Midland Healthcare Limited

Rushey Mead Manor Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 May 2018 and was unannounced.

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

Rushey Mead Manor provides nursing and residential care for up to 50 older people, some of whom are living with dementia and/or physical disabilities. The home caters for people from a range of cultural backgrounds. It was purpose built with accommodation on three floors and a passenger lift for access. The service has lounges, a dining room, and gardens. When we inspected there were 43 people living at the home.

The home had a registered manager. This 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 time of our inspection the registered manager was not at the home.

Improvements were needed to the way medicines were managed. Care plans and risk assessments were not always fit for person and people were not always receiving personalised care in line with their preferences and requirements. The oversight, monitoring, and day to day running of the home had been ineffective and failed to identify shortfall in the service provided.

People told us they felt safe living at the home and said they had confidence in the staff. They said the home had a happy and friendly atmosphere and the staff were caring and treated them with compassion and kindness. Staff encouraged people to make choices about their daily lives and communicated with them, where possible, in their preferred language. People said they could get up and go to bed when they wanted and follow their own routines.

The management team were in the process of updating and improving the home's staff training programme. People told us the staff were well-trained and gave us examples of staff supporting them in a skilled and effective way. Staff helped to ensure people's medical needs were met and accompanied them to appointments were necessary.

People said they were satisfied with the food served. Improvements were being made to the menu to help ensure the full range of people's dietary needs was met on a daily basis. The premises were in need of redecoration and improvement to make them more suitable for people's needs.
Staff understood the importance of people consenting to their care and support. Relatives said they could visit when they wanted and were made welcome by staff.

The home had an activities programme and we saw some group activities taking place. These included an indoor ball game, colouring pictures, and singing religious songs. Activities staff were being re-trained to help ensure they had the skills and knowledge they needed to provide suitable and accessible activities to everybody who wanted them.

People and relatives said they would speak to staff if they had any concerns about people's care. The home's complaints procedure, which was displayed in the reception area, was being improved and updated to make it more user-friendly and readable.

At the time of our inspection visit the home was undergoing a period of rapid change. A new management team was in place. They acknowledged the home needed to improve and had begun to make positive changes to the way it was run. People, relatives and staff were involved in making decisions about the home and the management team were approachable and easy to contact.

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

This service was not consistently safe.

Improvements were needed to the way medicines were managed at the home.

Risks were not always managed and reviewed regularly to keep people safe from harm

Staffing levels were satisfactory and subject to ongoing review.

People were protected by the prevention and control of infection.

Lessons were learnt following accidents and incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to the premises to meet people's individual and collective needs.

People's needs assessment did not provide staff with all the information they required to provide personalised care.

Staff had the training they needed to provide effective care. People were mostly supported to eat and drink enough to maintain a balanced diet.

Staff understood the principles of the Mental Capacity Act 2005, including gaining consent to care and people's right to decline their care.

Is the service caring?

Good

The service was caring.

The staff were kind, caring and compassionate and understood the importance of building good relationships with the people they supported.

People had a say in which staff members worked with them to ensure their preferences and diverse needs were met.

Staff supported people to be independent and to make choices. People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

Improvements were needed to ensure people received personalised care that was responsive to their needs.

Some care plans were not being followed and some did not include personalised information about people to enable staff to get to know them as individuals.

Information in the home needed to be made more accessible to people.

A complaints policy was in place and information readily available to raise concerns. People knew how to complain if they needed to.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Comprehensive audits to review the quality of care and nursing provided had not been regularly carried out.

People, relatives and staff had not been engaged and involved in how the home was run.

A new management team was making improvements to the home and working in partnership with other agencies to enhance this process.

Rushey Mead Manor Care and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was prompted in part by concerns raised by the local authority and NHS Clinical Commissioning Group (CCG) about the quality of care at this home

This unannounced comprehensive inspection, took place on 3 May 2018. It was carried out by two inspectors, a specialist nursing advisor, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience one this occasion had experience of services for people living with dementia.

Prior to the inspection visit we reviewed information that we held about the service such as notifications, which are events, which happened in the service that the provider is required to tell us about.

During this inspection, we spoke with seven people and three relatives. We spent time observing the people living in the home to help us understand the experience of people who could not talk to us. We spoke with the current management team consisting of the manager, a registered manager from one of the provider's other homes, and the provider's group operations director. We also spoke with two nurses, two senior care workers, three care workers, and an activities coordinator.

We looked in detail at six people's care records. We looked at information relating to other aspects of the home including safeguarding, medicines management, staffing, and quality assurance systems and processes.

Requires Improvement

Is the service safe?

Our findings

Improvements were needed to the way medicines were managed at the home. The medicines room's temperature was recorded daily. Records showed that on a number of occasions over the previous four months the room had reached an unsafe temperature of 28 degrees centigrade. This was of concern as storage conditions can influence the stability of medicines and recommended temperatures in medicines storage areas should not exceed 25 degrees centigrade.

There were systems in place for the disposal of unused medicines. However records showed that two controlled medicines belonging to a person who was not longer at the home had not yet been disposed of. A nurse told us this was an oversight and would be addressed.

Records showed that nurses checked controlled drugs records daily and signed and dated to show they had done this. However checks did not record stock levels of the medicines being used so the amount of these medicines being kept in the home was not clear.

We saw a nurse signing a record to say a medicine had been administered ahead of it actually being given to a person. In addition, the actual time medicines were given was not always recorded on the medicines administration records (MARs). All medicines were signed for against a scheduled time but some medicines were given later than that time.

There was no evidence of pain assessments being carried out for people receiving pain relieving medications. This meant we could not be sure that people were having these medicines when they needed them.

A syringe used for percutaneous endoscopic gastrostomy (PEG) flushes was kept in a person's bedroom once opened and a nurse said it was changed weekly. However there were no records to show when the syringe had been opened or changed.

The home's medicines policy and procedure, attached to one of the medicine trolleys, was water damaged so only part of the policy was legible.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The registered persons did not ensure that medicines were managed safely in the home.

We brought these issues to the attention of the management team. Following our inspection visit they sent us an action plan setting out how they would make improvements to their medicines systems and processes to ensure they were being safely managed.

People told us their medicines were given to them on time and as prescribed. One person said, "I get my medicines. [Senior care workers] bring them and sometimes the nurse. They record what I have." Another

person told us, "My medicines are all up to date. I get them regularly."

We observed some good practice when medicines were administered. Staff told people which medicines they were taking and offered them drinks to take them with. If people needed assistance to take their medicines staff provided this, if not they were discreetly observed. The staff spoke kindly and respectfully to people to people using, where possible, the language of their choice. The lead nurse, a staff nurse and senior care worker were responsible for medicines administration and checked stocks and records to ensure they had been given safely.

Photographs were used on MARs to identify people and staff completed records legibly and in black ink as required. There was a clear coding system in use on MARs if a dose of regular medication was not given for any reason, for example if it was refused. If any new or additional medications were prescribed by a person's GP or other prescriber these were recorded on the MARs and signed by a GP on their regular weekly visits to the home.

We saw a medicine being disposed of and this was done safely and with appropriate records kept. Sharps bins were in place and being used appropriately. New spare bins were available if needed. Records were kept when medicines arrived at the home and the nurse on duty checked and signed for them, recording the quantity and the date received. The medicines storage room was secure, clean and tidy.

Improvements were needed to some people's risk assessments/care plans to ensure staff had the information they needed to support people to stay safe.

Records showed that people had risk assessments/care plans for key areas where they were at risk of coming to harm including falls, bed rails, tissue viability, infection, and capacity and decision making. However the information in some of these was contradictory and confusing.

One person was assessed as being at high risk of pressure sores and their records stated 'uses specialist aids to relieve pressure'. However when we met this person we found they were not using any pressure-relieving aids. We spoke with the nursing staff who said the person's risk assessment/care plan was incorrect as they could mobilise and move independently so did not require any pressure-relieving aids.

Another person was risk assessed as being at risk of falls. Staff had used a falls risk assessment screening tool to calculate their risk and concluded it was 'high'. However their care plan/risk assessment for falls, which had been reviewed on 16 April 2018, stated, '[Person] is a low falls risk status'. This was despite the person having had three falls in 2018.

Another person was risk assessed as being at 'medium' risk of falls. They had been re-assessed monthly in 2018 with no changes being made to their risk assessment. However nursing staff told us this person had recently become more unsteady on their feet and their health was deteriorating. Despite this their risk of falling had not been re-assessed.

Another person had a malnutrition universal screening tool (MUST) assessment stating they were not at risk of malnutrition. However records showed their weight had reduced over the past four months and, according to the nursing staff, they were regularly refusing food. Despite this they had not been re-assessed, no changes had been made to their nutritional care plan, and they had not been referred to a dietician or other appropriate specialist.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 Safe care and treatment. The registered persons did not ensure risks were managed safely in the home.

We reported these issues to the management team who said they were aware that not all risk assessments/care plans were fit for purpose. They said these were being reviewed and re-written using a new format supplied by the provider and all the issues we had raised would be addressed.

The management team were working to an action plan to improve health and safety at the home. This showed that staff had had recent training in health and safety and moving and handling, and fire safety training was booked. The management team were reviewing health and safety policies and procedures. A new fire risk assessment was in place and fire alarms serviced for 2018. New first aid kits had been ordered. Contractors had carried out gas and electricity safety checks and the home was awaiting certificates for these. The passenger lift had also been checked for safety. Security for the premises and all storage room had been improved. The provider had installed a new boiler to improve the supply of hot water throughout the premises.

People told us they felt safe living at the home. One person said, "The place is safe for me. I've had no falls or bruises. No-one shouts." Another person told us, "I have faith in the people who work here. I get on with them all on day and night shifts." A relative said their family member was 'safe and comfortable' at the home. They told us, "We [the family] have never seen anything untoward whatever time we come in to visit. There hasn't been any abusive behaviour."

The management team were focusing on safeguarding as an area for improvement at the service. They acknowledged that previous safeguarding incidents had not always been reported in line with agreed safeguarding protocols. They had met with the NHS clinical commissioning group's safeguarding lead and had taken advice on how to improve safeguarding practices at the home. The provider's safeguarding lead had also visited the home to review safeguarding policies and procedures and raise awareness about this issue. Posters and other information about safeguarding for people, relatives and staff were displayed in the home explaining what safeguarding is and how they could report issues and concerns.

Staff had been re-trained in safeguarding and whistleblowing with the trainers delivering the training in both English and an Asian language to ensure they were fully understood. The provider's safeguarding policies and procedures were being rewritten and improved and the manager told us this work would be completed by the end of May 2018. The staff we spoke with knew how to report concerns about a person's well-being to the person in charge of the home. They also knew how to escalate their concerns it they felt they weren't being listened to.

People had mixed views of whether there enough staff on duty to support them to stay safe and to meet their needs. Two people said they thought there were. One person said, "I use the buzzer to call staff. I can reach it. I don't wait long for them to come. They will explain if they are busy and I can wait if my need is not urgent." Another person said they thought there were enough staff and said they came to them in twos as they needed two staff to support them to mobilise. A further person said, "There are enough staff but I have to wait a long time. Up to half an hour in the lounge. If I ring in my bedroom they come quickly. In the lounge they are busy."

One person said there weren't enough staff. They told us, "No, there is isn't enough staff. Some days they come and sometimes they don't. Even at weekends and nights I see a shortage of staff. But recently it is changing for the better." A relative said, "The home could do with more staff. There isn't enough staff on at weekends." Another relative said they didn't know whether there were enough staff or not but told us, "Staff come within five and 20 minutes if we use the buzzer in the bedroom."

During our inspection visit there were sufficient staff to meet people's needs and records confirmed the usual number of staff were on duty that day. Staffing number at weekends were consistent with those in the week. Staffing levels had increased since our last inspection. Staff assisted people when they needed it and answered buzzers promptly. The staff we spoke with said they thought staffing levels at the home were satisfactory. A senior carer said, "There are enough staff and no-one is being neglected here. If we think we need more staff we tell the manager." A nurse told us that since the new management team took over they had been authorised, when in charge of the home, to get in extra staff if they needed them. This meant there would be no delays in getting cover if, for example, another member of staff was unable to come to work.

We looked at how nurses were deployed at the home. There was one nurse on duty at night and two during the day. People requiring nursing care were accommodated over three floors. This meant that at night one nurse had to cover the whole home. On the day of our inspection visit some people with nursing needs appeared isolated. For example, there were six people being cared for in bed on the second floor who had no specific staff members allocated to them.

The management team told us staffing levels were continually being reviewed and adjusted to ensure people's needs were met. They said some people's care was being reviewed, in conjunction with their families and social workers, to ensure their needs could be met on a long term basis bearing in mind staffing levels at the home. They said they were looking at staffing in relation to the layout of the home and proposing to have people receiving nursing care on one floor only to make it easier for nurses to stay close to their patients.

We looked at how staff were recruited to ensure they were suitable to work in the home. The management team was auditing staff files to ensure safe recruitment policies and procedures had been followed. They had brought in a senior administrator from one of the provider's other homes to support their own administrator in recruiting staff safely. Records showed staff had had criminal records checks and supplied references prior to starting work at the home.

People were protected by the prevention and control of infection. The home was mostly clean and tidy although there was some rubbish in the car park, including broken glass. The management team said this would be cleared up. Some carpets were stained despite having been regularly cleaned and needed replacing which the management team said would be done. Staff had had recent training in infection control and had the appropriate personal protective equipment, for example gloves and aprons, to prevent the spread of infection.

Systems were in place to help ensure lessons were learnt and improvements made when things went wrong. The management team had reviewed safeguarding, accident and incident, and notification records to ensure they had been appropriately responded to. They had also had a meeting with staff to explain the provider's reporting system for accidents and incidents to ensure they understood it.

The management team and the staff we spoke with recognised the need to be open and transparent in relation to accident and incident reporting. Records showed that a recent incident, when a person had left the home unaccompanied, had been promptly reported to the appropriate authorities including the police, the local authority, and CQC. To prevent a similar incident occurring, the person was being regularly checked, with records kept, and the security of the home had been strengthened and improved. This was an example of managers and staff taking action to reduce the risk of people being harmed.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed prior to moving into the home to help ensure they could be met. The assessments we saw focused on people's physical and mental health needs. There was little about them as individuals, for example life history, family, career, hobbies and interests. The management team told us the home's assessment documentation was being re-written and improved and in future would include section for more personalised information about those coming to the home. This would make it easier for staff to engage with new people and get to know them.

The management team acknowledged that prior to our inspection visit a small number of people with complex nursing needs had been admitted to the home. This had presented a challenge to staff who hadn't always been able to meet these needs effectively. The management team said the people concerned were being reassessed. They also said that future assessments would be more thorough and realistic to ensure the home was suitable for the people admitted.

People told us the staff were well-trained and gave us many examples of staff supporting them in a skilled and effective way. One person said the staff knew how to help them mobilise using a hoist and were experienced in catheter care. Another person told us how one of the nurses was 'very accurate with her job'. Other comments included: "The staff know how to care for me. I think they are well trained"; "The nurses monitor my sugar. The carers shower me every day and help me dress. I think they are trained"; and "The staff are very well trained. They give me personal care. They wash me, change me and take me out of the room and bring me back."

Relatives also said they thought the staff had the knowledge and experience they needed to care effectively for people. They told us how staff supported their family members with their health and social care needs and also knew them as individuals. One family member said, "The staff know [family member's] habits and mannerisms and their likes and dislikes."

Staff told us they'd had an induction when they started working at the home and ongoing training in general care skills and health and safety. A care worker told us staff had attended dementia care training. They said that as a result new staff uniforms had been issued in brighter colours as staff had learned this would make it easier for people living with dementia to recognise the staff.

The management team were in the process of updating and improving the home's staff training programme. Records showed staff had had recent training including fire safety, infection control, moving and handling, basic life support, safeguarding, and personalised care. Further and ongoing training was booked including a course on nutrition. The management team told us some staff had a first language other than English so to help those who needed support with their spoken and written English they offered them in-house English classes.

People were satisfied with the food served and said it met their nutritional and cultural requirements. One person said, "Everything is perfect. I get a choice. The cook will make what I want and I get enough to eat.

I'm advised [by staff] not to put on too much weight." Other comments included: "[The food] meets my religious needs"; "My diet is checked since I am diabetic"; and "My carers know me. They know my likes such as food." People told us they were regularly offered hot and cold drinks.

Relatives said people's food choices and preferences were catered for. One relative told us, "I tell staff what [family member] likes to eat and what they don't like and the staff do that." They said food was prepared according to people's wishes and in keeping with their cultural and dietary requirements.

The management team told us improvements were being made to the menu to help ensure the full range of people's dietary needs was met on a daily basis. Following our inspection visit this was discussed at a relatives and residents meeting. The minutes showed that the management team discussed menus with the people present and made it clear what food was available at the home and where it was sourced. This meant people could be sure the food served met their cultural needs.

Some people needed support with their nutrition and hydration to ensure they maintained a balanced diet. Records showed staff referred people to dieticians if there were concerns about their weight and monitored their food and fluid intake to ensure their needs were met. However we met one person who had begun to decline meals and had a low daily fluid intake. These changes had not been reflected in their care plan and it was unclear how staff were meant to safely support them. A nurse and a care worker told us they were giving the person milk and fortified drinks to boost their calories but they were still losing weight. We raised this person's well-being as a concern and the nurse agreed to review their nutritional care plan to ensure their nutritional needs were being met appropriately and in the way they wanted.

People told us staff helped to ensure their medical needs were met. One person explained, "I go to the hospital for appointments that the home arranges for me. If I want the G.P, they [staff] will contact them. If I am not well they will contact [the GP] themselves if I need a visit." Another person said, "If I need [medical attention] I will discuss it with the staff." They told us they had a hospital appointment the following day and staff would support them to attend.

Relatives said access to healthcare professionals was good. One relative said there were sometimes long delays in getting mobility and incontinence needs assessments done. The manager said people were referred as soon as they needed assessing, but the healthcare professionals responsible for these had waiting lists so it was not always possible for people to be seen as soon as they would like. Two people said they were suffering from depression and although they were being treated with medicines they said they were only getting limited emotional support from staff at the home. We reported this to the management team and said they would look into it and take action as necessary.

Staff worked closely with healthcare professionals to help ensure people's medical needs were met. A GP ran a weekly surgery at the home and a district nursing team supported people with residential care needs. Staff liaised with hospital and community specialists, for example the enteral feeding team, tissue viability nurses, and mental health specialists, so people received ongoing healthcare support as required.

The premises were in need of redecoration and improvement to make them more suitable for people's needs. In some places paintwork was scuffed and damaged, wallpaper peeling, and carpets worn. The home appeared institutionalised feel with uniform paintwork and few personal touches to make it more homely. The rear and side gardens were overgrown and unusable at the time of our inspection visit. We looked at four people's bedrooms. Three of these had bare walls, one had a few family photographs displayed. Other than that these rooms were not personalised or homely and did not reflect the lives or interests of the people living in them.

When we visited the downstairs communal lounge the television was on loudly playing pop music. One person told us they did like this music. Another person came into the lounge but did not settle, a staff member told us they could not cope with the noise. Walking frames were stored in this lounge and added to its institutionalised appearance, as did the chairs lined up around the edges of this room. There was little appropriate signage displayed in the home to assist people with sensory or cognitive impairment to orientate themselves. Nor were there any adaptations made for people living with dementia and others, for example objects of interest or reminiscence, interactive materials, and other experiences in the environment.

The management team told us they were aware that improvements needed to be made to the adaptation, design and decoration of premises. They said the home had been assessed by contractors and a redecoration plan was in place for the entire home. The home's maintenance team were receiving additional support and maintenance hours had been increased. Work had already started on some people's bedrooms. People and relatives were being invited to make suggestions as to colours and styles of redecoration. The management said improvements to signage and making the home more dementia-friendly would be carried out alongside the general redecoration.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Some people had restrictions on their liberty authorised by the local DoLS team. Staff used a DoLS 'tracker' to enables them to see whose these people were, and when their DoLS decisions needed to be reviewed and reapplied for if necessary. DoLS assessors attended the home regularly to review people's DoLS authorisations. Staff were trained in the MCA and DoLS and understood the importance of people consenting to their care and support. Some improvements were needed to mental capacity care plans to ensure staff knew how best to seek people's consent. The management team said these were being reviewed to ensure they were personalised and fit for purpose.

Good

Is the service caring?

Our findings

People told us the staff were caring and treated them with compassion and kindness. One person said, "The staff speak with good manners and respect my Asian ways and my age." Other comments included: "Staff do come and chat"; "The staff are alright. They know me. I'm definitely comfortable with them"; and, "Staff speak fairly often with me."

Relatives said staff were caring and kind towards their family members. One relative told us, "The majority of staff are very friendly and nice and will do things for you." Another relative said, "Staff talk with [family member]. They call him [appropriate term of endearment]."

We talked with staff about how they provided people with caring and personalised support. One care worker explained how people were always given choice and received care in the way they wanted it. They gave us examples of one person preferring to get up later in the morning, and another person who liked their things 'just so' in their bedroom. They said that people could have a bath or shower whenever they wanted.

Another care worker told us how they supported people to make choices, for example by holding up different clothes and letting them pick an outfit, and showing them plates of food so they could choose what they wanted to eat. The care worker told us, "We look at people's body language if they are unable to verbally communicate." They described how they spoke directly into one person's ear in order to communicate with them and said they could understand if you did this. These were examples of staff communicating with people in a caring manner and enabling them to make decisions about their lives.

People told us they were encouraged to express their views and be actively involved in making decisions about their care and support. They said they could get up and go to bed when they wanted and follow their own routines. One person told us, "I wear my own choice of clothes." Another person said, "They [the staff] come and check me in my room. The staff are alright with my habits. If I fall asleep they won't bother me."

One person told us they knew they had a care plan and said it had been recently reviewed and they had been involved in this. Other people weren't aware of their care plans but felt confident they could talk to staff about their care needs. One person said, "Staff talk to me about my care." Another person told us that staff supported them with their care whenever they asked. A relative said, "I am aware of [family member's] care plan and went through it last week."

At the time of our inspection visit the management team were reviewing people's care plans. They told us that in future all people and their relatives would be given the opportunity to be involved when care plans were written and reviewed to ensure their views were incorporated. Following our inspection visit this was discussed at a relatives and residents meeting. The minutes showed that the home's new care coordinator spoke about care plans and offered to meet with people and relatives on an individual basis to explain what they were and how they could be involved in them.

During our inspection visit we saw staff knocking on people's bedroom door before entering, treating

people, kindly and respectfully and using Asian languages and English to communicate with people in the way they preferred. Relatives said they could visit when they wanted and were made welcome by staff.

People told us that if they had any preferences with regard to the gender of staff who supported them with personal care these were respected. One person said, "I prefer women staff to care for me and I only get women staff." A relative told us their family member was supported by staff to shower. The relative said, "[Family member] gets male and female staff and is OK with that."

There was a board in one of the offices listing the names of the people living at the home and some information about them. This could easily be seen by anyone in the corridor through a glass window in the door and could be a breach of data protection. We discussed this with the management team who agreed to remove this information from public view. In addition, a relative of a member of staff regularly waited in the clinical room for the staff member to finish their shift. Confidential information was accessible in this room. When we brought this to the attention of the management team they said they would find a more suitable place for the relative to wait.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place but they were not always being followed and some were not fit for purpose.

One person, who was being cared for in their bedroom, was distressed, confused, and continually calling out over the course of the day. This person had been diagnosed with dementia. Their care plan stated, "In the event of increased confusion check urine, temperature and push fluids. Staff need to check regularly to see if in any pain. Sit with [person] and gently hold hand to calm." There was no evidence in recent records of any of these strategies being tried. Staff told us they did spend time with this person on a one-to-one basis but we did not see any evidence of this taking place. Consequently, at the time of our inspection visit there was no evidence this care plan was being followed.

Another person, also being cared for in their bedroom, had a care plan was stated 'support with hygiene required' and that nail care was to be carried out by one member of staff. Their care plan also told to staff to make sure they person's radio was on when they were in their room. When we visited this person we found their personal care, including basic hygiene and nail care, had not been carried out to a satisfactory standard. In addition their radio had not been switched on for them. This showed their care plan was not being followed at the time.

Other improvements were needed to care plans. Some were written in poor English and difficult to understand. Three people's records had no information in them about people's life history, hobbies and interests. We spoke to staff about these three people and they knew nothing about them apart from their care needs. Some care records were difficult to navigate due to not having clear indexes and sections. Some staff told us care plans were inaccurate did not reflect the care people required or being delivered to them in practice.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The registered persons did not ensure that people's care and treatment was appropriate and met their needs taking into account their preferences.

The management team acknowledged that care plans were in need of improvement. In order to address this they had employed a new care coordinator tasked with reviewing, rewriting and personalising all care plans in conjunction with people, their relatives, and senior carers and nursing staff. At the time of our inspection work was beginning on this and the home had set a target of 30 June 2018 to complete the work.

Improvements were needed to the way information was presented to people at the home in order to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given.

Not all the home's information was presented in a user-friendly format. The menu was only printed in English despite this not being the first language of most of the people living in the home and no pictures

used to help people make choices about their meals. A list of activities for the week on the notice board was in small print, making it difficult to read, and like the menus only available in English. We discussed this with the management team who said work was in progress to present information in a more user-friendly format and in languages that were in keeping with people's preferences.

People and relatives told us staff respected people's religious and cultural needs. One person said, "I am a [particular religion] and that is respected." A relative said, "Our faith is respected. My [family member] has a radio in their room and can listen to prayers." English, Hindi and Guajarati music was played and people said they enjoyed listening to this.

During our inspection visit a specific religious group visited the home and provided what they told us was 'religious instruction' to 14 people from a range of cultures, some of whom were living with dementia. We could not be sure that people had consented to taking part in this activity and queried this with the management team. They told us the get-together was more social than religious but agreed to check with people to ensure people they were actively choosing to join in, with best interests decisions made where necessary. The management team said they would keep records to show people had been consulted about being part of this group.

The home had an activities programme and we saw some group activities taking place. These included an indoor ball game, colouring pictures, and singing religious songs. Staff told us activities were being provided on a on a one-to-one basis for people being supported in in bed due to healthcare issues. However one of these people told us, "The staff know my interests but there is no stimulation work by staff." The management team told us the home's activity programme was being reviewed and improved. Activities staff were being re-trained to help ensure they had the skills and knowledge they needed to provide suitable and accessible activities to everybody who wanted them.

Although some people and relatives we spoke with said they were unaware of the home's complaints procedure, all said they would speak to staff if they had any concerns. One person told us, "If I had a complaint I'd just tell the main people." A relative said, "If I'm concerned about anything then I talk to the area manager." One person told us they had previously made a complaint. They told us, "I complained to the manager and they sorted it out."

At the time of our inspection visit the complaints procedure, which was displayed in the reception area, was being improved and updated to make it more user-friendly and readable. Records showed that when people and relatives complained and their concerns were investigated and improvements made where necessary. One complaint was in the process of being investigated by the management team at the time of our inspection visit.

Following our inspection visit complaints were discussed at a relatives and residents meeting. The minutes showed that people and relatives were reminded of the home's complaints procedure. They were also told they could use this or speak to staff or managers if they had any concerns and they would be listened to. The manager said, "We are here to listen, we openly encourage feedback and we want the involvement of those in our care."

We looked at how people were supported at the end of their lives to have a comfortable, dignified and pain-free death. A nurse told us a local 'hospice at home' team had previously supported two people who needed end of life care and provided anticipatory medicines for them. This had helped to ensure the people in question were provided with responsive care.

However, we found care for those with palliative care needs or at end of life was not consistent. For example, one person's needs, relating to their nutrition and mobility, had changed but their care plan had not been updated to show this. There was also little mention of their spiritual needs in their records. We discussed this with the lead nurses who said the GP was visiting this person to discuss their needs with them and their care plan would be promptly updated to ensure staff had the information they needed to support this person in the way they wanted.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection visit the home was undergoing a period of rapid change. A new management team was in place. They acknowledged the oversight, monitoring, and day to day running of the home needed to improve.

Records showed that since our last inspection there had been no effective or regular review of the quality of residential and nursing care at the home. This was of concern as the provider is responsible for a number of care homes and we would have expected there to be systems and processes in place to monitor quality across all of these. Consequently the shortfalls in the way medicines were managed and the poor quality of risk assessments and care plans had not been identified until recently. In addition there was little evidence that people, relatives and staff had been engaged and involved in the running of the home or been asked for feedback on it. One relative told us, "I can't think of any satisfaction surveys being done."

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. The registered persons did not ensure that effective systems or processes were in place to assess, monitor and improve the quality and safety of the services provided.

The management team told us how they had begun to make positive changes to the home. Staff had been retrained in key areas including fire safety, infection control, moving and handling, basic life support, safeguarding, and personalised care. Further and ongoing training was booked including a course on nutrition.

Monthly audits of all aspects of the service had been introduced and were to be carried out monthly. These were already beginning to show results. A weight and nutrition audit had identified one person requiring a dietician and this had been actioned. New documentation was being introduced as a result of a care plan audit. Following a meeting with nursing and catering staff menus had been improved and new food suppliers sourced. A new key worker system was being introduced and staff were being trained to do care reviews. Policies and procedures were being reviewed and improved. The management team told us they had temporarily and voluntarily suspended placements to the home for four weeks while they began to implement the changes.

To keep people and relatives informed about the changes at the home the management team had invited them to a meeting to discuss some of the changes and involve them in the future running of the home. This was taking place on the evening of the day of our inspection visit and a poster advertising the meeting was on display in the home. A relative told us, "Today I saw a residents meeting notice. It's the first time I have seen one."

Following our inspection visit we were sent the minutes of this meeting. They showed it was well attended by people and relatives. The new management team were introduced and their roles explained. The manager explained that the home needed to improve and managers and staff were working with the local authority, health authority, and CQC to make that happen. Redecoration, the menu, activities, people's

cultural and spiritual requirements, and the home's complaints procedure were discussed. A further meeting was planned for June 2018.

The minutes of this meeting showed that the management team were setting out to promote a positive culture at the home that was more open, inclusive and empowering.

At our inspection visit people and relatives said they liked the home. One person told us, "I think the place is OK for me. I am happy here. They treat me as a person. In hospital you're just a number." A relative said, "I am very happy with this place." A care worker said the home had a family atmosphere and told us, "All the residents are very friendly. We [the staff] know people well and respect them." A nurse told us, "I love working here. I know the residents inside out. They are like my extended family."

Staff told us they had confidence in the new management team. One care worker said staff morale had increased and the regular staff meetings and supervisions gave them the opportunity to share their views about the home. Another care worker said the management team listened to the staff and took their views into account when making changes and improvements to the home. A nurse told us the home was improving under the new management team. They said the management team were contactable and available to staff any time day or night. They said they had called the group operations director at two o'clock in the morning for advice and they came to the home straight away to offer support.

The management team had introduced a daily 11am event when the staff, where possible, stopped what they were doing and had tea, biscuits and a chat with people and relatives. This brought all the people who lived and worked at the home together and enabled them to spend quality time in each other's company. One person said they had been asked for their views on the home. They told us, "They [staff] ask me if I like the place and if I am happy."

The manager and group operations director had made their mobile numbers available to people, relatives, and staff so they could contact them directly if they felt they needed to. This was evidence of an emerging culture in the home where management were approachable and anyone who wanted to discuss the home or raise concerns about people's care or safety were given the opportunity to do this.

The management team were working with the local authority and the health authority to bring about improvements to the home and acting on their advice and input. The provider had notified CQC of management changes at the home and were keeping us informed of other important issues.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons did not ensure that people's care and treatment was appropriate and met their needs taking into account their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not ensure that medicines were managed safely in the home. The registered persons did not ensure risks were managed safely in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not ensure that effective systems or processes were in place to assess, monitor and improve the quality and safety of the services provided.