were considered and acted upon.

The environment was clean and well maintained. We have made a recommendation about reflecting research around environmental support for people living with dementia.

People told us they received the care and support they needed. They felt safe. They were protected from harm because staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected the person's preferences. Staff also knew how to identify and respond to abuse and told us

they would whistleblow if it was necessary.

Everyone described the food as good and there were systems in place to ensure people had enough to eat and drink. We have made a recommendation about ensuring staff understanding of people's needs is consistent.

Care staff were consistent in their knowledge of people's on going care needs and spoke confidently about the support people needed to meet these needs. They told us they felt supported in their roles and had taken training that provided them with the necessary knowledge and skills. There was a plan in place to ensure staff received refresher training as deemed necessary by the provider.

People had support and care when they needed it from staff who had been safely recruited.

People were engaged with activities that reflected their preferences, including individual and group activities. There were plans in place and training scheduled to develop the activities available to people.

People were positive about the care they received from the home and told us the staff were kind. Staff were cheerful and treated people and visitors with respect and kindness throughout our inspection. Records were sometimes written in language that did not respect people. We have made a recommendation about this.

There were breaches of regulation with respect of safe care and treatment and the application of the Mental Capacity Act 2005 and the governance of the service. 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?

The service was not always safe. People did not always receive their medicines as prescribed and information sharing about medicines and treatment was not safe. The provider developed a robust action plan to address this. People felt safe and there were enough staff to meet their needs. People were supported by staff who understood the risks they faced and spoke competently about how they reduced these risks.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective. Staff did not always provide care within the framework of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately. This was addressed during our inspection. Health professionals were not confident that communication about people's health needs was effective. People who were able to consent to their care had done so and told us they directed the care they received. People's needs had been assessed and they were cared for by staff who understood these needs. People had the food and drink they needed.

**Requires Improvement** ●

### Is the service caring?

The service was caring. People received compassionate and kind care from staff. Whilst some written records were not respectful, staff communicated with people in a friendly and warm manner. Staff developed relationships with people and took the time to get to know them individually. They treated all people, visitors and colleagues with dignity and respect. People and their relatives were listened to and felt involved in making decisions about their day to day care.

**Good** ●

### Is the service responsive?

The service was responsive. People, and relatives, were confident they were listened to and knew how to complain if they felt it necessary. People enjoyed a range of activities and this was being developed. People were cared for with compassion at the end of their lives.

**Good** ●

### Is the service well-led?

**Requires Improvement** ●

The service had been through a period of unsettled leadership. A new manager had been appointed. People, relatives and staff had confidence in the management and spoke highly of the support they received. There were systems in place to monitor and improve quality including seeking the views of people and relatives. These had not been effective in highlighting the concerns identified during our inspection.

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# Branksome Heights

## 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 inspection took place on the 18 January and the 6 February 2018 and was unannounced. We made further calls to gather evidence on the 7 and 9 February 2018. The inspection team was made up of one inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. The provider had submitted a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

During our inspection we observed care practices, spoke with 11 people living in the home, two relatives, 10 members of staff, the manager overseeing the service and the provider's operations manager. We also looked at records, including medicines administration records, related to 15 people's care, and reviewed records relating to the running of the service. This included three staff records, quality monitoring audits and accident and incident records. Following the inspection we asked the registered manager to send us information about the safe administration of medicines, end of life care and some management information. We received this information as agreed.

We also spoke with four healthcare professionals who had worked with the service.

# Is the service safe?

## Our findings

People told us they felt safe and relatives also shared this view. One person told us: "All the staff are good. It is safe." A relative reflected on how the staff had ensured their loved one was safe: "They have given thought to (their) visual impairment... I feel (they) are safe, very well looked after." People described what made them feel safe. They told us the staff were nice and came when they needed them. Some people could not communicate with words about their experience of care. They were relaxed around staff. This was evidence of their comfort and ease.

There were a range of policies in place to support good safeguarding practice. The procedures reflected current legislation and contained the latest contact details for local safeguarding teams. Staff had all received training in how to follow the safeguarding process and were able to describe how they would report suspected abuse. They were confident concerns would be taken seriously by managers. One member of staff told us: "If I noticed changes in a person's behaviour I would talk with senior staff. I would also contact safeguarding or the local authority if necessary." The safeguarding policy identified people's right to an independent advocate to support them through the safeguarding process if this was appropriate and was clear that people would be supported to access this service.

People were supported by staff who understood the ongoing risks they faced. Staff described the risks people faced and the measures that were in place to mitigate these risks. Risk assessments were in place for each person. These assessments reflected individual need such as those associated with: people's mental and physical health; eating and drinking safely; skin damage and falls. Staff described how they supported people to reduce these risks, for example, some people who were at risk of falling used alarmed mats to alert staff if they were moving. One person was at risk of not eating and drinking enough and they were regularly offered high calorie foods and drinks they enjoyed.

Equipment owned or used by the registered provider, such as specialist beds and hoists, were suitably maintained. Effective systems were in place to ensure equipment was regularly serviced and repaired as necessary.

There were enough staff on duty to meet people's needs. People told us that staff were sometimes busy and we saw this was the case. However, some staff had time to sit and chat with people and did so throughout our visits. Staffing levels were determined with a dependency tool that reflected the support people needed. The service also employed cleaning, kitchen, and maintenance staff to help ensure the service ran effectively. These staff received appropriate training, were actively involved with people living in the home and worked effectively with the care team.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. Staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check. People were kept informed of recruitment within the home.

Staff received effective training in safety systems, processes and practices such as in moving and handling, fire safety and infection control. Staff were clear on their responsibilities to ensure infection control was effectively managed and we saw they used appropriate protective clothing when supporting people with personal care or cleaning. People's rooms and communal areas were cleaned throughout our inspection.

Medicines administration was not effective or safe and that this had resulted in people not receiving appropriate pain relief. The registered provider had a policy regarding the operation of the medicines system based on current legislation. This policy covered the administration of covert medicines (medicines hidden in food and drink) and self-medication. This policy was not being adhered to at the time of our inspection. One person was recorded as being offered but not wanting paracetamol. We found they did not have paracetamol in stock. Senior staff told us they did not like take tablets; however, when this medicine was made available after our first visit the person chose to take paracetamol most days. We checked their Medicine Administration Records (MAR) and found that they had not had this medicine available during one month. This meant they may have been in pain when they did not have paracetamol available. Another person who experienced pain daily was not receiving their paracetamol as prescribed. We raised this on our first visit and found that it remained the case on our second visit. This person was not being given all the pain relief available to them, including a topical gel, and they complained of pain regularly. There was no guidance in place describing when the topical gel should be offered and administered and this was also the case for two other people prescribed this medicine.

There was not a personalised approach to people's medicines administration. Ineffective use of pain relief had not always been picked up and addressed with medical professionals. Where advice had been sought the guidance received was not always followed, as in the case of the person not receiving their paracetamol as prescribed. MAR records recorded pain relief only at the times of the medicines rounds indicating that this was administered in a system-based manner rather than as a response to individual need.

Medicines have a shelf life during which they are safe and effective to take. We found that four people had open medicines where the date of opening had not been recorded. This meant it was not possible to tell when the medicines would expire and people were at risk of taking unsafe and ineffective medicine.

Some people took medicines that required stricter controls by law. These checks were not robust, and there was no guidance in place to ensure staff knew when to offer them appropriately. This raised the risks of errors in the management of these medicines.

Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored and within the acceptable range. The temperature of the room where medicines were stored was also monitored and was within the acceptable range.

Staff responsible for the administration of medicines had undertaken training and had their competency assessed. This had not, however, resulted in appropriate medicines administration for people. We saw an example of recording that did not reflect the medicines policy and put a person at risk of not receiving their newly prescribed dose. Staff had not identified the issues we raised either through their day to day medicines related tasks or through auditing systems.

We spoke with the manager and operations manager about our concerns and asked them to provide us with an action plan addressing them. They provided this information and put in place a robust oversight system for medicines.

Accident and incident reports were all reviewed and actions taken as necessary. These had included records



of medical assistance being sought for people. Communication and monitoring systems were not effective when people had required non routine or emergency medical input. Handover records and the care recording systems did not reflect this information and staff were not always aware of the information. For example a treatment had been advised by a GP to alleviate a person's symptoms. This was not recorded in the handover or on the person's care notes. One senior member of staff told us this advice was being followed. Another senior member of staff told us it wasn't being followed and a member of staff was not aware that it had been suggested or that the person had not been well. There were no records that people were offered regular pain relief after falls or injuries.

We spoke with the manager and operations manager about this and they put in place a daily recorded handover meeting attended by the manager.

People did not always receive their medicines as prescribed and people were at risk of not receiving safe care and treatment because staff did not record and communicate their needs.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us they were confident if they had concerns the manager and operations manager would listen and take suitable action.

# Is the service effective?

## Our findings

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 people lack mental capacity to take particular decisions, any decisions 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).

MCA assessments and best interests decisions were not always in place to determine the least restrictive way to provide people with the care and support they needed. Some assessments and best interests decisions were recorded for people, including specific decisions such as whether staff should administer their medicines and whether the use of bedrails was appropriate to reduce the risks a person faced. However, restrictive care practices had not always been considered by following this process. For example, a senior member of staff, and a member of care staff, told us that a person did not like the use of an alarmed mat. The senior member of staff told us they could get aggressive in response to its use. There was no MCA assessment about their capacity to consent to the use of the mat. There was no best interests decision indicating that the person did not have capacity and this was the least restrictive care available. We highlighted this with the manager and operations manager and they commenced a review of the application of the MCA for everyone living at Branksome Heights.

There were systems in place to check if people living at Branksome Heights had a Lasting Power of Attorney (LPA) for health and welfare arrangement in place. This means they would have appointed people to help them make decisions or make decisions on their behalf. The manager understood this process, however, where these arrangements were in place the LPA had not been asked to provide consent to care. The LPA was contacted before the end of our inspection in an effort to resolve this. They had previously been asked to contribute to a best interests process.

There was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in MCA and DoLS and demonstrated an understanding to the principle of gaining consent before they carried out personal care. They told us they checked with people before providing any care and explained what they were doing. We saw that people were offered choices such as where they wanted to sit at lunchtime and whether to get involved with activities. However, staff who updated care plans had not understood how to act within the law when a person did not have capacity to consent to their care. This meant that care was being provided without the framework of a best interests decision or the consent of a person who had the legal right to make decisions about a person's care. Care staff had not understood the implementation of DoLS and as a result had not flagged up when people were actively

requesting to leave.

DoLS applications had not been made where appropriate. For example, a person was regularly saying they did not wish to live in the home. Senior staff told us they did not have the capacity to make this decision for themselves and no DoLS had been applied for. We identified these concerns on the first day of our inspection. When we returned DoLS applications had been made for seven additional people. The person who had been saying they wanted to leave was going to go back to their home with support. Another person had had a DoLS authorisation that had a condition for the person to go out regularly and for this condition to be recorded in their care plan. This condition had not been met and the person told us they would "love to go out". We raised this with the manager and operations manager and the person had gone into town and had a fabulous time when we visited again.

There was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

In addition to the MCA training, records showed staff received comprehensive training which enabled them to carry out their roles. For example, care staff received training in first aid, fire safety, infection control, moving and handling and safeguarding. Staff told us they felt supported by their colleagues, the manager and the operations manager. They all commented on how accessible the management was. One member of staff reflected on the support of the whole staff team saying: "I am always able to ask questions. It is very supportive." Another member of staff commented: "I feel well supported." There was a system in place for staff to take part in regular supervision and appraisal sessions. This gave them an opportunity to discuss any concerns, highlight any training needs and discuss their career. We heard about training that had been identified in response to staff requests. For example, additional training on using the computerised records system had been identified by staff and this was scheduled. Staff had also received training on understanding challenging behaviour after requesting this.

The staff team was mostly made up of experienced staff who had worked in care work for a number of years prior to joining the newly established staff team. As new employees they had all completed a comprehensive induction programme prior to Branksome Heights opening in April 2017. Newer staff had also had the opportunity to undertake training and shadow staff. If staff needed to undertake the Care Certificate this was available but had not been necessary at the time of our inspection. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. The induction process supported staff to familiarise themselves with the organisation's approach to equality and diversity. Staff all spoke about the importance of learning about people and what mattered to them.

People were supported with their day to day health needs in conjunction with health care professionals. One person described the guidance they had received from the doctor since moving to the home. Relatives commented on how health issues they had been concerned about were addressed. Records showed that people had regular contact from a range of health professionals such as: nurses, GP's, physiotherapists and consultants. People's views, histories and lifestyles were respected as part of the support they received to maintain their health. Health care professionals raised concerns about communication difficulties between senior staff within the home leading to the care and treatment people received being less effective. They gave examples of staff not knowing people needed health input and information not being shared. We spoke with the manager about these concerns. The operations director sent us a plan that detailed that the newly appointed manager would seek to understand and address these concerns as a priority.

The physical environment was being used in a way that supported people to maintain relationships and

spend their time meaningfully. People used communal areas and their bedrooms and there were quiet places for people to meet with friends and family. The service was on four levels and there were working lifts in place. There was access to secure outdoor spaces where seating and planting provided a pleasant environment. Many of the people living at Branksome Heights were impacted by dementia, which had not been the expectation when the home was refurbished. We saw that people who moved independently found their way around the building however the decoration and use of space did not reflect current good practice regarding creating dementia friendly environments. For example, the colour scheme was neutral throughout which did not support people's orientation in the building. Toilets were not clearly differentiated making them harder to find than necessary. We spoke with the manager who explained that the home was still developing its environment to reflect the needs of people. A hair salon was being created whilst we visited.

We recommend the service plans environmental developments in line with research- based good practice guidance about supporting people with dementia through the environment.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs and enabled the service to determine whether or not they could meet those needs. The Equality, Diversity and Inclusion Policy made it clear that no one would be discriminated against and we were told that this applied during the admissions process. Staff described how each person was treated with respect. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. Admission assessments on people's files identified basic needs. These assessments were used to develop a care plan for the person. There were prompts in the care plan software that set out areas to cover and this promoted care planning in line with current legislation, standards and good practice guidance. For example, where people had a continence care plan there were prompts to undertake appropriate risk assessments and reflect on skin condition.

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was being explored. There was a call bell system which people could use to alert staff if they needed them. This system was being adapted to make the sound less intrusive. An electronic care planning system had been introduced that allowed for scheduled reviews to be monitored. This supported the staff in ensuring that care plans were kept up to date and relevant.

People were involved in decisions about what they ate and drank. They were mostly positive in their feedback about the food: One person said: "It was nice. I enjoyed my meal." Another person said: "The food is very good, there is a choice." Meals were spaced and flexible to meet people's needs. People chose where they ate their meals. We observed people at lunch and saw it was a relaxed and social occasion. People were able to take their time eating. Some people required assistance and this was done patiently and with kindness.

People were asked about what they liked to eat as part of their assessment process and this included any dietary, cultural or religious needs. A relative told us that staff had gone out of their way to encourage their loved one to eat. People fed back about the food frequently and were asked whether they enjoyed the food. The chef had attended the last residents meeting and taken feedback regarding the menu. If people changed their mind about their choice of food they were offered alternatives. Choices were offered verbally and menus were written with words. The chef explained they were working to introduce a pictorial menu to show people what the meal would be.

People were supported to have a balanced diet that supported their health and well-being. Some people had been identified as being at risk because they did not want to eat or drink enough to maintain their

health. Food and fluid charts were kept and people's intakes were monitored and their weight was regularly checked. We observed that a fluid tally for one person was not accurate as the amount recorded on the fluid chart was the amount given not the amount drunk. It is important that this information is accurate to ensure that people's intake can be monitored and action taken to address any emerging concerns. We heard that this did happen from a relative who was aware that staff had noted a decrease in the amount their loved one was drinking and this had led to them encouraging more drinks. Care plans contained guidance for staff on how to support people to eat enough and information about people's preferences. There were systems in place to ensure safe swallow plans drawn up by a speech therapist were followed but these were not implemented effectively. One person had a safe swallow plan in place and staff in the kitchen and care staff described their needs differently. The safe swallow plan was not kept where the person ate. This put them at risk of receiving the wrong food. We spoke with the manager and found the person was receiving their food as described in their safe swallow plan. We recommend you review your system for ensuring consistent understanding of people's nutritional needs.

The Food Standard Agency had awarded a top rating of five following an inspection in April 2017. This meant they had met standards of hygiene and safety.

# Is the service caring?

## Our findings

The service was caring. One person told us: "The staff are very good here." Feedback on the caring approach of the staff team was also positive from relatives. One relative told us: "The staff are lovely, I haven't met one who isn't. They go the extra mile." The relatives we spoke with said they could visit the service at any time and always felt welcome.

Staff all told us they enjoyed their work and enjoyed spending time with the people they supported. They were kind, compassionate and caring and spoke with enthusiasm for their work. They all expressed their motivation for their work being the people living in the home making comments such as: "The residents are lovely." They also spoke with respect for their colleagues, making comments such as: "They all care. You can see that in the way they work. It is not just a job."

Throughout our inspection there was a calm and welcoming atmosphere in the home. We observed all staff interacting with people in a caring, respectful and compassionate manner. For example, during meal times staff were patient and attentive as they supported people. They demonstrated a concern for people's well-being and were gentle when needed. One person was feeling sleepy and staff checked on them regularly with kindness and concern. Whilst attentive the staff also respected the person's space and how they liked to be supported. This respectful approach was not always evident in care records, where we saw people referred to as "demanding" and "compliant". The language used to describe people and their experience of their day is important as it reinforces how they are seen and expected to behave. We recommend you review your processes for promoting a culture of respect.

People were encouraged to use all the communal areas in the main house. People using the communal lounge were relaxed and comfortable in each other's company. Staff took time throughout the day to sit and talk with people in the lounges and visiting people in their rooms. Some conversations were light hearted and familiar and this was appreciated. One person engaged in regular conversation with staff about issues they had found interesting. They offered suggestions to staff based on their research, which were warmly and respectfully received. The whole staff team worked in this way and we heard how people had formed bonds with members of non-care staff due to their attentiveness and care.

We spoke with staff about people who could no longer communicate easily with words due to the impact of dementia and they described how a combination of their facial expressions, movements they made and noises communicated how they felt and what they might need. One member of staff reflected on this acknowledging: "Sometimes you are not sure ...you look for involvement. It can be hard." Staff knew people well. Relatives of people with dementia commented on the staff's ability to support their loved ones. One relative told us that this was because "they find out what (person) likes and what works."

People and their relatives told us staff respected people's privacy and dignity. Staff knocked on people's doors before entering and did not share personal information about people inappropriately during our visits. A visiting health professional informed us this was not always the case; we heard of an example where a person's personal information was spoken about in front of another person living in the home. Where

possessions were important to people, their bedrooms were personalised with belongings, such as furniture, photographs and ornaments. People were encouraged to make decisions about their appearances, for example what they wished to wear. People appeared well cared for and staff supported them with their personal appearance.

Staff supported people to maintain their independence and the impact of this support was evident throughout our inspection. For example, people were calmly and patiently supported with their mobility. Staff were not rushed and could describe what parts of daily life people could undertake themselves.

We heard about support for people's personal relationships. Valentine's Day was approaching and people were being supported to make cards for their loved ones. Private dining was being planned for some couples. We discussed with the operations manager the extent to which people were supported to retain autonomy and dignity in their personal lives. They identified that expression of sexuality had largely been addressed at assessment in terms of how people wished to receive their personal care as opposed to expression of their human rights. They explained the provider's policies required staff to work in ways that respected people's human rights and promoted equality and that staff had all received training on this.

People's cultural and spiritual needs were identified at assessment and informed their care and support. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms including time spent in privacy and communal rooms. Work was being done to ensure staff had access to information about people's histories and the people who mattered to them. This information was used to support people's established relationships and to help staff develop relationships with people.

## Is the service responsive?

### Our findings

Staff described people's needs without judgement and emphasised people's individuality in all their discussion with us. Care plans had been reviewed and covered a range of areas including mobility, communication and nutrition and hydration. They were individualised with some information about people's likes and dislikes and referred to people who were important in people's lives. Care plans and records were not reflective of all current information and we saw that guidance from other professionals was not added in a timely manner. There was a risk that people would not receive safe care and treatment as a result of this. Staff were aware of each individual's care plan however they told us they learned about people's needs from colleagues. This increased the risk that people would not receive appropriate care and treatment. We spoke with the manager and operations manager about the detail of some aspects of care plans. They highlighted that staff were getting training in how to use the computerised system and also told us they would be introducing a daily handover meeting to ensure information was shared effectively.

Where care plans had been updated the reasons for the change were recorded. This meant it was possible to monitor people's changing needs.

There was ongoing work to ensure that people had meaningful things to do with their time. The manager had acknowledged that activities had not always been happening as planned and committed to this changing. An activity co-ordinator supported group and one to one activities. They explained that they were attending the OOMPH training in March 2018 and the operations manager reinforced the provider's commitment to this approach to promoting people's wellbeing by providing activities that help people stay connected, and promote physical and emotional health. People had made suggestions about activities at a residents' meeting in early January 2018. Their suggestion to buy more board games and activities was being actioned. People were involved in a range of activities that reflected current events. These included baking, craft, and entertainers, and trips out were scheduled. An interactive theatre company had been a big hit with everyone. We saw people enjoying activities during our visits. The garden was an accessible part of people's lives and we heard from one person who particularly valued this space. A bench had been requested by people living in the home and one person had decided to buy this for everyone. They were choosing the style of the bench when we visited. Events were also organised to celebrate important events in people's lives, and the lives of those they cared about.

Any communication needs were identified at assessment before people moved into the service. These were recorded in the care plan so staff had information about people's needs. The care plans were updated to reflect changes and new information. One person was blind and their relative told us that staff made sure they explained everything verbally to enable their loved one to make informed decisions.

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint and felt any concerns raised would be dealt with to their satisfaction. Complaints had been addressed in a transparent manner and within the timescales laid out in the provider's policy. Where learning needs were identified it was clear that this had been acted on with individual staff members.



Information was gathered to enable the staff to care for people in ways that met their wishes at the end of their lives. When appropriate the service consulted with the person and their representatives about the development and review of this care plan. We heard about the systems in place to ensure that people and their loved ones were supported at the end of their lives. This had included staff being available throughout and bowing their heads and wishing 'goodnight' to the person as they left the building.

## Is the service well-led?

### Our findings

The home had been through a period of unsettled leadership since registering with CQC in February 2017. The second registered manager had left the service in December 2017 and had applied to deregister with CQC at the time of our inspection. A new manager had been appointed and they were scheduled to join the team in February 2018. People had been kept informed about all the leadership changes and these updates were recorded in residents' meeting minutes. In the absence of the registered manager the provider was maintaining oversight: The registered manager from one of the provider's other homes was managing the service in conjunction with the operations manager. Whilst this oversight had not been effective in identifying the issues highlighted during our inspection, the staff were unanimously positive about the arrangements and told us they felt supported. One member of staff said: "I feel supported practically with resources and to develop my knowledge and skills." Another member of staff commented on the accessibility of management saying: "The door is always open."

The manager and operations manager were visible within the service so were aware of day to day issues brought to their attention by staff. People reacted with familiarity to them and this was reciprocated. One person told us: "The managers are nice. You can talk to them." The senior management team spoke highly of the staff team and told us they were all motivated to do the best for people. The staff team was continuing to develop as more people moved into the home. Whilst it was a developing team the staff spoke highly of each other and were confident that everyone they worked with had people's best interests at heart. They told us they were part of a "good team" Relatives also spoke highly of the senior team, commenting on their availability and responsiveness.

The service had a clear management structure with senior staff working within the home and the manager reporting to their line manager from the provider organisation. Weaknesses in communication within this structure were highlighted and addressed during the inspection. The new manager implemented a planned handover meeting each day to ensure all senior staff were sharing information effectively. The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications, had been complied with.

The registered provider had a quality assurance process that included regular provider visits to the home. The manager and senior staff undertook audits. We found that these had not been effective in identifying the on going medicines errors, the use of disrespectful language in records, communication and recording errors regarding professional advice and the failure to act within the framework of the MCA. Actions were taken to improve the effectiveness of oversight, audits and checks during and immediately after our inspection. The operations manager provided us with a detailed plan including additional oversight by the new manager. We have not been able to check the sustainability of this oversight.

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

The approach to quality assurance included a survey and informal feedback from people. Relatives told us

they were able to comment on all aspects of the service with confidence.

Records were stored securely and there were systems in place to ensure data security breaches were minimised. Staff had individual log ons to access computer based records and rooms containing records were locked when not occupied by staff.

Staff spoke with pride about their own work and that of their colleagues in securing good outcomes for people. One member of staff described the changes in a person since they had been admitted and all staff told us about how much a trip out had been enjoyed.

The manager and operations manager were open in response to inspectors and we saw that they identified opportunities for learning and shared these with staff and relevant professionals. There was a culture of openness evident in their actions. Staff told us they would be confident to whistleblow if this was necessary. They were appreciative of the openness and availability of the managers to address any concerns.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>People's care and treatment was not always provided within the framework of the MCA.</p> <p>Regulation 11 (1) (3) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People did not always receive their medicines as prescribed and people were at risk of not receiving safe care and treatment because staff did not record and communicate their needs.</p> <p>There was a breach of Regulation 12 (1) (2) (b) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Deprivation of Liberty Safeguards (DoLS) had not been applied for appropriately and the conditions of a DoLS had not been met.</p> <p>Regulation 13 (1) (5) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality assurance systems had not been effective in identifying the failure to ensure safe care and treatment to people.</p> <p>Regulation 17 (1) (2) (b)</p>