

Barchester Healthcare Homes Limited

Park View

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?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Park View provides accommodation and 24 hour care, including personal care for up to 108 adults. This includes nursing care for older people and younger adults who may be living with dementia. The service is a large purpose built property. The accommodation is arranged across five units over two levels. There are four units for people living with dementia and complex needs all providing nursing care and one unit for people living with dementia. There were 106 people living at the service at the time of our inspection.

The service had a registered 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.

At the last inspection on 9, 10 and 16 June 2016 we found one breach of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was because staff did not always receive supervisions in line with the provider's policies and procedures and did not always receive up to date training to carry out their role. Some staff did not have a clear understanding of application of the Mental Capacity Act 2005.

At this inspection we found improvements in staff supervision and training. However we found gaps in staff knowledge of the Mental Capacity Act 2005. We found three breaches of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was because the approach to recording management plans in risk assessments was not always consistent. People using the service, their relatives and staff felt there were not enough staff at the service. Medicines were not always managed and administered safely. Guidance for how to administer medicines covertly was not always clear and some decision forms were incomplete. Staff were not always supported to receive on-going training to enable them to fulfil the requirements of their professional role. Quality assurance systems in place to identify areas of improvement were not always used effectively. Staff had mixed views about the support they received from the management team. You can see what action we told the provider to take at the back of the full version of the report.

We have made recommendations about providing opportunities for people to participate in meaningful activities and about involving people in their care.

People and their relatives told us they felt safe using the service. Staff knew how to report safeguarding concerns. There were effective and up to date systems in place to maintain the safety of the premises and equipment. Recruitment checks were in place to ensure new staff were suitable to work at the service.

Appropriate applications for Deprivation of Liberty Safeguards had been made and authorised. People using the service had access to healthcare professionals as required to meet their needs.

People were offered a choice of nutritious food and drink. Staff knew people they were supporting including their preferences to ensure personalised care was delivered. People using the service and their relatives told

us the service was caring and we observed staff supporting people in a caring and respectful manner. Staff respected people's privacy and dignity and encouraged independence. People and their relatives knew how to make a complaint.

Regular meetings took place for staff, people using the service and their relatives. The provider carried out satisfaction surveys to find out the views of people and their relatives.

People and their relatives told us the registered manager and management team were supportive and approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Medicines were not always managed safely and information contained in some risk assessments did not ensure risks were minimised and managed.

People using the service, their relatives and staff expressed concern about staffing levels.

People and their relatives told us they felt the service was safe.

There were safeguarding and whistleblowing procedures in place. Staff understood what abuse was and knew how to report it.

Staff were recruited appropriately.

The provider carried out regular equipment and building checks.

Requires Improvement ●

Is the service effective?

The service was not always effective. Staff did not always receive appropriate support through supervision meetings. Staff did not always have a clear understanding of the application of the Mental Capacity Act 2005 to practice.

People's health and support needs were assessed and reflected in care records.

People were supported to maintain good health and to access health care services and professionals when they needed them.

People had access to enough food and drinks.

Staff received appraisals and training to support them in their role.

Requires Improvement ●

Is the service caring?

The service was not always caring. We have made a recommendation about involving people in decisions about their care.

Requires Improvement ●

People told us the service was caring and staff treated them with respect and dignity.

Care and support was centred on people's individual needs and wishes.

Staff knew about people's interests and preferences.

The service enabled people to maintain links with their culture and religious practices.

Is the service responsive?

The service was not always responsive.

We have made a recommendation because people did not always have the opportunity to participate in meaningful activity

People's health and care needs were assessed and individual choices and preferences were discussed with people who used the service.

People were encouraged and supported to provide feedback about the service.

There was a complaints process and people using the service and their relatives said they knew how to complain.

Requires Improvement ●

Is the service well-led?

The service was not well led. Systems in place to monitor the quality of the service were not always utilised effectively.

The service had a registered manager.

Staff had mixed views about the level of support they received from the management team.

People using the service and relatives found the management team approachable.

Requires Improvement ●

Park View

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 checked 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 18, 19, 21 and 28 July 2017 and was unannounced. On the first day of the inspection, the inspection team consisted of two inspectors and a specialist advisor. A specialist advisor is a person who has professional experience in caring for people who use this type of service. The specialist advisor was a specialist in nursing. On the second day the inspection team consisted of one inspector and a pharmacy inspector. An expert by experience with expertise in dementia care accompanied the team on the first and second inspection day. 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 third and fourth day of the inspection were carried out by one inspector.

Before the inspection we looked at the concerns raised and information we already held about this service. This included details of its registration, previous inspections reports and information the provider had sent us. We contacted the host local authority with responsibility for commissioning care from the service, healthcare professionals, Health Watch and Clinical Commissioning Group to gain their views about the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 32 people and three relatives of people who used the service. We spoke with 34 members of staff. This included the registered manager, two deputy managers, the regional director, eight registered nurses, three senior care workers, eight care workers, two housekeeping staff, five catering staff, two administrators, activity co-ordinator and maintenance person.

We examined various documents including 11 care records, 17 medicines records and personal emergency evacuation plans (PEEPs) for people using the service. We reviewed 10 staff files including staff recruitment, training and supervision records, minutes of staff meetings, audits and various policies and procedures

including adult safeguarding procedures. We used the Short Observational Framework for inspection (SOFI) for a period of 30 minutes on four units of the service. SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Is the service safe?

Our findings

Medicines were not always managed and administered safely. We looked at Medicine Administration Records (MAR) on three of the five units within the service and observed medicines administration rounds. We observed a staff member did not administer medicines safely because they had prepared medicines for three people using the service and signed all three MAR in advance of administration. We spoke with the management team about this. Immediate action was taken to address this and measures put in place to ensure this did not reoccur.

Guidance for how to administer medicines covertly was not always clear and some decision forms were incomplete. This included guidance about medicines which should not be crushed before administration. This was highlighted as a concern at the last inspection of the service in June 2016. We had recommended the service seeks and follows best practice guidance in the management of medicines in care homes. When people required their medicines crushed, a pill crusher was used. We found this contained powdered residue and was not effectively cleaned after use.

Arrangements in place for recording the administration of medicines were not always clear or fully completed. Records were not always checked to ensure correct information was available for treatment. The service had omitted to recognise an issue with medicines for a person using the service recently discharged from hospital.

One person's MAR chart showed they had missed medicines due to lack of stock. This had not been reported as a safeguarding concern or investigated by the service. The service was in the first cycle of changeover to a new pharmacy provider and there were issues related to supply and communication. Recording of some medicine stock balances did not reconcile when stock was received from the supplying pharmacy. Staff explained the concerns found were a record keeping error and action would be taken to rectify this. The registered manager told us they were working closely with the pharmacy to resolve the issues.

On 20 July 2017 the registered manager submitted an action plan addressing the medicines concerns we had highlighted. We saw records of completed medicines competency assessments for all nursing staff on 27 July 2017. We received an update on 3 August 2017 confirming people using the service who required medicines administered covertly had their assessments and agreements updated.

People told us they received their pain relief medicines when needed and their individual requirements were met and discussed with the nurse administering their medicines. Medicines taken as needed or as required are known as 'PRN' medicines. Information was available to enable staff to make decisions as to when to give these medicines. However, we noted a lack of monitoring of some PRN medicine administration protocols with dates for review incomplete or missing.

The service stored and managed controlled drugs appropriately. Controlled drugs are medicines which the law requires are stored subject to special storage and recording arrangements.

Medicines requiring cool storage were stored appropriately at the correct temperature. However, on one unit the medicine fridge was also used for storing specimens. This practice was brought to the attention of the registered manager. On 20 July 2017 we received confirmation that a fridge had been purchased for storing specimens.

Risks to people were identified with plans in place to manage them. Risks assessments were updated six monthly and more often when people's needs changed. These assessments included risks associated with specific medical conditions, pressure areas, infection control, mobility and falls, nutrition and behaviour that challenges the service. Staff were aware of individual risks to people. However, there were instances where risks were not managed appropriately and left the person vulnerable. For example, some people had medicines administered via a flexible feeding tube is placed through the abdominal wall and into the stomach called a PEG which stands for percutaneous endoscopic gastrostomy. Not all medicines administered via the PEG were recorded as such on the MAR chart. The providers policy states to ensure all medicines are suitable for administration by this route and risk assessments kept with the person's MAR. We did not see this procedure followed which meant staff may not be aware of the risks or guidance to mitigate these risks.

One person had a bedrail assessment carried out because of their risk of falling out of bed. The bed was fitted with padded covers to prevent risk of entrapment. However, another rail on the bed that was not in use was left unsecured and could present a risk of injury. There were bedrails on other beds that were not secured and staff did not have keys to secure the rails. By the end of the first day of our visit the bedrails had been secured. On the second day the maintenance person had made keys available to all units to enable staff to secure bedrails when required.

The approach to recording risk assessments was not consistent. There were several risk assessments in place for people and their environment. However, the level of detail and actions to mitigate risks although known by staff was not always documented. Some included how to manage behaviours that challenged the service. Triggers to behaviours were not always noted. Similarly another person's risk assessment for refusing to take their medicines did not have a clear escalation protocol following consecutive refusals.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have sufficient systems in place for the proper and safe management of medicines or to assess the risks to people's health and safety.

Other risk assessments such as moving and handling, risk of scalding from hot water, fire hazards caused by the use of soft paraffin were in place. People were protected from the risk of developing pressure ulcers and their treatment was overseen by the local NHS tissue viability nurse when required. People with medical conditions that affected their immune system had a universal risk management plan in place. There was information to guide staff about the safe management of the person's condition.

People and their relatives had mixed views about staffing levels at the service and felt there were not enough staff at night and during the weekend. When asked if they thought there were enough staff available to meet their needs one person told us, "Yes and No. Yes as it is at the moment but not at times when there is a crisis or an incident." Another person said, "There doesn't seem to be. You ring the call bell they don't come for half an hour." One relative told us they felt there were not enough staff which meant staff did not have time to talk to them. However other people felt were enough staff available. One person told us, "There is always staff about when you need them."

We asked staff about staffing levels. One staff member said, "It's unbearable sometimes no breaks all day we

don't have time to spend with the resident sometimes." Another staff member told us they 'felt rushed' often staying beyond their shift times "to get everything done." One nurse said, "Medicine rounds goes on until late because there are too many people to give medicines and there are only the two of us. We are also disturbed by the other staff who seek advice and help and this does not help us to complete the medicine round on time. We really need another nurse." We observed nurses stopped the medicine round to complete dressings that needed be completed at a certain time. Staff told us they often had to work beyond than their allocated hours to ensure people received care.

Staff told us more time was needed to address clinical needs as the targets were set by the management team who were aware of staffing concerns. Staffing levels varied on each unit depending on the needs of people using the service. The service used a dependency tool to allocate staff numbers to each unit. We reviewed the staffing rotas from 12 June to 9 July 2017 to check staffing levels and found them to be consistent with the exception of a few dates and shifts and on one unit where we saw the staff levels were consistently one nurse and two care workers for 34 people.

The registered manager told us they were employing more bank staff to reduce the amount of agency staff used. The service currently had permanent vacancies for two nurses and four care staff. There was now a pool of 30 bank staff available to cover shifts at short notice due to staff absence. On the first day of inspection interviews were being carried out to recruit care workers. The manager was confident they would appoint two candidates subject to references.

We remain concerned people using the service may be at risk of not having adequate staff available to meet their needs. The above findings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service had mixed views about how safe they felt. One person told us, "I do I feel safe in myself. The staff are nice people." Another said, "Yes just look around me. They take very good care of me." Other people told us they did not always feel safe because some people using the service displayed behaviour that challenges. One person told us, "Well no one is going to break in and do me any harm but I don't feel I am in the right place and I don't feel safe around the other patients. They have different needs to me and that makes me feel uncomfortable"

The service had a safeguarding and whistleblowing policy and procedure in place to guide practice and records confirmed staff had completed the relevant training. Staff were knowledgeable about the process for reporting abuse and knew who to notify. Staff were confident about raising concerns about unsafe practice. We looked at safeguarding concerns raised by the home and investigations carried out by the local safeguarding team. At the time of our inspection an allegation was also being investigated by the police. We saw records of actions taken by the service and management plans put in place to mitigate recurrence of such incidents. However, we found the service had not reported as a safeguarding concern or carried out an investigation when people missed their medicines due to issues with the availability of medicines.

The provider had a staff recruitment procedure in place. Staff were employed subject to the completion of various checks including references, proof of identification, eligibility to work in the UK and criminal record checks. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people using the service.

Nursing staff had their registration status with the Nursing and Midwifery Council (NMC) checked by the service to ensure they were registered to practice. We found all nurses working at the service up to date NMC registrations and no restrictions on practice.

Infection control policies and procedures were in place and monthly audits were carried out. Staff were clear about infection control procedures including those put in place when people using the service had symptoms of a suspected infection. Staff wore aprons and gloves when serving meals, carrying out cleaning or preparing to support people with personal care. Staff followed infection control procedures to minimise the risk of infection. This meant the service had processes in place to minimise the risk of the spread of infection.

The service had procedures in place for fire safety including weekly fire alarm checks and staff training in evacuation procedures. Fire evacuation procedures were based on each person's needs and mobility. However, on the first day of the inspection staff on three units were unable to locate plans. When located the plans seen were out of date and had not been reviewed to reflect people's needs since 06 April 2016. On the second day of the inspection we saw action had been taken and noted PEEPs were located in each unit and were accessible for staff in an emergency.

Systems were in place for the maintenance of the building and equipment to monitor the safety of the service. Maintenance records were up to date. Checks included audits of the environmental health and safety and equipment checks.

Is the service effective?

Our findings

At the last inspection in June 2016 we found staff were not always supported to receive training to enable them to fulfil the requirements of their role. Staff did not have positive experiences regarding their supervision sessions and did not always receive appropriate support they required to carry out their roles through supervision meetings.

At this inspection we found staff had mixed views about their supervision sessions. Supervision meetings were held so staff and their manager could discuss the staff member's on-going performance, development and support needs, and any concerns. Records of supervision meetings showed supervision sessions took place every two months. Supervision was done in groups as well as individually. Group supervision covered topics such as infection control, documentation, dress code and appearance. Individual supervision reviewed performance and identified development needs addressing issues such care practice.

Care staff were positive about supervision meetings. One staff member said, "Supervision is good, we get told if we do something well and if we need to improve in other things." Another said, "Really good, its changed for the better, more useful now." Nursing staff were less positive about their supervision meetings and felt they were not provided with the support to meet people needs effectively. One staff member said, "I have doubts about the quality of the supervision. First it is not regular and most importantly it is not about ensuring that my knowledge and skills are in line with good practice. Supervision here is about the senior staff telling you what to do". Another said "At least five staff have left because of meaningful professional development and stress. One staff left recently without giving notice. [Staff member] refused to come back to work because was so stressed."

Records showed training courses attended by all staff annually. The service had a designated training co-ordinator who carried out group and one to one training with staff as required. Care staff told us they received appropriate training and could recall training completed. Records showed additional training was scheduled when learning needs were identified. Staff gave examples of training delivered as an extra training session. However, nurses told us two clinical training dates had been cancelled and they were worried they may not be able to gather enough evidence to revalidate their registration. One staff member said, "I am due to have my revalidation soon and I am worried about my training. My training had been cancelled recently and I don't know when it has been rescheduled." We saw within appraisal records that revalidation of nurses was discussed.

The service had an induction procedure which covered all aspects of working at the service. Prior to the commencement of employment, all staff underwent an induction programme which included shadowing training activities and assessments. Staff told us they had found the process useful. Care staff were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within 12 weeks of starting. However, we found six files checked had no record of staff induction. This meant the service did not ensure induction records were up to date.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not always supported to receive on-going training to enable them to fulfil the requirements of their professional role.

Staff appraisals took place annually. Appraisals were detailed and contained information about development goals and training needs were identified. Systems were in place to ensure appraisals were up to date and indicated when the next meeting was due.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The service was working within the principles of the MCA. Care records included appropriate assessments of people's capacity to make decisions. There were communication plans in place which explained how staff supported people to participate in decision making. Records showed the service complied with DoLS, with applications submitted to the local authority when people were subject to restrictions to their freedom.

The management team were knowledgeable about the MCA and completing mental capacity assessments for people using the service. Records showed staff had attended MCA and DoLS training however, some staff demonstrated knowledge gaps in their understanding of MCA 2005. We discussed these findings with the management team. On the 4 August 2017 the registered manager confirmed they had addressed the concerns we raised about staff knowledge including individual and staff group supervision sessions. We were satisfied the service had taken appropriate action to address the concerns raised during our inspection of the service.

People using the service told us staff obtained consent before carrying out care or providing support. One person told us, "Yes, they ask you first." Another person said, "They tell you what they are going to do." Staff were knowledgeable about how to obtain consent before they carried out any aspect of care or support. One staff member said, "Our residents sign consent forms for things like photographs and support but that doesn't mean that you should not ask each time you are going to do something for them. You always ask." Peoples care records showed they had signed consent to care and support where able to do so.

Care plans contained information about the nutritional and hydration needs of people using the service. The malnutrition universal screening tool (MUST) was used to assess people with the risk of malnutrition. Care records showed specialists, such as dieticians were involved in the planning and monitoring support given to ensure their nutritional needs were met. Care records included monthly weight monitoring charts as well as dietary and food texture needs. People's likes and dislikes in relation to food and drink was clearly documented.

People told us they enjoyed the meals at the service. One person said, "Good dinners here, plenty of food." Another person said, "I've always needed tea and toast as soon as I'm awake and I always get it. Then I have a second breakfast, my real breakfast. The carers are really kind they make sure I get that." A relative told us, "They [staff] are so good with the meals they tempt my [relative]. They've sent out for Chinese and Indian takeaways, anything to tempt her."

People using the service had access to appropriate meals to ensure their nutrition and hydration needs were met. The kitchen team were aware of people's specific dietary needs to manage medical conditions. Allergies, cultural needs and if people required a soft or pureed diet was catered for. Information relating to people's needs was displayed in the kitchen to guide the team. Meals were prepared especially for people who had a poor appetite or required meals that were not on the menu and included fortified drinks for people who had poor appetite. Snacks were provided throughout the day and evening for people using the service and a variety of drinks were available to people and were placed within their reach.

One member of the kitchen team said, "It's not an issue if someone wants something different. The younger people here love chicken so they can have that if they want. We've done Chinese meals and special foods when there's an occasion like St Patricks day." One person using the service told us, "The kitchen makes me things if I want my own kind of food."

We observed meal times on three units and in the main dining room and noted people enjoyed the lunchtime experience. People sat at dining tables with their friends or had their meals while watching the television. Staff supporting people with their meals did so patiently maintaining their dignity by ensuring any food spilled was cleared. Staff spoke with people during the meal offering more and providing drinks.

Records showed the relevant safety checks were carried out daily in the kitchen, for example temperatures of the fridges, food labelling and expiry date checks and reheating guidelines.

People told us they were supported to access healthcare services and receive on-going healthcare support to maintain their health. One person said, "Yes the doctor comes every Wednesday. I see the Chiropodist every six weeks." Another person said, "Yes the local GP, he is a nice person. I see the chiropodist. I don't really need to see the optician." Peoples care records contained information relating to various appointment letters following on from referrals and people were supported to attend specialist health appointments. People had regular dental appointment, eye checks and hearing aid checks. Records confirmed twice weekly GP visits took place to review the health needs of people living at the service. The GP could also be contacted for visits at other times if people became unwell. Records showed and we observed visits to the service from various health care professionals such as mental health team, speech and language therapists, palliative care team and dieticians.

Is the service caring?

Our findings

People and their relatives told us the service was caring. One person said, "The carers are very kind, top marks from me." Another person said, "They are more than caring. For example, they get things for you if you need them, if you are not well." Other people described the staff as "Excellent," "friendly" and "kind." One relative said, "The staff are kind and explain things well."

Staff told us they felt it was a caring service. One ancillary staff member said, "I've not seen anything that's not caring. I think we are a good home, the carers and nurses are very good." Observations showed staff interacting with people in a kind, respectful and personalised way. There was laughter and good natured exchanges between staff and people using the service.

People told us they had developed good relationships with staff. One person when speaking about two staff members said, "They are just like us, we all guys together and they sometimes take us out and we have a good laugh. Lots of laughs." Staff described how they developed relationships with people including speaking with the person and their family to gather information about their life history and their likes and dislikes. One member of staff told us, "We get to know them and their needs, to be there for them. I treat them well because that's how I would want my parents and grandparents to be treated." However, staff were concerned there was not always enough time to speak with people using the service. At times they felt their work was task focused.

We recommend that the service seek advice and guidance from a reputable source, about supporting people and involving them in their care, treatment and support.

Staff were aware of people's communication needs. Staff took time to listen to what people were saying. They spoke slowly, maintaining eye contact ensuring they were at each person's eye level when speaking with them. Care records had communication guidelines to help people make choices.

Staff responded to people's wishes. For example a young person with complex physical needs had expressed a wish to be transferred to the unit with younger people. Whilst this was being organised, the staff provided them with opportunities to meet with younger people by arranging visits to the unit and facilitating opportunities for them to participate in activities.

Staff provided information and explanations when supporting people with daily living activities. Staff told us how they promoted people's dignity, choice, privacy and independence. When asked how they promoted dignity one staff member told us, "If I take their top off I keep them covered with a towel so they are comfortable and not exposed or embarrassed. I maintain their dignity it's important." We observed staff knocking on bedroom doors and waiting for a response before entering.

People using the service told us the service respected their privacy. One person said, "They seem to respect my privacy quite a lot." Another person said, "Yes if I want to come to my room they shut the door and don't come in."

People told us they had choices. One person said, "I decide when I go to bed and when to wake up no one decides that for me." Another person said, "I can have a lazy day and not join in with anything." Staff told us how they ensured people had choices.

People were supported to remain independent and were encouraged to participate in activities outside the service. They told us about different groups they attended with staff support. Staff involved people using the service in small tasks to keep them independent. One person using the service was involved in helping to settle new people into the service by chatting with them and showing them around. Staff told us they asked people if they would like to go with them when they took the tea trolley back to the kitchen or went to collect laundry so they felt involved.

People were supported to take part in their cultural or spiritual practices. We observed one person speaking with staff about their own religious beliefs and saw staff listened carefully and asked questions. People using the service told us staff ensured they could attend cultural events and records showed they were supported to take part in religious services. Staff knew about peoples cultural backgrounds and told us how they supported them with preparation of specific meals and observing cultural practices. One person told us, "They [staff] give the ingredients and the carers help me cook." The service had a kitchen on one of the units designated for this purpose. We observed staff speaking with people about their childhood in other countries. Staff were attentive and interested and brought other people into the discussion to share their experiences.

People told us they were encouraged to give their views about the service. One person said, "Yes they do, they are advertised and we all go downstairs every couple of months and have a meeting." People using the service told us they were invited to be involved in the service with one person explaining they had the role of chairperson. Residents meetings took place on average once every two months and we saw records of these. The service had a fast track feedback form so people and their relatives could give on-going feedback about the service. People told us they completed surveys about the service and results showed people were satisfied with the service and rated it as excellent for care and support, food and drink, safety and security and being treated with dignity and respect.

At the time of our inspection the service was supporting people who were at the end of their lives. Care plans were reviewed or updated on a daily, weekly or monthly basis to ensure they were receiving the appropriate care in line with their wishes. Care plans included advanced care planning with peoples wishes stated for end of life preferences and included preferred place of care and specific funeral plans. Staff knew peoples wishes. One staff member told us about the recent death of someone using the service and how they had provided care to the person and support to their family. They said, "We all made sure they had the best death, it's so important that we work with the doctor and end of life team." Staff had bereavement and end of life training and worked closely with the GP and Macmillan nurses to support people at the end of their life. The service had a procedure for ensuring staff could identify people who at the end of their life did not want resuscitation to be attempted. Records showed there had been discussion with the person and with the involvement of their family members and medical professionals.

People's individual need for maintaining meaningful relationships was included in their pre-admission assessment and in care plans. At our last inspection of the service in June 2016 we recommended the service seek and follow best practice guidance on supporting people who identify as lesbian, gay, bi-sexual or transgender (LGBT) in care homes. At this inspection we found staff had attended equality and diversity training and care files contained information relating to people's needs and staff explained how they ensured people were respected and valued by staff and each other.

Is the service responsive?

Our findings

We found inconsistencies in the opportunities for people to take part in meaningful activities. People using the service and their relatives had mixed views about activities at the service. When asked if there were enough activities one person said, "There are none since [staff member] went. I have never seen them do anything. No exercises sitting down is the activity. The quieter people are the better for them [staff]." Another person said, "This is it watching the television. There are people here they need a lot of looking after." However, other people said there were activities available. One person told us, "Backgammon, Chess, Draughts, arts and crafts, live music and a singer, DVD'S, video." Another person said, "I went to play Bingo today I love it."

Care plans contained information about the types of activities people enjoyed however; not everyone using the service had an individual planner for activities.

We observed the morning group activity in the main lounge. Activities were interactive with the activity co-ordinator and care staff supporting people in small groups to participate in flower arranging and making greeting cards. Other people spoke with care staff while watching television.

We noted that on some units there was limited activity and people mainly watched television although staff did interact with people during this time. One unit had some renaissance décor in some areas perhaps to encourage reminiscence therapy although we did not see this type of activity during our visit. This meant the service was not always responsive to people's preferences for meaningful activities.

The service had two activity co-coordinators. One had recently joined the service. Activities included monthly music therapy, arts and crafts, games, cake decorating, film afternoons and flower arranging. When people were unable to join in with group activities one to one activities took place in their bedrooms. This included reading, hand massage and manicures, tea and a chat, dominoes and card games. Staff said, "We try to do two or three individual activities in the afternoon." They said it was difficult to do more activities without input from care staff who were sometimes "busy." Staff spoke positively about the work the activity co-ordinators did but expressed the need for more activity staff to facilitate weekend activities.

There was a programme of activities displayed at the service. We asked how people using the service knew about activities taking place. Staff told us the weekly activity programme was not given to everyone but to people who asked for it. They said, "I go round to each person and let them know what activities take place but now I'm thinking I should give out a weekly planner to each person."

We recommend that the service seek advice and guidance from a reputable source about supporting people to participate in meaningful activity of their preference.

People told us they took part in an initial assessment before living at the service. One person told us, "When I first came here we all talked about the care I would receive." Another person said, "We sat down and went through everything." All care records reviewed had details of an initial assessment and up to date person

centred care plans for each person.

People were involved in discussions about their care and treatment. One person said, "Yes my care plan gets updated regularly." Another person said, "Yes I have spoken with [staff member] about my care and I have done a dementia test. I have also spoken with an advocate." One relative said, "We've had meetings about mums care and what she needs." There was a section with hopes and concerns for the future which could be further developed to support people achieve their aspirations as these were not always detailed. One staff member said, "I am the named nurse for six persons. This means that I am responsible to write their care plans and review them. I would like to discuss care of people with their relatives but don't always find the time for example last night I stayed back two hours to discuss a person's care with the relative." They showed us a record of the discussion with the relative.

Care records demonstrated that people had effective plans in relation to their care and treatment. Care plans were detailed, personalised and included information about people's individual needs as well as their preferences such as their preferred names and food. Details about medical conditions, religious beliefs and personal life history were clearly documented. Care plans were reviewed and updated every six months and evidenced involvement of people and their relatives at least once a year.

Each person using the service had a keyworker. A keyworker is a staff member who is responsible for overseeing the care a person receives and liaising with other professionals involved in a person's life. Where relevant, people's families attended the care plan review meetings and this was documented. This meant people had up to date care plans which reflected their needs and preferences.

Staff were able to explain how they used the care plans and risk assessments to ensure appropriate care was given to meet people's needs. Staff we spoke with told us, "We check the care plans daily. It's all our responsibility to make sure the information is up to date that way you give the correct care."

The service gave people choice and encouraged individuality. People were given the option to decorate their rooms to their own individual styles and most rooms were personalised with peoples own furniture. People told us they liked their rooms and described it as "My space" and "Just the way I like it."

The service had a complaints policy and procedure. People using the service and their relatives said they knew how to complain if they needed to. One person told us, "I would complain to the staff but I don't need to complain about things as everything is well." Another person said, "I would go to the top. I have never had a complaint before." Relatives said they would speak to the management team if they had any concerns. The management team and staff were able to explain how they would deal with a complaint. We looked at records of complaints received by the service. All complaints received had been responded to and resolved in line with the providers' complaints procedure.

Is the service well-led?

Our findings

Quality monitoring systems in place were not used effectively and did not identify the issues we identified during the inspection such as training and quality of staff supervision meetings. Incomplete records relating to recruitment, fluid intake, and personal emergency evacuation plans and medicines management were also not identified. The management team had not managed the delay in the supply of medicines for people using the service and had not identified issues with the administration and management of medicines. Staff had recorded a list of concerns relating to medicines stocks and informed the management but it was not clear how this information had been used in a timely manner to resolve issues. We were concerned that people using the service may not have received their medicines in line with their prescriber's intention; the provider's policy or those systems were in place to monitor the management of medicines effectively.

The registered manager and deputy managers had responsibility for completing audits. Records of audits included care planning, risk assessment, nutritional needs, wound care, infection control, falls monitoring and medicines management. The provider had service improvement action plans from each audit used to improve quality of service delivery. However, we found action plans generated from findings of audits did not always include details of when actions were completed. The management team were not always able to give an update regarding actions taken as information was not consistently entered in records relating to actions. We found gaps in audits. For example, monthly audits of care plan reviews had been carried out in February and May 2017 but not in March, April and June 2017. Records were not always maintained and audits did not identify shortcomings. For example there were fluid balance charts in use to record the fluid intake and output. The target amount was not always identified and added up at the end of 24 hours.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the audit systems were not used effectively to monitor the quality of the service.

As part of the quality monitoring there was a 'Resident of the day'. This person had their care file including care plans and risk assessments reviewed, maintenance checks completed in their room, and they received a special meal and activity of their choice. This meant the service had a system in place to monitor the quality of records and service provision.

People using the service and their relatives knew the management team and told us they found them approachable. One person said the deputy managers were "very supportive." A relative said, "The manager is approachable and explains things." Throughout our inspection we saw the management team knew the names of people who used the service and interacted positively with them and their relatives

The Staff had mixed views about support they received from the management team. Staff told us morale was low at the service and had led to staff leaving. One staff member said, "When I speak to the [management team] I don't think [management team member] takes me seriously, because things don't change." Another staff member said, "I don't have the time to supervise the work of the carers because there is so much to squeeze in a short space of time. The [management team member] sets unrealistic targets for

us." However, other staff did not share these views. One staff told us, "[management team member] is always around, very easy to talk to and supportive." Another said, "Very visible. All we have to do is call or ask." When asked about the registered manager they said they had minimal interactions and therefore could not comment. One healthcare professional shared their observations of the culture of the home. They said, "The deputies do an excellent job but from what I have observed they are not supported by the manager and relies too much on the deputies and I feel if it continues good staff will leave."

Staff told us they supported each other. One staff member said, "It's a good team and good communication between the carers and the nurses, kitchen and laundry everyone works well together." Another staff member said, "We all know each other even though it's a big home and we can work on any unit and just get on with it."

The service had a registered manager who had been working in the service for ten months at the time of our visit. They told us they were "proud" of the staff team for the care they provided and team work they demonstrated. They told us they worked together to develop a culture which was supportive. Staff were nominated by their peers and people using the service for 'Staff member of the month'. Good practice and team work was recognised and units received awards in recognition of this. The service had two deputy managers. One was responsible for the three units supporting younger adults and people with complex needs. The other deputy manager was responsible for the residential and nursing units in the home. They had joint responsibility for clinical practice and we observed they worked well together.

The management team told us they felt supported by senior management. They said they had regular visits and audits carried out to improve the service. There were support structures in place for nursing staff which included internal and external peer support. The provider had a clinical regional nurse who provided training and support for nursing staff. The management team met with senior managers and registered managers of the other services within the providers group to ensure they kept up to date with best practice.

The service sought feedback from relatives about the service. Meetings took place at the service and relatives told us they could speak with the management team outside of the meetings and didn't have to wait to raise any concerns or ask questions.

The service worked in partnership with other agencies and health professionals. One health professional told us, "The staff respond to the needs of their residents and know who to contact and when. If they are unsure they will contact me. I have a good working relationship with the staff and they have embraced the philosophy of [medical condition] comfort and care. They have a good relationship with their GP practice that is based on respect and reassurance." Another healthcare professional said the service "remains good when it comes to care and treatment." Both health professionals were complimentary about their interactions with staff, communication and documentation in the nursing records and professional knowledge of staff.

The service had daily 'Stand up' staff meetings. These meetings were attended by a representative from each unit and included staff from all departments of the service. Records showed discussions included clinical overview, staffing and management updates. Staff told us and records showed monthly team meetings had taken place. Team meetings were categorised by department and unit. There were records of recent meetings for each department or unit.

Accidents & incidents were managed by the service. We saw records of incidents that had taken place involving people who use the service. Recommendations had been made and recorded following accidents and incidents to prevent reoccurrence. Serious incidents were reported to the local authority safeguarding

team however notifications of incidents were not always submitted to the Care Quality Commission in a timely manner. Staff we spoke with knew the procedure for reporting accidents and incidents.

During the inspection the registered manager was open about areas of improvement. Throughout the inspection we requested records and information from the registered manager, deputy managers, care staff, nurses and administration team which was provided promptly and with detailed explanations. All staff were helpful, co-operative and open in their engagement with the inspection team.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	<p>The provider did not follow policies and procedures for managing medicines. 12 (1) (2)(f)(g)</p> <p>The provider did not always include plans for managing risks. 12 (1) (2)(a)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>Systems or processes were not established and operated effectively to ensure compliance with the requirements. 17(1)</p> <p>The provider did not ensure that their audit and governance systems were effective. 17(2)(f)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p>Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of people using the service. The provider did not ensure persons employed by the service receive appropriate support, training, professional development and supervision and necessary to enable them to carry out the duties they are employed to perform. 18 (1)(2)(a)</p>

