Bupa Care Homes Limited

Gorton Parks Care Home

Inspection report

121 Taylor Street
Gorton
Manchester
Lancashire
M18 8DF

Tel: 01612209243

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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

We carried out an unannounced inspection of Gorton Parks Care Home on 10, 11 and 12 July 2017. This was the first inspection of Gorton Parks Care Home since it had been re-registered with the Care Quality Commission in January 2017. The re-registration had taken place as business entity to reflect changes to the providers named responsible people. This did not create any changes to the overall registration of the home. The home, under its previous legal entity, was inspected in April 2016. References throughout this report to 'the last inspection' concern this inspection.

Gorton Parks Nursing and Residential Home is owned by BUPA Care Homes. The service consists of four 30 bedded units; Melland House, Abbey Hey, Sunnybrow and Debdale. Part of the Debdale unit and a fifth unit on the same site are contracted to the NHS for re-ablement services for people discharged from hospital. They were not part of this inspection; being inspected by the CQC hospitals directorate. Each unit specialises in either nursing or residential care. Each unit has a lounge, dining area, a conservatory, a smoke room and a kitchenette. All bedrooms are single with no en-suite facilities. Accessible toilets and bathrooms are located near to bedrooms and living rooms.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a clinical services manager.

A new breach with regards to medicines was identified during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

Daily and weekly medicine monitoring sheets were in place to check that all medicines had been administered as prescribed. However we saw a weekly dose of one medicine had not been administered and this had not been noted by the monitoring process. The Bupa policies for missed doses had therefore not been followed. The registered manager instigated an investigation when we informed them of what we had found. Charts for the addition of thickeners to fluids and the application of creams were not fully completed so it was not possible to determine if they had been administered as prescribed.

A new breach with regards to activities was identified during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

There were few activities arranged to engage and stimulate people living at the home. One activity co-ordinators was on maternity leave and their hours had not been covered during this time. The activity co-ordinators in place worked across the four residential and nursing units. This meant they had very little time to arrange activities on each unit or engage in 1:1 activities with people who were nursed in bed.

People told us they felt safe living at Gorton Parks. Some relatives we spoke with said they thought their loved ones were safe at the service; however others said some people living at the service sometimes became aggressive towards them or their loved ones. Notifications had been made to the Local authority and the Care Quality Commission where required.

Care plans included details of people's care and support needs. Risks had been assessed and guidance was provided for staff in how to reduce these, including how to support people whose behaviour may be seen as challenging. We saw that where appropriate people's relatives had been involved in reviewing their loved ones care plans.

Daily notes were written for each person after each shift. These detailed the support a person had received.

A system was in place to recruit new members of staff. The reason for a gap in the employment history of one employee had not been recorded. New staff undertook a week's induction and completed training, including safeguarding vulnerable adults, appropriate to their roles. Staff refresher training was being arranged and the number of courses had increased. Refresher training for challenging behaviour was required.

Staff said they felt well supported by the unit managers, clinical services manager and registered manager. Staff supervisions were held, although these were not as frequent as Bupa's policy. Staff meetings were also held. Staff were able to contribute to discussions about the service and their training and development.

A new breach with regards to staffing levels and organisation around meals was identified at this inspection. There were sufficient staff to meet people's support needs; however meal times on two units took a long time to complete, with people having to wait for support to eat their meal. The registered manager used a dependency tool to establish the number of staff required. We saw the staff on duty was above the number identified by the dependency tool.

We have made a recommendation to review the system used to handover information about people's health and wellbeing to staff starting their shift. We found the handovers varied on each unit; however they were completed in communal areas or as walking handovers in the corridors which may mean that confidential information would be overheard by other people.

Staff knew people's needs well. People and relatives said the staff were kind, respectful and supported them to make their own choices and complete tasks they were able to on their own. However we witnessed one staff member attempt to grab a person to prevent them from leaving the lounge area at lunchtime. This had been reported to the unit manger by a member of staff and they had promptly addressed the issue.

People were supported to maintain their health and nutritional intake. Records were kept were appropriate of what people had eaten and drunk. We saw referrals to relevant health professionals were made, for example to the Speech and Language Team, district nurses and GP's.

We saw people were supported to make advanced decisions about the care they wanted at the end of their lives. Each unit had been accredited by the Six Steps programme for end of life care and support.

We found the service was working within the principles of the Mental Capacity Act (2005). Each person had a capacity assessment in place. Appropriate best interest decisions were in the process of being recorded.

All areas of the home were clean and there were no malodours on any of the units. Procedures were in place

to prevent and control the spread of infection.

Regular checks of the firefighting equipment were made. Equipment was serviced and maintained in line with the manufacturer's instructions. Checks on the water system had started to be carried out following a legionella risk assessment report.

A new breach with regards to governance was identified during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

Bupa has a number of quality assurance audits in place, including monthly care plan audits, medicines audits, monthly area manager audits, quarterly health and safety and infection control audits. However; issues identified during this inspection had not been identified by these audits. Only one of monthly area managers audit was available at the time of our inspection; therefore any issues identified could not be acted upon by the registered manager as they did not have sight of the audit.

Bupa also carry out surveys for relatives and staff. The registered manager told us they had not seen the results of the surveys. After the inspection we were informed the staff survey was in the process of being collated by the central Bupa department and the relative survey for 2017 had not been conducted as yet..

A number of night visits had been completed by the unit managers and clinical services manager. Unit managers were to start completing a night shift each month. These had been well received by the night staff who had commented that they made them feel more part of the team.

Systems were in place to record, investigate and respond to any complaints made to the service. All accidents and incidents were reviewed by the registered manager. A number of statistics were compiled for monitoring purposes, for example falls, pressure sores, nutrition, medicines errors, the use of bed rails and hospital admissions. This meant any trends or patterns of behaviour could be identified and action taken when necessary to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Cream and thickeners charts were not fully completed, especially by the night staff. A medication error had not been identified by the daily and weekly medicines audits.

Monthly checks of the water system had not been completed prior to a legionella risk assessment having been completed by an external company. These were now being undertaken.

Staff were busy in the mornings and people had to wait for their breakfast or a drink on two units.

A safe system of staff recruitment was in place; however the reason for the gap in one staff members employment history had not been recorded. Staff received training in safeguarding adults and knew the procedure for reporting any concerns.

Care records included information about the risks people may face and guidance for staff in how to mitigate the risks. Guidelines were in place for staff supporting people who may display behaviour that challenges.

Is the service effective?

Requires Improvement

The service was not always effective.

Handovers were held in communal areas of each unit meaning confidential information may be overheard by people living at the service.

Staff received training to undertake their role; however training in challenging behaviour had not been updated.

The service was working within the principles of the Mental Capacity Act. Further best interest decisions were in the process of being recorded.

People provided mixed feedback about the food at the service. Some people had to wait for support to eat their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw kind and respectful interactions between staff and people who used the service.

However we also witnessed one staff member try to grab one person who was leaving the dining area. Another staff member also reported this to the unit manager who immediately spoke with the staff member.

People were supported to have advanced care plans in place for the support they wanted at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of activities to engage and stimulate people living at the service.

Care plans provided details of the support people required and guidance for staff to meet these needs.

The service had a formal system for recording and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

A registered manager was in place as required by the service's registration with CQC. A Care Service Manager was in place to support the registered manager.

The system of audits and monitoring in place at the service had not identified the issues raised in this report.

Night visits had been undertaken by unit managers which had been well received by the night staff.

Staff said they enjoyed working at the service. They said the registered manager, clinical services manager, unit managers and senior care staff were approachable and supportive.

Gorton Parks Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 10, 11 and 12 July 2017 and was unannounced. The inspection team consisted of three inspectors and an expert by experience on the first 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 expert had experience of services for older people. One inspector returned for the second and third day of the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. The PIR 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. We reviewed other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We contacted the local authority commissioning and safeguarding teams as well as the local Healthwatch board and the Clinical Commissioning Group (CCG). The CCG commissions services for people requiring nursing care.

We had brought this inspection forward as we had been notified by the Manchester mental health team of a safeguarding allegation and had received information of concern from a 'whistle blower.' A whistle blower is a person who works or has worked at the service who raises concerns directly with the Care Quality Commission. These concerns and our findings are included in the main body of the report.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten people, five relatives, the registered manager, the clinical services manager, seven

registered nurses and 14 care staff. We observed the way people were supported in communal areas and looked at records relating to the service. This included 13 care records, six staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, quality assurance systems, incident and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said that they felt safe living at Gorton Parks. One said, "Yes, it couldn't be better than here." Some of the relatives we spoke with also said they thought their loved one was safe at the service. However two relatives raised concerns with us that other people living at the service sometimes became agitated and had been aggressive towards them or their loved ones. One relative said the staff always informed them when this had happened and completed checks to ensure their loved one had not been harmed.

Some people living with dementia can become anxious and agitated at times. We saw a behaviour assessment tool was used on Abbey Hey unit where appropriate. This provided guidance for staff on how to support a person if they were agitated or refusing care. On other units we saw this information was in other care plans, for example the 'choices and decisions' or 'mental health and wellbeing' care plan.

Care staff sometimes work in different units, therefore we recommend that a consistent method is used to record guidance for staff when people may display behaviour considered as challenging and the potential triggers for this behaviour.

All the staff we spoke with were aware of the safeguarding procedures in place at the service and who they would report any concerns to. Staff said they had received training in safeguarding vulnerable adults, this was confirmed by the training records we viewed.

At the last inspection in May 2016 we found protocols for when 'as required' medicines should be administered were not sufficiently detailed. The information in these protocols should help ensure staff were aware of how people who used the service might communicate their need for particular medicines, either verbally or non-verbally. At this inspection we found improvements had been made, although two 'as required' protocols on Sunnybrow unit stated staff needed to administer the medicine 'in [name's] best interest.' This does not guide staff what signs they needed to be aware of that would indicate the person required the 'as required' medicine to be administered. All other 'as required' protocols on Sunnybrow unit provided clear guidance for staff. The nurse on duty on Sunnybrow told us they would review the 'as required' protocols on the unit.

The mental health team had raised a safeguarding alert concerning the use and review of anti-psychotic medicines for one person. Following an investigation this concern had been unsubstantiated. Anti-psychotic medicines are a group of medicines prescribed to reduce and control people's symptoms of psychosis, for example anxiety and agitation. We checked the usage of anti-psychotic medicines on all four units at Gorton Parks. We found they had not been prescribed for many people, with only one being prescribed 'as required' and all the others being a regular daily dose. We spoke with the nurses and senior carers responsible for administering the medicines. All were able to explain that the anti-psychotic medicines were regularly reviewed by people's GP's. We saw the 'as required' anti-psychotic medicine had not been regularly administered. This meant it had not been over used for this person.

We looked at the way medicines were managed on all four units. We saw the medicine administration records (MARs) had been fully completed. The quantity of medicine held by the service corresponded with the amount recorded on the MARs. People we spoke with told us they received their medicines when they should do. However we noted one person on Debdale unit had not received one dose of a medicine that was administered once per week in May 2017. We saw that the missed tablet had been disposed of as 'excess stock' at the end of the medicines cycle. The nurse on duty on the unit was able to explain the procedure to be followed if a medicine dose was missed. This included contacting the person's GP for advice, advising the person's family and reporting the missed dose using the Bupa incident procedures so that the unit manager, clinical services manager and register manager were aware of the error. This is important so that all medicines errors could be monitored and appropriate action taken where required, for example providing additional training.

Each unit completed a daily checklist following each medicine's round to ensure the MARs had been fully signed. A weekly check was also carried out by the unit manager. None of these checks had identified the medicines error we saw. In addition the error had not been picked up by the nurses administering the medicines in the days following the error, especially the week after the missed dose when this particular medicine was next administered. The error had also not been questioned with the unit manager when the tablet was disposed of.

We discussed this with the clinical services manager and registered manager, who acknowledged that the checking and auditing system had not picked up the error. Following the inspection the registered manager informed us they had initiated an investigation, including looking at training, competency and auditing of the medicines.

We looked at the recording systems in place for the application of topical creams. The care staff applied these creams and signed a cream chart when they had done so. We saw on Sunnybrow unit that the cream charts had only been signed by the day staff. This meant that any topical creams prescribed to be applied in the evening had not been recorded. On Abbey Hey we saw that the night staff were not consistent in signing the cream charts. This meant on these two units it was not possible to tell if people had their topical creams applied as prescribed. The nurses we spoke with on both units told us the creams were being applied, but was not being recorded.

We also looked at the recording systems when thickeners were prescribed to be added to people's drinks. Thickeners are used where people have swallowing difficulties and reduce the risk of choking. The staff member adding the thickener to a person's drink signed a chart when they had done so. We again found that on Sunnybrow the thickener charts were not being fully completed. All the charts we looked at on Sunnybrow indicated that thickeners were used during the day from 9 am to 5pm. However no charts were signed after 5pm. The nurse on duty stated that people had drinks after 5pm and thickeners were used where they had been prescribed but the staff had not signed the relevant chart to show they had done this. This meant it was not possible to tell if people's drinks were being thickened as prescribed or if they were at a higher risk of choking as they were given un-thickened drinks.

The failure of daily and weekly medicines audits, the lack of reporting of the missed medicine dose and the cream and thickeners charts not being signed was a breach of Regulation 12(1) with reference to (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had refused to take their prescribed medicines we saw best interest meetings had been held to assess if the medicines should be administered covertly, for example by being crushed and added to their food or drinks. The meetings involved the GP, the person's family where appropriate and the unit manager

or clinical services manager. A best interest decision can only be made where a person does not have the capacity to make an informed decision themselves, for example due to the effects of dementia. The best interest decision made was recorded and signed by the people involved. This meant where people did not have the capacity to make a decision about whether to take their medicines, their rights had been protected.

We saw medicines that were controlled drugs were stored and recorded correctly and a weekly stock check was carried out. Controlled drugs are drugs which by legislation require special storage and recording.

We noted that nurses and senior care staff who administered medicines had completed medicines training. They were then observed administering the medicines before being signed off as competent. Nurses we spoke with said they were then observed administering medicines annually by the unit manager or clinical services manager, however records were not always kept of these observations.

We checked that the service's recruitment procedures protected people from the risks of unsuitable staff being recruited. At our last inspection we found reasons for any short gaps in the staff members' employment history had not been recorded and one recruitment file only contained one reference. At this inspection we looked at six staff recruitment files. We found they contained an application form detailing previous employment histories, a record of the interview and a numeracy and literacy test. One application form had a two year gap in employment between 2009 and 2011. There was no evidence that the reason for this gap in employment had been discussed with the prospective employee. Appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. The registered nurse's registration with the Nursing and Midwifery Council (NMC) had been checked to ensure they were registered to practice as a nurse in the UK. All files contained two references.

This meant that a system to safely recruit staff to work with vulnerable people was in place, but the reasons for gaps in people's employment history continued not to be followed up and recorded.

We looked at the staffing levels and rotas on each unit. We saw there were consistent staffing levels in place and agency staff were used where cover from within the staff team could not be found. Some people we spoke with said there were enough staff on duty and they didn't usually have to wait long for staff to respond to their needs. One person told us, "I don't have to wait too long; staff may be with another patient but on the whole they are very good." However other people told us staff were very busy in a morning. People told us, "The staff are rushed off their feet in a morning" and "They are short staffed in the morning, you have to wait for a while." During our inspection we saw staff responding promptly to the call bells and to requests for assistance with people's personal care needs.

We noted that staff were very busy in the morning, supporting people to get up and to have their breakfast. On Melland unit one care staff member was designated to serve the breakfasts, a senior carer administered medicines and three staff supported people to get up. Some people had to wait for their breakfast as the staff member was busy supporting other people with their breakfast. This led to some people leaving the tables before they had been served breakfast and others becoming agitated because of the delay. We also noted on Melland that some people who had been up at 6am did not receive a drink until 08.20am as the staff were all supporting other people to get up. We raised this with the registered manager who suggested a thermos flask being available on each unit would enable staff to quickly get people a drink in a morning whent hey first got up.

On Melland and Sunnybrow units we saw some people were getting up later in the morning and therefore

were only having their breakfast at 10.45am. Lunch meals were not plated up if people had recently eaten and may want to eat their lunch later. This meant the organisation for serving breakfast contributed to raising people's anxiety and there was only a short gap between breakfast and lunch for some people, which may impact on the amount of food they eat at lunch time.

We also saw that 20 people on Sunnybrow unit ate their meals in their rooms at lunchtime, the majority of whom also required support to eat their meal. We saw two people who had their lunch on a table by their bed but had not eaten it as they needed support to do so staff; however were busy supporting other people.

On Melland unit one person was prompted in passing by staff four times to eat their food. The person did not start to eat for 15 minutes until a staff member was able to spend the time to stay with them and encourage them to eat.

The staff on Abbey Hey and Debdale units felt there were sufficient staff to meet people's needs. We saw that whilst people had to wait a short time for their meal it was not excessive.

Staff on all four units said they were less busy in the afternoons when they were able to spend a little time talking and engaging with people. We noted that call bells were responded to promptly on all four units.

One staff member said that staff on Sunnybrow had to cover for staff shortages on other units, leaving them short staffed. Other staff on the unit felt there were sufficient staff, although the mornings were very busy. We were told on Melland unit that if they were short staffed a staff member from another unit would come to work with them. The unit managers, nurses and registered manager told us that this was not a regular occurrence and may happen if a staff member phones in sick at short notice and cover cannot immediately be found.

The night staff on Abbey Hey unit told us the night shift was very busy especially if people were anxious, agitated or walking around the unit. From the rota we saw there was one nurse and two care staff on duty to support 30 people. The night nurse on duty told us that if someone was unwell they would discuss this with the unit manager and a 'twilight' shift would be added to the rota to work between 8pm and 12pm. They gave an example when this had been implemented two weeks before our inspection due to one person being very anxious at that time. Other staff we spoke with confirmed this.

The registered manager showed us a Bupa dependency tool used to calculate the staffing levels for each unit. A 'care band' was assessed for each person which then gave the number of hours required for each unit to meet people's needs. The care band could be changed for a person as their support needs changed. We were shown that the actual number of support hours was higher than the dependency tool calculated for each unit.

People did not receive their support with their meals in a timely fashion as there were insufficient staff available at these times. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate care plans were developed to mitigate the identified risks, for example a moving and handling plan. Where required an assessment for the use of bed rails was in place to reduce the risk of people falling out of bed.

We checked the systems that were in place to protect people in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) were in place for all people who used the service and a copy was kept

by the main door to each unit in a 'fire file'. These plans detailed if a person was independently mobile, required support from one person or would require two people to evacuate them from the building as they were not mobile. The fire procedure document in the fire files was out of date. The fire files contained a plan of the unit. A fire risk assessment had been competed for each unit in August 2016. Any issues identified in the assessment had been actioned.

We looked at records for the maintenance of equipment within the home. We saw weekly tests for the fire alarm had been recorded from June 2017 only. We were told a new fire alarm system had been installed and commissioned during the refurbishment of the units. The weekly checks for the old fire alarm system had been archived and new paperwork started for the new system. Staff confirmed that the fire alarms were tested each week. We noted that when the old fire alarm had been serviced in November 2016 the fire log book had been fully completed with all relevant checks having been made.

Records showed equipment within the home, for example the emergency lighting, nurse call system, fire extinguishers, hoists, wheel chairs and gas checks had been completed.

We saw a legionella risk assessment had been completed in June 2017. Legionella is a bacteria that can colonise water systems and cause lung infections. Best practice guidance is for temperatures of hot and cold water to be monitored, including the temperatures of the water in the boiler system. Water systems should be flushed to ensure water is kept flowing within the water system. The risk assessment found temperatures had not been recorded monthly and low usage water taps had not been flushed. Bupa had recording sheets in place for all these checks, but they had not been completed. We noted these checks had now commenced following the legionella risk assessment.

The service had a business continuity plan which contained contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak or power failure.

We saw care records identified risks to people's health and wellbeing, including the risk of falls, moving and handling, pressure ulcers and malnutrition using the Malnutrition Universal Screening Tool (MUST). We saw these were evaluated on a monthly basis.

All areas of the home looked clean and tidy and there was no malodour. The clinical services manager completed a daily walk round and recorded if any malodours were present and ensured action was taken to remedy this, for example by using a carpet cleaner. The housekeepers we spoke with had a cleaning schedule for each unit. We saw staff used personal protective equipment (PPE) such as gloves and aprons.

An infection control audit was completed every three months for each unit and any actions identified. All units scored over 90% in the latest infection control audit. We noted there were no waste bins in the bathrooms for the paper towels. We were told this was due to people living with dementia sometimes urinated in them.This had been discussed and reviewed with the local authority infection control officer during an infection control audit completed in July 2017. This issue had been identified in the infection control audit for Melland unit in May 2017. This meant paper towels could be left in the bathrooms, which increases the risk of cross infection, or be put in to the toilet, which risks causing the toilet to block. Signs were seen in the toilets stating paper towels were not to be put into the toilet. However people living with dementia would not be able to read the sign and without an alternative they may dispose of them in the toilet. This meant the cleaning schedules in place kept the units clean, but the solution for the disposal of domestic waste for the toilets had not been established.

Prior to our inspection a whistle blower had alleged that there were not enough continence pads available

to meet people's needs. All the staff we spoke with told us that there had never been a shortage of continence pads on any of the units. The people we spoke with also did not say that this was an issue.

Sluice doors and cleaning cupboards were kept locked to ensure people who were ambulant did not gain access to potentially dangerous chemicals.

Incidents and accidents were recorded and monitoring put in place following an incident or fall. They were reviewed by the clinical services manager. We saw the incident forms contained details of what had occurred and what action had been taken by the staff. The clinical services manager noted on the forms if the local authority safeguarding team and the Care Quality Commission had been notified of the incident. All incidents and accidents were entered into the Bupa computer system. A monthly report was produced which could be used to highlight any trends in falls or incidents.

This meant the registered manager had an overview of accidents and incidents and steps were put in place to reduce the likelihood of them re-occurring.

Requires Improvement

Is the service effective?

Our findings

A recently recruited member of staff told us they had completed a five day Bupa induction which included training courses for moving and handling, safeguarding, mental capacity, infection control and health and safety. They then shadowed experienced members of staff so they could get to know people and their needs. We were told, "I've felt well supported by my buddy since working on the unit and I've not been asked to do something which I haven't been trained for first."

Staff told us they received regular refresher training. Records we viewed confirmed courses had been completed and refreshed for safeguarding, mental capacity, nutrition and moving and handling. The training record stated that 98% of 140 staff had completed training in dementia awareness; although two of the 14 care staff we spoke with said they had not completed a dementia awareness course. We saw that Bupa's induction includes a course on dementia awareness.

We also noted that 129 staff had received training in supporting people with challenging behaviour, this had not been refreshed and only 3% of staff were recorded as being current with this training. One staff member told us they had worked at the service for three years and had not completed training in managing challenging behaviour. This training was especially relevant for staff supporting people with dementia, as some people living with dementia may have behaviour that is considered as challenging. We discussed this with the registered manager, who was aware of this and were prioritising staff on Abbey Hey and Melland units for this training.

We saw clinical training courses were arranged for the nursing staff, for example wound care and catheter care.

The registered manager showed us that the percentage of staff compliant with the Bupa training requirements had increased over recent months. We were also told that the Bupa trainer had had a period of time off work, which had led to some courses having to be cancelled or postponed. This meant that apart from challenging behaviour training the staff had the training to provide effective support to people living at the service. We will check that this had been completed at our next inspection.

We noted that there was only one Registered Mental Health Nurse (RMN) working at the service and they worked on the night shift. RMN's have additional training in area's such supporting people living with dementia, especially where this leads to behaviours that may challenge staff or other people.

We raised this with the unit manager on Abbey Hey unit, the registered manager and clinical services manager. They said the unit manager for Abbey Hey was a Registered General Nurse (RGN) and had, confirmed by the training records, completed additional training in dementia awareness and dementia care and had many years' experience working with people living with dementia. We spoke with the RMN who told us they would write the clinical care plans for people who may display behaviours that challenged staff with the unit manager. We were told most people living in Abbey Hey unit were awake when the night shift started and went to bed after supper. This meant the RMN knew them and was able to write the relevant

assessments and care plans.

The registered manager and clinical services manager were also RGN's with a lot of experience supporting people living with dementia. They all felt that there was enough training and experience in dementia care at the service to meet the needs of this client group.

We were told that if required the unit manager would ask for support from the NHS community mental health team. They could also request support from the Bupa Admiral nurses who did have RMN experience. The Abbey Hey unit manager told us they had not done this so far. The registered manager told us that the service had struggled to recruit RMN's and when they did they found that they left quite quickly as they did not wish to work with people living with dementia. They said that they were constantly looking to recruit additional RMN's and as stated above, the care staff and nurses received training in dementia care.

Staff told us that they had supervisions with their unit manager. They also said they were able to approach their unit manager or nurse on duty if they needed any advice or had any concerns. The staff and the unit managers told us that the daily handovers were used to convey information about the service, for example from managers meetings that had been held.

The target was for supervisions to be held every two months; however this was not always met. We saw a supervision tracker had been established since our last inspection so the registered manager and clinical lead were able to monitor when supervisions were being completed. This showed that all staff had received a mid-year review in June 2017, but supervisions had not been held in April as planned. On Debdale unit all staff had had a supervision in March, whereas only 50% of staff working on Abbey Hey unit had a supervision in February.

Unit managers told us they had supervisions with the registered manager; although this was not every two months. However they met with each other regularly at the daily and fortnightly meeting's and said they were able to talk with the registered manager or clinical services manager whenever they needed to.

This meant that whilst staff said that they felt supported by their unit managers formal supervisions did not always take place as planned.

Staff told us a handover was given at the start of each shift. This provided staff with information about any changes in people's health and well-being so they were able to provide the appropriate support to people. At the last inspection we noted that 'walking handovers' were used where staff went to each person's room to be given the up to date information. This meant that confidential information was discussed in the corridors which could have been overheard by other people who were passing. At this inspection we observed the hand over on all four units. One was a walking handover with all the care staff team (eight in total) going from room to room. One was a walking handover between the night nurse and oncoming day shift nurse, who then provided the care staff with the handover information in the dining area. On two units the whole handover was conducted in the lounge or dining area, where people who used the service were sitting. The handovers were not held in a private area, which meant people's privacy and confidentiality may not be respected as other people may be able to hear what was being said.

We discussed this with the registered manager and clinical services manager. They said they felt it was important for staff to visually see people during handover as this was part of the 'ward round' and could be used by the nurses to check any clinical observations required. However only two of the units did a visual check of people as part of the handover and neither of these was used to check any clinical observations; the nurses simply saying good morning and asking how people were if they were awake.

We recommend a handover system is adopted that maintains people's privacy and confidentiality whilst providing staff with the essential up to date information they require to provide continuity of care and meet people's needs.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw people's care plans contained an assessment of their capacity. Where people were assessed as not having the capacity to make a decision we saw some best interest decisions were recorded, for example for advanced care plans and living at Gorton Parks. We saw that some people had an Independent Mental Capacity Advocates (IMCA) to act on their behalf if they did not have any family who could represent them.

Where people had been assessed as not being able to consent to living at Gorton Parks a DoLS application had been made to the relevant local authority. The registered manager had a DoLS tracker for each unit noting when applications had been made and when re-applications were required.

We saw care staff asked people if they wanted support before providing it. Staff explained how they gave people day to day choices, for example about what they wanted to eat or wear. We noted some people who were living with dementia were not able to make a choice about their meals from the verbal information provided by the staff. Pictorial menus of the choices available, which may have helped people to choose what they wanted to eat, were not used. Where people sometimes refused support, for example with personal care, this was documented in people's care plans. Guidance for staff on how to respond in these situations was also documented, such as leaving the person and returning after 10 minutes or a different staff member offering to support the person.

This meant the service was working within the principles of the MCA and was in the process of documenting additional best interest decisions made on people's behalf.

On the first day of the inspection we arrived at 6am. We found there were not many people up at this time. Staff were clear that people were able to stay in bed if they wanted to. People we spoke with confirmed this. One said, "I could stay in bed if I wanted to; I like to go to bed early and I get up early as well."

We looked at how people were protected from poor nutrition and were supported to eat and drink. We received some mixed feedback about the food at Gorton Parks. Some people told us they enjoyed the food and there was always a choice of two meals. One person said, "The food's not bad at all; there is a choice between two meals so there is always something you can have or you can ask for sandwiches." However one relative said the food was often cold when it was served to his loved one. We also observed one person being told that they were not able to have one option as it was a pureed option only, but on other units this was one of the choices people had.

As noted previously in this report the staff on Melland and Sunnybrow units were not always able to support people in a timely manner with their meals. This meant people had to wait for their meals and breakfast took a long time to serve to everyone. We saw people who had been provided with their meal in their room but were not eating it. Staff were busy supporting other people and so the food was left and would be cold before a staff member was able to support the person.

We spoke with the chef. They said they received information about people's dietary requirements from the unit manager when people moved in or if their needs changed. Each unit sent the kitchen people's meal choices for the next day. This noted how many soft or pureed meals were required. We saw vegetarian or halal diets were catered for. We were shown that the kitchen provided a 'Night Bite' box for each unit. This contained items such as bread, soup, sandwiches, cheese and crackers that the night staff could use to provide supper for people who wanted it.

We saw people were weighed monthly or weekly depending on their needs. We noted referrals were made to the Speech and Language Team (SALT) or dietician if people were at risk of choking or had lost losing weight.

This meant the service had systems in place to meet their nutritional needs and provided meals to meet people's dietary needs; however some people had to wait for the support they needed to eat their meals.

People living at Gorton Parks were registered with a local GP. The GP surgery completed weekly visits to Sunnybrow and Debdale units. The Nursing Home Team also made weekly visits to Melland unit. This meant people's health needs could be responded to quickly.

Referrals were made to occupational therapists, tissue viability nurses and district nurses as required. We saw the service provided appropriate pressure relief care for people at risk of developing pressure area sores. We also saw detailed records of wound care when people developed pressure sores. Pressure relief mattresses were used as required and records maintained of when people were supported to re-position.

We saw the community mental health team had held sessions with the staff team around the behaviours of one person and how they could support them. The doctor noted the positive attitude of the staff to these sessions and trying to establish support techniques that recued this person's anxieties, for example if they picked up some cutlery give them something else to hold when taking it off them. This had been found to reduce this person's aggressive behaviours.

People we spoke with said that medical professionals were contacted when needed. This meant people's health needs were being met by the service.

We saw that the units had recently been re-painted and some units required pictures to be re-hung in the corridors and some bedrooms. We noted that the bedroom doors had transfers on to look like the front door of a house and the toilet doors were a distinctive colour compared to the walls. Dementia friendly signs were used on toilet doors. Doors for rooms such as sluices or store rooms had a handrail on them which was the same as the handrail on the adjoining walls. This meant people living with dementia were less likely to try to access these rooms. We also saw reminiscence boxes next to the bedroom doors on some units. People or their family could put photographs or small items in the reminiscence boxes to support people to recognise their own room. This meant people living with dementia may be able to orientate themselves within the unit.

Requires Improvement

Is the service caring?

Our findings

All the people and relatives we spoke with said the staff were kind and caring. We were told, "Nothing is too much trouble for them (the staff)" and "I like living here very much." Another person said, "They (the staff) chat all the time when they are supporting me."

Throughout the inspection we saw kind and respectful interactions between staff and the people they were supporting. We saw that some people carried a doll with them. Doll therapy is a recognised technique that may help reduce people's anxieties, where people living with dementia may treat the doll as a baby. Staff were respectful of this and spoke with people about their 'baby' in a kind and caring manner. We noted that the staff were very busy, especially in the morning and so did not always have time to spend talking with people.

However on Abbey Hey unit we observed one member of staff attempt to grab one person as they were leaving the lounge area at lunch time. The staff member was trying to get them to return to the table to have their pudding. We raised this with the unit manager who had already been informed of what we had seen by another member of staff. They had spoken to the staff member and said they would arrange further training and supervision for the staff member. The unit manager told us it was about knowing the person and how to support them. The person in question would have soon returned to the dining area as they liked to walk around the unit. Therefore the staff member should have allowed the person to leave the lounge and engage with them when they returned to prompt them to eat their pudding.

This meant one staff member did not follow the plan of care for this person It also meant that other staff members felt able to raise their concerns with the unit manager who then promptly dealt with the concerns.

We asked the staff we spoke with about the needs of the people they supported. They were able to explain people's needs and how they preferred to be supported. Staff were able to explain how they supported people who refused support or may have behaviour that challenged the staff. One member of staff said, "We look for the trigger points for each person, for example [name] becomes anxious when they need personal care." They were then able to describe how they supported the person so they were able to remain calm.

Staff were also able to explain how they maintained people's privacy and dignity whilst they were supporting them. This included ensuring doors were shut, curtains closed and ensuring people were discreetly supported when asking if they needed the toilet. However on the first morning of the inspection at 6am we saw one person was using their commode in their room with the bedroom door open. We raised this with the unit manager and registered manager. This person's care plan noted that they would often prop their own bedroom door open with pieces of furniture and did not like the door being shut. However staff needed to be vigilante of this, especially first thing in a morning when the person was waking up, so they could support the person to close their door when using the commode to maintain their privacy and dignity.

The care plans we looked at contained information, where available, about people's family, their life and

interests. This should help staff to form meaningful relationships with people.

We looked at the arrangements in place to support people at the end of their lives. We saw advanced care plans were in place where people had wanted to discuss their wishes. People's families, the nursing home team and GP's were involved in these discussions. Where appropriate best interest decisions had been made if people lacked capacity to make a choice about their end of life care. This included decisions about whether the GP should issue a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form and whether the person should be admitted to hospital at the end of their life or remain at Gorton Parks. We were told that the majority of people passed away at the service rather than going into hospital.

We saw the service had been accredited with the Six Steps end of life care programme. The Six Steps is a nationally recognised programme for supporting people and their families about making advanced decisions about the care they want at the end of their lives and their wishes after death.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that the activities available for people to engage in had been reduced due to two of the activity co-ordinators being off long term from work. At this inspection we found there were 90 hours per week allocated for activity co-ordinators to plan activities and engage with people. However one co-ordinator was on maternity leave and their hours had not been covered during this period. This meant there were two part time activity co-ordinators in place, providing an average of 60 hours of activities per week across all four units.

We saw an activity plan was available showing what the activities were for each day. This included some external entertainers in some weeks. However the staff we spoke with were not aware of these and did not know when the activity co-ordinators were due to be working on their unit. We were told people could go to any activity on any unit, but again staff seemed unaware of this and said they did not support people to go to other units for activities.

As mentioned previously in this report the staff were busy supporting people with their needs, especially in the morning, and did not have time to engage people in activities. We did not see activity items on any of the units, for example games or fiddle toys, fiddle muffs or other items that people living with dementia could handle. These items can be useful to occupy or distract people living with dementia, reducing their anxiety and agitation.

The staff we spoke with commented that there were not many activities available to stimulate and occupy people. We saw limited activities being arranged during our inspection. The radio or television was on in the units but the sound was at a low volume which meant people would not be able to hear it properly. We saw each unit had access to a secure garden area which people could access in warm weather. Staff said that day trips were not currently organised, but they thought some may be in the future; however they did not know any details.

We noted that one person who moved to the service in May 2017 had only six entries in their activity log for the 40 days they had lived there. Two of these had been short conversations with the activities co-ordinator when they moved in, one was to sign a card and one was to have their nails painted. On one occasion they did not want their nails painting and on another they were asleep when the activities co-ordinator visited them.

We also saw another person who was nursed in bed had a weekly entry on their activity log when they played cards with the activity co-ordinator. No other activities had been recorded. One person told us that they enjoyed playing dominoes once a week with the activities co-ordinator.

This meant that whilst some activities were organised to provide people with stimulation and engagement, these were not sufficient to engage with many people and the care staff did not have the time to support people in these activities. The registered manager had not covered the hours to maintain the activity programme whilst one activity co-ordinator had been off work on maternity leave. This was a breach of

Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were attending a Bupa conference the week after our inspection which was discussing therapeutic activities. They said they hoped to gain ideas about different ways to engage with people.

We looked at 13 care files across all four units. Each file contained a pre-admission assessment of need. This was written with input from the person themselves where possible, their family and other care or health professionals as appropriate, for example social workers and hospital nurses. The assessment identified any equipment a person required; for example a hoist or pressure relieving mattress.

Staff told us they had a verbal handover of people's needs before they moved to the unit. When people moved to the service key care plans and risk assessments were written within the first 72 hours. The clinical services manager checked that these were completed. All the staff we spoke with said that they had enough information to be able to meet people's needs when they moved to the service.

The care files contained details of people's health, personal and social care needs and preferences. We noted that the care plans had been regularly evaluated to ensure they were current. Daily notes were used to document the support people had required during each shift.

Each file had a 'My Portrait' document at the front of the file. This gave a brief overview of the person's needs for each of the areas covered by the full care plans in the file. These were a useful introduction to people's needs for staff to refer to.

Where appropriate we saw people's relatives had been involved in their loved ones care plans. Relatives told us that the staff kept them informed of any changes in their loved ones health and wellbeing.

The service had a formal complaints system in place. All complaints were logged and investigated by the registered manager or clinical lead. The complainant was informed of the outcome of the investigation. We were told that most issues are resolved by the unit managers without the need to resort to the formal complaints policy. We also saw that resident and relatives meetings were held on each unit every three months. These gave people the opportunity to raise any concerns they had with the unit managers, who could then deal with them directly. The meetings were also used to provide information and updates about any changes on the units.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place as required by their registration with the Care Quality Commission (CQC). The registered manager was supported by a clinical services manager (CSM).

We saw the service had a series of audits and checks in place to monitor the quality of the service. These included monthly audits for medicines and care plans. The area director also completed a monthly visit audit; however there was only one month's audit on file for 2017 (May 2017) at the time of our inspection. The registered manager sent us a further audit for June 2017 following our inspection. We were told that these audits were regularly completed and emailed to the home; however they were not readily available to the registered manager so they could be reviewed..

We saw daily walk rounds were completed by the CSM. These checked each unit and also updated the CSM and registered manager of any changes in people's health and needs. For example it recorded if there had been any falls or hospital admissions.

Quarterly infection control audits were also completed. These were seen to be scored highly and any issues were identified.

Surveys were conducted by a central Bupa department for relatives and staff. However we did not see any results from these surveys during our inspection. The registered manager said they had not seen the results of the surveys. Following the inspection we were informed that the 2017 staff survey results had been in the process of being collated by the central Bupa department and were now available for the registered manager to review.

The audits had not identified the issues noted in this report. As noted previously not all maintenance checks had been carried out to the required schedule and a medicines error had not been seen and reported. There was a lack of activities at the service to engage and stimulate people as the activity co-ordinators hours had not been covered whilst they were on maternity leave. We found this was a breach of Regulation 17(1) with regard to (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager showed us how they monitored trends of falls, pressure sores, nutrition, medicines errors, the number of people prescribed anti-psychotic medicines, the use of bed rails, hospital admissions, accidents and incidents across all units through a Bupa computer system. All details are put into the computer system and graphs and tables of the data are produced. We saw that the registered manager made comments on the report where appropriate, for example it had been noted that there was dietician involvement where there had been an increase in people having lost weight. This meant the registered manager reviewed the information provided to ensure any action required had been taken.

The registered manager held daily meetings with the unit managers, chef, maintenance and head housekeeper. These were used to share information about any issues on the units.

We were told that a series of night visits had been started by the CSM and unit managers. These were to meet and talk to the night staff and ensure people's needs were being met. These were now to be completed each month. We were also told that unit managers were going to start working a night shift each month on a rota basis. This would enable the unit managers to observe the support provided during the night and speak directly to the night staff. We were told that the initial feedback from the night staff had been positive in that the visits made them feel more part of the team for the unit.

Staff told us regular team meetings were held for each unit. They said they were able to contribute to these meetings and raise any concerns or issues they may have. Quarterly residents and relatives meetings were held on each unit.

We noted that short daily meetings were held with the heads of each department. These were used to update the head of departments about any issues that had arisen. Unit managers also had a fortnightly meeting with the registered manager and clinical services manager. A weekly clinical meeting was also held with the CSM to raise and issues around falls, wound management, behaviour and nutrition.

Staff were positive about working at the service and said that the unit managers, nurses and senior care staff were approachable and would listen to them when required. Staff said, "The unit manager is really good. I feel very supported by them and the deputy" and "I'd feel very comfortable going to them (unit manager or deputy manager) with any issues." Another member of staff commented, "I feel like I'm part of a team. Communication between the staff is good and the residents are nice."

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC. We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care This meant that whilst some activities were organised to provide people with stimulation and engagement, these were not sufficient to engage with many people and the care staff did not have the time to support people in these activities. The registered manager had not covered the hours to maintain the activity programme whilst one activity officer had been off work on extended leave. People did not receive their support with their meals in a timely fashion as there were insufficient staff available at these times. This was a breach of Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure of daily and weekly medicines audits, the lack of reporting of the missed medicine dose and the cream and thickeners charts not being signed was a breach of Regulation 12 (1) with reference to (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits had not identified the issues noted in this report. As noted previously not all maintenance checks had been carried out to

the required schedule and a medicines error had not been seen and reported. There was a lack of activities at the service to engage and stimulate people as the activity officer hours had not been covered whilst they were on an extended period of leave.

We found this was a breach of Regulation 17 (1) with regard to (2)(a)