

Barchester Healthcare Homes Limited

Wimbledon Beaumont

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an unannounced inspection that took place on 7 and 8 August 2018.

Wimbledon Beaumont is a 'care home'. 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. Wimbledon Beaumont provides care for up to 49 people including people with dementia and is located in the Raynes Park area of west London.

This responsive inspection was prompted by concerns raised by relatives, health care professionals and current and former staff.

The home did not have a registered manager. 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 and associated Regulations about how the service is run.

The home was covered by the registered manager of another home within the organisation since mid-May 2018. Staff did not think the acting manager and organisation provided good support, that enabled them to do their jobs effectively. Many people and seven of eight relatives we spoke with said they did not find the acting manager approachable or responsive and they did not encourage negative feedback from people. People and their relatives said that they did not feel listened to. The registered manager who left in September 2017 had been in post for 11 years, since they left there had been inconsistent management and oversight of the service, with another manager leaving after only a very short period.

At the last inspection in June 2017 the key questions of effective, responsive, caring and well-led were rated "Good" and safe "Requires improvement". The safe key question required improvement because staff were not following corporate policy in using separate slings for people who required the use of lifting equipment to transfer. The overall rating was "Good". At this inspection staff were following the corporate policy.

Some people and their relatives that we spoke with said they were happy with the care and support provided by the home and way it was delivered, whilst others told us it was not of the quality they expected. All the people said that the staff were caring and did their best, however they felt there were too few staff to safely meet people's needs. There was also a high turnover of key staffing and management roles over the previous two months. Some relatives told us they felt staff did not have the experience, training or received the managerial support to carry out senior roles competently. A new experienced deputy manager was recently appointed.

Medicine was not safely administered and medicine records were not complete and up to date.

Other records such as activity care plans were not fully completed.

The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Not all appropriate applications had been submitted by the provider or applications under DoLS been authorised, and the provider was not complying with the conditions applied to the authorisation. They were aware of this and endeavouring to complete the required outstanding applications.

The home's quality assurance system failed to identify short-comings in the service provided in a timely manner and did not consistently monitor and assess the quality of the service provided. The acting manager had picked up some of the areas in which the home was not performing well and was addressing them.

People and their relatives were encouraged to discuss health needs and they had access to community based health professionals as well as nursing and care staff. People had balanced diets that also met their likes, dislikes and preferences and protected them from nutrition and hydration associated risks. People and their relatives told us the meals provided were of excellent quality and plenty of choice was provided. Staff supported people to eat their meals and drink as required whilst enabling them to eat at their own pace and enjoy their meals.

The home was clean, well-furnished and maintained. The front entrance door did not provide a safe environment for people to live in. This was attended to during the inspection.

Staff were knowledgeable about the people they supported and had the appropriate basic skills and training to meet people's needs competently on a day to day basis. They focussed on providing people with individualised care and support and this was provided in a professional, friendly and supportive manner.

Staff were aware of their responsibility to treat people equally and respect their diversity and human rights. They treated everyone equally and fairly whilst recognizing and respecting people's differences.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

There were not appropriate numbers of skilled staff to meet people's needs.

People's medicine was not administered safely and records were not up to date. Medicine was not satisfactorily audited, safely stored and disposed of if no longer required.

Requires Improvement ●

Is the service effective?

The service was not always effective.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures and staff were provided with training. Not all people that required them had undergone mental capacity and DoLS assessments or been supported to make decisions through 'best interests' meetings.

People received care and support the quality of which varied depending on numbers of staff available.

People's care plans monitored food and fluid intake and balanced diets were provided. The home was decorated and laid out to meet people's needs and preferences.

Staff teams worked well together internally and across organisations.

Requires Improvement ●

Is the service caring?

The service was caring.

People felt that staff tried hard to meet their needs on a daily basis. Staff provided support, care and encouragement as best they could in an environment that was re-active to people's immediate individual needs. This was rather than a planned approach. The support provided was kind, caring, respectful and attentive.

Good ●

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People had their support needs assessed and agreed with them and their families. They chose and joined in with a range of recreational activities.

People's care plans identified the support they needed, although there were gaps and inaccuracies in some of the information recorded.

Relatives told us that concerns raised with the home or organisation were not always addressed satisfactorily.

Staff were trained to meet people's end of life needs.

Is the service well-led?

The service was not always well-led

The home did not have a registered manager.

The quality assurance systems were not robust enough to assess, monitor and improve the quality of the service people received, in a timely fashion. People, their relatives and staff were involved in these processes although they told us they did not feel listened to.

The organisation had a clear vision that focussed on people as individuals although the management of the home did not project a positive and transparent culture.

The home provided advancement opportunities for staff.

Requires Improvement ●

Wimbledon Beaumont

Detailed findings

Background to this inspection

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

This was an unannounced inspection that took place on 7 and 8 August 2018.

This inspection was carried out by three inspectors on the first day and one inspector on the second day.

There were 31 people living at the home. We spoke with five people, eight relatives, nine staff, the acting manager, two area directors and contacted six healthcare professionals whom had knowledge of the home.

Before the inspection, we reviewed the information we held about the service. We considered concerns raised regarding the home, notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff numbers, training, supervision and appraisal systems, medicine records and the home's quality assurance systems.

We looked at the personal care and support plans for four people and four staff files.

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

Is the service safe?

Our findings

People said they felt safe living at the home although some relatives expressed concerns surrounding staffing levels and medicine not being correctly administered. One person told us, "I feel safe here." A relative said, "This was a very lovely home. I only had fantastic things to say about the place and the staff, but that has now changed. There are just not enough staff." Another relative told us, "The poor girls [staff] are just rushed off their feet and subject to constant criticism. I don't blame the good staff for leaving now." A further relative commented, "I am very worried about medication. [My relative] has developed a new tremor over the past few days, how can I be sure [they] are getting the correct medication?"

Medicines were not managed safely. We reviewed the medication administration records (MAR) of six people living at the home and found errors in the recording of when these medicines were given. Where people received medicines of variable doses their MAR did not always reflect the dose they had been administered, nor were variable dose records being utilised. Staff did not use MARs correctly to record any reasons for medicines not being administered, or any omissions.

People did not have protocols in place for 'as required' medicines, meaning that there was no appropriate guidance for staff on how to support individuals with these medicines, or the circumstances in which they should be administered. We saw that one person had homely remedies guidance, however their name was not recorded to show that these homely remedies were safe for them to take. The home forwarded a medicine audit dated 4 August 2018 that was completed by an RGN working at the home. Under the heading "Are there any unexplained gaps in the MAR" recorded there was an entry "no" and "Is the homely remedy form the up to date copy from the Management of Medicine policy the most up to date" was ticked as "yes".

The provider did not ensure that there were stock balance checks of people's prescribed medicines. We checked the balance of people's medicines for the six MAR sheets we looked out and found that most of them did not have the correct amount of medicines remaining. People were not always receiving their medicines as prescribed. In the home's forwarded medicine audit dated 4 August 2018 under the audit heading "Tablets remaining in blister packs correspond with MAR", the RGN had written yes.

The provider told us that registered nurses had been trained to administer medicines, however they were unable to show us these medicines competency checks. A medicines audit conducted in April 2018 highlighted that nurses required retraining in medicines administration, however there were no records to show this had been actioned. A copy of the competency check was e-mailed by the acting manager that showed seven nurses had completed the check between April and May 2018.

Controlled drugs were stored in a secure cabinet, however records showed that on one day these medicines had not been checked. Temperature checks were made of medicines storage areas daily, however we found that two weeks of checks were missing. The home's forwarded medicine audit dated 4 August 2018 recorded under the audit heading "Controlled drugs, CD register- stock check weekly – two signatures against each administration – date and time recorded – check expiry dates of medications" a yes was recorded. The section of the audit pertaining to medication errors was not filled in.

There were also discrepancies in the way that medicine was prescribed with two systems running simultaneously using two pharmacies. The home had arranged an audit and report by one of the two pharmacies used.

The incorrect administration of medicines and the errors in record keeping of medicines administered constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we checked the staffing levels for people based on Barchester's Dependency Indicator Care Equation (DICE) tool that the home used to calculate required numbers of care workers and nurses to safely meet people's individual needs. This was used within the care home industry. We checked the home's tool against the staff rotas for July 2018. We found that there were insufficient numbers of nurses and care workers to meet people's needs. The home met their identified number of nurses required on three days and care workers on 23 days in July. The home sent us a copy of the summary of the DICE core hours dated 21 August 2018 that indicated that it was exceeding the required staffing levels. The rota for week ending 12 August 2018 showed a current occupancy of 36 on the care worker rota, 34 on the nurse rota and we were told that the occupancy was 31 people. This meant the staffing level information fed into the tool was inaccurate.

The home was currently recruiting to vacant posts, as there had been a substantial turnover of staff between 1 May and 7 August 2018, many of which were senior posts that in some instances experienced staff had filled for a period of years. The vacant posts included the Registered Manager, Deputy Manager, Registered General Nurse (RGN), Head Chef, Head of Maintenance, receptionist and two hostesses.

We observed an activity in a small lounge, on the ground floor, on the first day that was being run by an assistant activities co-ordinator. There were also people present in the garden area that opened from the lounge. They were the only staff present. There was one other member of staff supporting a person in their room. The other staff were taking their break. They explained that they had to take their break between 11.30 and mid-afternoon.

We observed the morning handover for staff coming on duty. This was conducted by the nurse coming off duty and those coming on duty and consisted of doing a round of each person. Whilst this was happening the oncoming care worker staff were assembled in a ground floor lounge awaiting their handover and instructions as to where they were working. We walked around the building prior to joining the care workers and could not find any staff on the floors.

The timesheets of nurses and care workers recorded that on the week commencing 16th July, an RGN worked 12.25 hour shifts every day, for a total of 85.75 hours for the week. The timesheet demonstrated that the nurse worked 67.5 hours, 49 hours and 61.25 hours for the other three weeks in July. She worked 276 hours in total in July. Similarly, a care worker worked at least six 12 hour shifts each week of this month. The weeks were 66 hours, 66 hours, 68 hours and 70 hours for a total of 292 hours in July. Another care worker worked 55 hours, 39 hours, 66 hours, 66 hours for a total of 248 hours for July. There were three other care workers that recorded similar hours. The extensive hours worked by individual staff members meant there were not enough staff deployed and those working were at high risk of fatigue.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. This constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training and were aware of how to raise a safeguarding alert and when this was required. The staff handbook contained safeguarding information and relevant local authority contact numbers were also accessible to staff. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. Staff knew the procedure to follow and agencies to contact to make sure people were safe.

Staff were trained in how to keep people safe from harm and abuse and had access to the provider's policies and procedures regarding these areas. This was reflected in their care practices during our visit. Staff said that protecting people from harm and abuse was included in their induction and refresher training and an essential part of their jobs.

People's risk assessments identified areas of risk relevant to them and covered areas such as mobility, skin integrity and nutritional needs. Where one person required support with moving and handling there was guidance for staff on how to support them with the use of their zimmer frame. People had bed rails assessments in place, to ensure that they were used safely. Another person had a specific care plan in place for seizures that detailed for staff how they should support the person should they occur. One person had a care plan for Parkinson's Disease and there were specific strategies in place for staff to support them with this.

Although there were appropriate risk assessments in place for staff to follow, they did not always result in staff having the appropriate information to support the person. For example, one person was at high risk of malnutrition and had experienced significant weight loss since moving into the home. They had been reviewed by the dietitian and strategies put in place to reduce these risks. However, their care plan had been reviewed and updated as 'no change' since the strategies had been implemented by the dietitian. This left them at risk of not receiving the high calorie snacks and fortified milkshakes they needed to gain weight to a healthy level. In other examples risk assessments were reviewed and updated as people's needs and interests changed. Relevant information was shared by staff, during shift handovers, staff meetings and when they occurred. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of, although they told us they did not feel confident using.

The home carried out infection control checks and staff had received infection control and food hygiene training that was reflected in their working practices. The home also held a good stock of equipment including gloves and aprons for supporting people with personal care to minimise the risk of infection. The kitchen had a five-star rating for food safety.

There was a thorough staff recruitment procedure that recorded all stages of the process. This included advertising the post, providing a job description and person specification. Prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's communication skills and knowledge of the service the home provided. During the interview prospective staff were given the opportunity to experience if this was the type of work they wished to do by spending a couple of hours with a member of staff during a general activity. It also enabled the home to ascertain the level of commitment of prospective staff. References were taken up, work history checked for any gaps and Disclosure and Barring Services (DBS) security checks carried out prior to staff starting in post. There was a six-month probationary period. The home had disciplinary policies and procedures that staff confirmed they understood.

Staff had received training in de-escalation techniques to provide appropriate support in instances where people may display behaviour that others could interpret as challenging. These were focussed on people individually and staff had appropriate knowledge to do this successfully. Staff actions were recorded in people's care plans.

Is the service effective?

Our findings

People did not comment directly regarding their involvement in planning their care and support. The majority of relatives we spoke with said initially they were involved in the decision-making process, but the home did not respond effectively to or address concerns that they had raised. One relative told us, "Not impressed at all, we have to look after mum's care. It used to be everyone together, now it's just a showroom." This comment was in reference to chairs being taken from the reception area so that people could not sit there. However, another relative said, "I get on well with the [acting] manager and things get sorted." A further relative told us, "I visited [my relative] at 11:30am and [they] were still in bed and not dressed yet – there was a training session for hospitality going on and there were not enough staff left to care for people, so they were still in bed awaiting their medicines at 11:30am. Who cares about hospitality? It's appalling."

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 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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Not all required applications had been submitted by the provider and applications under DoLS had not all been authorised, and the provider was not complying with all the conditions applied to the authorisation. Consent was not always sought in line with the requirements of the MCA 2005. One person's records contained an assessment of the person's capacity to understand "osteoporosis", however there was no outcome of the capacity assessment, nor was the decision recorded. This assessment also noted that the person "did not have disturbance of the mind", although they had been diagnosed with dementia and their 'mental health and cognition' care plan noted they were "very disorientated to time and place." Additionally, the acting manager was not aware who was subject to DoLS and this information was not routinely stored in people's personal care and support records. This increased the risk of people's rights not being protected, or of the appropriate safety considerations not being made. The acting manager informed us they were awaiting the authorisations of several applications as these had not been completed historically. One person's records noted that their friend had consented to use of the bedrails on the person's behalf, however the records also noted that the person did not have anyone authorised to make decisions on their behalf through deputyship or attorneyship granted by the Court of Protection. The deputy manager said that when they started two weeks ago only seven DoLS had been applied for since November 2017. They had gone through individual's files and found others that needed DoLS where the MCA had not always been done.

Because consent was not always sought in line with the requirements of the MCA 2005, the service was unable to ensure that the care and treatment of service users was provided with the consent of the relevant person. This constitutes a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had the communication skills to enable people to understand them and increase the opportunities of staff to meet people's needs in a way that was appropriate to them. Staff made the effort to talk to people in an unrushed way so that they could understand what staff were saying. Unfortunately, this was hampered by their lack of numbers and effective systems in place to take breaks.

Staff were given induction and annual mandatory training. The induction was comprehensive, included core training and information about staff roles, responsibilities, the home's expectations of staff and the support they could expect to receive from the organisation. Aspects of the service and people who use it were covered and new staff shadowed more experienced staff. This expanded their knowledge of the home and people who lived there. The training matrix and annual training and development plans identified when mandatory training was due.

Training encompassed the 'Care Certificate Common Standards' and included customer care and effective communication, dementia awareness, duty of candour, fire training, manual handling, medicine, food safety and food allergens and health and safety. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

Staff meetings took place that included opportunities to identify further training needs. Bi-monthly supervision sessions and annual appraisals were partly used to identify any gaps in training. There was also access to further topic specific training.

There was a clear policy and procedure to inform other services within the community or elsewhere of relevant information regarding changes in people's needs and support. People's personal care and support records demonstrated they had seen the optician, dentist, podiatrist and dietitian recently. One person's records showed they regularly saw the Parkinson's specialist nurse at the home. There was a GP practice attached to the home and regular GP rounds took place, including one during the inspection. However, communication issues were identified regarding prescriptions and medicine, which the acting manager told us they were trying to address through the introduction of a service level agreement between the home and the GP practice.

People's care plans contained a section regarding health, nutrition and diet and they had annual health checks. The home carried out nutritional assessments that were generally updated. If required weight charts were kept and staff monitored how much people had to eat and drink. The first day of our visit was very hot, and the service had taken measures to support people to keep cool such as opening all of the windows as much as possible, having fans oscillating in all of the corridors and offering iced drinks.□

Staff had access to person specific information regarding any support required at meal times, including any possibility of choking. Staff had also received training regarding choking and dysphagia. Dysphagia is difficulty or discomfort in swallowing, as a symptom of disease. Further training in respect of choking was also provided as part of the basic life support training.

During our visit staff supported people to have their meals at a pace that they wished and provided people

who needed it with encouragement to eat. This was delivered by waiting staff and care workers depending on the level and type of people's support needs and included people with dementia. Staff met their needs in a patient, re-assuring and encouraging way

Staff, including the catering team provided nutritional advice. People had access to the daily menu and meal choices that included vegetarian options available for all meals and people were provided with special meals to suit their needs when necessary, such as pureed and diabetic meals. The menu options were explained to people who required it. Staff reiterated this information as many times as people needed to help them understand what their choices were. They also spent time explaining to people what they were eating, during the meal and checked that they had enough to eat. Staff supported people in a timely way at mealtimes and no one had to wait for their lunch. The meals were of excellent quality and special diets on health, religious, cultural or other grounds were provided. They were well presented, nutritious and hot. This made mealtimes an enjoyable experience for people. One person said, "The trouble is, everything [food] is so good! I have gained weight here." A relative told us, "Can't fault the food." The dining room was very nicely set with lovely linen, flowers and stemmed glassware.

The home was clean, well decorated, well-maintained and with no unpleasant odours. The environment was not very dementia friendly with a lack of pictorial images or personalisation to support orientation. People's rooms had the same doors with just their names written next to them.

There were lounges in each wing of the building for people to use, however these were very small and except on the ground floor we did not see them being used. The main lounge was only used for a very short time during our visit, or when people were waiting in reception for transport or visitors. During an activity on the second inspection day there were seven people plus staff in a small lounge whilst there were four people reading newspapers or watching television in the large lounge. One person's relative told us, "The [acting] manager doesn't like to see old people in wheelchairs in the front lounge, says it gives a bad impression of the place. But it's a nursing home! So instead people are stuck being squashed in the small lounges for activities."

Is the service caring?

Our findings

The service people received was based on treating them with dignity, compassion and respect. People and their relatives thought staff listened to and acknowledged them and valued their opinions whilst delivering support in a friendly, patient and helpful way. Positive staff care practices reflected that they cared about people. People were stimulated and encouraged to have conversations with each other as well as staff in a patient and skilled way. Staff applied their knowledge of people and their needs and preferences enabling them to lead happy and rewarding lives where possible. This was individually and as a team. People were treated with kindness and understanding with staff taking an interest in them.

Staff received equality, diversity and human rights training that enabled them to treat everyone equally and fairly whilst recognising and respecting people's differences. This was reflected in the positive staff care practices and confirmed by people and their relatives. People were treated very respectfully, equally and as equals with staff not talking down to them.

We observed some lovely caring interactions between staff and people. One care worker was dancing with a person in a wheelchair, who was smiling and laughing. The person had dementia and had lost the ability to communicate very well in English, so the staff member communicated by touch and dancing instead. During an activity session, on the second day, we observed staff being inclusive, making sure everyone who wanted to join in, did so. They gave clear explanations of what was going on and repeated this as necessary speaking at a pace that people could follow and understand. One care worker had a message to relay to a person which they did by kneeling in front of them and speaking quietly to them so that the activity was not interrupted.

There was good support and interaction that staff delivered at eye contact level and using appropriate body language that people responded to. The support was re-assuring with appropriate physical contact such as holding hands and a cuddle. If people were struggling with the activity taking place, the activities co-ordinator politely enquired, "Shall I help you with that" and encouraged them to continue. There was also a round of applause for each person's contribution that people's smiling faces and body language indicated they appreciated. People and their relatives said that the way staff provided care and support was what was needed and delivered in a friendly, relaxed, patient and professional way. One person said, "People [staff] are so nice and helpful." Another person told us, "It's nice, they [staff] are very good here." A relative said, "The girls [staff] are very professional, but the [acting] manager! I have spoken with other relatives and we seem to feel the same way – we can't wait for her to leave and for the new manager to start. Maybe it can be a nice service again." Another relative told us, "Mum is so happy here, it's the girls [staff] that make it." A vicar who visits regularly told us, "I am here every month. The staff are very friendly and the residents are very happy" and "The home is very much highly regarded in the community – a lot of parishioners say they see themselves here when the time comes for them to need care."

Staff addressed people by their preferred name or title and knocked on their bedroom doors and waited for a response before entering. People had their name on their bedroom door, some with titles according to their preference.

People had their own items of furniture and personal belongings in their rooms, where practicable.

There was an advocacy service available that people had access to if required.

There was a carer's support group (for family carers) advertised on the noticeboard that met monthly.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect, that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the people.

Is the service responsive?

Our findings

People did not comment whether they thought the service was responsive. Their relatives, in the main, did not feel that the service was responsive or that issues raised were resolved. Although on the day of inspection people appeared clean, one relative told us this was not always the case. They said, "[My relative's] hygiene levels have really been deteriorating. [My relative] was wearing the same stained, dirty clothes for three days straight, and [they] smell really bad a lot of the time now. [My relative's] hair isn't washed enough and it is usually dirty and greasy now. At times there is only one carer on each floor." Another relative told us, "There is now a total lack of communication. The good staff are leaving and the [acting] manager just doesn't think it worth telling us what is going on. Residents and their relatives just aren't important anymore." A further relative said, "Since May things have been arbitrarily changed without reason – chairs and tables have been moved in the reception, so now it's difficult for people in wheelchairs or who have trouble seeing as things are moved around. There's just no consideration for the person anymore."

The written information about the home, including pre-admission was provided for people and their relatives in a format that was easy to understand. It was in sufficient detail to enable them to understand the type of care and support they could expect. It also laid out the home's expectations of people.

People were invited to visit as many times as they wished before deciding if they wanted to move in and fully consulted and involved in the decision-making process. These visits were also used to identify if they would fit in with people already living at the home. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person.

People mainly referred themselves or referrals were made by their families. Many people had first experienced a respite stay at the home prior to moving in permanently. If a service was commissioned by a local authority or the NHS, assessment information was requested from these bodies or from a care home if they had been transferred. The home carried out assessments of people's needs with them and their relatives, and if it was identified that needs could be met people and their relatives were invited to visit.

People's assessments were the basis of their initial care plans. The care plans covered the various aspects of people's health and well-being. This included up-to-date care plans for people who were at high risk of pressure sores with evidence of people being seen by the Tissue Viability Nurse (TVN) when necessary and appropriate strategies put in place, for example supportive booties and turning regimes. Choking risks were also dealt with well. Each person's personal care and support records included an 'activity care plan', that provided information that gave people the opportunity to identify activities they may wish to do. However, these were blank for two of the four people's care and support plans we looked at. The 'monthly activities evaluations' seemingly described one day of activities, instead of evaluating the person's engagement over the month, for example one person's stated "July 2018: Woke up and enjoyed scrabble game with other residents."

The home provided a variety of activities based on people's wishes and staff and knowledge of people's

likes and dislikes. The communal activities were reviewed regularly to make sure they were focussed on what people wanted. People were also kept informed by a newsletter. During the inspection people were consulted by staff about what they wanted to do and when. When activity sessions took place, people were encouraged to join in but not pressurised to do so.

A timetable of weekly activities was available that took into account people's interests and ability to participate. Staff reminded people of what was taking place during each day. The activities co-ordinator facilitated a programme of activities that people had chosen. The home provided a number of activities including, quizzes, keep fit, sensory sessions and book club. A discussion group regarding the life of Charlotte Bronte took place during the inspection. There was a "You said, we did" board on the noticeboard in the lobby. The issues noted were more activities and trips out, and the response was that the home had organised a silent disco and sensory sessions; three big activities per month; and two trips out per week. The acting manager explained that trips out had not taken place for the previous two weeks as the driver was on a sabbatical. One person said, "We go out on trips a few times a week, it's marvellous." Other relatives told us that they thought people enjoyed the activities provided and they were appropriate.

The home ran a 'Resident of the Day' activity that was focussed on a specific person and activities they wished to do as well as all aspects of their care and the environment they live in.

The home provided end of life care and staff had received appropriate training from the organisation. There was specific reference to end of life in people's care plans including guidance and people's wishes. When providing end of life care, the home facilitated relatives to be involved in the care, if they wished during a distressing and sensitive period for them. The home liaised with the appropriate community based health teams and organisations such as palliative care teams.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a system for logging, recording and investigating complaints. However, they did not feel the complaints made were acted upon, learnt from or care and support adjusted accordingly. One relative said, "I made a complaint, tried to raise it with the [acting] manager but you can't raise any issues with her, she won't accept it." Staff said they had been made aware of the complaints procedure. They also knew of their duty to enable people to make complaints or raise concerns.

Is the service well-led?

Our findings

The home did not have a registered manager. A new general manager was due to commence in post on 3 September 2018. They would be applying for registration as manager.

People did not comment directly on whether the home was well-led. Their positive body language towards staff indicated they trusted and were comfortable with them. Relatives said the acting manager operated an open-door policy, but they did not feel their opinions were valued or listened to. This meant they did not feel comfortable in approaching the acting manager although they did feel they could approach staff.

There was an issue of communication between the acting manager and people's relatives, and the acting manager and the GP surgery. The outcome of this was that some people did not receive their medicines as they have needed them. A relative said, "The manager has been so rude. Lots of good staff have been leaving. She is rude and objectionable and doesn't listen to what people are saying." A further relative commented, "The employee of the month scheme seems to have stopped. We used to have a box in reception where we could nominate the carers who had been especially good, but that's gone now. There is no recognition for good staff, they are just clinging on." Another relative said, "It's a completely different atmosphere to what it was. I can't wait for her [acting manager] to leave."

The organisation had a vision and values that staff understood. The vision and values made clear what people could expect from the organisation, home, its staff and the home's expectations of them. Staff said the vision and values were described and explained as part of their induction training and revisited during staff meetings. Staff practices reflected the vision and values as they went about their duties.

During a conversation with a group of staff, they said they were happy with the way the acting manager ran the home. However, in individual conversation with the same staff, they said they felt bullied and intimidated by the acting manager and were scared of losing their jobs if they spoke to us. They also said that staff had been humiliated in front of people and their relatives.

The organisation provided staff with opportunities for personal advancement. Some senior posts at the home had recently been filled by staff that had been promoted internally. However, some relatives spoken with had reservations whether they had the appropriate skills and experience or support to carry out their new roles successfully. Staff had personal development plans.

There were clear lines of communication and areas of responsibilities throughout the home and organisation and staff were aware of their areas of responsibilities. Staff said they would not be comfortable using the whistle-blowing procedure if they needed to.

Staff did not feel well supported by the acting manager. They thought that the suggestions they made to improve the service were not listened to or given serious consideration. Staff said they no longer enjoyed working at the home. A staff member told us, "There are not enough of us and I don't feel supported to do my job."

The quality assurance system contained performance indicators that identified how the home was performing, areas that required improvement and areas where the home performed well. However, the system did not always pick up areas of concern in a timely fashion, as highlighted by the concerns regarding staffing levels, medicine and MCA and DoLS. The CQC received concerns raised directly by relatives, former and present staff and health care professionals. This was regarding the responses they had received to concerns they raised with the home and organisation. They stated that they did not feel their concerns had been appropriately responded to or addressed. The home and organisation performed a number of audits that included areas such as nutrition care and dining experience that incorporated fluids and hydration, assistance with meals, food service and modified diets. The care plans audits sampled a percentage of people's care plans and also included nutrition and hydration. The clinical governance audit stated that medicine and documentation audits should take place monthly, therefore the expectation should be that discrepancies and errors would be identified at this point and an action plan put in place. The evidence in the above paragraphs constitute a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us there was an action plan to address the areas that required improvement. Regular visits from the regional director took place.

Our records demonstrated that appropriate notifications were made to the Care Quality Commission (CQC) when needed.

The home forwarded us a copy of the last residents and relatives meeting that took place on 23 May 2018 and was the first meeting attended by the acting manager. The acting manager had also produced a brief newsletter outlining some of the staffing changes that had occurred in the home recently, and updates about what was planned over the summer. The service was holding a public open day on Sunday 11 August from 12 to 4pm.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The care and treatment of service users was not provided with the consent of the relevant person. Regulation 11 (1), (2) and (3)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure the proper and safe administration of medicines. Regulation 12 (1) and (2) (g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not operate effective systems to assess, monitor and improve the quality and safety of the services provided, nor seek and act on feedback from relevant persons. Regulation 17 (1) and (2) (a) and (e)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed.

