

Bupa Care Homes (CFHCare) Limited

Wentworth Croft Residential and Nursing Home

Inspection report

Bretton Gate
Peterborough
Cambridgeshire
PE3 9UZ






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11 October 2016

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 11 October 2016.

Wentworth Croft Residential and Nursing Home provides accommodation for up to 156 mainly older people who require nursing and/or personal care. The service offers accommodation over one floor within four separate houses. Woolsack House provides personal care, Hayward House provides dementia care, Harvester House provides dementia care and nursing, and Yeoman House provides nursing care. Each house has single occupancy bedrooms with ensuite facilities and there are internal and external communal areas, including lounges, dining areas, a pamper room, cinema room, and gardens for people and their visitors to use. There were 69 people using the service at the time of our inspection.

During this inspection there was no registered manager in place. A manager was working at the home and they had started to apply to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection on 12 April 2016 this service was placed into special measures by the Care Quality Commission (CQC). Breaches of seven legal requirements were found and the service was rated overall as 'inadequate.' After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to; safe staffing levels; safe medicines management; robust safety checks on all new staff; safe moving and handling techniques to be used on people; improvements in staff training and staff support; people's nutrition and hydration needs being met and robust quality monitoring, good governance and management of the service.

During this inspection we found that there was sufficient improvement to take the service out of special measures. We found that the provider had made the necessary improvements to demonstrate that the majority of the legal requirements were now compliant. However, we noted that some improvements were still needed. We found that there were still concerns around the safe management of people's prescribed medicines. This was because we could not be assured that people were receiving their medicines safely. Detailed records as guidance for staff on when to administer people's 'as required' medicines were not always kept.

Safety checks were carried out on all new staff to make sure that they were deemed safe to work with people who lived in the service.

There was a sufficient number of staff to provide people with safe assistance and care.

People had care and support plans in place to give guidance to staff on the assistance a person required. Records included how people wished to be supported, and what was important to them. People's care

records had been reviewed and they or their appropriate relatives had been involved in this process.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Where people had been assessed as lacking capacity, decisions were made in their best interest and this was clearly recorded in their care and support plans. Applications had been made to the local authorising agencies to lawfully restrict people's liberty where appropriate.

Staff understood their roles and responsibilities to report any concerns of poor care practices and harm.

Staff had received training to develop their skills and knowledge to support people's individual care and health needs in an effective way. Staff received regular supervision and appraisals.

The majority of people's nutrition and hydration needs were met.

There was a system in place to receive and manage and resolve people's complaints.

Improvements had been made to the provider's and managerial oversight of the service. Quality monitoring systems were in place and improvements identified and completed or were on-going. However, improvement for the safe management of people's medicines had not been identified by the provider's audits.

People and their relatives provided feedback on the quality of the service so that the provider could see what was going well and what required improvement.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

People's prescribed medicines were not managed safely.

People's individual care and support needs were met in a safe and timely manner.

Safety checks were in place to recruit new staff safely.

Is the service effective?

Good 

The service was effective.

Staff were trained to meet the individual needs of people.

Staff received supervision and appraisal for their role.

Staff had a basic understanding of the MCA and DoLS to ensure that people were not having their freedom restricted in an unlawful manner.

The majority of people were supported to maintain their hydration and nutrition.

Referrals were made to the appropriate external health care professionals for people when required.

Is the service caring?

Good 

The service was caring.

Staff on duty spent time positively interacting with people. People were assisted in a kind and caring manner.

Staff encouraged people to make their own choices where possible about things that were important to them and help maintain their independence.

People's privacy and dignity were respected.

Is the service responsive?

Good 

The service was responsive.

Staff were able to respond to people's needs in a timely manner.

Activities happened within the service and people were supported by staff to take part or maintain their individual interests.

There was a system in place to receive and manage people's concerns and complaints.

Is the service well-led?

The service was not always well-led.

There had been no registered manager at the service since March 2015.

Systems were in place to monitor the quality of the service provided. Not all of the improvements required around the safe management of people's medicines had been identified prior to this inspection.

People who lived in the service and their relatives were asked for their opinions on the quality of the service provided.

Requires Improvement 

Wentworth Croft Residential and Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 October 2016 and was unannounced. The inspection was completed by an inspection manager, a pharmacist inspector, four inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service. Their area of expertise was older people and people living with dementia.

Before the inspection, we asked the provider to complete and return a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. The provider completed and returned the PIR form to us and we used this information as part of our inspection planning.

We looked at other information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law.

On the day of our visit, we observed how the staff interacted with people who lived in the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who lived at the service and seven of their relatives (one by telephone). We also spoke with the home manager; clinical services manager; three unit managers; an interim unit manager; a deputy unit manager; one nurse; three senior care staff; eight care staff; two activities co-ordinators; a house

keeper; and a hostess. We received feedback about the quality of the service provided from a representative of the local authority. The provider had an action/sustainability plan in place for the service following a multi-agency large scale enquiry and we used this to inform part of our inspection planning.

As part of this inspection we looked at 10 people's care records and three staff records. We looked at other documentation such as quality monitoring information, complaints and compliments, staffing rotas, medication administration records, staff and relatives meeting minutes and feedback on the service.

Is the service safe?

Our findings

At the previous inspection in April 2016 we found that the provider was breaching three legal requirements in this area and was rated as inadequate. We found at this inspection that the provider had made some improvements to manage people's medicines safely; however, we noted that there were still some areas of concern around the safe management of people's medicines. We found that the provider had made significant improvements to the number of staff available to support people with their care and support needs. We also saw that improvements had been made to make sure that robust safety checks took place on new staff prior to them commencing work.

A member of the CQC medicines team looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Records showed overall that people were receiving their medicines as prescribed. However, we noted several minor record-keeping discrepancies. We also found that one person had received two incorrect doses of anticoagulant medicine, warfarin, over the four days prior to the inspection. This placed the person's health and welfare at risk of harm. One person told us they sometimes did not receive their medicine because it had not been obtained in time. We found that there were other medicines that had not been available for short periods of time and therefore, people had not been given their medicines as prescribed.

When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines. However, more detail was required for medicines prescribed in this way that were used to treat people's psychological agitation to ensure they were used appropriately and consistently. Pain assessment tool records were in place for people prescribed pain-relief medicines. However, these were not always completed when people were given pain-relief medicines prescribed on a when required basis. Additional charts were in place to record the application of prescribed skin patches; however, these were also sometimes not completed by staff. In addition the charts did not record the removal of previous patches to ensure safety.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. There were internal audits in place to enable staff to monitor and account for medicines. We saw that where errors had been identified they were reported to the manager as incidents, and actions were taken.

We noted supporting information to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on how people had their medicines given to them. For people with limited mental capacity to make decisions about their own care or treatment, there were records of

decisions to administer their medicines given to them crushed in food or drink (covertly). The records showed staff had consulted with the people's GPs about this and there were records showing that assessments of people's mental capacity had been carried out.

At this inspection we found that improvements had been made to the number of staff on duty to support people with their health, care and support needs. The majority of people and relatives spoken with said that they were happy with the staffing levels. One person told us, "Things have improved; they [staff] answer my call bell much better now." A relative said, "I have seen an improvement [in staffing numbers] over the last few months." Another relative told us, "I am really pleased with it now; there are a lot more staff."

Our observations showed that during this inspection there were sufficient staff on duty to meet people's assessed needs. We saw staff in communal areas of the service supporting people and on the corridors, and staff were available so that people could ask for information when needed. We also observed that people's care call bells were in reach so that they could call staff when help was required. One staff member told us, "There are lots of staff and it means that we can spend time with people." We noted that staff were busy, but they did not rush people, and supported people at their own preferred pace. One unit manager said, "A daily staff allocation list is in place since the last inspection. This provides details of the people that we are caring for each day. Care staff are allocated to work in pairs [on their house]. Male staff don't work together and agency staff don't work together." Another staff member told us, "Staffing levels have been increased." A third staff member said, "[The] increased staffing has helped."

Staff told us that to cover staff sickness or leave agency staff were used to help. One staff member told us, "We use quite a few agency staff at the moment so it will be great when we have permanent staff on the unit. The agency staff are good but we do have to support them at times." A unit manager said that they tried to use the same agency staff so they knew the people they were assisting, their likes and dislikes, their care needs and their routines. This meant that there were arrangements in place to try to cover staff short term absences.

We saw that people had their dependency levels assessed to check whether they needed support from either one or two staff members and the time (hours) that this support would take. People were assessed and placed into a 'banding' of 'one to four', which represented their dependency needs on their pre admission assessment when new to the service. These bandings were then used to inform the staffing needs assessment tool. However, it was still unclear how this information directly established the safe number of staff needed to meet people's care and support needs. We discussed this with the manager during this inspection and they confirmed to us that they would look into this.

Records showed that pre-employment safety checks were carried out prior to potential new staff starting work at the service and providing care. We found that improvements had been made and safety checks included references from previous employment and a criminal record check that had been undertaken with the disclosure and barring service. Proof of current address and photographic identification had been obtained, and any gaps in employment history explained. This meant that safety checks were in place to make sure that staff were of a good character and that they were suitable to work with people living at the service.

People had individual risk assessments undertaken in relation to their identified health, care and support needs. We saw that specific risk assessments were in place for, but not limited to, people at risk of falls, moving and handling, the use of bed rails and poor skin integrity. Assessments also included medicines, mental health, poor nutrition, and poor swallowing/choking. These risk assessments gave prompts to staff to help support people safely and for them to live as independent a life as possible. Records to monitor

people deemed to be at risk were in place for staff as guidance.

However, we noted that one person in Hayward House was assessed as being at risk of poor nutrition as they were being given a pureed diet due to swallowing and choking concerns. The person's care and support plans and monitoring charts for this swallowing and choking risk gave conflicting information on how the food should be presented to the person. Staff we spoke with also were unclear about the person's assessment by the speech and language therapist team and the consistency their food should be and what they could eat safely. We also noted that there was no evidence of the person's pulse being checked as required when their medicine was given. Nor did we see a documented prompt for staff to encourage fluids when the person's fluid intake was low. This meant the person was at an increased risk of unsafe care and support due to the conflicting information in place as guidance for staff. We spoke to the clinical service manager and the interim unit manager about this during this inspection. They assured us that these records would be reviewed, updated and corrected.

Staff said that they had undertaken safeguarding training and records we looked at confirmed this. They demonstrated to us their knowledge on how to identify the different types of abuse and report any suspicions of harm or poor care practice. One staff member said, "I would speak to my manager [about any concerns] and document with [written] statements" Staff told us what action they would take in protecting people and reporting such incidents and knew how to escalate any unresolved concerns should this be required to external agencies such as the Care Quality Commission or social services. This demonstrated to us that staff knew that they could also report any concerns to external agencies.

Staff said that they would have no concerns to whistle-blow if they suspected poor care practices and that they were confident to do so. One staff member said, "We've a 'speak up' policy if we witness any abuse. There's a telephone number [to contact] –posters [reminding staff of this] are everywhere." Another staff member told us, "I will speak up if I hear anything untoward and I have whistle-blown in the past. Action was taken straight away by the unit manager."

Is the service effective?

Our findings

At the previous inspection in April 2016 we found that the provider was breaching three legal requirements in this area and was rated as inadequate. We found at this inspection that the provider had made improvements to support people with their moving and handling needs without putting them at risk and improvements to support and training that staff received had been made. We also saw that there had been improvements to make sure that people's nutrition and hydration needs were met.

There had been improvements because during this inspection we observed that good staff practice in line with people's care records was being used when moving and repositioning people safely and effectively. Where people were supported by staff, staff interacted with people to make sure that people were aware and consented to the assistance being given. One staff member was seen to ask, "Are you comfortable, are you sure?" when assisting a person with their mobility. This meant that staff made sure that people understood why they were being supported and checked that they were carrying out this support in an effective way.

Staff told us that they had training opportunities to develop their skills and knowledge. One staff member who worked in Harvester House said that they had received training in; dementia; moving and handling; the Mental Capacity Act (MCA); food hygiene and fire safety. Another staff member on Yeoman House told us, "The [Unit manager] is fantastic. She has changed so many things. She is active, we really see her a lot. She gives us advice every day and she is very good. I have lots of training now. I have had updates about Deprivation of Liberty Safeguards (DoLS) and safeguarding. Without training we are not able to do our job properly." A third staff member said, "There's always something you learn from the training." A unit manager told us that they had undertaken training in leadership which had helped them develop as a good leader. Other training they had received was catheterisation and continence assessment. This meant that they would be able to carry out continence assessments on people living in the house without have to wait for an external continence advisor to arrive. Other training included, but was not limited to; nutrition and weight management training and health and safety. Records we looked at confirmed this.

Staff said that when they first joined the service they had an induction period which included mandatory training and shadowing a more experienced member of staff. This was until they were deemed confident and competent by the home manager and unit managers to deliver safe and effective care and support.

People and their relatives told us that they were happy with the food served to them / their family member in the service. One person said, "The food is fine, there's more than enough, they [staff] are generous with their meals." The majority of staff we spoke with had an understanding of the different diets people needed in relation to their health conditions. For example; food softened in line with speech and language therapists (SALT) guidelines for people at risk of poor swallowing, fortified foods (high calories) or low sugar diets.

We saw that people were provided with a selection of hot and cold drinks and snacks throughout the day. Our observations during the meal time showed that people could choose where they wanted to eat their

meals. Some people chose to eat in their own rooms, in the lounge or at the dining room tables and this choice was respected by staff. Choices of meals were given via a menu that was pictorial as a visual aid for people requiring this assistance. One relative told us, "I've seen them [staff] tell them [people] what's on their plate." We also noted that staff talked through the menu choices with people in general conversation during lunch. However, we did see that for some people who chose to eat their breakfast later on in the morning, the time between them finishing their breakfast and being served lunch was only a couple of hours. This meant that for some people they may not have been ready for their lunch, when it was served to them.

Where people needed some assistance from staff with their meals, we observed that this was carried out in a patient manner at the persons preferred pace. The provider had introduced the role of 'hostess' which was a staff member who supported care staff during the peak meal times. Staff told us that this had meant that they had more time to be able to assist people during these peak times. One care staff member told us, "The hostess [role] has helped to ease it [at peak times] but they only work Monday to Friday. You can tell the difference at weekends." We also observed people using adaptive cutlery and equipment which enabled them to eat their food independently. People were offered other choices of food by staff if they were unhappy with the main choice. One person told us, "If you don't want what is on the menu you can ask for something different." This showed us that staff supported people to maintain their own independence and respected their choices.

We saw that where people were at an increased risk of malnutrition that appropriate referrals had been made to a dietician, GP or speech and language therapist. Additional checks had been completed such as weighing people more frequently and the monitoring of a person's weight loss by staff. This indicated to us that staff referred people to external health professionals when the monitoring had identified any concerns with the person's health and well-being.

People were referred to the most appropriate health care professional when needed. Records showed that staff had support from the local GPs, speech and language therapists, dieticians, specialist nurses such as tissue viability as well as community nurses. We found, and people confirmed, that they saw the GP, dentist, chiropodist, or optician when they needed. One relative said, "The home [staff] will call the GP if needed." Another relative confirmed to us that the chiropodist and optician visited the home on a regular basis. This indicated to us that people could be assured that the staff would take action to reduce and prevent any risks associated with their health.

Staff members told us they were supported by management within their houses. Staff said they attended staff meetings and received supervisions and appraisals of their work. Staff told us that during these meetings they could discuss issues of concern, their support and development needs and assess their performance and felt listened to. One staff member said, "We can talk to managers when we need to and they listen to us. They want to know how we are and how the residents are." Another staff member told us, "[We have had] outstanding support from the recovery team [specialist provider team placed into a service that requires help to improve] and the new managers." We saw that there were staff handovers each day, unit managers meetings held every week and a 'take ten' meeting held at 11.00am each day. Staff told us that during these meetings topics such as service updates, staffing, and the updates on people they supported were discussed. This showed us that staff were supported within their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We noted that each of the houses had a 'DoLS' tracker in place which logged key information about people who were subject to a DoLS, when it had been authorised by the supervisory body and when a renewal was due. This demonstrated to us that there was a process in place to monitor and safeguard people under this legislation.

Appropriate applications had been submitted and in some cases acknowledged by the local authority to lawfully deprive people of their liberty. This was to help ensure that people were safely supported with their decision making. People's care records clearly documented each of the day-to-day decisions that required staff support in the person's 'best interest.' One staff member said, "We do things in their best interest where they are unable to make a choice themselves." Staff we spoke with were able to demonstrate their knowledge of the MCA and how this safeguarded the people they assisted.

Is the service caring?

Our findings

At the previous inspection in April 2016 we found that significant improvements were required and the service was rated as inadequate. We found at this inspection that the provider had made improvements to make sure that staff had time to support people in a patient and caring manner.

People and their relatives told us that staff were kind and caring. People valued the relationships that had developed with staff members. One relative said, "Staff are wonderful." Another relative told us, "When I arrived yesterday, staff were still assisting [family member] to get up and both were giving [family member] a kiss on the cheek. It was lovely to see. [It feels like] part of a big family." A third relative said, "The staff here are brilliant, I'm happy with everything."

We observed examples of staff seeking assurance as to people's wellbeing. Where people were displaying an increased anxiety we saw that staff took the time to reassure the person by talking to them to explain what they were doing, or what was happening, stroking their hands to relax them and making eye contact to demonstrate respect and to check the person's understanding. However, we did observe some missed opportunities for staff to verbally engage with people. This was reported back to the unit managers during the inspection for them to make the necessary improvements.

People, and their relatives, were involved in the development of people's care plans and records. This was during the pre-admission assessment stage when agreeing the person's care that was to be provided at the service. Relatives told us that they were then asked if they wanted to be involved in the review of their family members care so that they could discuss any concerns, change to needs or updates required. One relative said, "They [staff] did ask me if I wanted to review [family members] care plan with them. I said no as it was done two-three months ago." The service had also introduced a 'resident of the day.' Staff told us that this meant that the person was focussed on by staff, to get to know them better and a review of their care plans also took place.

We saw, and people confirmed, that staff were always polite and spoke to them in a respectful way. Examples included ensuring people's private conversations were respected and also when people wanted to be on their own. Staff gave people time to consider their decisions as well as allowing people to do things at their own pace or when offering to help. One staff member was observed at lunch time asking a person, "Shall I help you cut that?" This demonstrated to us that people were assisted by staff to maintain their independence, but were offered assistance when required in a respectful manner.

Staff described how they respected people's privacy and dignity. Our observation showed several occasions when staff readjusted people's clothing to make sure that the person's dignity remained intact. Other ways we saw included staff distracting people with general conversation during the provision of personal care. One relative confirmed to us that, "They look after [family member], [family member] is well cared for...he always look clean and nice...they [staff] treat them [people who use the service] like they are one of their own." Other ways staff used to respect people's dignity was by gaining permission to enter their room and closing curtains and doors when delivering personal care.

We found that people had relatives, friends and representatives who acted as an advocate for them if required. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. External support organisations as well Independent Mental Capacity Advocates [IMCA] were available when required. This showed us that staff took steps to ensure people's wishes, needs and preferences were ascertained and respected where people were not able to speak up for themselves.

People told us, we saw, and staff confirmed, that visitors could call in at any time people were in the service. One relative told us, "I can come in any time I want."

We saw that people had documented their end of life wishes. This included their wish to either be resuscitated or not. One record we looked at did not document a discussion around this choice with the person's next of kin. We have asked the manager to investigate this further.

Is the service responsive?

Our findings

At the previous inspection in April 2016 we found that significant improvements were required and the service was rated as inadequate. We found at this inspection that the provider had made improvements to make sure that staff could respond to people's needs, concerns and complaints in a timely manner.

There had been improvements because we saw that the manager listened to people's suggestions, concerns and complaints and tried to resolve them where possible.

Staff told us that if a person raised a concern or complaint that they would, in the first instance, try to resolve the matter themselves with the person's permission. They would then escalate the concern to their manager. One person told us that they had no complaints but would speak to staff if they needed to. A relative said that they also had no complaints, "But if I did I would tell them [staff]." Another relative told us that they had no concerns but would tell the manager if they had any because they liked them and felt that they could talk to them.

We looked at recent compliments and complaints received by the service. We found that, records demonstrated that complaints were investigated and responded to and resolved to the person's satisfaction where possible. This was also demonstrated with a 'customer feedback wall' which documented any requests from people and their relatives and the action taken by the provider. The wall was called 'you said, we did' and we saw evidence that a request for up to date staff pictures in each of the houses had been actioned as a result of listening to this suggestion.

At this inspection we found that there were various activities for people to take part in should they wish to do so. We observed a mixture of group and one to one activities were taking place. These included but were not limited to, music sessions, sing-a-longs, reminiscence sessions, and jig-saw puzzles. One person told us that on occasion people, with the support of staff, would go to a local pub for a meal. They went on to tell us that every week a film was shown for people in the garden lounge which had been an activity they enjoyed. A relative said that their family member didn't join in the activities but that staff would spend time sitting and chatting with them so that they did not feel isolated. Another relative told us that the activities co-ordinators, "Did a good job."

Support and care plans were developed by staff at an initial meeting, in conjunction with the person, their representative, and/or their family. This, in combination with the local authority's single assessment process formed the foundations of people's care and support needs plan. These plans provided prompts to staff on the care and support the person needed and their wishes.

We found that people's personal history was recorded where this was available. This included the important aspects of people's lives and their most precious in their memories. For example, their family members, friends, their working lives and life achievements. This was then used as information and guidance for the staff that supported them. The individual support that people received from staff depended on their assessed needs. Support included assistance with their prescribed medicines, personal care and meal time

support. Reviews were carried out to ensure that people's care and support requirements were recorded, updated and met the persons current care needs.

Care plans gave the information staff needed regarding the ways people communicated. For example, the prompts for staff included giving the people they supported information verbally or by visual prompts and/or using subjects of reference. We saw that individualised pictures were in place on people's bedroom doors in the dementia houses. This was to help people living with dementia to identify where they were and where their room was.

Is the service well-led?

Our findings

At the previous inspection in April 2016 we found that the provider was in breach of one legal requirement in this area and was rated as inadequate. We found at this inspection that the provider had made significant improvement to the provider's and managerial oversight of the service. We also noted that there had been some improvements to identify and act upon areas of improvement required. However, we identified some areas on the safe management of people's medicines that required improvement. These areas for improvement had not been identified by the provider's quality monitoring.

There had been no registered manager in place to oversee the running of the service since March 2015. There had been two home managers recruited since then with the intention that they complete the application process to become the registered manager. However, both of these managers had, at different times, resigned. It is a condition of this services registration that a registered manager is in place.

The service was currently being run by a manager who started on 7 July 2016 to submit their application to the CQC to become the registered manager. They were supported by a team of care staff and non-care staff. People, their relatives and staff we spoke with had positive comments about the new manager. One staff member said, "The current manager is fantastic, they are really supportive and are seen on the units every day. She is very firm but fair." They went on to tell us that staff seemed, "More enthusiastic and energised."

Following the number of safeguarding concerns raised and whistle-blowing reports received by both the local authority and the Care Quality Commission a large scale enquiry was being carried out by Peterborough City Council adult social care team and other agencies. This had resulted in an embargo on people moving into the service for people requiring support with personal care. Cambridge and Peterborough Clinical Commissioning Group had also put an embargo in place for people who required nursing care. A BUPA action and sustainability plan had been put in place. This action plan documented all the improvements needed as identified by the safeguarding concerns to ensure that the service provided safe care and support to the people living there.

Quality monitoring systems to identify areas of risk and trends within the service were in place to identify or resolve the areas found to be requiring improvement. We saw that each house carried out their own quality monitoring on areas of risk such as, medication administration records, compliments and complaints received, safeguarding concerns and incidents. We noted that action to make the necessary improvements had been completed or were on-going. However, during this inspection we identified a number of shortcomings in the safe management of people's medicines that had not been identified by these monitoring systems. This meant that the quality monitoring systems in place had not identified all areas of concern and/or improvements required, nor had improvement been sustained.

People and their relatives said there were meetings where they were given the opportunity to feedback on the quality of the service provided. One person said, "Oh yes, we have meetings, we had one last week." A relative told us, "[The new manager] always comes round and talks to me." Another relative said, "They've got a really caring manager now; she comes round and asks you things."

Surveys for people, and their relatives were sent out to gather opinions on the service. The latest report we saw collated the feedback received from the December 2015 survey. There had not been a formal survey since the previous inspection in April 2016, so we were unable to review this evidence at this inspection.

Staff showed us that they understood their roles and responsibilities to people who lived in the service. They knew the lines of management to follow if they had any concerns to raise. They demonstrated to us their knowledge and understanding of the whistle-blowing procedure and said that they now felt listened to. Staff told us that the overall culture across the service had improved. One staff member said that the service culture was, "More vibrant." This demonstrated to us that staff were now involved in the continual development and improvement of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	We could not be assured that people were receiving their prescribed medicines in a safe, accurate and timely manner. Robust records that gave staff detailed guidance on how and when to administer people's 'as required' medicines were not always kept.
Treatment of disease, disorder or injury	