Four Seasons (Evedale) Limited

The Gables

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced inspection on the 12 December 2016. The Gables provides nursing care and support for up to 51 older people who may also dementia. At the time of our inspection 39 people were residing at the home. The home is divided into two separate units. One on the ground floor and one on the first floor of the home.

We undertook a comprehensive inspection of this home in April 2016 when we identified that improvements were needed throughout the service. We judged the home to require improvements in all five of our key questions. We found the registered provider had breached one of the legal regulations. This was because the systems in place to monitor the safety and quality of the service had not been effective. This inspection identified that these systems remain ineffective and we are considering what further action to take.

A new home manager and senior management team have started work at the home, and we found that significant efforts had been made to improve the environment of the home, to recruit new staff and to make improvements to the experience of people living at The Gables. People had noticed these changes and told us about them with pleasure. However the systems to check the safety of the home had not been entirely effective. People were not receiving their medicines safely or as prescribed. The registered providers own systems had not picked up these issues. The registered provider was not meeting all the legal requirements and people could not be certain their needs would consistently or safely met.

The home has a recently appointed registered manager who was unable to be present at our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider had arranged for another member of their staff to be in day to day control of the home.

People did not all receive their medicines safely and there were ineffective systems in place to monitor medicines administration.

People told us that they were confident no individual member of staff would hurt them, and that generally they felt safe living at the home, however some people shared examples of things that had occurred indicating that they were not always safe. Staff had knowledge of possible signs of abuse and could describe action they would take in reporting any concerns.

Action had been taken to improve the number of staff available. Staff told us they had received induction, sufficient training and on-going support. The handovers between shifts had improved and staff were able to share with us the current needs of the people they were supporting.

Staff had some knowledge of the Mental Capacity Act (MCA) (2005) and described how they supported

people with making choices. We identified that restrictions to the liberty of people who had mental capacity had not always been identified. It was possible that people we being restricted unlawfully. Where deprivations to people's liberty had been identified the relevant applications had been made and kept under review.

People had access to regular healthcare and specialist healthcare advice.

People's feedback about the food provided was mixed. Some people enjoyed the food and other people we spoke with told us they did not always enjoy the food offered to them. People living on the first floor of the home had not been appropriately supported to eat and drink enough to meet their nutritional needs.

Relatives were happy with the care provided by individual staff and told us that staff were kind and caring. Relatives told us with pleasure about the relationship they and their loved ones were building with the new staff. Staff enjoyed working at the home and many demonstrated that they knew the people they supported well. During our observations we saw some good staff practice that ensured people were treated with dignity and respect.

People told us that they had limited involvement in planning their care to meet their individual needs. Reviews of care did not show the involvement of people or their relatives to ensure people were still happy with the care they were receiving.

People told us they were more frequently able to sit in the lounges to join in with activities. These people were provided with increased opportunities to receive stimulation, participation and company. People cared for in bed had fewer opportunities to undertake activities that would protect against social isolation and give them the chance of stimulation and company. The activities worker described plans they had to improve upon this situation. However we found people cared for in bed were at a greater risk of social isolation

The majority of people and their relatives all told us the new management team had made a positive impact on the environment and atmosphere of the home in the past few months. They told us they felt able to approach them with concerns or feedback, and people told us they were enjoying the more comfortable and homely environment. People had been supported to provide feedback about of their experience of using the service. The systems in place to monitor the quality and safety of the service had not been entirely effective. Whilst numerous developments and improvements had been achieved since our last inspection people could not be certain they would receive a consistently good, safe service that would meet their needs and wishes.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

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 consistently safe.

People could not be certain their medicines would always be administered as prescribed or managed safely.

Risks to people were not always investigated or well managed.

People did not consistently enjoy a hygienic, clean home.

People were supported by adequate numbers of staff, and further action was underway to improve consistent use of registered nurses.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive the support they required to eat and drink enough to meet their needs and maintain good health..

People's liberty and human rights were not always protected.

People received support from a range of professionals to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

People had limited opportunities to be involved in planning their care.

People could be confident they would be supported by staff who were kind and compassionate and who would maintain their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not all experience a service that was person centred and empowering.

There were opportunities for some people to partake in activities that provided stimulation and participation within the home.

Systems were in place to identify and investigate concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor and improve the safety and quality of the service had improved since the previous inspection, but had not been effective at ensuring compliance with regulations or ensuring people's needs were consistently well met.

People and their relatives had been provided with opportunities to feedback about the running of the service and to make suggestions.

The Gables

Detailed findings

Background to this inspection

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

This unannounced inspection took place on the 12 December 2016. The inspection team consisted of two inspectors, a specialist pharmacy inspector and an expert by experience. An expert by experience is someone who has experience of caring for someone who uses this type of care service.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. At our last comprehensive inspection we found the provider was in breach of one legal regulation and not consistently meeting people's needs. After that inspection the registered provider responded and supplied us with an action plan. The registered provider and their senior staff team have provided us with regular updates throughout the year. We reviewed the information from notifications and the information we had received in the action plans to help us determine the areas we wanted to focus our inspection on. We also received feedback from the local clinical commissioning group, and the local authority that monitor the quality of the service.

We visited the home and spoke with nineteen people. We met all the other people who lived at the home. Some people living at the home were unable to physically speak with us due to their health conditions. We spent time in communal areas observing how care was delivered. This helped us to understand the experience of people who could not talk with us.

We spoke with the person in day to day control of the home, the regional support manager, one agency nurse, a Care Home Assistant Practitioner and nine care staff. (The care home assistant practitioner is is a senior support worker who has received additional training to undertake additional tasks to support the nurse on duty.) We also spoke with four relatives. We had feedback from three healthcare professionals. We looked at records including parts of five care plans and the records kept to show the care and support people had been offered. We looked at medication administration records. We looked at three staff files

including a review of the provider's recruitment process. We sampled records from training plans, incident and accident reports and quality assurance records to see how the provider monitored the quality of the service. After the inspection we were sent copies of records about staff training and the registered provider's quality assurance systems.

Requires Improvement

Is the service safe?

Our findings

People living at the home required support to receive their medicines safely. We observed part of a medicine round and saw that staff interrupted people's mealtime to administer medicines. This was not a person centred approach and not in line with good practice. People told us that the medicines were usually administered without any problems, and one person told us, "I get my tablets from the nurses. I am happy with that."

Four people were prescribed controlled drugs to manage their pain. Controlled drugs are medicines that require extra records and special storage arrangements because of their potential for misuse. The records we looked at showed that these people were regularly not getting their medicine on time or as prescribed. Some records showed that they had received too much medicine and other records showed that doses were missed. No assessment of these peoples pain had taken place and there was a risk that these people would suffer avoidable pain. We found that the medicines were stored securely but they were not recorded correctly.

Some people had medicine prescribed that was to be taken "when required". There was no information available to staff on why the medicine would be needed, how much to give, and when. This meant there was a risk that staff did not have enough information about what medicines were prescribed for and how to safely give them consistently and appropriately. We asked a member of staff responsible for administering medicines what some of the medicines were for and they were unable to tell us. Two people had medicine prescribed to manage their behaviour or to help them sleep. Both medicines were prescribed only to be given when necessary. We looked at the records for both people on the days the medicine was given but could not see any evidence why these people needed it.

When people needed to have their medicines administered directly into their stomach through a tube the necessary safeguards were not in place to administer these medicines safely. There were no written protocols in place to inform staff on how to prepare and administer these medicines and therefore there was serious risk that people's health and welfare could be affected.

We checked the medicines available in the home against records maintained by the nursing staff. This is a way of determining if people have received the correct doses of prescribed medicines. Our checks showed that people had sometimes received more medicines than they had been prescribed and sometimes less. Failing to administer the medicines at the times and in the doses prescribed means the likelihood of the medicine working effectively is reduced. This can result in people's conditions being less well controlled and people experiencing unpleasant symptoms.

Some medicines were prescribed "as directed" and there was no information to let the staff know how to administer the medicine. Staff told us which eye they would administer an eye drop in but this was from memory. There was no written record of which eye the drop should be used in. There was a risk that some staff members would use the eye drops in the wrong eye(s).

Carers applied prescribed creams to people's skin. Although body maps were available to staff to show where the creams should be applied, they were not filled in for most people. Records of administration showed that people were not always getting their cream as prescribed. A person's skin may become dry or their skin condition would not be treated if creams are not applied as often as the doctor intended. Staff that were applying creams did not have any training or competency checks to administer medicines or apply creams.

People could not be confident that their medicines would be well managed, or given as prescribed. Failing to manage medicines is a breach of Regulation 12 of the Care Standards Act 2008.Care Homes Regulations 2014.

People told us that they mainly felt safe living at the home. Comments we received from people included, "The way they pay attention to [the people] makes me feel safe. The staff are calm and patient….I think it is safe here." Another person told us, "I feel safe when I am sitting in my chair. The staff treat me properly." One person told us that items had gone missing from the home including their glasses and a watch. There was no evidence that these had been found or the appropriate action taken. Relatives we spoke with told us that overall they felt their loved one was safe. They were all confident individual staff would not be unkind or neglectful to their relative, however the majority of relatives we spoke with did share concerns and negative experiences they had at the home. Positive comments included, "We have no concerns with her safety" and, "Overall I feel she is safe." People then went on to share examples including bruising that had occurred when staff had knocked the person or dropped something on them, another person told us of a drugs error that they had not been aware of until a safeguarding social worker contacted them. While relatives reported they were satisfied with the overall safety of their loved one, incidents such as these caused them some anxiety about the care provided.

Records showed that when accidents or incidents had occurred immediate checks had been made on the person's well-being. The staff had reported the incidents appropriately and this had enabled a review of trends to take place so that the provider could take action to reduce the chance of similar events happening again. One of the people we met had a bruise on their face and three other people we spoke with had bruising and marks on their arms, legs and hands. Research shows that the skin of older people can become increasingly sensitive and bruises can result after even a minor accident. We looked at how these bruises and marks had been recorded and investigated to ensure that people had received suitable, safe care. Only one of the four people's bruises had been recorded in the person's care file or on a body map. The manager looked on the registered providers reporting systems and identified that not all incidences of bruising had been recorded. The failure to question and record bruises and marks on people's skin had not ensured that people were safeguarded from care practice, procedures or equipment that could cause them harm.

The management team were aware of their responsibilities to report any safeguarding concerns that may arise. Notifications had been sent to the local authority and CQC as is required. Staff told us they had received safeguarding training in their induction and on-going refresher training. This ensured they had been made aware of current processes to follow and the signs to be aware of. One member of staff we spoke with demonstrated a good knowledge of safeguarding and went on to tell us, "I currently have no concerns here about people's safety". The staff told us that they felt recent improvements within the home helped to keep people safe, and their comments included, "We need to carry on with the improvements. It is really helping people." One relative told us that they were pleased to see [name of person] looking so much brighter. Staff we spoke with described safe working techniques they had been trained in, and told us new staff were not allowed to support people until they had completed manual handling training. This knowledge and confidence within the staff team ensured people could be certain allegations of abuse would be identified and reported, however people could not be confident staff would question bruises and

marks to ensure these were investigated and that the person received any additional support they required.

At our last visit in April 2016 we identified issues with the cleanliness of the home. The local Health Protection team undertook a full audit of infection control procedures at the home in August 2016.This identified significant shortfalls with the cleanliness of the home. Inadequate levels of cleanliness are unpleasant for people and placed them at risk of acquiring infections. The registered provider had undertaken significant work to improve the cleanliness and presentation of the building, and when the audit was repeated significant improvements were noted. While we observed the premises were cleaner overall we saw that individual chairs people were sitting in had drink and food residue on them and some cutlery and place mats that had been used to set the tables ready for meals were also dirty. This did not provide people with a clean or homely place to live, and did not fully protect them from risks associated with dirty equipment and premises. While new systems had been established these findings provided evidence that they were not fully embedded and that their effectiveness was not being monitored by senior staff.

During our inspection we observed adequate numbers of staff to support people promptly when they requested help. People told us the number of staff on duty had recently increased, and that this was an improvement. One person told us, "The staff are now all regular, not agency which is better. I'm able to have a good relationship with them." Feedback from other people included, "A few weeks ago they got more staff. I have been lucky recently. When I press my buzzer they are usually here within minutes," and "Sometimes they are short staffed. They have to get a nurse from elsewhere. One night I didn't get to bed until midnight. I had to wait. That was earlier this year. They have put more [staff] on now. They have more nurses and that means I can go to bed when I'm ready." A recent recruitment initiative meant that the number of care staff on duty had improved, however the number of nurses employed remained too low to ensure all shifts could be covered with nurses employed by the registered provider. The registered provider was able to explain the actions they were taking to improve upon this situation. The majority of nurse shifts were covered by agency nurses. We were informed the nurses had been 'block booked' to increase consistency and to reduce the impact of constant changes from new staff on people living at the home. Improvements had been made to the number of staff on duty and the delegation of staff within the home. The registered provider had commenced work to ensure that people could be sure adequate numbers of staff would always be on duty to support them.

Recruitment files we looked at for staff that had been recruited recently showed that a robust process was in place that checked the suitability of staff to work with people prior to them commencing work at the home. These checks included obtaining Disclosure and Barring Service Checks (DBS) which provides information about any criminal records. Staff we spoke with confirmed these checks had taken place, one newly recruited member of staff told us, "I had an interview, DBS check, induction and then some shadow shifts." Routine checks had been carried out on the registration of nurses working at the service to ensure that their registration was current. Completing these checks is a way of ensuring people are supported by staff suitable to work in Adult Social Care. Records we looked at for staff that had been recruited earlier this year, before the new management team took over the running of the home showed the recruitment checks had not been as robust. Although all documents had been collected, checks had not been made to verify the validity of the evidence.

Requires Improvement

Is the service effective?

Our findings

People's feedback about the food provided at The Gables was mixed. Some people told us it was good and their comments included, "I never leave any. It isn't wasted!" and "The food is very good." Other people told us the food did not meet their needs and their comments included, "It's the food mainly that I don't like here. I was ill after. Physically sick," and "The bacon is all gristle, it's hard to chew." Another person told us, "It tastes all right, but I have no idea what it is." The management team told us that feedback about food was variable and that they had already requested support from the registered provider's chef to review the food offered. This review had been arranged for January 2017.

We looked in detail at the support some people received to eat and drink. On the ground floor we saw people received consistent support from the same member of staff throughout their meal. People had the opportunity to sit at a table or to eat from a specially fitted lap tray that attached to their wheelchair. The experience when dining for people on the first floor was very different. On the first floor we observed people with trays balanced precariously on their lap. We saw people who used a wheelchair were unable to sit close enough to the table to comfortably eat. The result of this was that they lifted their plate and bowl from the table to hold it close enough to them to be able to eat. This resulted in people spilling food onto their hands, arms and clothes. We observed one person eat the meal with their hands. This caused distress to two people sitting at the same table but staff failed to observe this. We asked staff if the person would benefit from support to eat, or with their meal presented in a way that would make finger feeding easier. Staff were receptive to this suggestion but had not identified this need or taken any action to make mealtimes more pleasant for the person and others at the dining table. There was very limited space available in the first floor dining room when everyone was there for lunch, and the room felt crowded. We saw that staff were not easily able to stay alongside people and help them to eat. The majority of support we observed was from staff who walked up to the person, offered them a loaded spoon of food and then walked away. We saw individual people receive support from up to four people during one course of their meal. This type of support can be disruptive and stressful for people, and can detract from the enjoyment of their meal. The registered provider had failed to ensure that good practice was consistently used and shared across the home.

Throughout the day people were offered both hot and cold drinks. People who were able to drink these independently enjoyed them. However in the bedrooms of people being cared for in bed we saw full cups of drink that the person had not been supported with. Some of the hot drinks had gone cold, indicating they had been there for some time and that people had not been supported to have drinks. People who were at risk of malnutrition had a record made of the food they had eaten. Some of these records were completed well, however we observed that the staff completing the records had not always been present during the mealtime and had not observed first-hand what the person had eaten. While the records showed the correct choice of meal, the quantity eaten was not always consistent with our observations. Senior staff we spoke with confirmed that registered nurses who completed the records did not routinely oversee the daily intake of people's food and fluid and that changes were in hand to improve on this. Whilst we did not find evidence that this had caused anyone harm, the current system could result in people at risk of not eating or drinking enough failing to receive the support they require. This meant that the records used to help determine

people's nutritional risk were not always an accurate reflection of the meals and drinks they had eaten.

People and their relatives gave us mixed feedback about the ability of the staff to support people effectively. Comments from some people and their relatives included, "The staff are excellent. They have good skills," and "The staff are aware. Nobody knew [name of person] when they came in, but they have got some idea about her now." Other people told us, "The new staff don't know how to deal with [name of person.] Throughout the inspection relatives we spoke with shared concerns about the turnover of care staff, nurses and managers. They reported that this had been unsettling, but that overall they were pleased with the new staff, and the support staff were receiving to get to know people living in the home. Staff we spoke with were able to describe people well, and were aware of things that were important or which could be unsettling to people.

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Not all people were certain that they had been asked about or had been involved in planning or reviewing their care. People were not all certain that they had been involved in making decisions about their care, although in some records we saw that people had signed to show they had been consulted. Staff had received training on the MCA and had some knowledge of how it applied to people living at the home. Staff explained that they did involve people in daily decisions about their care and had knowledge of best interest decisions. Staff we spoke with gave examples about involving people in choosing their clothes, about what they would like to eat or drink, about which room or which position in the room they would like to sit in. A relative we spoke with confirmed this and told us, "I hear them saying to [name of person] Is it okay, or is alright to do such and such?" Another relative told us, "They allow [name of person] to be as independent as they can be". "One of the people living at the home told us, "The best thing about living here is the freedom. You don't have to do anything if you don't want to."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. Where people had identified restrictions on their care the registered manager had applied for DoLS appropriately, some of which had been approved. Staff were aware of who had a DoLS approved and how this impacted on the person's care. There were systems in place to review and if necessary re-apply for DoLS before they expired to ensure the person continued to receive the support they required. We identified that one person was unhappy with the bed safety rails fitted to their bed. This person had been assessed to have capacity to make decisions. The staff we spoke with and records available did not show how the use of the bed safety rails had been explored or agreed with the person. As the person had mental capacity this could have been an unlawful restraint.

The new management team had improved the handover between shifts. This had included the introduction of a written summary for each member of staff. Staff used this document to help answer questions about people during their shift and to record information that would be useful to pass on to the next shift. This was a way of ensuring good communication and consistency between each shift.

Staff told us they had received sufficient training to carry out their role effectively. Staff starting work at The

Gables had received an induction that covered safe working practices and some of the specific needs and conditions of the people they would support. Recently recruited members of staff that we spoke with told us they had received an induction and the opportunity to shadow more experienced members of staff. Staff that are new to care are required to undertake a nationally recognised induction called the Care Certificate. This ensures the staff are provided with the skills and knowledge they need to care for people safely and following good practice guidelines. When staff required this, it had been provided. Staff told us training was good. Comments from staff included, "I'm still new but been told I can go on courses to develop my skills." We were provided with a copy of the registered providers training plan. The plan showed how all new and existing staff were being supported to develop and refresh their knowledge in both the specific needs of the people they were supporting and safe working practices. Staff confirmed that they felt supported in their role. Staff we spoke with confirmed that individual supervisions were currently not being offered frequently however there were regular staff meetings and, 'flash meetings' [a way of addressing a specific issue at the time it occurs.] The management team also described on 'the spot' practical supervisions undertaken to ensure staff were meeting people's needs. Registered nurses are required to undertake continuous professional development to meet the requirements of the Nursing and Midwifery Council (NMC) and to ensure that they maintain current, best practice knowledge. Nurses we spoke with confirmed that training to help them meet this requirement as well as support with their revalidation was provided.

People told us they were happy with the healthcare they received. Comments from people included, "I have annual health checks to make sure my medical needs are all under control." The person went on to describe a medical condition they lived with and said, "They check my sugar levels and I am happy with that. They weigh me once a fortnight." Another person told us, "I have seen the optician, I had a dental check-up and I go to the hospital." One of the relatives we spoke with told us, "[name of person] has a chest infection. She has seen the doctor today and now we are waiting for the medicines." The relative went on to say, "They took steps when [name of person] became ill, and she was looked after. We have no concerns with healthcare." Records we viewed showed that people were supported to see the relevant healthcare staff when their needs changed. One health professional we spoke with told us that staff called them appropriately and followed the guidance they provided. Staff we spoke with were aware of people's support needs and the support they needed to maintain good health. This included helping people to change position, to attend promptly to their requests for help with personal hygiene as well as people's specific conditions such as Diabetes. People could be certain they would receive the support they required to stay healthy.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave mixed feedback about the involvement they had in planning care. Involving people ensures they have a chance to state how they wish to be supported. Care plans we viewed showed that people's views and preferences had not routinely been sought. The records of care did not always show how the registered provider had tailored the service to meet people's needs and expectations. The records we viewed did not always evidence that people received care in the ways they preferred. One of the people whose care we looked at in detail had stated they preferred their personal hygiene needs to be met by having a bath. The person we spoke with could not recall when they last had a bath, and records we viewed had not recorded this.

We asked people if they had the opportunity to maintain their culture and faith. One person told us, "I'm not keen on traditional English food. I like curries and I do get them occasionally." We observed a member of staff speak with another person in their preferred language. This brought the person pleasure, and the staff told us they made a point of speaking with the person whenever they were on duty. Staff we spoke with had some knowledge about people's cultural and religious needs. One person we spoke with told us in the past they had been supported to attend a local church, however in recent times they had chosen to stop doing this. Records that contained information about people's needs and preferences (assessment documents) included details about people's cultural and religious needs. People did have some limited opportunities to express their individuality, faith and culture.

People we met were wearing clean clothes, had fresh bedding and attention had been paid to ensure people's skin was clean. People we met told us that they were helped to wash and bathe, and people we spoke with told us the staff were, "Chatty," and one person told us they felt, "Happy and comfortable" living at The Gables. People we spoke with shared many positive examples of the compassion they had experienced from staff. Comments from people included, "I have nothing but praise for the staff," and I get on with all of them. [referring to the staff] They have changed recently. They are all alright, but I particularly like the blokes." Visiting relatives we spoke with told us, [Speaking about their relative living in the service] "They clearly trust the staff, and they have a laugh together," and "On the whole it's good. The carers are nice." Relatives we spoke with told us they were made to feel welcome at the home, and were offered a drinks when visiting. We observed some relatives eating a meal with their relative living in the service. Relatives were pleased that a Christmas party had been organised, and told us that they felt confident they would be made to feel welcome if they attended.

Staff told us they enjoyed working with the people who lived at the home. Comments from staff included, "The culture of the home is good; staff are patient they are calm and reassure people. We try not to rush." We observed numerous kind, caring interactions between people and staff and saw staff take the time to sit and talk with people about topics that interested them. The activities co-ordinator was aware of the risk to people who were cared for in bed of becoming socially isolated. Although this work was yet to start, they demonstrated a strong commitment to improving the opportunities for people cared for in bed to enjoy the company of staff. Many of the staff had a relaxed and friendly manner, and we saw people enjoying their company when possible.

Staff we spoke with described the actions they took to ensure people's dignity was maintained. These actions included closing doors and blinds for example when providing personal care and where possible offering people staff of the same gender to support them. Staff described changing the water often when they were supporting people to wash to ensure the water stayed fresh and warm for people. We saw notices had been developed for display on people's bedroom doors to clearly state when people were receiving personal care. This was a way of ensuring unnecessary disruptions were avoided, and people's dignity was maintained. We observed many interactions where staff did promote people's dignity, including covering the legs of ladies when hoisting them.

Requires Improvement

Is the service responsive?

Our findings

Some people told us the care and service was very flexible and fitted in around their needs and wishes. Comments from people included, "I can go to bed any time. If I want to go to sleep after tea I can. No one says anything." Other people told us they felt the care offered could at times be restrictive. Some people told us they did not feel free to leave the table, or to go back to their room for example if they wished to get something. These people told us, "If I say I want my cardigan they ask me, 'Where do you want to go, and bring me back." Another person told us the staff always brought them back when they left the dining table. This level of intervention caused these people frustration and to feel restricted. People could not always be confident they would be enabled or supported to make every-day routine decisions.

The people we met were living with health conditions that had changed over time, and we found that the written plans had not always been adjusted to reflect people's changing needs. Despite this staff we spoke with were able to describe people's current needs and we saw staff providing care that was consistent with the descriptions they gave us about people. We found that people or their relatives had completed documents that provided information about the person in their earlier life, such as information about their career, or family members. Having this information available helps staff to connect with people. It also adds value to the person's life experiences. One person we spoke with told us, "There are a few staff who ask me about the army [their career]. That's fair enough." Some of the staff we spoke with and observed had knowledge of people's life experiences and we heard them talking with people about things that were of specific interest to them. We were shown examples of a new care summary document that had recently been introduced. This was a way of providing the many new staff with the important information they would need to support people safely and according to their needs and preferences.

One relative we spoke with told us, "The social part of the home has 'probably' improved. There are more social things to do now." People told us they had the opportunity to participate in exercise sessions, to complete crafts and that on occasions a catholic priest would visit the home and conduct a religious service. The activities worker we spoke with described the activities people could partake in, and this included occasional visits outside of the home. They informed us six people had arranged to attend a Christmas lunch in the local community in the near future. The staff member advised that the people would be supported to attend. People we spoke with told us, "What I like more than anything is that they talk to me. Always say hello and smile," and "The television in the room is linked up so I can watch cricket and football. The staff are often too busy to talk, but I do sometimes talk about the football with the men."

Several people told us they enjoyed going outside of the home. People consistently told us they needed staff to help them with this, but this this support was not always available. Comments from people included, "I'm waiting to go outside for a cigarette. They will tell me I can go, but then I have to wait. Then they take me outside in a wheelchair." Another person told us, "Walking is a joy of my life. But going out depends on the availability of the staff or my family." We undertook observations in both of the units of the home. We saw staff spontaneously start to talk with people. We saw people attend appointments with the in house hairdresser and enjoy talking about the Christmas party that was planned for the following day. The range and frequency of activities was improving and we saw people were enjoying activities which were based on

their interests and needs and that encouraged stimulation and participation.

Systems had been developed to ensure staff were kept up to date about changes in people's care, We were informed that handover's took place between staff teams. These are an opportunity to share important information about the people living at the home and their needs. The staff we spoke with told us, "The handover sheets are helpful and supportive. We know who we are supporting and the handover ensures we are updated about people's needs such as who is poorly, who has fallen, [who has] not eaten and so on." Information sharing systems worked well to ensure people received continuity of care which is important for people's well-being and safety.

We looked at the systems for raising concerns or complaints. People told us they would feel able to raise any concerns. One person told us, "I would speak with one of the gentleman carers if I couldn't sort something out myself." Another person told us, "If you ask for anything they will come up with it. Anything I am not happy with I tell them" The manager showed us the work undertaken to investigate formal complaints. The written records showed people could be confident their concerns would be taken seriously, investigated and detailed feedback provided.

People and their relatives were given opportunity to feedback or raise complaints within regular meetings that took place with all the people living at the home. One relative we spoke with told us, "We have been to the relatives meeting. At meetings things have been brought up and some of them have gone through. They do follow up on things." A person we spoke with told us, "I went to one residents meeting. It was a general chat. They said if you have a serious problem go to the senior staff. It was about a month ago. I believe things have improved." This demonstrated an open culture to complaints and feedback.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured the systems to check on the safety and quality of the service were adequate. After our inspection the registered provider developed a plan of written information about the action they would take to ensure this breach was addressed. At this inspection we found that improvements had been made, but these had not been adequate to comply with the legal regulations or to consistently ensure people would receive good and safe care.

A wide range of systems to monitor the quality and safety of the service had been utilised on a regular basis, in conjunction with 'spot checks' to follow up on specific issues or areas of concern. However the systems in place to monitor and manage risks to people had not been effective as issues that were identified during the inspection had not been identified by the registered providers own quality assurance processes. While the processes in place had helped to drive forward and improve some aspects of the service our inspection identified further work was required to ensure that everyone experienced a consistently safe, good quality service, and that improvements were made in a timely way. One person we spoke with told us, "The home has physically improved, but it is taking such a long time." Relatives we spoke with told us, "A lot has changed over the past few months. It's hard to say what exactly has improved. We are seeing things happen bit by bit," and "Mums loo has never worked. She uses the commode and they take it else-where to flush it away. Why can't that be sorted out? At the moment it [the en-suite toilet] really, really smells."

This inspection identified examples such as the meal time experience where systems to ensure consistent good practice was shared and implemented throughout the home had been ineffective. People were receiving inadequate support at meal times. The inspection identified that checks and audits to monitor the quality and safety of the service, for example in relation to safe medicines management and the cleanliness of the environment had been ineffective. Records we viewed relating to individual care and the running of the business had not all been maintained to an acceptable standard or that were fit for purpose. The quality checking systems in place had also failed to determine if people were having their needs met in the way they wished and preferred. People we spoke with gave examples of not always being able to receive support in the way or at the time they would like. There was no evidence of how this information was being used to improve and drive forward the service to better meet people's needs.

Failing to have effective systems to review and improve the quality of the service offered is a breach of regulation 17 of the Health and Social Care Act 2008. (Regulated Activities.) 2014.

The registered provider had recently appointed a new manager. They had been unable to significantly impact on the running of the home since their appointment due to an unexpected absence from work. The registered provider had appointed another member of staff from within the organisation to cover the management of the home on a day to day basis. They were being supported several days a week by a regional manager. Some people, relatives and staff gave positive feedback about the new management team and their relationship with them. Some people told us they felt able to speak with any member of the

management team and that interactions with them were positive and compassionate. Staff told us the new management team had been supportive to them and their comments included, "Both the senior managers and the deputy manager are all very supportive they go above and beyond to help and support me in my role on a day to day basis. The residents are their number one priority as are their relatives and the staff." One person we spoke with told us, "They have made a lot of improvements recently." Other people were unaware that the management had changed and told us, "I didn't know the manager was male. I didn't know it had changed." And a person living at the home told us, "I haven't seen the manageress since I have been in. That's hard to understand."

The management staff we spoke with understood their responsibility to inform CQC of specific events that had occurred in the home. We were informed that a lead clinical nurse had recently been appointed, and the senior management team we spoke with anticipated they would be able to support with the improvement and development of clinical, health related aspects of the service. Senior staff had ensured the previous rating of the home was on display as is required by law

The registered provider had put systems in place to ensure feedback was sought from people living at the home. Relatives and staff told us that there were meetings where topics such as activities, menu planning and concerns were discussed. The registered provider carried out surveys with people to measure their satisfaction with the service. Opportunities had been provided for people to feedback their experience of living, visiting and working at the home, on a computer tablet that had been provided by the registered provider of this service. Real time feedback was sent to the responsible manager when concerns were raised.

The management team and registered provider showed a strong commitment to improving and developing the service further. Improvements had been made in the past six months, however these were not yet established or working consistently across all areas of the home or staff group. This meant people could not be certain they would consistently benefit from safe, strong leadership and governance.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that the management and administration of medicines was not always safe. We found that people were not always getting their medicines as prescribed and at the right time. We found that there was no assurance that pain relief medication prescribed for people was being administered as prescribed.

The enforcement action we took:

Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place had failed to identify specific issues and areas of concern that were identified during the inspection. Despite these being detailed in the previous action plans significant shortfalls were found again in relation to medication management. The systems used had failed to identify that issues related to hygiene and cleanliness which were below expected standards needed to be addressed. The systems in place and had failed to identify and ensuring that people were being supported in line with their wishes and preferences.

The enforcement action we took:

Issued a warning notice.