Care Uk Community Partnerships Ltd

Cherry Orchard

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Cherry Orchard provides accommodation and nursing care for up to 40 older people. There is a 12 bedded unit for older people with mental health care needs and two units for 28 people living with dementia. The home is a large purpose built property. The accommodation is arranged with all 3 units on the ground floor level. There were 38 people living at the home at the time of our inspection.

This was an unannounced inspection, carried out over three days on 14, 17 and 24 November 2014. The home had a registered manager in post. 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.

We last inspected Cherry Orchard on 10 October 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

Summary of findings

We observed care and support in communal areas, spoke with people in private, and looked at care and management records.

People were not always kept safe at the home. There were poor arrangements for the administration of medicines. Incidents were not reported or managed in an appropriate way. Risk assessments did not address the risks to people using the service relating to behaviour that challenges which put people at risk of harm.

Each person had a care plan which set out their individual and assessed needs. However some people were not protected against the risks of unsafe or inappropriate care and treatment by monitoring of their medical condition.

Staff told us they undertook regular training. However the training matrix showed that staff had not received up to date training in relation to dementia, behaviour that challenges and care planning. We did not see evidence of regular clinical supervision for registered nurses.

Staff demonstrated they had an awareness of the Mental Capacity Act 2005, which meant they could support people to make choices and decisions where people did not have capacity.

People told us they felt cared for. People were treated with dignity and respect. The staff knew the care and support people needed. However the current staffing rotation meant that people did not get to know their key worker well.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the full version of this report.

Summary of findings

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.

Risk assessments were in place but it was not always clear how identified risk was managed relating to behaviour that challenges. Medicines were not always administered safely as staff did not monitor if people took the medication given to them. Safeguarding incidents were not always reported to the local safeguarding team in a timely manner and the risk managed appropriately during the investigation.

The service had a safeguarding procedure in place and staff were aware of their responsibility with regard to safeguarding adults.

There were enough staff at the service to keep people safe.

We have made a recommendation about staff allocation in relation to the specialist needs of people living with dementia.

Is the service effective?

Inadequate

The service was not always effective. Staff told us they undertook regular training however the training matrix showed that staff had not had recent training in areas of dementia awareness, care planning and behaviour that challenges. People were at risk of receiving nutrition which was not compatible with their specific dietary requirements.

Peoples care needs were met and they had access to health care professionals.

Staff demonstrated they had an awareness of the Mental Capacity Act 2005, which meant they could support people to make choices and decisions where people did not have capacity.

We have made a recommendation about adaptation, design and decoration of the service.

Is the service caring?

Good

The service was caring. Care was provided with kindness. People were treated with dignity and respect. The staff knew the care and support people needed. However the current staffing rotation meant that people may not get to know their key worker well.

Is the service responsive?

Requires improvement

The service was not always responsive.

Each person had a care plan which set out their individual and assessed needs. However some people were not protected against the risks of unsafe or inappropriate care and treatment by monitoring of their medical condition.

Most people said they joined in with the activities at the home.

Summary of findings

People said they knew how to complain if they needed to. However the manager found dealing with complex complaints challenging.

We have made a recommendation about the management of complaints.

Is the service well-led?

The service was not always well led. We found that the provider had not sent in notifications to the Care Quality Commission about the decisions of or applications submitted for Deprivation of Liberty Safeguards.

The service had systems in place to monitor quality of care and support in the home.

Requires improvement

Cherry Orchard

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 was brought forward because we received concerning information about how complaints were handled, administration of medicines, infection control, safety of people living in the home and staff knowledge about caring for people living with dementia.

We visited the home on 14, 17 and 24 November 2014 and the inspection was unannounced. On the first day of our inspection the inspection team consisted of two inspectors and a specialist advisor. A specialist advisor is a person who has professional experience in caring for people who use this type of care service. On the second day a pharmacist inspector visited the home.

Before our inspection we reviewed the information we held about the home including the Provider Information Return (PIR) completed by the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection. We contacted the local commissioning team for the service to obtain their views about it.

During our inspection we spoke with six people who lived in the home, two visitors, two administrators, the head chef, eleven care assistants, three registered nurses, the activities co-ordinator, deputy manager and the registered manager of the home. We observed care and support in communal areas, spoke with people in private, and looked at care records for seven people. We also looked at records that related to how the home was managed.

We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Requires improvement

Is the service safe?

Our findings

People were not safe. Although people told us they felt safe, we found significant problems with the reporting and management of incidents. All staff said that unfortunately due to the complexity of people's needs it was likely that they would be verbally abused or physically injured on average once a week. People's risk management plans did not contain clearly defined triggers for behaviour that challenges. One person was on a one to one observation plan due to high risk of harm to others. It was recorded that they responded better to female care assistants however, this knowledge did not seem evident in staff discussion around aspects of their care.

We looked at the incident reporting log for the previous six months and noted there were no incidents reported. There were no records of actions or outcomes after an incident had taken place. Staff we spoke with were unclear about the process for reporting incidents of physical injury or verbal abuse. One person said, "I've had bruises, cuts and scratches." We asked how they reported the incidents and they told us they did not know who to report incidents to or who the first aider on duty was. Other staff told us they would report it to a senior member of staff but did not know how the information was recorded and were not made aware of any actions taken to minimise further incidents from occurring.

The deputy manager and registered manager told us that incidents were reported in the care plans of people using the service. Records of incidents did not show actions or risk assessments carried out following the incident to minimise the risk of reoccurrence. They told us they did not always record the type of injury, the effect the incident had on the member of staff or actions taken to minimise further incidents. There was no clear process in which staff could be offered support. On the second day of the inspection we noted that the manager had included incident reporting in the staff supervision form and had devised a new form for reporting incidents. Not all staff we spoke with were aware of this. These findings were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff stated they felt safe on duty and that their colleagues were supportive when people were challenging in their behaviour.

We observed that most of the people living on one unit were without shoes or slippers. People were wearing socks. We checked with staff who told us that not all socks had grip suction at the bottom and it was not a routine request for relatives to purchase these. Staff explained that people would take shoes off regularly, or that shoes would go missing. This meant that people were at an increased risk of falling due to wearing inappropriate footwear. During the course of the morning having raised this as a concern we noted later that people were wearing appropriate footwear.

We noted that all of the beds in people's rooms were set at the lowest level. Staff told us this was done to minimise the risk of falls there was no evidence that risk assessments had been carried out to see if this was a specific risk to each person using the service. This meant that people were not receiving individual risk assessments appropriate to their needs.

These findings were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One of the units had an unpleasant and unacceptable strong pungent smell of urine. We asked staff about this. Staff explained that one person was prone to urinating in areas in the unit that were not designated as the toilet. Whilst the staff were responsive and cleaned the spillages up, certain areas in the unit were carpeted (bedrooms) and the urine had seeped into the fabric of walls and flooring. It was seen that no industrial air fresheners were on the unit walls.

Domestic staff who carried out the cleaning were not wearing any personal protective clothing this included gloves and aprons. We brought this to the attention of the registered manager. These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not always administered safely. We looked at medicines storage, medicines and records about medicines for people using the service and reviewed documents supplied by the service. During the inspection we observed the registered nurse administering medicines during the meal which is not good practice. The trolley was left locked in the middle of the lounge whilst the nurse went to administer medicine for one person. Another inspector observed that the nurse did not observe the person actually swallowing the medicines before moving

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Is the service safe?

on to the next person. This meant staff did not know if the medicines had been taken or not which was unsafe practice. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them.We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be given) were in place. They provided information to enable staff to make decisions as to when to give these medicines. This ensured people were given their medicines when they needed them and in way that was both safe and consistent.

Medicines were stored safely. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. We saw that controlled drugs were managed appropriately.

We also saw the provider did daily and monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

We spoke with the local safeguarding team about safeguarding incidents that had been raised since the last inspection. The manager told us and we saw records of three incidents that had been reported to the local safeguarding team. However we were concerned that a fourth safeguarding incident had not been reported to the local safeguarding team in a timely manner by the registered manager. We were also concerned that although the incident was still being investigated there was no risk management plan documented in the persons care file to keep them safe. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager had not made a notification to the Care Quality Commission (CQC) as required. This meant that the service was not reporting safeguarding concerns appropriately so that the CQC could monitor safeguarding issues effectively. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of Other Incidents.

People told us they felt safe living at the home. We spoke with six people and they told us they felt safe. One person said, "I feel very safe here. If I didn't feel safe I wouldn't live here." A visitor told us they felt their relative was safe living in the home.

The service had safeguarding policies and procedures in place to guide practice. Staff told us they received training in safeguarding adults. They told us about the different types of abuse and the procedure for reporting abuse. They said they would report it to the nurse in charge of the unit or to the manager in the first instance. Staff were able to explain whistleblowing and knew how they could report concerns. One person said, "I have done safeguarding training. I have to make sure I watch for abuse such as physical, mental and financial. I would report to the manager or nurse. I would take it further if nothing was done about it. I know about whistleblowing."

We looked at the training log and noted that 24 of the 70 staff working at Cherry Orchard were due to complete a refresher course in Safeguarding of Vulnerable Adults. The manager told us refresher training had been booked and was scheduled to take place on 18th November. We saw records that this had been completed by 18 staff on our second visit to the home. Further training was booked for early January 2015.

Of the three units, one unit was much cooler than the others and it was noted that the heating engineer was present. It was a concern that the heating engineer had a ladder erected and there was a loose cable which presented a trip hazard. This was not being guarded and no one was managing the risk to people. We brought this to the attention of the deputy manager who addressed this.

Requires improvement

Is the service safe?

However an hour later we noticed that the ladder was again in place and no one was monitoring people to ensure their safety. This meant that people were not safe from the risk of injury.

Pressure area care was safe at the home. We looked at risk assessments relating to pressure area care in people's care files which showed that assessments had been carried. We saw treatment plans for three people who had been admitted to the home with pressure ulcers and how this was monitored.

Safe recruitment procedures were in place. The service had a Recruitment and Selection Policy which was dated October 2014. The policy covered Disclosure and Barring Service (DBS) checks, verifying ID which included photo ID such as driver's license and passport and documents with address. The policy included that a minimum of two references were needed including at least one professional.

We looked at seven staff files and saw there was a robust process in place for recruiting staff that ensured all relevant checks were carried out before someone was employed. These included appropriate written references, professional registration and proof of identity. Criminal record checks were carried out to confirm that newly recruited staff were suitable to work at the service.

During our inspection we saw that the staff provided the care people needed, when they required it. People told us they felt there were enough staff available to meet their needs. One person said, "it's not too bad but when there's staff sickness it can be an issue." We found that staff had concerns about the number of staff on duty. Staff told us they were sometimes short staff. One said, "I sometimes don't get time to spend with people when short staffed. We have too much paperwork." Another told us it gets busy on certain days of the week. They said, "it gets really busy on Wednesdays. People get visits from the GP, social workers and we often book in the psychiatric reviews for that day." Staff told us that staff absence can sometimes pose a problem.

The provider did not have adequate systems in place to cover staff absences. Sickness absence was covered by using bank staff. On other occasions bank staff were not brought in but staff covered the work of their absent colleagues and were paid an extra two hours in overtime pay. Staff we spoke with said this sometimes worked well except on very busy days. One person said, "Sometimes we are short of staff now and again. We get staff in to cover but not always." Another said, "there are times when sickness is an issue."

The registered manager told us that in the last two months due to high staff sickness absence rates a management decision was made to alter how staff would be rotated on each shift. All staff would work one long day on each unit. We looked at staffing rotas and noted that registered nurses and care assistants were allocated to work on different units each day therefore in a working week they were on each unit once a week. This posed a problem for continuity.

Some staff told us that working on different units each day meant that they were not always able to get to know people living on the units well while other staff said they enjoyed the variety. One person said, "I work on all units so I know people really well." Some staff said that they felt the lack of continuity contributed to people behaving in a way that challenges others. Another said, moving around makes you wonder if it wouldn't be better to get to know people a bit better. It's the small things like, who takes sugar and who prefers coffee. It's hard to remember what people like and it can make it stressful all the moving around."

We were concerned that people living with dementia may find it difficult to build a rapport and to recognise the member of staff who was their key worker or named nurse due to a lack of continuity as staff moved between units daily. One person told us, "for continuity I would like to get to know people and also it makes people confused." We spoke with the manager about our concerns. They told us they felt that moving staff to different units for each shift meant they would get a better understanding of all the people living in the home. They explained that working on some units was more challenging than working on others and moving staff around meant they would address this. They told us they would speak with staff in the next staff meeting to find out if they had a preference for working on a particular unit.

From speaking with staff we noted that care assistants were allocated as keyworkers for up to two people and nurses had an allocation of five people. The rotation system in place meant that the responsible keyworker was having contact with their named person less than once a week and may not be able to adequately monitor changes in their needs. The staffing rota was organised so that there was

Requires improvement

Is the service safe?

also an allocation of associate key workers which continued during the night shift. This meant there was a risk that the continuity of care for a person living with progressive dementia may be compromised and people may be at risk of receiving inappropriate care or treatment.

We recommend that the service finds out more about staff allocation based on good practice, in relation to the specialist needs of people living with dementia.

The registered manager told us that recruiting new staff had been a slow process as they had needed to recruit five nurses and 11 care assistants since April 2014. These posts were filled in August 2014. At the time of our inspection there were no staff vacancies at the home. We were concerned with this number of new staff it meant they were adjusting to working with new colleagues as well as moving between units on a daily basis which impacted on the level of continuity within the service.

Inadequate

Is the service effective?

Our findings

We discussed the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) with the registered manager. MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests.

However, people on one unit had assessments that identified they did not have the mental capacity to consent. There was little documentation relating to how the person's relatives or advocates views of interventions or goals were used to plan their care or decisions made in their best interests. The provider did not ensure people's rights were upheld in line with the MCA.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager and deputy manager knew how to make an application for consideration to deprive a person of their liberty. There were currently three DoLS in place and 35 applications going through the authorisation process. We looked at four applications which included detailing risk, needs of the person and ways care may be offered and least restrictive options explored. We found that the provider had not sent in notifications to the CQC about the decisions of applications submitted for Deprivation of Liberty Safeguards (DoLS). This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of Other Incidents.

The training matrix showed the core training included dementia awareness, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), care planning, medicine management, infection control, moving and handling, wound care, diabetes, first aid, basic life support, pressure care and safeguarding of vulnerable adults. The training matrix showed that some staff had not attended training or were overdue their refresher course.

Whilst staff demonstrated an understanding about dementia and how it affects people they told us they sometimes found it difficult to manage behaviour that challenged the service. We looked at the training matrix which showed that of the 70 staff working at the home 22 staff had not had up to date training about caring for people living with dementia. The training matrix also showed that 45 of the staff working at the home had not received up to date training in how to deal with behaviour that challenged which left staff and people living in the service at risk of being injured.

The availability of clinical supervision for nursing staff was an issue. All staff stated they had access to supervision which took place on average once every three months. Supervision was a time where managerial issues were discussed for example, performance. Nursing staff told us they received supervision however they did not always receive clinical supervision. We saw records that confirmed this. There appeared to be an absence of clinical supervision. All staff stated that learning and contribution to clinical issues were undertaken in the handovers and not on a one to one level. This meant that clinical practice was not adequately monitored.

Each person had a care plan which set out the individual and assessed needs of people. The registered nurses were responsible for updating the care plan. The registered manager told us staff were trained in care planning. We looked at training records and noted that of the 16 nurses working at the service 14 had not received up to date care planning training. We did not see evidence that future training had been scheduled. This meant that some people were not protected against the risk of unsafe or inappropriate care and treatment as care planning was being carried out by staff who had not received up to date training.

There was an induction process for new staff working in the home. We looked at the induction policy and spoke with a member of staff who had recently started working at the home. They were able to explain the induction they had received. We saw records of this in their staff file. They told us they had not received a one to one supervision meeting since being employed and did not know how well they were progressing in their role. We looked at the induction policy which stated that during induction staff would receive supervision from the manager/deputy/clinical lead at the end of the fourth week. We saw that the staff file had no record of this. We spoke with the manager who told us the meetings had not taken place. These matters were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff stated that opportunities for training were available and these were easy to access. One person said, "The job is

nice and rewarding. I get enough training. I can't remember my last training as we have so many." Another said, "The training is really good here and I get the opportunity to share my expertise and knowledge with my colleagues."

We looked at records in the staff file of one to one supervision meetings which took place every three months and included topics on monthly audits, cleaning schedules, policies and training. Staff told us they had regular supervision meetings and found these useful. One person said, "There are opportunities to grow here. I'm interested in progressing in my role and this company acknowledges your efforts and develops you." Another said," I get one to one every three months. We talk about if I am happy with work, any problems, people in the home, and if people are pulling their weight." Staff told us they had an annual appraisal and we saw records of this.

Monthly staff meetings took place. There were separate meetings for care assistants and registered nurses. We looked at records of these meetings. One member of the staff team said, "We have staff meetings once a month, one for carers and one for nurses. We discuss fluid charts, any incidents and make sure they are documented. They said staff did not always speak up in the meetings but that the manager always gave people the opportunity to participate.

People did not always receive their meals or support to eat their meals in a timely manner. We observed lunch time on two of the three units. Meals were served from a central lounge and then distributed to people in the three units. We asked why the food trolleys were not brought into the lounge areas. Staff said this was to minimise risk to people living in the home however they were unable to explain what sort of risks. We observed the process was very slow with one tray being brought into lounge at a time. Some people were waiting for up to 20 minutes for their meal. Hot food was served on cold plates. We asked the staff member how they knew if the food was hot enough. They stated you could feel the temperature of the food on the plate. We were concerned that the food would go cold quite quickly.

On one unit we observed a care assistant going to one person and shaking their hands and saying, "Your lunch is ready". We saw that the food was placed in front of them however they did not seem to notice but looked straight ahead. We noted that it was ten minutes before another care assistant sat down with them to support them with their meal. This meant the person had to wait to be assisted. Also people were at risk of not having a good mealtime experience as food was not at the correct temperature to be appetising.

People were supported by care assistants to complete a meal selection form the day before to decide what they would like to eat. We looked at forms for 14 November 2014 which had each person's name. The form stated if the person had pureed food or required a special diet for example a diabetic diet. The head chef told us if a person is diabetic but not insulin dependent they would have the same meals as other people but in moderation. They told us they never had anyone who was insulin dependent living in the home. We checked care records and noted that on the day of our inspection there were people who were insulin dependent.

One staff member told us they would find it easier to know peoples dietary requirements if there was a way that they could see this when serving meals rather than having to work out who had special dietary requirements. They said it was not always clear. This meant that people were at risk of receiving meals that were not suitable for the management of their medical condition.

The menu for the home did not contain a vegetarian or culturally specific option. One person told us, "The food is alright but I don't get what I really want to eat. There's no [culturally specific] meal on offer. I don't really get my kind of food." The head chef told us they were not aware of anyone in the home who had a food allergy or required a culturally specific option during the period they had been working in the home.

These matters were a breach of Regulation 14 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010

We noted that during the lunch period people received different levels of support and interaction with staff appropriate to their needs while having their meal. One person had a care assistant with them for the duration of the lunchtime. They were engaged in conversation while being supported to eat a pureed meal. We observed that the care assistant supported the person to eat their meal patiently, speaking with them constantly and asking if they wanted more while assisting them. We observed another person eating unassisted throughout the lunch period with minimal engagement from the staff.

Inadequate

Is the service effective?

On the second unit, seven people required assistance to eat their meal. There were three staff assisting them. We saw many attempts to assist each person to maintain as much independence as possible. Staff were gently encouraging people as well as paying attention to capacity and consent . For example asking whether the person wanted a sip of drink or another mouthful of food and this continued throughout the meal.

The entrance of the home and on each unit. The menu covered seven days for breakfast, lunch and dinner. Each meal had two choices. The menu choices were provided on a four week rolling menu. Staff told us the menu was a standard menu for Care UK but changes were possible depending on people's preferences. We saw one person had recorded on the form they wanted a jacket potato with cheese as they didn't like the menu for that day and they received their choice.

The service carried out an annual satisfaction survey and held relatives meetings where people could give feedback relating to the food provided at the home. The head chef said people did not provide feedback about the food. We looked at the survey forms and noted that most people had responded positively about the quality of meals served.

We looked at the care file of one person who we observed needed support with eating their meals due to difficulty in chewing. We noted they had lost weight due to this but saw a referral had been made to the dietician. We saw they had been prescribed supplementary drinks and this was clearly documented and their weight monitored.

The home appeared clean. The main lounges on each unit had armchairs lined against the walls. Each contained dining tables or a separate dining area. The environment and the standard of décor differed on the units as some areas had been recently updated. The registered manger told us they were upgrading the home in stages. We saw evidence of this in the newsletters for the home updating relatives of the changes. During our visit we saw one unit was being decorated.

Each bedroom had a framed picture of the occupant. We saw some rooms had been personalised with family photographs and personal items. However, people's bedrooms did not always contain information about the person's life or interests. We did not see evidence in relation to consideration of appropriate adaptive needs in the communal areas to assist independent living for example, toilet signs or pictures at eye level. This meant that people living in the home may find it difficult to familiarise themselves with their living environment as there were no dementia friendly signs to help assist people to navigate their way around the unit.

We recommend that the service seeks advice and guidance from a reputable source about how to meet people's individual needs by adaptation, design and decoration of the service.

Good

Is the service caring?

Our findings

People told us staff were caring. One person said, “it’s nice here. Staff are kind.” A relative described the care as “brilliant”. They felt staff were approachable and listened to any issues raised.

Each person using the service had an assigned key worker. The staff we spoke with were keyworkers for people. We noted that there were up to four keyworkers in any one team for one person. The issues with continuity have been reported in the safe section of the report but individual interactions between staff and people were caring. Staff were able to describe how they developed relationships with people which included speaking with the person and their family to gather information about their life history and likes and dislikes.

We observed staff interacting with people in a kind, respectful and personalised way, making efforts to try and understand what the person was communicating. We saw staff speaking to people face to face at their eye level.

Staff told us how they promoted people’s dignity, choice, privacy and independence. For example they said they always ensured doors were closed when providing personal care to people. We saw staff assisting people with daily living activities. Personal care was being carried out in the privacy of the person’s room or bathrooms. Staff explained how they sought consent from people before assisting them or offering support with their daily needs. One staff member said, “everyone needs to be treated with respect and care.” Another said, “you just think about how you would want to be treated, with respect and dignity.”

We saw one person watching a member of staff who was cleaning a window externally. We saw staff speaking with them and then offering them a plain cloth so they could join in cleaning the window from the inside. Staff told us the person often liked to be involved in small tasks like this.

We observed staff interacting with two people who were distressed. They comforted them in an appropriate way and spoke with them in a calm manner.

We saw plans in people’s care files regarding their wishes for end of life care. After our visit we spoke with one of the end of life facilitators. They told us that the home worked well with them and were proactive in ensuring that people needing the service were referred in a timely manner. They told us the staff at the home arranged meetings with health professionals and the person’s family as appropriate to plan care. Staff we spoke with were able to tell us about end of life teaching sessions they had attended.

Requires improvement

Is the service responsive?

Our findings

Each person had a care plan which set out the individual and assessed needs of people, however some people were not protected against the risk of unsafe or inappropriate care and treatment by accurate monitoring of their medical condition.

People's blood sugars were not monitored appropriately. We found one person had been admitted to hospital due to a raised blood glucose level following an infection. Staff had not considered that the person would require an increase in monitoring their blood glucose levels because of the infection which resulted in an emergency admission. It was noted in two care records of diabetic people that although the care plan outlined the appropriate level of required testing there was no intervention or action related to monitoring blood glucose levels when people developed an infection.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the care files reviewed had up to date care plans that were dated 27 October 2014. In three files we saw people had a completed Alzheimer's 'This is Me' document which gave good personal detail about people. However some of the electronic care planning appeared to be repetitive. We noted the same structure of sentences copied in other care plans. In addition paper records were also available.

There were risk assessment plans for people, Deprivation of Liberty Safeguards (DoLS) checklists, a covert medicines agreement where appropriate and a completed 'Do Not Resuscitate' form (DNR). All care records reviewed had a multidisciplinary entry updated by health professionals involved in their care. Daily records showed care that had been given.

There was comprehensive information about people in the care plan records. The staff we spoke with had a good knowledge of the people they were the allocated keyworker for, however the current rotation of staff between the units meant that there was a risk that this level of knowledge and history could be lost.

People we spoke with said they joined in with the activities at the home. One person told us, "there's a new activities person so it's getting better." A relative said, "my [relative] can get involved, especially in the summer when the gardening activities happen."

The home had a newly appointed activities co-ordinator. People said that although the activities program had improved and there were additional staff, there was a lack of activities at the weekend. One visitor told us they had raised the issue of weekend activities with the staff who listened and organised an outing especially for their relative.

The activities co-ordinator told us a new program had been developed for the weekend following feedback from relatives of people living in the home. A designated activities worker was available at the weekend to facilitate the activities. We looked at the activities program for September to December and saw events had been planned to take place in the home as well as outings to local events. Staff were able to tell us about people's preferred activities and how this was linked to their life histories as documented in their care plans. We saw records of this which showed activities people participated in linked to their life histories.

We observed an activity session in one of the units and saw people taking part in an arts and crafts session. People were engaged in various activities of painting, twisting and making shapes out of large coloured pipe cleaners. People we spoke with said they were enjoying the activity. There was spontaneous laughter and appropriate music was also being enjoyed in the background.

Meetings were held with people living in the home and with their relatives to discuss the service and plans for the home and to find out their views. We looked at minutes of these meetings which showed how people and their relatives were involved in issues such as planning the redecoration of the home.

People we spoke with said they knew how to complain if they needed to. They said they would tell a member of staff. One visitor told us they had made a complaint and felt staff dealt with it appropriately. The service had a complaints procedure. The procedure included timescales for responding to complaints and details of who people could

Requires improvement

Is the service responsive?

complain to if they were not satisfied with the response from the service. We looked at the complaint log and saw complaints that had been received and how they had been dealt with in line with the providers policy and procedure.

The registered manager and staff were able to explain how they would deal with a complaint. They told us they sometimes found dealing with complaints challenging and that complaints were discussed in staff meetings. We saw records of these discussions in minutes of staff meetings.

We received concerning information prior to our visit about the complaints process at the home. The registered manager told us how this complaint was dealt with and we saw records of this. The complainant remained dissatisfied with the outcome of their complaint. The manager was unable to provide an update of the next stage of the complaint but told us they would be discussing it with a senior manager. We recommend that the service seek guidance from a reputable source, about the management of and learning from complaints.

Requires improvement

Is the service well-led?

Our findings

Services that provide health and social care to people are required to inform the care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had not informed the CQC of significant events in a timely way. This meant that the CQC were unable to monitor that appropriate action had been taken.

The service had two forms of record keeping. There was an electronic recording system and a paper system. Staff told us there was sometimes a delay as new staff could not use the system until they had received a log in access. They said they had not been able to use the electronic system and were having to document everything on paper. This limited their access to information.

The service had a registered manager who had been working in the home for seven months at the time of our visit. People who lived in the home said they found the registered manager approachable. One visitor told us they found the manager helpful and always available to respond to any concerns they may have.

Staff we spoke with said they felt supported by the registered manager. Staff told us there had been many changes due to recruitment of new staff but they felt they were beginning to work as a team. One member of staff said, “there have been lots of changes. We are all new but we grow and learn together.” They told us they felt confident about speaking to the manager about any concerns they may have about the practice or behaviour of other staff members. Staff told us they attended monthly meetings and we saw records of these. Staff also attended formal one to one supervision meetings with a senior member of staff where they could raise any concerns about the service.

People who lived in the home and visitors we spoke with told us they were asked about the service provided and completed annual surveys to give feedback. We saw that most of the comments on the relative’s survey were positive.

The service worked in partnership with other agencies and health professionals. We spoke with a best interest assessor on the day of our visit and they commented positively about the service.

We saw there were systems in place for the maintenance of the building and equipment to monitor the safety of the service. This included monthly audits of environmental health and safety. There were systems of daily checks to ensure peoples safety, however they had not identified the other issues we had identified during our inspection. This meant people and others were not protected against the risks of inappropriate or unsafe care and treatment by regular assessments and monitoring of the quality of services provided. These findings were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we fed back our findings to the registered manager they were open to our feedback and were able to provide some evidence of actions taken to address the issues of safeguarding training and incident reporting.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services and others were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user; And the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs, ensure the welfare and safety of the service user, Regulation 9 (1) (a) (b) (i) (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. (c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to— (i) the analysis of incidents that resulted in, or had the potential to

This section is primarily information for the provider

Action we have told the provider to take

result in, harm to a service user,

Regulation 10 (1) (a) (b) (c) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse. Regulation 11 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who use services and others were not protected against the identifiable risks associated with acquiring such an infection by the means of effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection. Regulation 12 (1)(a) (b) (c) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use service were not protected against the risks associated with the unsafe use and management of medicines, by means of safe administration of medicines used for the purposes of the regulated activity. Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People who use the service we not protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs; (b) food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background; and (c) support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The registered person did not notify the Commission without delay of the incidents which occur whilst services are being provided in the carrying on of a regulated activity.

Regulation 18 (2) (b)(d)(g)