Bupa Care Homes (CFHCare) Limited

Old Gates Residential and Nursing Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection which took place on 1 and 7 July 2015. The service was last inspected in July 2014 when we found it to be in breach of three of the regulations we reviewed; these related to consent to care and treatment, the management of medicines and staffing levels in the service. Following the inspection in July 2014 the provider sent us an action plan telling us what they intended to do make the improvements needed. During this inspection we found the required improvements had not been made. You can see what action we told the provider to take at the back of the full version of the report.

Old Gates Residential and Nursing provides accommodation in three units, for up to 90 people who need either nursing or personal care and support. These

Summary of findings

units are Cherry, Holly and Rowan. Care and support for people living with a dementia is provided in Rowan. There were a total of 70 people using the service on the day of our inspection.

The service had a registered manager in place. 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 systems for managing medicines in the service needed to be improved to ensure that people always received their medicines as prescribed. Appropriate action had not been taken to ensure that, where people were unable to consent to take their medicines as prescribed, any decisions made were in line with the Mental Capacity Act (MCA) 2005. This meant there was a risk people's rights might not be upheld.

Although most staff told us they had completed training in the Mental Capacity Act, care records did not include information about the specific decisions people who used the service were able to make for themselves. Where people were unable to consent to their care and treatment in Old Gates, the legal requirement to ensure any restrictions were legally authorised had not always been adhered to.

Recruitment processes were sufficiently robust to help protect people who used the service from the risks of unsuitable staff. During the inspection people gave positive feedback about the caring nature of staff. However, people also told us there were not always enough staff on duty to provide the care people required. Relatives of people on Rowan unit also raised concerns about the skills and abilities of staff to deal with the needs of people who were living with a dementia. Two staff we spoke with who were deployed to work on Rowan unit confirmed they had not completed training in how best to support people living with a dementia. The registered manager told they would ensure all staff on Rowan unit received this training as a matter of urgency.

All the staff we spoke with during the inspection told us they had received training in safeguarding adults and were aware of the action they should take if they witnessed or suspected abuse. However, from our review of care records we noted a person who used the service had made an allegation of abuse which had not been reported by staff. This meant there was a risk people who used the service might not be adequately protected.

We saw there was a system in place to record the risks people might experience including those relating to falls, poor nutrition and skin integrity. However, we found it difficult to find the most recent assessments on the electronic care records as out of date assessments had not been archived. This meant there was a risk staff might not be aware of the most up to date information relating to people who used the service.

We saw there were risk assessments in place for the safety of the premises and the equipment used by staff. All areas of the home were clean and well maintained. Procedures were in place to prevent and control the spread of infection. Systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply to the premises.

There were systems in place to assess people's health and nutritional needs. However, we found a lack of communication in the service had led to one person not receiving the care and treatment they required in relation to their health care needs.

People who used the service told us staff were kind and always treated them with dignity and respect. This was confirmed by our observations during the inspection. Relatives told us staff would always support people who used the service to be as independent as possible.

Care records had not always been regularly reviewed and updated to ensure they accurately reflected people's needs. This meant there was a risk staff might not have access to the most up to date information about the care people required.

People told us there were not enough activities in place, particularly for those people living with a dementia. However, we noted the recent recruitment of two activity coordinators should help to ensure a range of activities were provided throughout the service.

There were some opportunities for people who used the service and their relatives to comment on the service provided. However, we found people were not routinely included in reviewing the care they received.

Summary of findings

We received conflicting opinions about the leadership in the service. All the people we spoke with who used the service and their relatives were aware of the manager responsible for the unit on which they or their relative lived and were confident to raise any issues with them. However some people were less sure about the identity of the registered manager and one person told us they did not always feel timely action had been taken to address any issues raised.

Most staff we spoke with told us they enjoyed working at Old Gates. However, other staff raised concerns about the culture in the service and told us they did not always feel that their views were listened to or respected.

There were a number of quality assurance measures in place in the service, including audits relating to care plans and medication records. However, these had not been sufficiently robust to identify the shortfalls we found during the inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Necessary Improvements had not been made to the way medicines were managed in the service

Staff were safely recruited. Our observations during the inspection showed there generally enough staff to meet people's needs. However people told us they considered there were not always enough staff on duty.

Staff told us they knew of the action to take to report any suspected abuse. However, records we looked at showed one recent alleged incident had not been brought to the attention of senior managers.

Risk assessments were in place in relation to people who used the service and the environment. Systems were in place to ensure equipment was safe for staff to use.

Is the service effective?

Requires improvement

The service was not effective.

Care records did not include information about the decisions people were able to make for themselves. Required improvements had not been made to ensure that people who used the service, or those acting lawfully on their behalf, had given consent before any care or treatment was provided.

People who used the service told us staff knew them well and provided the care they needed. However relatives of two people on Rowan unit did not have confidence that staff had the skills and abilities required to provide appropriate support to people living with a dementia.

Staff were provided with induction, training and supervision. However, not all staff on Rowan unit had received training in working with people living with a dementia or how best to support people whose behaviour might challenge others.

Communication in the service was not always effective in ensuring people's health needs were met.

Is the service caring?

Good

The service was caring.

People who used the service spoke positively of the kindness and caring attitude of the staff. They told us staff respected their dignity and privacy when they provided care.

Our observations showed staff responded discreetly to people's personal care needs.

Summary of findings

Staff supported people to be as independent as possible.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

Care records had not always been regularly reviewed and updated to ensure they accurately reflected people's needs.

People told us there were not enough activities in place, particularly for those people living with a dementia. However, we noted the recruitment of two activity coordinators should help to ensure a range of activities were provided throughout the service.

Improvements needed to be made to the way people who used the service and, where appropriate, their relatives were involved in reviewing the care provided in Old Gates.

Is the service well-led?

Requires improvement

Improvements needed to be made to the way the service was led. The service had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

Although most staff told us they enjoyed working in the service, other staff did not feel their views were always listened to. People we spoke with were confident that the unit managers would always listen to them. However one person told us they did not feel the registered manager always responded to concerns raised in a timely manner.

There were a number of quality assurance processes in place but these had not been sufficiently robust to identify some of the shortfalls we found during the inspection.

Old Gates Residential and Nursing 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 inspection took place on 1 and 7 July 2015. The first day of the inspection was unannounced. We told the provider we would be returning on 7 July to speak with the registered manager who was on leave on the first day of the inspection and to look at additional records.

The inspection team consisted of two adult social care inspectors, a specialist advisor in the care of people with a dementia 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. The expert had experience of residential and nursing care services.

We had not requested the provider 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. However, before the inspection we reviewed the information we held about the service including the last inspection report and notifications the provider had made to us. We contacted the local authority safeguarding team, the local quality assurance team and the local Healthwatch organisation to obtain their views about the service. We were told the quality assurance team was undertaking regular visits to the service to ensure required improvements were made following a number of safeguarding referrals.

We spoke with 11 people who used the service across all three units and eleven visiting relatives. We also spoke with a total of 12 staff. The staff we spoke with were two unit managers, two agency nurses and a nurse who was undertaking their first shadow shift at the service, four members of care staff, the clinical services manager and the area manager. On the second day of the inspection we spoke with the registered manager.

We carried out observations in the public areas of the service. We looked at the care records for 10 people who used the service and the records relating to the administration of medicines for 27 people who used the service.

In addition we looked at a range of records relating to how the service was managed; these included six staff personnel files, training records, quality assurance systems and policies and procedures.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with who used the service told us they felt safe in Old Gates. One person told us, "The staff make me feel safe; the place is very secure." Relatives we spoke with confirmed they had no concerns about the safety of their family members. Comments relatives made to us included, "I feel [my relative] is safe here. The staff are very good" and [My relative] is safe She likes to be locked in at night but if she wants the door open she can open it herself."

At our last inspection in July 2014 we found a breach of regulation in relation to the management of medicines in the service. This was because medication risk assessments were not always in place to provide staff with information as to what they should do if a person refused to take their medicines. Policies and procedures had not been followed to ensure appropriate safeguards were in place when medicines needed to be given in food or drink without the person's knowledge. On this inspection we found the required improvements had not been made.

During the inspection we asked staff about arrangements in place to ensure people received their medicines as prescribed. The clinical services manager told us there was one person on Rowan unit who received their medicines in food or drink as they were unable to consent to taking them. They told us a number of other people had their medicines administered in food or drink but this was with their agreement to ensure they were able to take their medicines safely.

When we checked the records relating to the administration of medicines on Rowan unit we found appropriate arrangements had been put in place to ensure that the decision to administer medicines covertly for one person was in their best interests.

We looked at the electronic record system in relation to the administration of medicines on Rowan Unit. We noted there had been a total of 22 occasions between 3rd and 30th June 2015 on which the medication administration records for had not been signed. These omissions related to the medication records of 10 people who used the service on Rowan unit; ten of these omissions had occurred at tea time on 30th June 2015. This meant we could not be certain people on this unit had always received their medicines as prescribed. When we raised this with the unit manager they spoke with the nurse who was on duty on the 30th June 2015. The nurse reported that they had given the medicines but had forgotten to sign the administration record to confirm this. We were told by the unit manager that reports relating to medication errors were easily available on the system but that there was no procedure in place to ensure that any omissions were thoroughly investigated and appropriate action taken to prevent any re-occurrence.

From the 10 care records we reviewed we noted there were a total of 44 occasions between 22 April and 4 July 2015 when it was recorded that some of the medicines prescribed to six people who used the service were out of stock. This meant there was a risk people's health might be put at risk because they had not received their prescribed medicines.

We noted the medication care plan for one person on Rowan unit was out of date and did not reflect the current prescription. This meant there would be a risk that staff would not be aware of the medicines the person required.

During our inspection on Holly unit we were informed by the nurse in charge that one person was being given their medicines in food or drink without their knowledge. We therefore checked this person's care records to see what information was available for staff to ensure the person always received their medicines as prescribed. We found there was no information in the care plan or risk assessments to support the fact that medicines were to be given covertly. We could not find any evidence that this decision had been discussed with other professionals or family members to ensure it was appropriate and in the person's best interests for medicines to be given covertly. We also found no evidence that the person's capacity to agree to take their medicines as prescribed had been assessed, This meant there was a risk the person's rights might not be upheld and that medicines might not be safely administered.

We asked the registered manager about systems in place to ensure the competence of staff to safely administer medicines was assessed on a regular basis. They told us they were in the process of rolling out a new competence assessment process with staff but that this had not yet been embedded in practice.

Requires improvement

Is the service safe?

The ongoing lack of robust systems to ensure the safe administration of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at six staff personnel files and saw a safe system of recruitment was in place. The recruitment system was robust enough to help protect people from being cared for by unsuitable staff. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, a job description and at least two professional references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

All the staff we spoke with told us they had received training in safeguarding adults. They were able to tell us of the correct procedure to follow should they witness or suspect abuse had occurred. However, on the second day of the inspection one of the care records we reviewed indicated a person who used the service had raised a potential safeguarding concern the previous night with a member of staff which had not been reported to the managers in the service. The manager told us this would be followed up and any required referral made to the local authority safeguarding team.

We found some staff were not confident about the whistleblowing (reporting poor practice) procedures in the service. Although we were aware that the organisation had a 'Speak Up' telephone line for staff to access and share any concerns and that information about this service was displayed throughout the service, two staff members we spoke with told us they were unaware of this facility. However they told us they would raise any concerns they might have with either the local authority safeguarding team or the Care Quality Commission. One member of staff told us they and many other colleagues had used the phone line to raise concerns regarding a change in their working hours and advised us, "not a single one of us received a response." This meant there was a risk staff would not feel confident that any concerns they might raise would be taken seriously.

The area manager told us that, as a result of a number of recent safeguarding concerns, the reporting of possible abuse and poor practice were now standing agenda items on the supervision agenda for each member of staff. One of the agency nurses we spoke with told us in their opinion the standard of care provided in Old Gates was very good and as a result they were confident that all the people who used the service were safe.

At our last inspection in July 2014 we found a breach of regulations in relation to staffing. This was because there were insufficient staff available on two of the units to meet people's needs.

Our observations during this inspection showed there were generally enough staff on duty on each of the units to meet people's needs in a timely manner. However, people we spoke with gave conflicting views about the availability of staff across all three units. Whilst most people we spoke with did not raise any concerns about staffing levels, three people across all three units commented, "The night time is the worst as there are not enough staff", "I have regular medication but it does not always come on time because there are not enough staff", "Staff do the best they can but they could do with a few more."

Two staff members on Rowan unit told us, "There isn't enough staff. We can't spend time with the residents; we only cover the basics" and "Sometimes there is not enough staff so I feel more under pressure. These two staff also told us they did not have the time to familiarise themselves with the care records of people who used the service. This mean there was a risk people would not be provided with the care they wanted and required.

Staff we spoke with on Holly and Cherry units told us they usually had time to spend with people during the day and did not feel rushed in meeting their needs. However, we noted at lunchtime on Holly unit that there were no staff available in the lounge area for a period of 15 minutes. We noted that during this period, as a result of the hot weather, a door leading on to a car park was left open. This meant there was a risk that people who used the service might attempt to leave the building unnoticed when they were not safe to do so and that members of the public were able to access the building without being observed by staff. This presented a potential risk to people who used the service, visitors and staff.

A visiting health professional to Holly unit told us they were concerned that they had been waiting to find staff for 10 minutes to discuss the care of a person who used the service.

Requires improvement

Is the service safe?

One staff member on Holly unit told us they had concerns that there were only two staff on duty at night which they considered was insufficient to meet the needs of people who used the service in a safe manner. This was because 12 of the 18 residents on the unit required the assistance of two staff when providing personal care. The staff member we spoke with told us that if the two night staff were engaged in providing personal care to an individual, there were no other staff members available to respond to requests for assistance from other people or to deal with any emergencies which might arise. We discussed this and our observations with the clinical services manager and area manager who agreed to review the staffing arrangements in the service.

The lack of sufficient numbers of staff to meet the needs of people who used the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was a system in place to review the risks people might experience including those relating to falls, poor nutrition and skin integrity. However, we found it difficult to find the most recent assessments on the electronic care records we reviewed as out of date assessments had not always been archived. This meant there was a risk staff might not be aware of the most up to date information relating to people who used the service.

We looked around all three units and saw the bedrooms, lounge/dining rooms, bathrooms and toilets were clean. We noted there were no unpleasant odours on either Holly or Cherry units, although we did notice a smell of urine in some areas of Rowan unit. None of the people we spoke with who used the service or their relatives raised any concerns about the cleanliness of the environment. One relative commented, “The home is very clean. They clean through, sometimes twice a day.”

From the records we reviewed we noted regular cleaning checks and infection control audits had taken place. We observed that staff used correct personal protective equipment when providing care or support to help prevent the spread of infection. During the inspection we also observed one member of care staff check the infection control policy to ensure they were acting correctly to manage a potential risk of infection.

We saw that policies and procedures were in place in relation to ensuring compliance with health and safety regulations. The records also showed that the equipment and services within the home were serviced and maintained in accordance with the manufacturers’ instructions.

We saw procedures were in place for dealing with any emergencies that could arise in the service, such as utility failures and other emergencies that could affect the provision of care.

Our review of records showed that a fire risk assessment was in place and regular fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order. Personal evacuation plans (PEEPS) had been completed for all people who used the service; these records should help to ensure people receive the support they require in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

At our last inspection in July 2014 we found a breach of regulations as the provider did not have suitable arrangements in place to gain and review consent from people who used services and take appropriate action should people lack the capacity to make their own decisions. This was because the capacity assessments completed with people who used the service were general and did not relate to the specific decisions people might need to make. On this inspection we found the required improvements had not been made.

Where they were able to express a view, people who used the service told us staff would always ask for their consent before any care was delivered. One person commented, "The staff always ask me first if they can do something**."**

We looked at the care records for 10 people and found that, although assessments of capacity had been completed on eight of these records, none of these contained information about the specific decisions for which each individual's capacity had been assessed. We also saw that the assessment of capacity on one person's records contained conflicting information about the person's ability to make their own decisions. The lack of appropriate recording meant there was a continued risk people's rights might not be upheld.

There were no capacity assessments in place on the records we reviewed for one person on Cherry unit. We were told by the unit manager that this was because the person had been admitted for respite care and capacity assessments were not normally completed until a person became a permanent resident. We also noted that the assessment for another person on Cherry unit stated that the person's capacity could be variable. We were told this person had needed a number of medical interventions. There was no evidence that their ability to consent to this treatment had been assessed. However, the clinical services manager told us the person had been involved in agreeing all decisions about the medical treatment they had received.

We discussed the continued lack of robust capacity assessments with the registered manager. They told us they had not fully understood from our last inspection the need to ensure the assessment tool used by staff met the requirements of the Mental Capacity Act 2005. They told us they intended to ensure the tool was adapted so that staff could record the specific decisions to which assessments of capacity related as soon as possible

We asked staff we spoke with about the training they had received regarding the MCA. Two of the staff on Rowan unit told us they had not received training in this legislation although they were able to tell us how they would support people who used the service to make their own decisions wherever possible or, if necessary, act in a person's best interests in accordance with the principles of the MCA. One staff member told us, "You need to know people's likes and dislikes. If people can't make a choice of meal for instance you make that decision for them based on what you know about their preferences." The two staff we spoke with on Cherry unit were able to demonstrate a good understanding of the MCA and how this impacted on the care and support they provided to people who used the service.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We therefore asked the clinical services manager how they ensured people were not subject to unnecessary restrictions and, where such restrictions were necessary, what action they took to ensure people's rights were protected. The clinical services manager told us of the correct procedure to follow to ensure any restrictions to people were legally authorised. We noted that the care records for one person subject to DoLS clearly stated to what aspects of care the restrictions applied and the purpose of the safeguards.

However, when we discussed the care provided for one person in Holly unit, the clinical services manager advised us this person did not have the capacity to consent to their care and treatment at Old Gates. We found there were no assessments in place to record the decisions the person was unable to make or what action staff should take to ensure they were acting in the person's best interests. No action had been taken to ensure that any restrictions on the person were legally authorised. This meant there was a risk the person's rights might not be upheld.

The ongoing lack of appropriate procedures to ensure that people who used the service, or those acting lawfully on

Is the service effective?

their behalf, had given consent before any care or treatment was provided was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they considered staff knew them well and had the skills to provide the care they needed. One person told us, "Staff are lovely. They look after me well". A relative also told us, "Staff have got to know what [my relative] likes and dislikes. They do a marvellous job and get to know people as individuals." However, two of the relatives of people on Rowan unit were less sure about the capabilities of staff. One relative told us, [My relative] has dementia and she can be quite aggressive. I can handle her but I do not feel the staff are trained enough to look after people with dementia." Another relative commented, "I do not feel the staff are able to meet [my relative's] needs. I have raised concerns and at the moment someone is actually here today to discuss this with me." No concerns were raised about the skills and abilities of staff on either Holly or Cherry Unit.

The registered manager told us staff had access to 'flash cards' to assist them to communicate effectively with people, particularly those who were living with a dementia. However, we did not see any staff make use of these cards during the inspection and two of the staff we spoke with on Rowan unit told us they were unaware of any communication aids available to them.

Staff employed by Bupa told us they had received an induction when they started work at Old Gates and had found this to be helpful in understanding their role and responsibilities. One staff member told us they felt their induction was very thorough and "much better than other homes I've worked in. " However one agency nurse told us their induction had not included any information about fire safety and that they had been unaware until the day before our inspection of the location of the fire box. This meant there was a risk they might not be aware of the correct action to take in the event of an emergency

From the records we reviewed we saw that most staff had received up to date training in areas such as moving and handling, fire safety and infection control. We saw that the registered manager had a system in place to monitor the training staff had received and ensure any required training was arranged.

We were aware from our contact with the local authority safeguarding and quality teams that concerns had been raised with them by staff on Rowan unit regarding the lack of training they had received in supporting people whose behaviour might challenge others. We saw evidence from the training records we reviewed that four of the staff on Rowan had received this training. However, during the inspection two of the staff we spoke with on Rowan told us they had not received any training in either caring for people living with a dementia or how best to support people who displayed behaviour which might challenge others. This meant there was a risk that staff might not be aware of the most appropriate interventions to use to ensure people received effective care. However, one member of care staff who had completed the training said they had found it to be helpful and told us, "It makes you realise that medication isn't the only answer."

We discussed training for staff on Rowan unit with the registered manager. They showed us records to confirm that training in behaviour that might challenge others had been arranged on several occasions but that there had been a poor uptake from staff. They told us they intended to ensure that all the staff team on Rowan unit had completed this training as a matter of urgency.

We found there was a system in place to provide staff with supervision and appraisal. The policy for the service stated staff should receive at least six supervision sessions per year. From the records we reviewed we saw that most staff had received supervision in line with this policy.

We looked at the arrangements in place to help ensure people who used the service had their nutritional needs met. We saw that the menu was nutritionally balanced and that people had the opportunity to choose the meals they wanted. We noted that, where people did not like what was on the menu, the chef had prepared a different meal of their choice.

People we spoke with were generally positive about the quality of food provided in Old Gates. Comments people made to us included, "They always do a good soup", "The food is ok but you can never suit everyone", "Staff respect [my relative's] religion and culture. They get special meat and curries for her", "I am not happy with the food. I like just plain and simple and I cannot chew red meat"

We observed the lunchtime experience on each of the three units. We noted the atmosphere on Cherry and Holly

Is the service effective?

units was relaxed and sociable. Tables on these units were set with tablecloths and condiments. However, our observations on Rowan unit showed that the lunchtime experience was less of a social occasion. Although we saw positive interactions from two of the staff who were supporting individual's to eat, we observed limited interaction between other staff and people who used the service. We noted that there were no condiments available to people and we did not see people being asked if they wanted of vegetables to be added to their meal. Our observations were supported by a comment from a relative visiting Rowan unit who told us, "There is no choice given to people with dementia. The food is not very good and they are not shown what they are given."

We noted that people on Rowan unit were not all offered the opportunity to sit at a table to help make the mealtime a more sociable occasion. However we did note that visiting relatives were able to sit and eat with their family members. We also observed that, two people had to wait a considerable period of time before they received their meal and were visibly agitated during this period although they calmed down when their food was served. We did not see any evidence that staff had considered how they should prioritise when people were served their meal and the impact waiting might have on some people. We discussed our observations with the unit manager who told us they would review the dining arrangements with staff to help ensure people were encouraged to socialise at mealtimes.

We reviewed the systems in place to ensure people who used the service had their health needs met. We noted that, although people's health needs were appropriately identified, a lack of communication within the staff teams meant that arrangements were not always put in place to ensure the needs were met. One relative told us, [My relative] had to go to hospital as she fell and bumped her head. When the staff handed over they did not know about her head and brushed her hair. I wonder what they tell each other at handover time." This relative also told us, "The agency staff had not documented [my relative's] trip to hospital."

A visiting health professional to Holly unit told us they had concerns regarding how staff disseminated the advice they gave to ensure people's health needs were effectively met. They told us this had led to people receiving inconsistent care. They told us the person they had been visiting on Holly unit had not received the care they required in relation to skin care which meant they were at risk of pain and infection. We looked at the person's care records and could not find any evidence that their needs in relation to this health condition had been documented. This was discussed with the clinical services manager who told us they were unaware of the concerns raised by the health professional. They told us they would check why the health professional had been asked to visit the person concerned and why the care plan had not been updated to reflect this change in the person's needs.

We also noted from this person's care records that they required regular repositioning to help ensure their skin integrity. However we found that there were no records for three consecutive days at the end of June 2015 to confirm the required checks and positional turns had been completed. This mean there was a risk the person had not received the care they required

Good

Is the service caring?

Our findings

All of the people we spoke with during the inspection told us the staff in Old Gates were kind and caring. Comments people made to us included, “The staff respect my privacy and if I do not want to do something they do not pressurise me”, “When I have a shower the staff treat me with dignity” and “The staff listen to me and [my relative] and act upon it; they are very good.”

Our observations during the inspection showed that staff were respectful in their interventions with people who used the service. We noted staff asked discreetly if people needed assistance with personal care and were unhurried in their approach. Staff we spoke with told us they would always try to promote the independence of people who used the service; this was confirmed by all the relatives we spoke with.

We looked at care records to see what information was documented regarding the life histories, interests and preferences of people who used the service. This information is important in assisting staff to develop meaningful relationships with people. We saw that this information was completed on nine of the 10 care records we reviewed.

We noted that all care records were held and maintained electronically and only authorised staff had access to the information held about people; this helped to ensure that the confidentiality of people who used the service was maintained.

Staff we spoke with demonstrated they understood the importance of person centred care. This was confirmed by one relative we spoke with told us, “Staff have got to know [my relative’s] likes and dislikes. Staff do a marvellous job and get to know people as individuals.”

We looked at the results from the most recent survey distributed by the provider to people who used the service. We noted positive comments from people regarding the attitude and approach of staff. These comments included, “I have been treated well and staff are marvellous”, “Staff are helpful and caring” and “I couldn’t ask for more care than I receive.”

We noted there was a system in place for staff to discuss end of life wishes with people who used the service. Care records we reviewed contained information about the support and care people wished to receive at the end of their life.

Requires improvement

Is the service responsive?

Our findings

People we spoke with who used the service told us they received the support they required from staff. One person commented, "The staff listen to me and my husband and act upon it they are very good." Another person told us, "I can express my views I do not go to meetings but if I want to voice my opinion I will. The staff are very supportive." However, two relatives expressed some concern about the responsiveness of staff to their family member's needs. One relative told us, "I am concerned that [my relative's] toe nails have not been cut for a long time". Another relative commented, "The staff are doing something now because I have made a complaint about [my relative's] personal hygiene."

We looked at the care records for 10 people who used the service. The care records contained enough information to guide staff on the care and support to be provided. There was good information about the person's social and personal care needs. People's likes, dislikes, preferences and routines had been incorporated into their care plans. However, we found that on Rowan unit not all care plans had been reviewed or updated to help ensure staff had access to up to date information about people's needs. We were told there was a plan in place to ensure all the required reviews had been completed by the end of August 2015. However, until this time there was a risk people might not receive the care they required.

We looked to see what activities were provided for people in Old Gates. We were told two activities coordinators had been very recently appointed to work across the service. We were told they were in the process of consulting with people who used the service to develop a timetable of activities on both an individual and group basis and saw some evidence of this in the records we reviewed. Because of this some people made negative comments about the lack of activities prior to our inspection. Comments people made included, "There are not enough activities going on", "Sometimes we have entertainment like singers but we have not had one recently" and "There are no activities for men; sometimes we play bingo but that's about it." During the inspection we noted a volunteer led a singing group for people on Cherry unit.

We noted there was a complaints policy in place and that any complaints received had been recorded and investigated in line with this policy. Information about the complaints procedure was on display on each of the units and in the reception area of the service.

We asked people who used the service and their relatives what opportunities they had to comment on the care provided in Old Gates. Only one person we spoke with who used the service told us they had been involved in reviewing their care plan. In addition one relative commented, "I have had a lot of input with [my relative's] care plan and anything I have wanted they have done."

There was a 'resident of the day' system in place to help ensure the care records of people were up to date and reflected their current needs. However, when we asked about the involvement of the individual concerned or their family members if appropriate in this 'resident of the day' review we were told this did not take place. Some of the staff we spoke with told us they would sit with people to check they were happy with the care they received but we did not see any evidence of this on the care records we reviewed.

Records we looked at showed meetings had taken place on each of the units between staff, people who used the service and their relatives. We noted people had commented that the food had improved and staff on Cherry unit were described as being 'approachable with nothing too much trouble for them'.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager in place as required under the conditions of their registration with the Care Quality Commission (CQC). Although many of the people we spoke with were unaware of the identity of the registered manager, all were familiar with the manager of the unit on which they or their relative lived. Comments relatives made included, "I have spoken to [the unit manager] and have always found they have explained things and any issues are sorted quickly", "[My relative] has been in this home for six months and I have never met the manager. The only person I know is a senior carer who is always on the ball", "I know the manager; she is approachable" and "The manager listens but is slow to act."

We asked the registered manager to tell us how they monitored and reviewed the service to ensure that people received safe and effective care. They told us daily 'clinical risk' meetings took place between the management team to discuss any changes in people's needs in order to ensure any required action was taken. The clinical services manager also undertook a daily walk round on all the units to provide guidance and support to staff.

We were told that regular checks were undertaken on all aspects of the running of the home, including the auditing of medication and care plan records. However, we found that these checks had not been sufficiently robust to identify some of the shortfalls in care records and the administration of medicines which we had identified during this inspection.

Records we looked at showed regular audits were also completed by quality assurance team from the organisation. This process was used to help identify themes and trends within Old Gates.

Most of the 12 staff we spoke with told us they enjoyed working at Old Gates and felt well supported by the managers in the service. One staff member told us, "[The unit manager] does listen and the seniors are exceptionally good. I raised some concerns and felt listened to. I felt things were handled well." Another staff member commented, "The (registered) manager and clinical services manager are both approachable." However, four staff members were less positive about the way the service was led. One staff member we spoke with told us they did not feel the culture in the service was transparent; as a result they told us they had felt unable to raise concerns about the way they considered medication was sometimes used as the first intervention with people who displayed behaviour that challenged others, rather than diversionary techniques. Another staff member told us, "I have worked here for several months and have been asking the manager about dementia training. I told her I wanted to go on a course but nothing has happened. I do not feel supported by the manager." A third staff member told us "We feel our opinions aren't always respected." This staff member also told us they did not view supervision as a positive experience and stated "Supervision is usually when something negative is brought to our attention."

We raised these issues with the registered manager who told us staff had the opportunity to discuss any concerns or learning needs during supervision sessions which took place with the manager of the unit on which they worked. However, they had also arranged staff meetings on each of the units with the intention of encouraging staff to feel able to raise any issues of concerns directly with them or through the 'Speak Up' helpline.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient numbers of staff always available to meet the needs of people who used the service.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have robust systems in place to ensure the proper and safe management of medicines.

The enforcement action we took:
We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have sufficiently robust procedures in place to ensure that care and treatment of service users was only provided with the consent of the relevant person.

The enforcement action we took:
We issued a warning notice