Barchester Healthcare Homes Limited

Kernow House

Inspection report

Landlake Road
Launceston
Cornwall
PL15 9HP

Tel: 01566777841
Website: www.barchester.com

Date of inspection visit:
17 August 2016
18 August 2016

Date of publication:
19 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 August 2016 and was unannounced.

At the last inspection on 10, 12 and 16 November 2015 we asked the provider to take action to make improvements. We found that the systems in place to monitor the quality of the service people received were not effective, for example, audits had failed to identify areas of concern. We also found that records relating to people's care were not always securely stored. In addition, there were issues around the deployment of staff within the service, meaning that people's social needs were not always met and there was a lack of personalised activities on offer for people. The provider sent us an action plan which explained how they would address these breaches of regulation. During this inspection we found that some of these issues had been addressed.
Kernow House is part of the Barchester Healthcare group of homes. It provides personal and nursing care to a maximum of 98 people within five specialist units. There were two units for people with Huntington's Disease and three dementia units, one of which provided care for people who could become agitated and required more intensive staff support. At the time of the inspection there were 76 people living at the service.

The service was in the process of registering a manager. 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.

Incidents were recorded, however incident forms relating to safe holds or restraint lacked detail about the incident, which staff members had been involved and what action was taken. For example, where people had required restraint or "safe holds", staff had not recorded the incident in sufficient detail and there was a lack of clarity about the process for recording incidents such as this. Audits of the incident forms had failed to identify this concern. Some staff had not received training around safe hold techniques, despite being in situations where this had been required. Minutes of staff meetings indicated that staff had been requesting training in this area since August 2015.

Staff generally managed people's medicines safely, however people who had their medicines hidden in food or drink (covert administration) were not having decisions about their medicines recorded and reviewed in a way that ensured they were safe and their medicines were effective.

Staff had received training relevant to their role and there was a system in place to remind them when it was due to be renewed or refreshed. However not all staff had received training around safe holds. Staff were supported by a comprehensive induction and there was an ongoing programme of supervision, competency checks and appraisals.

We observed positive, compassionate and caring interactions between people and staff. Staff took the time

to stop and chat with people and to share appropriate humour. Staff knew the people they cared for well and spoke about them with fondness and affection. One staff member said; "I love it here. I love the people". A relative told us; "The care is marvellous. The way they encourage and support is incredible".

People's care plans were detailed documents which contained information about their background, history, likes and dislikes. Staff confirmed that the care plans contained the correct guidance and information in order to provide the right level of support for people. People's care plans were linked to risk assessments and contained information for staff on how to reduce the likelihood of them coming to harm.

People enjoyed the meals. They told us they were of sufficient quality and quantity and there were alternatives on offer for people to choose from. People were involved in planning the menus and their feedback on the food was sought.

People had their healthcare needs met. For example, people had their medicines as prescribed and on time. People were supported to see a range of health and social care professionals including speech and language therapists, podiatrists, doctors and social workers.

People were kept mentally and socially engaged through a range of activities, both inside the service and in the local area. The service employed an activities coordinator and activities were personalised to people's individual needs.

People were kept safe by suitable staffing levels. Relatives told us there were enough staff on duty and we observed unhurried interactions between people and staff. This meant that people's needs were met in a timely manner. Recruitment practices were safe. Checks were carried out prior to staff commencing their employment to ensure they had the correct characteristics to work with vulnerable people.

There was a safeguarding adult's policy in place and staff had received training around this. Staff confidently described how they would recognise and report any signs of abuse. There were policies in place around the duty of candour and whistleblowing which staff were aware of and applied to their practice. This encouraged an ethos of openness and honesty.

Staff were knowledgeable about the Mental Capacity Act and how this applied to their role. Where people lacked the capacity to make decisions for themselves, processes ensured that their rights were protected. Where people's liberty was restricted in their best interests, the correct legal procedures had usually been followed. People were involved in planning their care and staff sought their consent prior to providing them with assistance. However, there were some issues in the recording of decisions for those who required the covert administration of medicines

People, staff and relatives were encouraged to give feedback through a variety of forums including team meetings, residents' meetings and questionnaires. This feedback was used to drive improvements within the service. There was a system in place for receiving and managing complaints. Relatives said they felt confident that if they raised concerns these would be dealt with appropriately. There was a quality assurance system in place with a range of audits including care records and staff and resident satisfaction surveys, however not all audits successfully identified concerns.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not always safe.

Incidents forms relating to the use of restraint lacked sufficient detail.

People's medicines were not always safely managed where covert administration was required.

People were supported by staff who were safely recruited and there were sufficient numbers of skilled and experienced staff to meet people's needs.

Is the service effective?

Requires Improvement

Some aspects of the service were not always effective.

Not all staff had received training in using restraint techniques despite working with people who may require physical interventions such as this to keep themselves and others safe.

People were supported by staff who had good knowledge of the Mental Capacity Act 2005, which they put into practice to help ensure people's human and legal rights were protected.

People were supported to maintain a healthy balanced diet.

People were supported to see a range of health and social care professionals as required.

Is the service caring?

Good

The service was caring.

People were supported by staff who respected their dignity and maintained their privacy.

People were proactively supported to express their views, and were supported by staff who understood their history, strengths and goals.

People were supported by staff who showed kindness and

compassion. Positive caring relationships had been formed between people and staff.

Is the service responsive?

Good

The service was responsive.

Care records were personalised and focused on a person's whole life.

People were encouraged to remain physically and cognitively engaged. Staff understood the importance of companionship and social contact.

There was a system in place to receive and investigate complaints and people and relatives were aware of it.

Is the service well-led?

Requires Improvement

The service was not always well led.

Incidents were not always recorded in sufficient detail meaning that records of events were unclear, and audits failed to identify this concern, meaning opportunities for learning and improvement could be missed.

There was a culture of openness and honesty. Management were approachable and there was a clear management structure.

People were supported by staff who were motivated to develop and provide quality care.

Kernow House

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 17 and 18 August 2016 and was unannounced.

The inspection was undertaken by two adult social care inspectors, and a pharmacy inspector. Prior to the inspection we reviewed information we held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we looked around the premises, spoke with five people who lived at the service, five relatives, the manager, clinical lead and 21 members of staff. We also contacted three health and social care professionals who had contact with people living at Kernow House. We looked around the premises and observed how staff interacted with people throughout the inspection. We used the 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 looked at ten records relating to people's individual care needs and 34 records related to the administration of their medicines. We viewed five staff recruitment files, training records for all staff, a range of policies and procedures and records associated with the management of the service, including quality audits.

Requires Improvement

Is the service safe?

Our findings

Whilst we saw that staff generally managed people's medicines safely, people who had their medicines hidden in food or drink (covert administration) were not having decisions about their medicines recorded and reviewed in a way that ensured they were safe and their medicines were effective.

Staff gave some people their medicines hidden in food or drink in line with their assessed needs. Staff on one unit told us that if they thought someone needed their medicines given covertly, they would complete a MCA (Mental Capacity Act 2005) assessment, discuss the need with the person's doctor and ask a pharmacist to check that medicines could be mixed with food or drink. Staff told us there would be ongoing reviews, documented every six months. However, some risk assessments had not been updated for over 12 months. The records for one person showed the last risk assessment was in 2013 and records for another person showed their doctor had agreed that medicines could be administered covertly, but the form was not dated. A pharmacist had recorded that medicines for this person were suitable to be given covertly in 2014, but this assessment did not detail individual medicines. This means that people who were unable to make decisions about their medicines themselves, may not have been receiving their medicines in a way that kept them safe and ensured their medicines were effective.

Some people had difficulty swallowing and staff often crushed medicines to assist with this. We saw conflicting advice about crushing medicines in people's records. One person's medicines profile said "medicines need crushing" dated July 2016 yet a review by a pharmacist in June 2015 said some medicines "must be given whole and not crushed". This could lead to confusion for staff administering medicines and meant that medicines might not work effectively.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (1), 2 (g) - Safe care and treatment.

Medicine administration records (MAR) had been signed and updated to ensure medicines were correctly administered. Where refrigeration was required, this fell within the correct temperature guidelines.

Some staff members told us they had used safe holds, or restraint before they had received training. Comments included; "I have done very basic safe holding training but only for people who are sitting down. There is a new resident who can get aggressive and we've had to use safe hold techniques" and "There were some incidents before we had the training". Minutes of a staff meeting on 26 August 2015 stated that staff; "Need safe hold training as being involved in situations requiring safe holding". Incident forms relating to the use of restraint lacked detail about what had happened and who had been involved. Minutes of a staff meeting held on one of the units on 21 March 2016 reminded staff that incident forms needed to be completed, including information on what incident occurred and what happened next.

Staff reacted promptly when people showed signs of anxiety or distress. One person who regularly became anxious was encouraged to return to their bedroom. Staff told us they always seemed calmer in their bedroom and this also gave staff opportunity to speak one to one with the person and find out what they

needed. This was clearly documented in the person's care plan. One staff member told us; "Challenging behaviour is often due to an unmet need". Another person had been experiencing significant periods of anxiety. They had been referred to a psychologist who had changed their medicines and were feeling much calmer. A staff member said; "I've been off for two weeks and can definitely see the difference in them. They seem happy in themselves too".

Incidents were discussed in daily handover meetings so senior staff were kept up to date. A senior staff member reviewed all incidents to look for trends and to establish if any further actions were needed or if any learning could be shared with the staff team. Although we saw evidence of situations where this system had not been effective in relation to the recording of incidents involving restraint, we also saw some examples where learning was identified after incidents. For example, one person who had capacity had choked after eating lying down. Staff had followed the correct procedure to encourage the person to sit up but they had declined. Senior staff had discussed the incident with the staff members involved and decided that if someone decided to eat lying down when already assessed as being at risk of choking, staff would inform the nurse who would be able to reiterate the risk to the person and encourage them to sit up.

People were protected from discrimination, abuse and avoidable harm by staff who had the knowledge and skills to help keep them safe. Policies and procedures were available for staff to review to advise them of what to do if they witnessed or suspected any incident of abuse or discriminatory practice. Records evidenced all staff had received safeguarding adults training. Staff confirmed they were able to recognise signs of potential abuse, and felt reported signs of suspected abuse would be taken seriously. Posters were displayed in prominent places on each unit with the names of key individuals who staff could contact to report abuse. One staff member said; "I would report anything to my line manager or higher. I've never had a concern but I think I'd be taken seriously here if I raised anything."

People were kept safe by sufficient numbers of staff. The provider used a dependency tool to establish if there were enough staff to care for people and this was reviewed when new people came to live at the service. We observed staff interacting with people in an unhurried way and having time to respond to their needs in a timely manner. Staff took time to stop and speak to people when they passed them in the lounge or as they walked past in the corridors.

People were protected by safe staff recruitment practices. Records evidenced that all employees underwent the necessary checks prior to commencing their employment to confirm that they had the correct characteristics and were suitable to work with vulnerable people. One staff member told us; "The recruitment system is really good. It flags up whenever anything's due to be done".

People had PEEPS (personal evacuation plans) in place to provide guidance on what support they would need should an evacuation be required. The service also had contingency plans in place to deal with emergency situations such as fire, flood or bad weather. Staff had been trained to understand what their role was in the event of a fire and fire risk assessments were in place and up to date.

People were kept safe by a clean and hygienic environment. The home was visibly clean, with hand sanitising gel, gloves and aprons throughout the building which we saw staff using throughout the inspection. Cleaning rotas were evident throughout the home and there were infection control audits. There were contracts in place for the disposal of domestic and clinical waste.

Requires Improvement

Is the service effective?

Our findings

Some staff had not received training around restraint or "safe hold" techniques, despite being in situations where the use of such holds had been required in the interests of the safety of people and staff. Minutes of staff meetings indicated that staff had been requesting training in this area for over a year. We were told by staff that this had been raised with senior managers but training had not been provided. Minutes of a staff meeting held on 28 September 2015 stated that safe hold training was on hold as Barchester were going to undertake a new technique. Minutes of another staff meeting held in November 2015 read that safe holding training would be provided by MAPPA (Management of Actual of Potential Aggression), but no dates had been set. We highlighted this to the registered manager and were told that MAPPA training has now been arranged and all staff are in the process of completing it over the coming weeks. Without training it was unclear as to whether practices had been safe for the staff and people involved and incident forms relating to these events lacked the necessary detail to confirm this.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (1) Safe care and treatment.

The registered manager had a system in place to ensure staff were trained in all areas identified by the provider as being mandatory and to remind them when training was due to be renewed or refreshed. We noted that the training matrix indicated some bank nursing staff were not up to date with mandatory training. The registered manager told us that these particular members of qualified nursing staff would have undertaken this training elsewhere and had provided verbal reassurance that they had completed it. We noted however that there was no system in place to verify this and this was highlighted to the registered manager who assured us it would be addressed.

New staff underwent a thorough induction process. New staff shadowed more experienced staff and did not lone work until they had completed their induction. Staff comments included; "The induction was really good. It's all in-house so if you have queries you can go back to the trainer" and "If you are new to care you get five days of shadowing, but you can always ask for more until you feel comfortable". There was on-going regular supervision for staff on a one to one basis as well as an annual appraisal. Staff said they could use supervision sessions to discuss concerns, share ideas and identify training needs. They also discussed how they were getting on in their role and any keyworker roles they held.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 a person lacks the mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive possible. If a person lacked capacity their care was discussed with a range of professionals and family, where appropriate, to ensure the decisions were made in the person's best interest. People had decision specific mental capacity assessments on their files where it was required. Staff had undergone Mental Capacity Act

training and had a good understanding of the principles of the Act and how this applied to the people they supported. Capacity assessments were live documents, reviewed on a monthly basis recognising that a person's capacity can change over time. However, we did identify issues relating to the recording of people's decisions around the administration of covert medicines.

People can only be deprived of their liberty in order to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had sought authorisations under DoLS when they were required and the documentation was stored in their files alongside information on what this meant for the person being supported. Where people had an LPA (Lasting Power of Attorney), a copy of the documentation was also kept on their file. People who were subject to other legal orders, such as a guardianship order (section 7 MHA) had detailed care plans in place which explained to staff what the order meant in practice. There was also information in the care plan about the person's right to request an appeal to a tribunal.

People's consent was clearly obtained by staff prior to them undertaking a task, for example, staff asked before they provided any support, and if they moved a person, they explained where they were going and why. We heard a staff member ask; "Would it be ok if I moved your chair a little" and another asking; "Would it be alright to put this clothes protector on? If you're anything like me you will spill the gravy down you". People's files also indicated where people had consented to elements of the care plan, or where a best interest decision had been made for those who lacked capacity to give their consent.

People had their nutritional and hydration needs met. Hot and cold drinks were available for people throughout the day. We observed people having their lunch. The atmosphere during lunch was pleasant and relaxed. Tables were laid with table cloths and people were offered a range of drinks with their meals. Where there were different meal options to choose from, staff brought both out on a tray for people to visually decide what they wanted. This was useful for those with dementia who may have had difficulty in making decisions. A staff member said; "We try lots of different ways to give people what they want to eat and not what we think they want". Staff worked hard to encourage people to eat. One person was reluctant to eat anything. Staff tried several times to encourage the person. At each time they got down to the person's level to discuss with them what was available, describing how nice it was and offering alternatives. When people were new to the service, the cook would come to visit them to discuss their dietary requirements, likes and dislikes. Nutritional meetings were held when possible with the cook in order to identify any changes or improvements that could be made to individual's diets, taking into account their weight and health needs. Referrals were made to SALT (speech and language therapists) or dieticians as required. Food and nutrition charts were completed and information was carried through to people's care plans and risk assessments as required.

People had their healthcare needs met. Records indicated they saw a range of health and social care professionals including GPs, chiropodists, speech and language therapists, podiatrists and dentists, as required and staff supported people to attend appointments where necessary.

People's bedrooms were personalised and they were able to choose how they were decorated. One person liked miniature cars and a display unit had been purchased in which they could store them. Another person was nursed in bed, so posters had been put on their ceiling to occupy them. Shared spaces were bright and decorated to a high standard. There were quiet areas with fish tanks and soft lighting where music was playing quietly as well as stimulation areas with rummage stations and reminiscence objects. On one of the units, there was a world map on the wall and flags which could be stuck on to represent the correct country. A staff member told us people enjoyed this activity and staff would get involved too. There had recently

been a grand opening of the sensory garden in one of the courtyards. The flooring was artificial grass and there were dementia friendly items for people to use such as large beach balls and skittles. A staff member told us, everyone had the opportunity to come to the new garden, had cucumber sandwiches and cream teas.

There was a lift which was used to enable people to access different parts of the building. Corridors were wide enough for wheelchairs and other equipment and were fitted with handrails. There was signage around the home to help people orientate themselves. Adaptations had been made to support those with dementia. There were well maintained gardens with canopies and seating which people could access as they wished.

Good

Is the service caring?

Our findings

We observed warm, positive interactions between people and staff. One staff member who was taking people back to the lounge area after having their hair done was heard to pay them compliments and tell them how nice their hair looked. We observed staff gently rubbing people's backs and soothing them if they were distressed or anxious. On one of the units, one person had become distressed. We observed a skilled approach by a staff member who asked the person for their help in laying tables for lunch and telling them how much they valued the person's help. The person was later observed, engaged in this activity and appearing content.

Relatives told us the service was caring. Comments included; "I am very happy with the care my relative receives"; "There is a core team of long serving care assistants who I am very impressed with" and "I have observed the care that both my relative and other residents have received and it has frequently brought tears to my eyes. I' wouldn't hesitate to recommend them" and "The staff are very caring and pleasant". Staff demonstrated compassion and respect towards people and showed concern for their wellbeing. Staff comments included; "I wouldn't do anything else for the world. It's so gratifying seeing someone smile who hasn't smiled for a while"; "I love the clients" and "I love the people to bits".

Staff shared the ethos of personalised care and trying to make people feel at home. "You're coming into a person's home and trying to make them happy." When staff were supporting people to move they did this gently and with plenty of explanations and encouragement. One staff member excused themselves from supporting a person to eat so they could open the door for someone.

Staff told us they felt passionate about the support they provided and explained the importance of having a caring approach and making people feel they mattered. Staff comments included; "We want the residents to feel like this is their home"; "We try to make people happy. Sometimes it's only us that can speak for some of the residents" and "I enjoy it. Knowing the residents are well cared for".

People's privacy and dignity were protected. We observed staff knocking and waiting to be invited, before entering a person's bedroom. One relative told us that staff were always discreet about providing personal care.

People were supported to express their views through a variety of forums including residents' meetings. People were also actively involved in decisions about their care and involved in developing and reviewing their care plans.

Staff knew the people they cared for well, including their background, history and likes and dislikes. One staff member told us one of the people they supported had been in the armed forces during their working life. The staff member told us they would greet them each day with a salute and that the person appreciated this and responded to it with good humour. Another staff member said; "We're trying to get life stories done for everyone so we know about their background and what they used to enjoy doing." One person was sleeping at lunchtime. Staff tried to wake them but unsuccessfully. They explained, if the person was

sleeping, it was better for them to have their lunch later. This helped ensure they were more awake and meant staff had more time to take with them. This helped ensure they were comfortable and had as much to eat as they needed.

Good

Is the service responsive?

Our findings

At the previous inspection, the provider was not meeting the regulations in relation to the deployment of staff in order to meet people's social needs. The provider sent us an action plan which explained how they would address these breaches of regulation. During this inspection we found these issues had been fully addressed.

People had access to a range of activities in order to keep them socially and cognitively engaged. The service employed an activities coordinator and people were involved in arranging the programme of activities for the month ahead through discussions at the residents' meetings. There was a diverse range of options available such as visits from petting animals, picnics at the seafront, swimming, cake baking and going out on Sundays to buy the weekly newspapers. Staff comments included; "We have aromatherapy every fortnight and lots of trips out; I think they benefit everyone" and "We make bread with people. It stimulates their appetite as well as their memories".

People were supported to take part in personalised activities which suited their individual needs. Staff told us; "I've been out for a walk with someone this morning. He really enjoyed talking to me about his garden. I asked him if he'd like to visit the gardens of a stately home or a garden centre. He said it depends how he feels, so we'll ask him again and see which he fancies". Another staff member said; "We make sure we take out people that might be a bit more challenging too. It's still important for them to have time out". One person had always enjoyed completing jigsaws but now found this frustrating. Staff told us, they still spent one to one time with the person, but would try different things instead, even if it was just sitting and chatting and having a cup of tea together.

People received consistent personalised care, treatment and support. Prior to coming to live at the service, information was gathered from the person, their family and professionals. This was important for staff in understanding not only the person's support needs but also their history, social and cultural needs, strengths and aspirations for the future. People and their relatives were invited to come and look around the service to ensure it was the right place for them.

People living at the service had a named nurse and a key worker. A staff member told us there was a matching process and staff could choose people they had a likeness with or key skills that would particularly suit the person.

People's care records were comprehensive, personalised documents which guided staff on how to meet their needs. There was information around people's night care needs such as what time they wanted to go to bed and whether they wanted staff to check on them throughout the night. One person's care record indicated that being woken early could trigger agitation and distress and guided staff to allow the person to wake naturally. The care plan went on to say, that if this meant the person missed breakfast, staff should ensure they had something available to eat.

People's care records contained a section on "how will I know if the plan of support is effective". This guided

staff on how to identify if the plan was working for the person. People's care records evidenced that risk had been assessed using recognised tools such as MUST (Malnutrition Universal Screening Tool). Where a risk of malnutrition had been identified, care plans indicated what action staff should take to mitigate the risk. For example, people's body weight was recorded more frequently. If a person had a low BMI (body mass index) they were promptly referred to their GP for supplements and to speech and language therapists. Any advice from professionals was incorporated into the person's care plan.

Care records were well organised and easy to navigate with important information, for example, about any allergies, highlighted at the front. Records were reviewed monthly by the person's allocated keyworker and also audited regularly by the registered manager.

People were supported to maintain their independence. In the evenings, staff prepared the meal on the individual units, so people could get involved and experience the smell of the food cooking. A staff member said; "Staff make the tea in the evenings on the units and the residents get involved. Whatever you are doing, you get the residents involved in it". Another staff member said; "We are encouraging staff to enable people to practice daily living skills. One man really enjoyed doing the dishes yesterday. It's important to give people the option to do normal, daily chores. It helps keep them independent." One person had been a carpenter during their working life. A staff member would bring in pieces of wood and they would sand them down together. The staff member told us it kept the person active and allowed them to keep utilising their skills.

People were supported to maintain relationships with people who mattered to them. There were no restrictions on visiting times and relatives were able to take people out. Staff supported people to go out, for example to visit family by preparing their medicines and personal belongings for the day. People's care plans contained information around supporting social visits. For example one person's file indicated that staff should ensure a person and their relatives had an appropriate environment made available for them to spend time together in.

There was a system in place for receiving, investigating and managing complaints, supported by a policy. People and relatives said they felt confident to raise a complaint and felt that it would be dealt with to their satisfaction. One relative said; "If I had an issue I would raise it with confidence and it works both ways, they would raise any problems with me". If concerns had been raised, they were dealt with in a timely manner, an apology had been made and plans had been put in place to make improvements.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection, the provider was not meeting the regulations in relation to the effective running of systems in place to assess, monitor and improve the quality of the service. Additionally, records relating to people's care were not always held securely. The provider sent us an action plan which explained how they would address these breaches of regulation. During this inspection we found that these issues had not been fully addressed.

At this inspection, we found that people's care records and confidential information were stored in secure offices which were kept locked and no personal information was left on display.

However there continued to be an issue relating to the systems in place to monitor and improve the quality of the service. For example, we found that although incidents involving safe holds were recorded, incident forms often lacked detail. Where people had required restraint or "safe holds", staff had not recorded the incident in sufficient detail and it was not possible to identify which staff member had been involved and therefore whether they had received the appropriate training to carry out the safe hold. It was not possible to identify which safe hold technique had been used and for how long, what had triggered the incident and what had happened afterwards. We were told that incident forms were reviewed to look for themes; however this issue had not been identified by senior managers. There was also a lack of clarity about the process for the records relating to these incidents being overseen and monitored. For example, we were told by the registered manager that there was a second, more detailed form that staff were expected to complete if they had been involved in a safe hold in addition to the incident form. However staff we spoke with were not aware of this document and the registered manager was not able to provide us with any examples of this second form to correspond with the incident forms we reviewed.

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

The registered manager operated a cycle of quality assurance. Questionnaires were sent to people and relatives annually in order to gain their feedback on the service and to make changes if required. There were audits in place such as medicines, accidents, falls and cross infection to raise standards and drive continuous improvement, however their efficiency was variable as some concerns relating to safe holds were not identified through the audits. There were regular checks to ensure the building and equipment were safely maintained. The utilities were also checked to ensure they were safe. The service operated a "resident of the day" scheme on each unit. This was a system of checks for a person who was chosen at random each day. The checks included a thorough file audit, a spring clean of their room, physical health checks and a visit from the cook to look at their nutritional needs. A staff member told us; "It's like an MOT to ensure everything works well".

Staff told us the service was well led and that the manager was approachable and supportive. Comments included; "The manager has worked her way up through care and that is a good thing"; "The manager would deal with any issues". One relative said; "There has been a change to the management structure and under

this regime I find things much more constructive. There's a new mood which is more open and the staff are more cheerful".

Staff were able to raise suggestions and told us they were implemented by management where possible. One staff member told us; "We discuss new ideas at handover and in the communication book. For example, one person was spilling their tea a lot as they walked about, so we decided as a team to try cups with lids on. They seem to be ok with this and the information has gone into their care plan".

There were regular residents' and relatives 'meetings where people were able to put forward suggestions on service development and how they wished to be supported. Posters were displayed on the units to advise people when the next meeting was scheduled.

Staff were happy in their work, understood what was expected of them and were motivated to provide a high standard of care. Comments included; "I love it"; "I really enjoy it" and "I've worked for other homes, but this has been the best by far for me". The service operated an employee of the month scheme. Staff were able to nominate a colleague each month and the winner received flowers, chocolates or a gift voucher in recognition of their work.

The registered manager knew how and when to notify the Care Quality Commission (CQC) of any significant events which occurred, in line with their legal obligations. This demonstrated openness and honesty. The registered manager had a policy in place on the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. There were posters around the units, which told staff what the duty of candour was and how this applied to them in their role. One relative said; "The thing that has impressed me, is that I have received telephone calls to inform me when things have gone wrong, even though I'd have never found out. I find that openness very reassuring".

The registered manager also had a policy in place on whistleblowing, which staff were knowledgeable about. The policy supported staff to question practice. Staff confirmed they felt confident to raise any concerns with the registered manager or to go further up the management team and that they would be dealt with appropriately. There was a whistleblowing helpline displayed on a notice board which staff told us they would use if necessary.

There were clear lines of accountability within the management structure and the registered manager was supported in their role by a senior management team who were also visible within the service. There were regular meetings with senior management to provide oversight on the running of the service and to drive improvements.

There were a range of up to date policies which were accessible to staff and provided guidance and important information. These were reviewed and updated annually by the registered manager with the oversight of senior staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who had their medicines hidden in food or drink (covert administration) were not having decisions about their medicines recorded and reviewed in a way that ensured they were safe and their medicines were effective. Regulation 12 (1), 2 (g) Some staff had not received training on restraint, despite being in situations where it may be required. Regulation 12 2 (C)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality of the service provided were not operated effectively. Regulation 17 (1) (2) (1) (a) (b) (c) (e)

The enforcement action we took:

warming notice issued