

Bondcare (Bromford) Limited

Bromford Lane Care Centre

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This was an unannounced inspection visit which took place on 08 and 09 August 2017. We last inspected this service on 29 May and 01 June 2015 where the service was meeting all of the regulations and rated as 'Good'.

Bromford Lane Care Centre currently provides nursing care and support for a maximum of 116 people. Accommodation is provided over three floors comprising five separate units. Two units catering for the needs of people living with dementia, nursing care. Units A and G catering for the requirements of people living with complex needs including alcohol/drug dependency and/or other mental health conditions. The home also provides short stay interim beds (EAB unit) for people discharged from hospital, who may require further assessment of their care and support needs before returning to their own home or another form of care placement. At the time of our inspection there were 111 people living at the home.

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

We saw that the management of the service was stable and that the provider had established management systems to assess and monitor the quality of the service provided. However, they were not always effective at identifying the issues we found at this inspection. For example, dependency tools used to assess staffing levels had not recognised the need to increase staff numbers on the nursing unit for the first day of our inspection visit. Medicine audits had not identified gaps in recording topical creams and protocols for some 'when required' medicines were not in place.

There was a dedicated activities team that provided opportunities to optimise people's social and stimulation requirements. However, there was mixed opinions on the effectiveness of those activities and whether people were being supported to maintain their individual hobbies and interests. People and most of their relatives were confident that if they had any concerns or complaints they would be listened to and matters addressed quickly. Although, some concerns discussed with us by relatives had not been recorded in the provider's complaint's process and this required some improvement.

The management team had a number of systems to gain feedback from people living at the home, relatives and visitors. This included resident/relative meetings, satisfaction questionnaires and regular reviews. People, most of their relatives, staff and visiting professionals told us the home was well organised and well-led.

People who lived at the home were kept safe. Staff were trained to identify signs of abuse and supported by the provider's processes to keep people safe. Potential risks to people had been identified and appropriate

measures had been put in place to reduce the risk of harm. People were supported by suitably trained staff that had been recruited safely. People received their medicines as prescribed.

Staff were trained and had the skills to meet people's needs. Staff received supervision and appraisals, providing them with appropriate support to carry out their roles. Staff treated people as individuals, offering them choices whenever they engaged with people. Staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible, where possible. Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making processes. Therefore, the provider had acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Food standards were to a good level. When we discussed the quality of meals with people and their relatives, they said the food was 'good'. The kitchen staff ensured there were effective processes in place to support people with their nutritional needs. People spoke positively about the choice of food available. Staff supported people to eat and drink to maintain their health and wellbeing in a caring way. People were supported to access health care professionals to ensure that their health care needs were continuously met.

People were supported by staff that were kind, caring and friendly and who treated people with respect. Staff supported people in a dignified way. People were supported by staff and a management team that encouraged them to maintain relationships that were important to them. People's health care needs were assessed and reviewed. Relatives told us the management team were good at keeping them informed about their family member's care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were kept safe from risk of harm because staff understood their responsibilities to keep people safe and where any risk was identified, appropriate actions were taken by staff.

People were supported by acceptable numbers of staff that were safely recruited.

People were supported to receive their medicines safely.

Is the service effective?

Good ●

The service was effective.

People received care from staff who were sufficiently trained and understood people's needs and preferences.

Staff sought people's consent before providing care and support. There were processes in place to ensure that decisions were made in people's best interest.

People were supported to maintain a healthy diet which promoted their wellbeing.

People were supported to access health care services when required because the provider recognised the importance of seeking advice from community health and social care professionals so that health and wellbeing was promoted and protected.

Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect by staff.

Staff were seen to be involved and motivated about the care they provided.

People were supported by staff that knew them well and knew

how people preferred to be supported.

Is the service responsive?

The service was not continually responsive.

Some people were involved in the planning of their care that was reviewed regularly, although the information contained with the plan was not always person centred.

People were supported to engage in activities they enjoyed but activities did not always cater for people living with dementia and could be more person centred.

Most people and their relatives were confident that any complaints would be listened to and acted upon quickly.

People received care from staff that showed they had an understanding of the care and support needs of the people which promoted their health and wellbeing.

Requires Improvement 

Is the service well-led?

The service was not continually well led.

Quality assurance processes were in place to monitor the service so people received a quality service but they required some improvement as they had not identified the issues found at this inspection.

People, relatives and staff said they were asked for their views on the delivery of care.

Staff told us they felt supported by the management team.

Requires Improvement 

Bromford Lane Care Centre

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 08 August 2017 with a second announced visit on the 09 August 2017. The inspection team consisted of five inspectors, two experts by experience and two specialist advisors on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisors were qualified nurses who had experience of working with older people living with dementia and/or mental health difficulties.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned within the required timescale. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people. We also contacted the local authority directly as well as the clinical commissioning services to request their views about the service provided to people at the home. We also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care. We had received a number of concerns from partner agencies that related to keeping people safe and from risk of avoidable harm. We looked into these concerns as part of our inspection.

As part of our inspection we spoke with 23 people, 18 relatives, three health and social care professionals,

the registered manager, two unit managers, a clinical lead, a regional manager and 13 care and domestic staff. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived at the home. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at records in relation to 23 people's care and 11 medication records to see how their care and treatment was planned and delivered. Other records looked at included three staff recruitment files to check staff were recruited safely. The provider's training records to check staff were suitably trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a quality service.

Is the service safe?

Our findings

People spoken with told us Bromford Lane Care Centre was a safe environment to live in. Comments made by people living at the home included, "I feel safe in my room," "I feel secure here," "I feel safe because I have the same staff look after me" and "I'm never scared here." Comments made by relatives we spoke with included, "[Person's name] is in the safest place for her and I have no concerns," "There are locks and key codes to keep the residents safe," and "[Person's name] is safe and well looked after." Although one visitor expressed their concern because the carpets had been replaced with wooden flooring and a number of people living at the home walked about in their socks. However, we noted that the socks people were wearing had a type of grip on the sole to reduce the risk of slipping. A health care professional explained and we saw that there was always a member of staff in the lounge areas, on all the units, to ensure people remained as safe as possible.

People were kept safe from the risk of abuse. Staff spoken with told us they had received safeguarding training and staff were clear on what their responsibilities were for reporting any suspicions of abuse. Comments made by staff included, "The people living at Bromford (Lane Care Centre) are safe, there's no issues about abuse, our working practices are observed by the managers and they give us feedback on where improvements can be made." "I've never seen any poor practice here but if I did I wouldn't hesitate in reporting it to the nurse on duty." Another staff member explained, "We know people very well and we could tell if something was wrong by the way they reacted to you; you know, if they pulled away or flinched when someone was close to them, then we'd know something wasn't right." The Provider's Information Return (PIR) stated that any allegations of abuse were reported to the appropriate authorities and addressed immediately. Records we looked at and conversations we had with social care professionals confirmed this to be the case.

Risks to people were assessed and measures were put in place for staff to follow in order to reduce the risk of harm to people. For example, we saw there were a number of people living at the home with complex health needs and who could exhibit behaviours that could potentially pose a risk to themselves and/or other people living at the home. We found that where there had been altercations between residents, the appropriate action had been taken and measures put in place to reduce the risk of reoccurrences. In one person's case, we saw a staff member sat talking to the person until they became less distressed. The person was then on 15 minute checks to ensure they remained settled and calm. There were also a number of people assessed as having a high risk of developing sore skin. We found there were safe systems in place that showed people had been regularly repositioned to alleviate pressure on their skin which had been documented. The risk assessments had been reviewed regularly and the care plans had been updated as peoples' needs changed.

We saw there was a fire risk assessment in place and fire drills took place at regular intervals. The home carried out weekly fire test checks on the fire alarm system, checking emergency lights, fire doors, fire extinguishers and exit routes. This helped to make sure the fire safety arrangements in place at the home were effective. The home was well maintained with current maintenance certificates in place for gas safety, the electrical installation, the passenger lift, mobility hoists, bath hoists, portable appliances, the fire alarm

system, emergency lighting and fire extinguishers. There were also personal emergency evacuation plans (PEEPs) in place which recorded the support each person would need to evacuate the home in an emergency. Staff spoken with knew what action to take in the event of an emergency, for example if there was a fire or if a person began to choke.

All the people spoken with who lived on Units A, G and those residing on the EAB unit told us there were sufficient numbers of staff on duty to support them. However, a number of relatives spoken with told us they did not think there were sufficient staff numbers on duty on some of the units. They told us staff were 'always running around' 'very busy' and 'don't have time to sit and chat'. We were told the provider did not use agency staff to provide cover for planned and unplanned absences and existing staff were requested to cover absences as over-time. We received mixed views from staff members when asked about the staffing levels of the home. Some staff told us they thought there was sufficient numbers of staff whilst other staff we spoke with explained they did not always want to work the additional hours and that more staff was required. We looked at how the staffing numbers were calculated and found the provider had a system in place (dependency tool) to assist them in working out how many staff were required to meet peoples' individual care needs. We discussed the comments we had been told with the registered manager and operations director who said they would review the staffing numbers and the way in which staff were deployed. Our observations on the days we were on site showed staff were very busy but generally responded to calls for assistance from people in a timely way.

Staff told us they had pre-employment checks completed before they started to work at the home. The provider had a recruitment process in place to make sure they recruited staff with the correct skills and experience. Three staff files we looked at showed all the pre-recruitment checks required by law were completed, including a Disclosure and Barring Service (DBS) check and references. The DBS check helps employers to make safer decisions when recruiting and reduces the risk of employing unsuitable people.

People were supported to take their medicines safely. People we spoke with told us they received their medicine as prescribed by their doctor. We saw that nurses stayed with people until they had taken their medicine and we saw some good examples of how staff followed best practice guidelines when people refused to take their medicine. For example one person who had refused their medicine was gently encouraged by the nurse, who explained what the medicine was for and how it would help the person. The comfort given by the nurse reassured the person and they took their medicine. We looked at 11 peoples medicine administration records (MAR) and saw that overall these had been completed accurately. Medicines coming into the home had been clearly recorded and stored safely. We found the provider's processes for managing people's medicines ensured staff administered medicines in a safe way.

Is the service effective?

Our findings

People living at the home, their relatives and health care professionals we spoke with were happy with the support they received from nursing and care staff at the home. Comments from people we spoke with across all units included, "The ladies [care staff] are lovely, they try their hardest and they work very hard." "The staff are all good, they look after me." "I am quite happy with the staff, they are available when I need them." Relatives we spoke with explained, "The staff are very professional." "They [staff] are all very good, really pleasant; mum's looked after beautifully."

The Provider's Information Return (PIR) stated the provider offered regular training and supervision to support staff in their role. Staff we spoke with all told us they were happy with the level of training they had received from the provider. One member of staff said, "Training is good, I have learnt a lot and we practice CPR twice a week." Another staff member told us, "I have had lots of training including moving and handling, safeguarding, health and safety." A third member of staff stated, "We've had loads of training, fire safety, food hygiene, safeguarding and training on pressure sores, we are just refreshing these now." Staff who had recently joined the home told us, "The induction was good covered lots of areas including use of the hoists, sliding sheets and I shadowed other care workers on their shifts." Another staff member explained, "I'm doing the care certificate at the moment, I've completed about five modules, it's nice to do ongoing training." The care certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care to people. Staff we spoke with also told us they had received staff supervision with on-going support available from the management team.

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 make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. We checked the provider was working within the principles of the MCA. Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. Comments included, "You have to give people time and if they don't want you to help, you leave them for a while and then go back and try again." "Even if they [people living at the home] can't tell you – you still ask them if it's ok to help them." We saw where people lacked mental capacity to make certain decisions for themselves mental capacity assessments had been completed. This ensured that people were supported in the least restrictive way and their rights were being protected. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw applications had been made to authorise restrictions on people's liberty in their best interests in order to keep them safe. This ensured the provider complied with the law and protected the rights of people living at the home.

The PIR stated that people were empowered and encouraged to make decisions for themselves and where this was not possible, decisions were made in the person's best interests. Staff spoken with understood the importance of seeking people's consent and offering them choice about the care they received. Staff

respected people's choices and people we spoke with confirmed they got to make choices about aspects of their care and support, for example, what time they got up, went to bed, when and where they ate, how they spent their time and what social activities they did.

Everyone we spoke with was complimentary about the food and people said, they were supported to maintain a healthy diet. Food that was pureed or soft was presented in an appetising way. Comments about the quality of the food from across the units included, "The food is beautiful." "The food is good." "I get the food I need." "The food is? quite good I eat everything they [staff] give me." Lunch time was overall a good experience, calm with good social interactions. People were given verbal choices and a choice of drink was offered with their meals. There were some menus with pictures, but this was not observed to be the case in all dining areas. People who required assistance were seen to be supported by staff in an effective way. People could choose to eat in their rooms or in the dining rooms and drinks and snacks were made available throughout the day.

People's nutritional needs were assessed regularly and there was information in people's care plans that detailed their nutritional preferences and needs. The care plans we looked at showed some people were at risk of losing weight and we found plans had been put in place to guide staff in how to support people to gain weight and prevent further weight loss. We found advice was sought from dieticians and catering staff would add additional calories to people's food. Additional support was also sought from speech and language therapists (SALT) where people had difficulty swallowing their food. Although we found for one person, who had been assessed as risk of choking, had refused to have thickener added to their drinks to increase its consistency and reduce the risk of choking. We discussed this matter with the registered manager and operations manager. Post site visit, the registered manager informed us that a new referral had now been submitted to the SALT team to reassess the person's needs in this area.

People we spoke with told us they were regularly seen by the doctor and health care professionals, with one person telling us, "If I need a doctor they [staff] get one, there's no problem." Another person said, "I've got a chiropodist coming to see me soon and I've been to the hairdresser, I like to look nice and they [staff] help me to do that." A visiting healthcare professional who visited the home every week to monitor peoples' health needs told us staff were always helpful and responded effectively to changes in peoples' needs. They continued to explain staff carried out advice given and were 'proactive' in referring people when necessary. The healthcare professional had no concerns about the home, enjoyed visiting and felt people were being well supported.

Is the service caring?

Our findings

People and relatives told us the staff were very caring, friendly and kind. Comments received from across the units included, "It's lovely here, the staff are wonderful and treat me very nicely indeed." "The staff are very caring and kind." "The staff help me." "I get the help I want, I just have to ask." Relatives we spoke with told us, "The care here is very good, the staff are lovely." "I can't tell you enough how the staff have helped [person's name], they are so patient and kind." "The care staff are lovely and they absolutely love [person's name], they always make sure [person's name] is happy and comfortable." We saw people were relaxed in the company of all the staff and staff were visible, sometimes seen sitting with people on a one to one basis, engaged in friendly conversation. We saw that staff treated people with kindness and empathy; they spoke to people in a sensitive, respectful and caring manner.

People we spoke with told us they felt involved in decisions about their care and support needs. One person said, "They [staff] will get my things out and say would you want this or that on." Another person said, "I'm independent, if I don't want something, they [staff] know that." Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. Care plans we looked at included some information about people's previous lives, their likes and dislikes and their individual preferences. This ensured staff were kept informed of any changes and people were supported to make their own decisions about their care and staff respected people's individual choices.

Information was available in the home about independent advocacy services and the registered manager explained one person was currently receiving this support. Advocates are people who are independent and support people to make known and communicate their views and wishes.

People we spoke with told us staff respected their privacy and dignity. One person said, "Yes, staff do respect my privacy", another person said, "The staff knock on my door." A relative told us, "Staff are very respectful." We saw some good practice from staff when they engaged with people. For example, we saw staff bending down to a person's eye level to ask them if they would like a drink, if they wanted their medicine. We also saw staff touching a person's hand or arm to ask if they were okay and staff were seen popping in and out of bedrooms to check on people. People chose to have their door open or closed and their privacy was respected. We saw staff used a privacy screen when assisting a person in a communal area to ensure their dignity and privacy was respected. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity.

People living at the home were supported by the provider to maintain relationships with family and friends. Relatives we spoke with confirmed there were no restrictions on visiting. A relative we spoke with told us "I am able to visit any time." There were separate rooms and areas for people to meet with their relatives in private.

Is the service responsive?

Our findings

Care plans we looked at had been regularly reviewed and were detailed in respect of the person's health and care needs. However, we found some plans did not contain the more pertinent information about people's life histories. For example, in one person's care plan we noted they were a Roman Catholic but there was no mention of whether or not the person was still practising or what they would want at end of life. Another example was a person not being referred to by their preferred name. Which according to the person's relative could cause some distress. This was also evident in some of the conversations we had with staff. For example, staff had good knowledge about people's clinical needs but were not always aware of the person's personal history, their likes and dislikes. The registered manager explained they had 'resident of the day' and this would be used as an opportunity for staff to share with each other the more individual information about people. Post site visit, the registered manager informed us they were to introduce 'All about me' and that this information would be placed in people's care plans and in all daily folders so staff would have access to more personalised details.

The home had a dedicated team of activities staff. On the first day of our visit, we saw a small group of people at the end of a 'washing up session' and we could see that people who participated had enjoyed it with one person telling us, "I enjoyed washing up." We saw there was a rota of the activities on display around the home. We saw the activities team would visit each unit throughout the day and it was clear they enjoyed their role. On the first day of our visit, the team had dressed in costumes and visited each unit where they sang songs with people. On the second day of our visit, one of the team had dressed up as Elvis and we could hear people joining in with the songs and could see they thoroughly enjoyed this. We saw in the main lounge areas, on all the units, there were people sitting, relaxing, watching the television, or listening to music or the radio. Some people were engaged in conversation with each other. However, there was a lack of materials in the lounge areas in the dementia and nursing units to help stimulate people living with dementia, such as books or pictures, or items that people could pick up and feel. Some people we spoke with told us they 'felt bored.' One person said, "There isn't enough activities, there are a lot of people living here." The registered manager informed us that following our site visits the provider had purchased 'prop boxes' containing different activities and 20 'dementia blankets' to ensure that people living with dementia had access to 'meaningful activities' in the lounge areas.

We also saw that a lot of the time staff spent completing their observations on the corridors, they were sat watching or completing records. Whilst we recognised that some staff engaged in some interactions with people, there were missed opportunities which could have been used for staff to engage with people more effectively. For example, by utilising this time to find out more about a person's life history could enable the other staff including activities staff to understand the person's hobbies and work history and support them to tailor activities to be more person centred.

We found that in the units specifically for people living with dementia and those that required nursing care, the physical environment could be improved. Although the provider had tried to enhance people's memories with period style pictures and some of the walls on the units were brightly coloured, we saw there was poor signage on toilet doors and some residents could not easily find the toilet and had to be guided.

There was no memory clock or individual materials for people to stop and touch. We noticed on some people's doors there was no clear name or identifiable material to help them find their way back to their rooms. However, there was effective adaptation to the inside of the front doors leading from the dementia units. The mirages on the doors had been successful in reducing anxieties in some people, who became upset when seeing the door and had then continually tried to open them. We saw an area on one of the units had been created as a 'seaside beach' effect, with sand, deckchairs, pictures of the local sea side resorts, where we were shown pictures of people relaxing with an ice cream. The registered provider informed us that following our site visits, all 116 en suite bathrooms have now got clear signage, dining rooms now have colourful signage, community toilets and bathrooms also have appropriate 'dementia friendly' signage.

Although we found, at the time of our visits, that staffing numbers for the dementia units were adequate, staff could have been more responsive to attend to individual personal needs. For example, we heard one person ask to go to the toilet, the staff member replied with "I can't take you yet, I'll have to get someone for you" then carried on offering drinks to people. The person asked again fifteen minutes later and was again told they would have to wait. We found the person was eventually supported to the toilet 50 minutes later.

People and relatives we spoke with were confident to raise any concerns or complaints and knew who to speak with if they were unhappy. Comments made from across the units included, "I have no complaints, I'm very happy here." "There are no complaints, it's all good." "If I had a problem or concern, I would complain to the manager." "If I complained to the nurse, they would help me." A social care professional explained, "The management here are excellent, they really respond very quickly to any problems or issues." There were some mixed responses from relatives we spoke with that included, "We've raised a number of issues with the manager but nothing seems to get done." "The manager is approachable and quick to deal with matters." We reviewed the complaints file which contained an up to date policy and found most complaints were acknowledged, investigated and resolved to the satisfaction of the complainant. The registered manager told us complaints and concerns were taken seriously and used as an opportunity to learn and improve the service. We spoke with the registered manager about some of the issues that had been raised with us. We noted that not all the concerns or conversations with people or their relatives had been recorded. We discussed with the registered manager the importance of recording all conversations with people and their family members and notes of any meetings to be signed by the family as this can demonstrate that the provider had taken every reasonable step to address any concerns and ensure there is an accurate record of events.

People and relatives told us they were able to visit the home before they moved in. This gave them the opportunity to view the home in its entirety. A relative told us, "We had been to so many homes and this is the only one that could meet my wife's needs, I don't know what I would do without them [staff at the home]." The registered manager told us that following the initial assessment, a care plan was developed detailing the care, treatment and support the person required. This ensured staff understood the personalised support needs people required. People and their relatives spoken with, confirmed they were involved in the assessment, planning and review of their care and told us they were happy with how their care needs were being met. One person we spoke with said, "Staff involve my family in any [care] review and keep them informed of any changes." A relative told us, "We're very involved with [person's name] care and get regular updates from the staff."

People had the opportunity to maintain their religious beliefs if they wished. For example, we were told that the provider arranged for religious services to be facilitated and people's cultural and religious needs were met. We also saw staff speaking to people in their preferred language which appeared to offer comfort and supported the communication between them and staff. Staff we spoke with and records we looked at

confirmed that staff had received training on respecting people's equality and diversity needs, which included people from the Lesbian, Gay, Bi-sexual and Transgender community (LGBT).

Is the service well-led?

Our findings

There was a registered manager in place and the conditions of registration were met. It is a legal requirement that organisations registered with the Care Quality Commission (CQC) notify us about certain events. We had been notified about significant events by the provider and we saw where safeguarding incidents, accidents and injuries had occurred appropriate treatment and observations had been put in place to ensure peoples' safety and no long term injuries had been sustained. However, we found there had been some inconsistencies in notifying us when applications had been agreed by the Supervisory Body to lawfully restrict people, in their best interests to keep them safe. The registered manager explained there had been significant delays in some applications being approved and this had impacted on the provider notifying us. On the day of our visit, the deputy manager reviewed their applications and submitted the relevant notifications to us. Further discussions with the registered and deputy managers demonstrated to us that they were aware of their legal responsibilities and what these meant for the service.

The Providers Information Return (PIR) explained how the provider had quality monitoring and audit processes in place to ensure the service was well-led. We saw, for example, that regular audits of care plans, peoples' medication, health and safety checks around the home were completed by the management team. Following the audit, an action plan, where appropriate, was developed that detailed how they would address any identified shortfalls. This demonstrated the provider had procedures in place to monitor the service to check the safety and wellbeing of people living at the home. However, the audits had not consistently identified some of the issues we found during our inspection visits. For example, dependency tools used to assess staffing levels had not recognised the need to increase staff number on the nursing unit for the first day of our inspection visit. The provider's systems to monitor fluid and nutritional needs for one person had not identified there was a requirement to make a referral to health care professionals to assess the person's ability to swallow.

Medication audits had not identified that topical creams charts were not consistently completed with gaps in entries and protocols for medicine required "as and when" were available for some medicines. Daily checks had not identified that one person's medicines had not been made available in a timely way. Systems to accurately record complaints to monitor for themes and trends so that action could be taken to mitigate the risk of a recurrence had not been consistently applied. Although we found mental capacity assessments and DoLS applications had been completed, there was evidence that some information had been 'cut and pasted' from other peoples' records. Throughout our inspection we found that the registered manager was receptive to feedback and had taken immediate action, during our inspection process, to address the issues we had identified. However, this was a reactive approach to issues that should have been identified and addressed through the provider's own quality monitoring processes. Care plans, although reviewed, had not always identified some of the more recent information had been consistently recorded throughout. For example, we saw incomplete 'Do Not Attempt to Resuscitate' documentation, the falls log was not consistently completed for one person we reviewed who had regular falls. We also found that care plans lacked detail with regards to people's life histories, interests and hobbies and other pertinent information such as their religious practices had been missed, all of which had gone undetected by the provider's quality assurance systems. Environmental audits had failed to recognise the shortfalls identified

during the inspection, such as the need to promote a more 'dementia friendly' environment, as well as a lack of specialist resources and activities for people living with dementia despite being a dementia registered service.

Although we saw evidence to show the provider had conducted surveys about the quality of the care and service delivered at the home, we could not see what had been identified as areas for improvement, how these areas were followed up and what was put in place to reduce risk of any reoccurrence. We saw that meetings had taken place but some people and relatives spoken with could not recall being involved or invited. The provider had also encouraged the use of public review websites for example, www.carehome.co.uk and www.healthwatchbirmingham.co.uk which gave the service a rating of five stars. Comments included, 'Excellent place, well kept, staff amazing, very clean and tidy.' 'A good care home with all staff showing kindness and compassion.' 'Staff very caring and helpful, couldn't ask for more.' 'Very good staff, very clean and the food is good.'

Feedback we received throughout the inspection process was mostly complimentary about the service. A relative told us, "I can't thank the staff enough for what they do for [person's name]". We saw that people approached the registered manager and she had a presence around the home, supporting staff and speaking with people and visitors. A staff member told us, "[Registered manager's name] is always about."

Staff told us they felt like a team and were committed to providing a personalised service to the people living in the home. Staff said the management team were knowledgeable and led by example. One staff member told us, "I do love my job, I have received so much support from [registered manager's name]." Another staff member said, "It is hard work, but I enjoy it."

Staff members we spoke with told us the management team were approachable and if they had concerns regarding the service, they could speak with them. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations for example, CQC. Staff told us they were aware of the provider's policy and would have no concerns about raising issues with the provider or registered and care home managers and if it became necessary, external agencies. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to a person's safety), wrong-doing or some form of illegality.

It is a legal requirement that the overall rating from our last inspection is displayed within the home. We found the provider had displayed their rating as required. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found the provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visits we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.