

Park Avenue Healthcare Limited

Park Avenue Care Centre

Inspection report

69 Park Avenue
Bromley
Kent
BR1 4EW

Tel: 02084665267
Website: www.excelcareholdings.com






Date of inspection visit:
06 September 2018
17 September 2018

Date of publication:
12 November 2018

Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

Park Avenue Care Centre is a care home for older people, some of whom are living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Park Avenue Care Centre is registered to accommodate up to 45 people. There were 39 people living at the home when we visited.

This inspection took place on 6 and 17 September 2018 and was unannounced. The last inspection of the service took place 29 August 2017 where we found three breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. These related to the management of risks to people, staffing levels; and quality monitoring systems. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring and well-led to at least good. The provider sent us an action plan on how they would improve. At this inspection, we found that the service had made improvements we identified at our last inspection but we found other areas that required improvement. This is therefore the second time the service was rated as requires improvement.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that the culture of the service was not always open. People, relatives and staff told us they were not kept informed and updated with what was happening at the service. There had been a high turnover of managers. Staff told us changes in the management team had affected their motivation.

There were limited activities taking place for people to participate in to relax and occupy them. There was no activities coordinator to plan and organise activities. People received the care they needed in a safe way. However, there were mixed comments about staffing levels. The provider was reassessing the level of staffing required for the service at the time of the inspection.

People received their medicines in line with their prescription. Medicines were managed and stored securely to ensure they were safe. Risk assessments identified issues that could pose risks to people's health and safety, and management plans were in place to promote people's health and well-being.

The environment was safe and well maintained. Health and safety checks took place regularly. Infection control practices were safe. The home was suitable and had appropriate facilities for people to use.

People were safeguarded from the risk of abuse and improper treatment. Staff had received training on safeguarding and they were knowledgeable on the procedure to follow if they had any concerns. Staff knew

the procedure to follow to respond to emergency situations and events. Recruitment practices were safe. Applicants underwent checks before they were allowed to work at the service. Actions were taken to ensure learning from incidents. Actions were shared with staff through handover meetings and care plan updates.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People gave consent to the care and support they received. The manager and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People's needs were assessed following best practice guidelines. People's nutritional needs were met. People were supported to eat and drink as required. They were given choices of what to eat and drink and they had access to food and drinks throughout the day.

Staff were trained and knowledgeable in their jobs. Care staff received regular support and supervision from the nurses in charge of units. Qualified nurses were currently being supported by the care and support manager but supervisions had not been regular due to changes in management.

Staff liaised with various healthcare professionals to meet the needs of people. Healthcare professionals told us staff followed recommendations they gave. The service had a system in place to ensure people received a well-joined up service when they use other services.

People told us staff were kind and caring. We observed that staff treated people with respect and promoted their dignity. Staff communicated to people in the way they understood. They demonstrated an understanding of people's likes and dislikes and preferences. Staff respected people's dignity and privacy. People were supported to maintain their religious and cultural beliefs.

Staff supported people to meet their personal care, physical and mental health needs. Staff held reviews with people and their relatives to ensure the support they received reflected their current needs and care plans. Care plans included people's end of life wishes and how they wanted to be cared for. Staff had received training in end of life care. The service worked closely with families, palliative care teams and GPs to support people at the final stages of their lives in line with people's wishes.

People knew how to complain if they were unhappy with the service. The service followed their procedure to respond to complaints. The quality of the service was reviewed periodically to identify areas of improvement. Regular audits and checks took place to assess and monitor the quality of the service and actions put in place to address concerns identified.

The service notified us of notifiable incidents as required in line with the requirements of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe. Staff were trained and understood the various forms of abuse and knew how to report any concerns.

Risks were thoroughly assessed and management plans devised to reduce identified risks to people to keep them safe.

People received their medicines in line with their prescriptions.

Staff deployed to work at the service underwent checks to ensure they were suitable for the roles they had applied for. There were sufficient numbers of suitably skilled staff to meet people's needs.

The environment was safe and well maintained. Health and safety checks took place. Staff followed infection control procedures. Incidents and accidents were reviewed and actions taken to prevent a re-occurrence.

Is the service effective?

Good ●

The service was effective. People's needs were assessed in line with best practice guidance. Staff were trained, supported and supervised to meet the needs of people.

People had their care provided in line with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were given sufficient food and drink to meet their nutritional needs. People told us they enjoyed the food provided at the service.

People had access to a range of healthcare services to maintain their well-being and health. The service had a system in place to ensure people received a joined up service.

The home was suitable and had appropriate facilities for people to use.

Is the service caring?

Good ●

The service was caring. People told us staff were kind and friendly, and treated them with respect and dignity.

People were involved in planning their care. Staff communicated with people in the way they understood.

Is the service responsive?

The service was not always responsive. There were limited activities taking place to occupy people. People received care and support which met their individual needs.

People were supported to maintain relationships which mattered to them. People's cultural and religious needs were promoted. The service made information available to people in formats accessible to them.

The service provided end of life care to people in line with their wishes.

People knew how to complain if they were unhappy about the service and their complaints were responded to, in line with the provider's procedure.

Requires Improvement ●

Is the service well-led?

The service was not always well-led. There was no registered manager in post. There was no visible leadership at the service. There had been a high turnover of managers. People, relatives and staff told us they were kept informed and updated about the service. Staff told us they did not have clear direction and leadership they needed.

The service worked with other organisations to improve the service. There were a number of systems in place used to check and assess the quality of the service. Action plans were developed to address areas that required improvement.

The service notified us of notifiable incidents as required in line with the requirements of their registration.

Requires Improvement ●

Park Avenue Care Centre

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns we received about the service. These were mainly related to the management of the service and the care provided to people. We checked on these issues as part of our inspection.

This inspection site visit took place on 6 and 17 September 2018 and was unannounced. On the first day of our visit, the inspection team consisted of one inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a qualified nurse. The inspector visited alone on the second day.

Before the inspection we reviewed the other information such as notifications we held about the service and the provider. A notification is information about important events the provider is required to send to us by law. The Provider Information Return (PIR) was not due to be submitted before our inspection was undertaken. The PIR is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. The provider sent this form to us after our inspection, at the time it was due and we reviewed the information it contained as part of our inspection.

During the inspection we spoke with four people who use the service, 10 relatives, six care staff, three registered nurses, the regional director, the care and support manager, two quality managers from the provider and the provider. We looked at nine people's care records and medicine administration records for 39 people. We reviewed six staff members' recruitment, training and supervision records. We also checked records relating to the management of the service including quality audits and health and safety management records.

We undertook general observations of how people were treated by staff and how they received their care and support. We also used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

At our last inspection of August 2017, we found that risks to people were not adequately managed as plans to mitigate risks were not sufficiently comprehensive. We also found staff were not properly deployed to ensure people's needs were met safely.

At our last inspection, we found that staffing levels were not sufficient and staff were not adequately deployed to ensure people were supported appropriately with their needs. At this inspection, we found that people's needs were met by staff in a timely way but there were mixed views from relatives and staff as to whether staffing levels were adequate or not. One relative said, "I honestly don't think they have enough staff, there are people in bed all day, there aren't enough staff". Another relative commented, "They have been very short staffed sometimes" However, a third relative said, "There now seems to be a lot of carers around, it seems to have gotten better with staff and nurses being more visible." One member of staff told us, "Sometimes it's alright; we are just about right with it but we manage somehow. It can be difficult when staff call off sick and we don't find cover." Another staff member said, "Staffing should be deployed better. We are always short especially weekends." A registered nurse told us, "Staffing is much better now; however, we have days we struggle because someone cancelled and we are unable to find cover but we deal with it. We try to support each other to reduce the impact on people." We reviewed the rota and it showed that planned absences were covered but not all emergency absences were covered. For example, on the second day of our visit, a staff member had called in sick and the service was unable to find cover for that shift. We noted however that staff worked flexibly to cover the shift to ensure people's needs were met. Staff told us they were encouraged to work flexibly to accommodate and to do extra paid shifts to cover shortfalls. We observed that people's calls for help were answered promptly.

We discussed comments from relatives and staff about the staffing levels with the provider, the regional director and quality managers. They told us they determined staffing numbers based on people's dependency levels and service occupancy. They said they were currently carrying out an assessment to ensure staffing levels were sufficient and that staff were deployed to meet people's needs.

At this inspection we found that risks to people were adequately managed to protect people's health, safety and well-being. Risk assessments were completed comprehensively and appropriately. These included risks from moving and positioning, skin integrity, malnutrition, choking, falls and mobility. Actions had been taken to manage risks safely. For example, where there was risk to people's skin integrity, staff had involved the tissue viability nursing team (TVN) to help manage this. We saw that there were body maps in place to document any sores and these were well completed. People at risk had pressure relieving equipment and people were supported to reposition in bed as required to reduce the risk. Turning charts showed staff followed people's care plans and assisted people to turn in bed. The TVN we spoke with commented, "This home is very good with skin care, I hardly ever get any referrals." People at risk of choking had management plans in place with the involvement of speech and language therapists (SALT). The plans included information about the types of food texture and fluid consistency that was safe for them. Moving and handling plans were also in place for people to ensure they were transferred safely. Staff followed safe transfer procedures as detailed in people's care plans. One staff member said, "I always transfer with two

people and I have been trained." Records showed that staff were up to date with their moving and handling training.

People were protected from the risk of abuse. One person commented, "I feel safe. Most of the staff are regulars and this helps you to feel safe and at home." Staff had completed training in safeguarding and they understood the different types of abuse and the signs which might identify this. They were aware of how to report any concerns to their manager in line with the provider's safeguarding procedure. Staff felt confident that any concerns they raised would be taken seriously. One staff member said, "If I suspect abuse, I will talk about it. I will report to management or CQC. I don't believe in protecting colleagues or friends in that respect." A registered nurse told us, "I will follow the organisation's procedure to deal with any concern reported to me. I will let the nurse in-charge or manager know. I will definitely report it and follow it through." The provider, regional director and the care and support manager we spoke with understood their responsibilities to address safeguarding concerns in line with the London Multi-Agency Adult Safeguarding Policy and Procedures. The service reported safeguarding allegations as required to the local authority safeguarding team and to CQC.

The service took actions to ensure lessons were learnt from incidents. The service maintained records of incidents, accidents and near misses including falls and medicine errors. Incidents were discussed daily during handover meetings and actions taken. The head of care collated all incidents and analysed them monthly to identify trends and patterns so actions could be developed to mitigate the risk of them happening again. We saw people's risk assessments and care plans had been updated following incidents. Where required, other agencies such as CQC and local commissioners were notified.

People's medicines were administered and managed safely. Medicines were administered by qualified staff. We observed a staff nurse administer medicines during our visit and we saw they followed safe medicine administration and management guidelines. Medicine administration records (MARs) were completed fully and correctly. There were protocols in place for the management and administration of 'as required' and covert medicines; and nurses who administered medicines understood and followed these.

Medicines were stored securely and safely. Medicines fridges were checked to ensure the temperatures were within the recommended range. Controlled medicines (CDs) were kept in a separate locked cabinet. Staff understood and followed the guidance in place for the administration of CDs. Records showed they were regularly audited and accounted for.

People were supported by staff who were recruited safely. Recruitment records showed at least two references and criminal record checks, identification and right to work in the UK were obtained for staff before they could start working at the service. We saw the registration status of qualified nurses had been checked with the Nursing and Midwifery Council to ensure they had not been disqualified from practice. Their experience, knowledge and qualifications were also checked as part of the recruitment process. This meant that only staff that were deemed suitable were allowed to support people.

The health and safety of the environment was safely maintained. We saw valid maintenance and servicing certificates for gas, portable appliances, electrical installation, and water safety. Equipment such as hoists and the stair lift were serviced six monthly to ensure they were safe for use and were functioning properly. Fire risks had been assessed and actions followed to reduce the risk of fire. Fire safety checks and fire alarms test were carried out regularly. Record showed that the service practiced fire drills at least twice a year so that staff were familiar with the evacuation procedures.

The service had measures in place to reduce the risk of infection. One relative commented, "The home and

facilities here are very good and clean. "[My loved one's] room is nice." There were domestic staff available to maintain the cleanliness of the home. Both the domestic, care staff and qualified nurses were trained on infection control. Hand washing facilities were available in all washrooms and communal areas. The provider had appropriate arrangements in place for the disposal of clinical waste. We saw staff use personal protective equipment such as gloves and aprons appropriately. The service was free from unpleasant odours.

Is the service effective?

Our findings

Staff received support and supervision to do their jobs effectively. The care and support staff we spoke with told us they were supported by the nurses. One care staff said, "If I need support with our work or questions to ask about the job, I go to the nurses and they support me. I get one-to-one supervision at least every three months from the nurse in charge of my unit." Another care support staff mentioned, "The registered nurses provide me with supervision and direction I need. I feel supported." The registered nurses we spoke told us they currently received support from the care and support manager with their clinical practice. They however commented there had been a lot of changes in management recently so supervisions had not been consistent and regular. One nurse said, "We (nurses) get support from each other. We have learnt to be there for each other and to ensure that we are there too for the care staff. If we need support we go to senior nurses if there is one around, if not we call head office, if we can't resolve the problem ourselves. We don't have a home manager now, but the care and support manager is currently available to give us clinical and management support." Another nurse commented, "I had a supervision recently with the care and support manager. The managers try to support us when they are here. The problem is one day you have a manager and another day there is a different manager." Supervision records showed that most staff had three one-to-one supervision this year. The manager told us the provider's policy required at least five supervisions to be done in a year. The manager assured us they were working to ensure all staff received the required level of support and supervision by the end of the year.

Staff appraisals were held annually and these were used to address performance issues and to analyse training needs to enable staff to improve their knowledge and skills, and develop in their careers. Record showed that staff received appraisal in 2017. Appraisals for 2018 was on-going at the time we visited. The manager told us they would ensure all staff had an appraisal by the end of the year.

Staff received relevant training to enable them to care for people well. Staff told us, and training records confirmed that they received ongoing training. Training records confirmed that both care staff and nursing staff had completed training in moving and handling, safeguarding, health and safety, dementia care, dignity and privacy, and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We also saw that staff completed 'refresher' courses regularly to ensure their knowledge and skills were up-to-date. Staff also received training in specific areas such as challenging behaviour, diabetes and wound care. These training areas provided them with the knowledge, skills and experience to care for people with specific conditions. A care staff member said, "I have NVQ 2 and 3; and about to do NVQ 5. I am up to date with my training including challenging behaviour." Another care staff member mentioned, "I have done all mandatory including safeguarding and moving and handling training and my competency has been assessed. I have the knowledge and experience I need in the job. Park Avenue has booked me on all the trainings I need." A member of the nursing staff mentioned, "I am up to date with my revalidation and training. I take personal responsibility for my development." However, another nurse told us that they required more training and needed to update some of their current training. They said they had raised this with various managers but due to the changes in management it has not been followed through. They told us they would raise it again with their current manager, the care and support manager for follow up.

Records showed that new staff completed an induction when they first started. One new member of staff confirmed, "I was given induction before I started working. Part of it was shadowing experienced staff members for a few days. I did all my training too during my induction." The provider's induction was in line with the Care Certificate Induction framework. The Care Certificate is the benchmark that has been set for the standard for new social care workers.

The service assessed people's needs using a range of tools in line with the guidelines of the National Institute for Health and Care Excellence (NICE) before they moved into the service to establish if their needs could be met. These included Dolopius pain assessment tool, Malnutrition Universal Screening Tool (MUST) for nutritional needs and Waterlow assessment for people's skin integrity. Other areas of needs assessed were people's physical and mental health conditions, continence care, social interaction, mobility, and eating and drinking. Based on the level of needs identified, relevant professionals were involved to carry out further assessments and in drawing up care plans to meet the people's needs. For example, a dietitian was involved to improve people's diet who were assessed as needing this level of support.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager and staff had a good understanding of MCA and their responsibilities to ensure people consented appropriately to the care, support and treatment they received. We saw that the service, in conjunction with relevant professionals, had assessed people's mental capacity in relation to specific decisions being made. Where people lacked the mental capacity to make specific decisions, records showed relatives or an appropriate representative such as care managers or advocate had been involved in making the decision in their best interests. We saw best interest decisions made for people for the administration and management of medicines, use of bedrails and day-to-day care provided.

People were not unlawfully deprived of their liberties as the service made DoLS applications to the relevant supervisory body where it was deemed necessary to maintain the person's safety. The service maintained record of DoLS authorisations and reviewed conditions attached to these regularly to ensure they cared for people with these in mind.

People were appropriately supported to meet their nutrition and hydration needs. People's care plans included information about their nutritional needs and the support they required to eat and drink. At lunchtime we saw staff supported people in line with their care plans. People who had specific dietary requirements such as soft or pureed food received these. People who needed assistance to eat and drink received the support they required from staff. The menu had options for people to pick from and staff supported people to choose. People were encouraged to drink regularly; and staff offered snacks and fruits to people at regular intervals throughout the day.

People had access to healthcare services when they needed them. There was a GP linked to the service who visited twice weekly. Records showed evidence that people received input from several other healthcare professionals when required. These included tissue viability nurses (TVNs), a palliative care team, podiatrist,

GPs, dentist, optician, and dietitian and community psychiatric nurses. The TVN we spoke with was very complimentary about the way staff promptly involved them where needed and in the way, they followed recommendations.

Each person had a completed personal profile sheet containing important information about the support people required as well as details about their physical health, the medicines they took, their GP and their next of kin. Staff told us they handed a copy of this form to the ambulance service if a person was being taken to hospital and they ensured people had a copy with them when they went to use other services. Staff also told us they ensured people had important personal items with them such as hearing aids, glasses, and dentures.

The environment had adequate adaptations and was suitable for people. There were toilets and bathrooms with equipment such as grab rails, and specialist baths suitable to the need of people. and call bells for people to use. People had communal areas for them to relax and spend time with their visitors. People's rooms were decorated to their individual requirements with photographs and ornaments. However, there was limited Dementia friendly sign postings around the home. We spoke to the provider and manager about this and they said they would act on our feedback immediately.

Is the service caring?

Our findings

All the people and relatives we spoke with told us staff were kind and caring. One person told us, "They couldn't do enough for me here, they are very caring. When they walk passed my door they say hello." A relative told us, "I would say staff are looking after my loved one well. They treat people here with respect and are very attentive to them. The home has a relaxed atmosphere and people seem comfortable." We observed caring interactions between staff and people. Staff were polite, friendly and considerate in the manner they spoke to people and in their approach.

Staff knew people's preferences, likes and dislikes and they respected these. We heard staff address people by their preferred names. Staff also showed they knew what made people relaxed. For example, we observed a staff member reminding a person about the days and times their relatives visited the service. The person's mood brightened up and they agreed to eat their lunch. The staff member told us the person looked forward to their relatives visiting so staff provided reassurance to them when they were feeling low by reminding them of their relatives next visit day.

Care plans provided clear information about people's choices around their care and routines. People and their relatives, where possible were involved in their care planning. Relatives confirmed that they had an input in planning their loved one's day-to-day care. However, one relative we spoke with told us that in recent times actions agreed were not always followed. For example, one relative said that they had requested for their loved one to be put to bed to have some rest after lunch every day but this was not happening. They said they were not sure why staff were not doing this. We brought this to the attention of the head of care and they arranged a review meeting immediately to address this.

Staff communicated with people in a way they understood. One staff member bent down to a person's level and maintained eye contact with them while speaking to them. In another example we observed a staff member speaking to a person who they realised could not hear them, so they adjusted the person's hearing aid to enable them to understand what they were saying. People who used eye glasses for seeing or reading, had them on.

People's privacy and dignity was respected. One person commented, "The staff are very nice, they talk nicely to you and don't treat you like an idiot." We observed that staff knocked on doors to people's rooms and waited for a response before entering. Staff assisted people with their toileting needs discreetly. We also noticed that staff talked about people's personal matters where others could not overhear. People were neatly and appropriately dressed. Staff we spoke with understood what it meant to promote people's dignity and privacy. They were confident in giving us examples of how they promoted this in their day to day work. One care staff member said, "It's important to respect people, it means a lot to people and helps in building relationships with people. Dignity means speaking to people nicely, treating them with politeness, and respecting their personal matters. Another care staff member told us, "People's dignity is their pride. I won't take it away from them. I have to be sensitive to how people are feeling in all I'm doing." People were encouraged and supported to do the things they could for themselves.

Is the service responsive?

Our findings

There were limited activities available to occupy people or meet their needs for stimulation. One relative told us, "There used to be lots of activities taking place here but not anymore. They have occasional entertainment but nothing day-to-day planned." One staff member said, "People just watch TV all day or stay in their rooms. If we had an activities coordinator or allocated time for staff, then we could do activities with people." On the first day of our visit, the activities coordinator from one of the provider's other services was brought in to do activities for people but it was obvious that they did not know what people liked and enjoyed. They tried to engage eight people in the living area in ball throwing games. Whilst some people joined in and participated, we heard two people in the room tell the activities coordinator that they were not interested in that activity; and the others did not show any sign that they were enjoying it.

We observed a staff member in one unit giving people hand and foot massages during our visit. We also observed staff occasionally spent time chatting with people in the communal areas. However, we noted that those who were cared for in their rooms did not receive one-to-one time dedicated for social interaction or contact. The care and support manager and regional director told us they currently arranged for external organisations to deliver entertainment and activities weekly. Relatives we spoke with confirmed this. However, activities were not regular and were not tailored to meet the individual needs of people. The provider told us they would look at finding an activities coordinator for the service to deliver activities to people.

Care records detailed people's likes, dislikes, routines, backgrounds, physical health, mental health, personal care and social needs. Care plans were comprehensive and they addressed how people's needs would be met. We saw care plans in place regarding how staff should support people with diabetes, heart conditions, and other physical conditions. One relative told us that staff were good at encouraging their loved one to drink regularly as they were susceptible to urinary tract infections. Another relative talked about how staff had helped improve their loved one's nutritional intake. Staff knew people's care plans and followed them accordingly. Care plans were reviewed regularly or when people's needs changed. Staff told us they knew about changes in people's needs through handover meetings and updated care plans.

People's religion, culture, disability, relationship, gender and sexuality were noted in their care plans. The care and support manager told us that the service catered for people who require specific diets to meet their cultural or religious needs. Religious services were held at the service monthly or on request by people if they wished. The service was adapted and accessible to people with physical disabilities. Staff had training in equality and diversity and knew to respect people as individuals.

From April 2016 all organisations that provide NHS care or adult social care are legally required to meet the requirements of the Accessible Information Standard. This standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively. The Interim Care and Support Manager told us that they could produce information in different formats such as in braille, large prints, easy read or in a pictorial format if people required this to make information more accessible to them. The Head of Quality and

Compliance from the provider also confirmed that if people had been assessed as requiring information provided in a specific format that the organisation would meet this need as required.

People's relatives could visit the home as they wished. We saw relatives and friends visit during our inspection. They told us they were always welcomed. Some relatives spent time with people in the communal areas and some visited people in their bedrooms. Staff gave them the space they needed.

People and their relatives knew how to make a complaint. The service had a complaints procedure which set out what to expect if a person expressed their unhappiness and how to escalate their concerns if their concerns remained unresolved. Record showed that there had been 11 complaints received in the three months period before our visit. These related to issues such as the management and administration of the service, care fees and funding for people and staffing levels.

At the time of our visit, the new regional director was addressing these concerns. Two relatives we spoke with about their complaints told us they have had a meeting with a member of the provider's management team in view of resolving the issues raised. They told us they knew how to escalate their concerns should they not be resolved satisfactorily.

People received the end of life care they wished. People had completed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in their care records and nurses we spoke with knew people's DNACPR status. The service involved people's GPs, palliative care nurses, and hospices to care for people at this stage of their lives to ensure they received suitable end of life care that met their needs. Record showed qualified nurses and most care staff had received training in end of life care. Staff knew to follow people's end of life care plans; and to make sure people were kept comfortable and people's relatives were supported appropriately too. The service had 'Platinum' status award (The highest level) with The National Gold Standards Framework Centre in End of Life Care in recognition of the high standard of care provided to people in this area. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis.

Is the service well-led?

Our findings

At our last inspection we found that the systems in place to assess the quality of the service were not effective as they failed to identify the issues we found. The issues included inadequate risk management plans which put people at risk, and poor deployment of staff. At this inspection, we found that the quality of the service was regularly assessed through surveys, audits, checks and monitoring visits. These were conducted locally by area managers, regional directors and the provider's quality and compliance team. Areas of the service checked included the care provided to people, care records, incidents and accidents, staffing levels, staff files, training, health and safety, DoLS applications and complaints. There was a service improvement plan developed to address areas which needed improvement. For example, the level of staffing required for the service was under review at the time of our visit following complaints and feedback from relatives and staff. The quality and compliance team told us they were reviewing people's dependency levels so they could use this information to determine staffing levels. The provider's quality and compliance team who were undertaking a complete review of the service to identify areas of improvement told us they were committed to improving the quality of care people received.

At this inspection we found that the provider did not operate an open and transparent culture. People, relatives and staff told us they were not aware of what was happening at the service and the provider did not give them updates and feedback about the management of the service. One relative commented, "I feel disillusioned with what is happening at this home. Communication is lacking. We don't get told anything anymore and no one gets back to you with information. Relatives meetings don't happen anymore. I feel sad really." Another relative said, "There's been no communication about the management or anything happening at the service. Recently, a fence around the property has been put up, which means we now have to enter the building from a different way. We were not informed about this and it is frustrating as nobody explains to you." Staff also expressed their frustration about the lack of information and updates. One staff mentioned, "The communication has been poor – no one tells you anything about what is going on. It is really upsetting. Everything seems to be a secret. We just want to know what is going on and not to be left in the dark. We see different faces around, no one bothers to tell us who they are or what they are doing and then we hear whispers around. It is so disrespectful the way they have treated us." We discussed this concern with the provider, care and support manager, regional director and quality team. They agreed to arrange a meeting with staff; and then with people and their relatives to update and consult with them about the service. After our inspection, the provider told us that they had set up other ways to enable effective communication between management, people, relatives and staff. These included, regular care surgeries, newsletters and meetings.

The service lacked visible leadership, and management. There had been no registered manager at the service since May 2018. We were informed that there had been four different managers deployed to manage the service within a four month period. Relatives and staff complained about the recent high turnover of management and the effect it has had on the service. One relative told us, "There isn't a permanent manager and that has been concerning as we are not sure who to go to if we have issues. I feel lost sometimes." Another relative said, "We are now thinking of moving my [loved one] to another care home because of what is happening with the management here. We feel as though we are in no-man's land

currently!" Staff also commented about the lack of leadership and management direction available and how it has affected their motivation. One staff member said, "Management has been awful really! It has been a bit of disaster. Our main concern now is to ensure people are well cared for and we are doing our best." Another staff member said, "It is demoralising not knowing who oversees the home." A nurse commented, "Management needs to improve. We are basically relying on ourselves - staff supporting each other and trying to create a good atmosphere for people. The mess in the management has made us unhappy and affected our mood."

We asked the provider about the plans they had to ensure a stable management and leadership at the service. They told us they were considering a couple of options. They said it was important to them to get an experienced team of managers to manage the service. After our inspection, we received an update of the management structure that had been put in place. An interim home manager had started at the service. The interim home manager had previously worked with the provider so understood the provider's systems. The interim home manager will be supported by the care and support manager. We will continue to monitor the management situation at the service and take actions as necessary.

The service used the daily 'Dashboard' meetings which is held with the representatives from each area in the service such as kitchen, housekeeping, domestic, nurses and, clinical manager to discuss and identify actions that needed to be taken to improve the service for people. Areas discussed included people's well-being, hospital admissions, accidents and incidents, staffing issues; health and safety, and catering.

The service worked in collaboration with the local authority to improve the service. The local authority carried out a monitoring visit in June 2018, they had highlighted an issue which we also found at our inspection which relates to staff support and supervision. We noted on the service improvement plan that the service was implementing the actions agreed. The service also worked closely with GP services, local hospice and other healthcare services to meet the needs of people.

The provider had notified us of incidents categorised as reportable as required. They had also displayed the rating of their last inspection as required on their website and at the service.