Bupa Care Homes (GL) Limited

The Highgate Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service

The Highgate Care Home is a residential care home providing personal and nursing care to 31 people with complex physical and cognitive support needs at the time of the inspection. The service can support up to 52 people in four separate units. People living at the home are provided with 24-hour care and support.

People's experience of using this service and what we found

People told us they felt safe and that the staff who supported them were kind and respectful. Family members told us that they had not always been satisfied with the support that their relatives received but they did not currently have any concerns.

People's care and plans and risk assessments had been updated in areas such as medicines and nutrition. However, other information contained in people's care records had not been used to update care plans and risk assessments. For example, the information about people's communication needs and support contained within their care plans was not always consistent with the information recorded in their reviews. A plan had been put in place to ensure that care plans and risk assessments were updated and maintained in the future.

People's medicines were stored and administered safely. The provider had addressed concerns about medicines raised during recent health and social services monitoring visits. Staff were liaising with the local pharmacy service to improve the quality of the support they provided.

Improvements had been made to ensure that people who required specialist nutritional support in relation to swallowing difficulties received suitable nutrition and hydration. People's care plans had been updated to reflect current good practice in relation to their nutritional needs.

Staff members received regular training to support them in carrying out their roles. However, we found that staff had not always received regular supervision from their manager during the past year. The provider recognised that staff supervisions had not taken place regularly, and when we inspected they had commenced a regular programme of supervision for all staff.

Systems were in place to assess and monitor the quality and delivery of care to people. However, these had not always identified or addressed failures in people's care and support. A quality improvement plan had been put in place to address these and some improvements had been made with planned actions in place to address other concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice.

Staff were caring and treated people with dignity. People's differences including cultural and religious needs were understood and respected by staff.

Staff understood the importance of social interaction. People were supported to maintain the relationships they wanted. A daily activity programme took place at the home that included music therapy, exercise sessions, flower arranging, arts and crafts and discussion sessions. Social events included the celebration of religious festivals and birthdays. Activities were also provided to people who were unable to leave their rooms. For example, a music therapist and physiotherapist visited people to provide one to one sessions following their group activities. The activities co-ordinator also visited people in their rooms to ensure they received activities and social engagement. Some people had been supported to identify their individual wishes in relation to hobbies and interests and staff had supported them to achieve these.

Staff knew what their responsibilities were in relation to keeping people safe. Staff knew how to recognise and report any concerns they had about people's welfare and how to protect them from abuse.

The home was clean and safely maintained.

The interim manager showed effective leadership. Staff felt supported. Staff and family members told us that they were satisfied with, and well informed about, the changes the management team had put in place.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 26 July 2018).

Why we inspected
The inspection was prompted in part due to concerns received about medicines, nutritional support, care plans and failures in relation to the Mental Capacity Act 2005. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well-led sections of this full 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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Highgate Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and a specialist advisor with working experience of this type of service.

Service and service type
The Highgate Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not working at the service when we inspected. However, an interim manager was in place.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people who lived at the home and four relatives about their experience of the care provided. We spoke with 17 members of staff including the interim manager, members of the provider's senior management team, nurses, senior care workers, care workers the activities co-ordinator, the client engagement manager, the administrator and the assistant chef. Some people were unable to speak with us, so 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 with us. We observed care and support being carried out. This included activities taking place at the time of our inspection.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at 10 staff files in relation to recruitment and staff supervision and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with two professionals who worked with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Concerns had been raised to the CQC about failures in the safe management, storage and recording of people's prescribed medicines. We looked in detail at the systems for medicines administration on each of the three units at the home. We found that the provider had acted to address these failures.

● People's medicine administration records (MARs) had been accurately completed.

● Where people had been prescribed 'as required' medicines, for example, for pain relief, protocols had been developed. These provided guidance for staff on when they should administer the medicines.

● Medicines were securely stored and daily monitoring records showed that they were maintained at safe temperatures.

● Weekly monitoring audits of medicines and medicines records had taken place. Stock counts of controlled drugs had been carried out each time they were administered.

● The nurses and senior care workers who were responsible for giving medicines to people had received training in medicines administration. Recent assessments of staff competency in administering medicines had taken place. Where a required standard of competency had not been achieved, the staff concerned were unable to administer medicines until they had passed a further assessment.

• When staff members administered medicines to people they did so in a sensitive way, describing what the medicines were and offering water.

● The home had worked with an advisory pharmacist to develop their medicines management systems. When we visited we noted they were also liaising with their local dispensing pharmacist to improve the quality of the MARs that the pharmacy provided to the home.

Systems and processes to safeguard people from the risk of abuse

● People told us that they felt safe living in the home.

● The provider had policies and procedures in place to safeguard people from abuse.

● Staff undertook safeguarding adults training. They understood their responsibilities to protect people from abuse or poor care. They understood the importance of immediately reporting any suspicions or concerns.

● Reviewed the safeguarding records maintained by the home and saw that all recent safeguarding concerns had been reported immediately to the local authority. The provider had also notified the CQC about safeguarding concerns.

Assessing risk, safety monitoring and management

● Risks to people's safety were assessed and reviewed regularly. We found, however, that some risk

assessments had not always been updated to reflect information contained in the review notes. Risk assessments and care plans included guidance for staff on managing identified risks. However, these were handwritten and not always easy to read.

● We saw that risk assessments and care plans had been updated in relation to people's medicines, nutritional needs and the use of bedrails. The interim manager and quality manager showed us their plan to ensure that people's care plans were fully updated. Staff were receiving training and coaching on effective record keeping and report writing, and progress on improving people's risk assessments was to be discussed during planned staff supervisions.

● Staff we spoke with knew what actions they should take to manage people's assessed risks, such as those associated medicines and nutrition.

● We saw that staff supported people to move and transfer safely. Staff knew that they needed to report any concerns to do with people's safety to management.

● Service checks of equipment and the water hygiene, gas, electrical and fire safety systems were carried out as required.

● Each person had a personal emergency evacuation plan. These described people's health conditions and physical and sensory impairments. However, they did not include any information about their specific support needs or requirements if there should be a need to evacuate the building in an emergency. The interim manager told us that they would ensure that the plans were reviewed and updated as a matter of priority.

● The building was well maintained, and records showed that maintenance concerns had been immediately addressed.

Staffing and recruitment

● Staff recruitment checks had been carried out to ensure that staff were suitable for the work they would be undertaking. These included reference and criminal records checks.

● People and their family members told us there were enough staff at the home to provide support when they required it. We observed staff members responding promptly to call bells and people's requests. A person said, "Staff come quickly when I need them."

● The home's staffing rotas matched the staffing we observed during our inspection.

● Two family members told us they had been concerned about the level of support provided to their relatives at night. However, they both said they no longer had concerns since the interim manager had been working at the home. The interim manager and quality manager had carried out unannounced checks of staff performance at night and advised us they would continue to do so on a regular basis.

Preventing and controlling infection

● There were policies and procedures to minimise and control infection. The premises were clean and free from odour.

● The laundry arrangements ensured that people's clothes and bed linen were washed at appropriate temperatures to prevent and control infection.

● Staff followed effective infection control procedures when supporting people with personal care. They washed their hands and wore gloves and aprons when necessary.

● Safe arrangements were in place for the storage and disposal of waste, including clinical waste.

● Food hygiene practice was safe, and the service had achieved a four-star (Good) rating in food hygiene standards when checked by the Food Standards Agency in April 2019.

Learning lessons when things go wrong

● The provider had reacted responsibly to concerns raised by local health and social care teams. Additional management resources had been put in place. Actions had been taken to address immediate concerns

around medicines management and nutritional support.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- Concerns had been raised to the CQC regarding failures to assess capacity to make decisions and apply for DoLS authorisations for some people living at the home.
- We found that action had been taken to ensure people's capacity to make decisions had been assessed and included in their care plans.
- The service had worked in partnership with a local authority DoLS officer to ensure that DoLS authorisation applications had been made for the people who required these. When we inspected a number of authorisations had been granted. The interim manager had put a DoLS tracker in place to enable them to identify when these needed to be chased up, and to identify when renewal applications were due.
- Best interests decisions had been made for people unable to make decisions for themselves, for example, in relation to the use of bedrails and percutaneous endoscopic gastronomy (PEG) feeding. A PEG provided nutrition through a tube and is used where people are unable to take food orally, for example, due to poor swallowing reflexes. The records of these showed that relatives and other health and social care professionals had been involved in supporting best interests decision making. However, the names of the people involved in decision making had not always been recorded. The interim manager told us they would review these records and ensure that they were updated to include the names of the people involved.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People who were able to speak with us said they made choices and received the care and support from

staff that they needed and wanted.
● People's needs were assessed before they moved into the service. This helped the provider and the person or their relatives to decide if the home was suitable and met their needs and preferences. Some people's assessments lacked detail about, for example, their personal histories and likes and dislikes. However, an exercise was being undertaken to seek and collate this information and the activities co-ordinator and client engagement manager showed us evidence that this was progressing.
● People's relatives told us that they hadn't always felt involved in the care of their relatives in the past. However, they now considered that they were kept well informed about their needs. A family member said, "I now feel confident that I can see the information that shows that my [relative] is being properly supported." Another family member said, "I feel up to date. The staff take time to tell me how [relative] is doing."

Staff support: induction, training, skills and experience
● People were supported by skilled and competent staff. Staff received an induction when they first started work to learn about all areas of the service and about their role and responsibilities. One person told us, "They are very good. I am sure that they are well trained." A family member said, "The staff were quite good before, but they seem to be getting better."
● Staff received the training that they needed to carry out their role. The provider offered a range of training for staff that met mandatory requirements. Staff had recently started to attend local training sessions provided by local authority and health services.
● Staff told us that they felt supported since the interim manager had been working at the home. However, they said they had not received regular supervision during the past year. The interim manager told us they had identified that many staff members had not received formal supervision for some time. They had already provided supervision for senior staff members. They showed us that a regular supervision programme for all staff members had been developed and that we saw that this had commenced.
● Staff had a good understanding of people's needs. They were knowledgeable about people's individual needs and preferences.

Supporting people to eat and drink enough to maintain a balanced diet
● Several people living at the home were supported to receive nutrition through a PEG. Other people living at the home had been prescribed fluid thickeners. These are used to reduce the risk of choking when taking fluids by mouth.
● Before we inspected the home we had been advised of concerns in relation to the support that people received in relation to nutritional support. The home was not using current speech and language therapy guidance in relation to the use of PEG nutrition and food thickeners. Food thickeners were not always stored safely and staff were not always using the guidance provided on people's prescriptions.
● We found that the provider had acted to address these concerns. Up to date information about people's nutritional support needs was contained within their care records. Food thickeners were stored safely and clearly labelled. Records of people's nutritional and fluid intake were in place and these appeared to correspond with guidance and prescriptions.
● The individual guidance for a person's PEG regime had been updated recently. Although this was recorded in the person's care plan review records, their care plan had not been updated to reflect this. The interim manager said they would ensure that the care plan was updated immediately.
● People who were able to tell us about the food provided by the home said they enjoyed the meals. They told us that they were asked for their views about the menus and we saw that changes had been made in relation to people's views.
● We observed a communal lunch and saw that, where people wished to eat food that was not on the menu, they were provided with alternative choices. People were offered second helpings of the food which looked

appetising and well presented. People were offered choices of drink and we observed that some people chose wine which was provided to them.
● During lunch, staff provided encouragement and supported people to eat and drink at a pace that suited them.
● Some people ate meals in their rooms and these were taken to people on trays. Staff sat with people in their rooms where they required support to eat and drink.
● Hot and cold drinks and snacks were regularly available outside of meal times. Staff came to the communal areas and visited people's rooms to provide these.
● People's weights had not always been regularly monitored in the past to ensure that staff were aware of any unexplained weight loss or gain. The interim manager had acted to ensure people's weights were recorded regularly and that staff knew that they needed to report all changes in people's weight to management staff and to healthcare professionals when there were concerns.

Staff working with other agencies to provide consistent, effective, timely care
● Before our visit we had been advised that other health and social care professionals had not always been contacted in a timely way where there were concerns about people's health and wellbeing. Guidance provided by professionals, such as speech and language therapists, had not always been followed.
● The provider had acted to address these concerns. This was confirmed by health and social care professionals we spoke with before and after our inspection.

Adapting service, design, decoration to meet people's needs
● The communal lounges and dining areas at the home were bright and well-decorated. Corridors were wide and handrails were installed to assist people with mobility needs.
● Adapted bathrooms included hand rails and adjustable baths to meet people's mobility and care needs.
● Some people with very complex physical impairments were unable to access other floors at the home as the lift was too small to accommodate some specialist wheelchairs. The installation of a new lift had been commissioned and work was due to start shortly after our inspection. The provider had an arrangement to use the lift of the next-door service, which could be accessed through adjoining doors, whilst works were in progress.
● Plans had been developed to complete a full refurbishment of the home when the new lift had been installed. The quality manager told us that, as part of the refurbishment, the provider would be ensuring that appropriate visual and sensory aids would be provided to support people's orientation and independence.

Supporting people to live healthier lives, access healthcare services and support
● During our inspection we spoke with a GP who visited the home on a twice weekly basis to see people who were unable to attend surgery appointments. They told us that they found staff to be open and responsive in relation to people's health needs. They said, "There have been some issues, but these are now resolved. I am aware that they are working with their local pharmacy to sort out their concerns about the supply of medicines."
● People received physiotherapy support to assist with their mobility. During our visit we observed a regular group exercise session facilitated by a physiotherapist. People were supported to participate in this activity in accordance with their individual abilities. Following the session, the physiotherapist visited people in their rooms to undertake individual exercise activities with them.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- There was a friendly and welcoming atmosphere. People told us staff were kind and that they were treated well. Staff were respectful to people and provided them with assistance in a considerate manner. A family member told us, "I always feel welcome when I am visiting now. I find the staff are very caring and kind to [relative]." One person told us, "I like the staff. They are really helpful and sort things out for me when I need it."
- People's diversity needs were recognised and supported by staff. People's personal relationships, beliefs, likes and wishes were recorded in their care plans. People's cultural choices were respected and staff were knowledgeable about these. The activities co-ordinator told us that faith representatives had visited to support people's religious needs. However, they had recently left the area and staff were making contact with local places of worship to seek further support.
- Staff told us about learning words in a person's language to assist with communication. The activities co-ordinator had developed a suite of picture cards to use with the person who was unable to communicate verbally.
- Where people had expressed preferences in relation to the gender of staff members providing personal care this was recorded in the care plan.
- Staff told us people were given privacy when family members, friends and significant others visited them. A family member said, "They don't disturb us when we are together. If they need to give [relative] medicine, they knock and wait." A staff member described the home's approach to supporting people's relationships. "It's important that people spend time with their loved ones as this is about supporting their quality of life. We support people's preferences here and would only ever get involved if we thought someone was unsafe."

Supporting people to express their views and be involved in making decisions about their care

- People were involved with planning and review of their care where they were able to do so. People told us they made everyday decisions and choices including when they wanted to get up and what they wanted to wear. A staff member said, "When people can't tell me, I show them things to choose from and try things out. I can tell straight away if they are unhappy, so I try something else."
- Residents and relatives meetings took place. We saw that a recent meeting had taken place to discuss changes at the home. The interim manager also had 'open door' sessions for people, family members and staff to come and discuss any concerns. Information about these were displayed throughout the home.
- A family member told us, "When the new manager came, he met with me straight away. [Relative] can't speak and I haven't always felt confident about them meeting their needs. I feel much more confident now."

Respecting and promoting people's privacy, dignity and independence

● People told us staff were respectful of their privacy. During the inspection we saw that staff knocked on people's bedroom doors and waited for a response before entering. Where people were unable to respond, staff knocked on their doors and announced themselves. Staff supported people with their personal care in a manner that maintained their privacy and dignity. A staff member said, "Some people prefer to have their doors open, but we always close them when we are supporting people with care."

● People's independence was supported. People told us they were encouraged to be independent and to ask for help if required.

● One person's room had been adapted so that they could use their IT equipment to maintain their independence. This meant they did not have to call staff if they needed to switch lights on and off, play music or watch television. Another person had a sensory light system that threw calming light displays around their room. The quality manager said the provider would be looking at installing similar equipment for other people where appropriate when the home was refurbished.

● People's private and personal information was stored securely, and staff understood the importance of confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant there was insufficient evidence to show that people's needs were always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were being reviewed to ensure that information was up to date. Plans had already been updated in relation to medicines, nutritional support and capacity assessments.
- Some of the care plans we looked at required further updating. Although, people's care plans had been reviewed on a regular basis, information about changes in their needs had not always been recorded in the plans. Some care plans contained information that was inconsistent with other information contained elsewhere in people's records. For example, the care plans for some people who were unable to communicate verbally, indicated that they were unable to communicate in any way. However, other information in their care files described non-verbal responses that they gave to staff who were supporting them. Staff confirmed that they knew when people were happy or unhappy with their care through body language, facial expression or noises. This information had not always been recorded in their care plans.
- People's daily care records contained details of the personal care provided to them. However, there was little information about mood, activities and engagement with staff. The activities co-ordinator and client engagement manager had made a record of activities and interactions with people when they visited them in their rooms. Other staff members had not always recorded that they were supporting people in the same way, even where their care plans indicated that they should do so. For example, staff were encouraged to use visual aids with a person, but they had not recorded that they had done so.
- Our concerns about people's care plans and daily care records meant that we could not be sure that people's needs were always being met. We discussed this with the interim manager. They told us they had already identified that there had been a failure to fully record people's needs and how they were met. Training was being provided to staff on record keeping and the quality of care plans would be discussed in forthcoming planned supervisions.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider had a policy on the AIS which included information about how they planned to develop actions to ensure that all information was made accessible.
- People were provided with some accessible information such as menus, complaints procedures and activities plans. However, people's care plans were written by hand and were not always easy to read. The provider was currently undertaking a pilot of an online recording system. This was likely to be 'rolled out' to

the service in the future. This would mean that care plans and care records could be provided to people in more accessible formats according to their individual needs.
● Although people had communication care plans, information about the communication needs of people who were unable to communicate verbally was limited. Guidance for staff on recognising and responding to, for example, signs of pain or distress was not always recorded in their plans.
● The care plans for people with sensory impairments were also limited. For example, for a person with a visual impairment, their plan described how staff should communicate with them verbally. However, there was no evidence that staff were supporting them to access information in other ways, such as recorded information and 'talking books', should they so wish.
● The interim manager told us that they recognised that information about the support people required in relation to their communication needs was limited. They said that this would be addressed with staff during planned training and supervision sessions.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Activities organised by an activity co-ordinator were available each day. These activities included arts and crafts, baking, discussions, tea parties and one-off events, such as celebrations of festivals and visits from local schools. We observed group music and exercise sessions taking place. These were facilitated by a music therapist and physiotherapist who visited the home regularly. We saw they fully engaged all the people who participated in the groups. Following each group session, they visited people who were unable to leave their rooms and engaged them in individual activities.
● The activities co-ordinator and client engagement manager showed us how they were developing individual profiles for people to support the development of activities. These included information about people's histories and the interests they had pursued before moving to the home. They had asked people about any individual wishes around personal activities and were seeking ways of ensuring that these wishes were fulfilled. For example, an outing had been organised for a person who wished to visit a seaside resort they had fond memories of. Another person had been supported to obtain a signed picture from a singer they liked.
● The activities co-ordinator told us that faith representatives visited the home to provide support to people where they wished. However, two faith representatives had recently left the area, and the activities co-ordinator had contacted the relevant places of worship to seek a continuation of this support.
● Some people had been supported to obtain and use tablets to enable them to do their own shopping and to keep in touch with family members and friends. The activities co-ordinator showed us a tablet that they took with them when visiting people in their rooms. This contained individual music playlists based on people's expressed preferences or, where they couldn't communicate these, information obtained from family members. They told us they also used these to find pictures or websites of interest to people so that they could show them these when they visited their rooms.

Improving care quality in response to complaints or concerns
● The provider had policies and procedures on raising complaints, concerns and compliments. A complaints procedure was available in an easy to read format and information about this was displayed in the home.
● People told us that they would speak to a member of staff if they had any complaints or concerns. Two family members told us they felt that their complaints had not been listened to or dealt with in the past. However, they both said they now felt confident that complaints would be dealt with. One family member said, "It's really much better now. When I raised things with this manager they sorted it out immediately. I never felt I could approach the manager before, but I do now."

End of life care and support

● At the end of their lives people were supported to remain at the service [when this was what they wanted], in familiar surroundings, supported by their family and staff who knew them well.

● Healthcare professionals including GPs, palliative care nurses and tissue viability nurses provided the service with guidance, and support. At the end of their lives people were supported to remain at the service, in familiar surroundings, supported by their family and staff who knew them well.

● Healthcare professionals including GPs, palliative care nurses and tissue viability nurses provided the service with guidance, and support. Staff had received end of life training.

● People had end of life plans but the quality of these was variable. Some records were detailed but others had little or no information recorded. The interim manager and quality manager told us they planned to develop and improve people's end of life plans, so that the service had the information needed to provide people with personalised end of life care.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created had not always supported the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Before our inspection we had been advised of concerns that indicated that the provider's quality assurance systems had not identified failures in fully supporting people's needs. These included failures in managing people's medicines, nutritional support, meeting the requirements of the MCA and maintaining the quality of people's care plans.
- We found that the provider was acting to address these failures. People's care plans had been updated in respect of medicines, nutritional support and the MCA.
- There were systems in place to monitor the quality of the service and any risks to people's safety. A range of audits and checks were carried out. The provider recognised that their monitoring systems had failed to identify concerns and use learning from these to develop and improve the quality of the service provided to people. Action had been taken to improve the efficiency of quality assurance monitoring at the home.
- The registered manager was not currently working at the home and an interim manager was in place, supported by members of the provider's senior management team. They were clear about their role and responsibilities and had the skills, experience and qualifications to lead the service with assistance from other management staff.
- Staff were familiar with the aims and objectives of the service, which promoted personalised care, dignity, privacy and anti-discriminatory practice. They were clear about their roles in supporting those goals. However, this was not always evidenced in people's care records. We noted that training and support was being provided to all staff to ensure that they developed the skills and knowledge to ensure that recorded information was fully personalised.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People told us they were happy with the support and information they received from staff and management. Family members told us that had not felt included or listened to in the past and felt positive about the recent changes at the home. A family member said, "I feel so much better about [relative] now. I can raise anything with the management and it's much easier to get information about [relative]'s care."
- Staff meetings provided opportunities for staff to receive information, provide feedback and to discuss best practice guidance. Staff members spoke positively about the recent management changes. A staff member told us, "I didn't always feel I could speak up before. Now I feel able to be open about any concerns I have. We always get an explanation about why anything is happening which is good. I enjoy coming to

work so much more now."
● Information about activities and events was displayed around the home. Other information, for example, about the manager's 'open door' sessions and how to make complaints or raise concerns was displayed clearly in each unit.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was open and honest about their failure to ensure that the quality of support and record keeping had been maintained.
● The provider's quality improvement plans were being updated on a regular basis to reflect improvements that were being made and further actions that were required. These were shared with the CQC and other stakeholders.
● The provider had submitted notifications about significant events and concerns to the CQC on a regular basis as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The interim manager had recently organised a residents and relatives meeting to discuss changes and people and family members told us that appreciated this. There were plans to hold further meetings to share information and ask for feedback.
● The interim manager held 'open door' sessions at least twice weekly where people, family members and staff could come and speak with him in privacy. A family member told us the interim manager was available at other times if they needed to discuss their relative's care and support.
● Some people had significant physical, sensory and communication impairments and were unable to leave their rooms. The activities co-ordinator and client engagement manager showed us records of regular visits that they made to people's rooms. These showed, for example, that they spoke with people, played music that they liked and engaged in activities such as hand massages and use of pictorial prompts. When we visited, we saw that a music therapist visited people in their rooms and played songs that were meaningful to them. A physiotherapist also visited people in their rooms to provide physical and touch activities.

Continuous learning and improving care
● The provider acknowledged that they had failed to identify and address failures at the service in the past.
● The interim manager and quality manager showed us their plans to ensure the quality of care and support to people improved. We saw that actions had taken place to address concerns. The plans we viewed showed that further actions were planned to ensure that the quality of care and support was improved and maintained.
● A system had been put in place to ensure that reflective discussions with staff took place after any incident. These were used to look at why things went wrong, whether staff could have done anything differently and to discuss and agree how to prevent similar incidents taking place in the future.
● Staff we spoke with told us that the management support they were receiving was enabling them to provide a better service to people. One staff member said, "I feel much more able to suggest ideas that might improve someone's life and know that they will be discussed and acted on."

Working in partnership with others
● The health and social care professionals we spoke with prior to this inspection told us that the service had not always worked in partnership with them to achieve positive outcomes for people. For example, specialist professional support had not always been sought in relation to people's care needs. Training had

been offered by local health professionals, but this had not been taken up.

● When we inspected the service we found that improvements had been made. Information about people's needs was now shared in a timely manner and additional professional support was sought where required. Staff had started to attend training sessions provided by local health and social care professionals.