Barchester Healthcare Homes Limited

Meadowbeck

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

This inspection took place on the 16 and 17 May 2016 and was unannounced. At our last inspection of the service on 7 August 2014, the registered provider was compliant with all the regulations in force at that time.

Meadowbeck is registered as a care home with nursing for up to 60 people including adults over the age of 18, older people and people living with dementia. The service is purpose built; set in its own grounds and offers accommodation over two floors. The service is located approximately two miles east of York city centre and is close to public transport routes. There are a number of local shops close by.

The registered provider is required to have a registered manager in post and at time of our inspection the position was vacant. The previous registered manager left their post in March 2016. There was a peripatetic general manager in place, who is referred to as 'the manager' in this report. Active recruitment for a permanent manager was taking place. 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.

During our inspection we found that the recording and administration of medicines was not being managed appropriately in the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Record keeping within the service needed to improve. We saw evidence that care plans, risk assessments, food / fluid charts, turn charts and end of life plans were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

We found the level of cleanliness in the service was satisfactory, but the infection prevention and control practices within the service did not follow best practice.
We have made a recommendation about infection prevention and control within this report.

The manager of the service had made improvements to the number of staff completing essential training, but there remained work to be done to improve the number of staff receiving regular supervision. This had been identified by the manager and was part of their on-going action plan.

Some people who used the service were subject to a level of supervision and control that amounted to a deprivation of their liberty; the manager had completed a standard authorisation application for each person and these had been reviewed by the supervisory body of the local authority. This meant there were adequate systems in place to keep people safe and protect them from unlawful control or restraint.

People were able to talk to health care professionals about their care and treatment. People told us they could see a GP when they needed to and that they received care and treatment when necessary from external health care professionals such as the District Nursing Team or Diabetic Specialists.

People had access to adequate food and drinks, but this was not always well recorded by the staff. We found that people were assessed for nutritional risk and were seen by the Speech and Language Therapy (SALT) team or a dietician when appropriate. People who spoke with us were satisfied with the quality of the meals, although one or two said they could be better.

People were supported to maintain their independence and control over their lives. The majority of people reported that the service delivered effective care, but two people raised concerns about staff skills in moving and handling. This was being investigated by the manager. People gave us a mixed response when we asked them if staff were caring and supportive. Some were very positive in their feedback, but others were more reserved and indicated that their care was satisfactory depending on who was on duty. The manager was aware of this and the quality of care was being improved through on-going staff training and development.

End of life care within the service was not appropriately recorded, although we saw the care and support being delivered to people was in accordance with their wishes and needs.
We have made a recommendation about end of life training for staff, based on best practice, in this report.

People and their families, had been included in planning and agreeing to the care provided. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions. We found that people's care plans did not clearly describe their needs. We saw no evidence to suggest that people were not receiving the care they required, but judged that the care provided was not well recorded. This was addressed in the well-led section of this report.

People had access to external gardens and community facilities and most participated in the activities provided in the service. We saw that staff encouraged people to join in with social activities, but respected their wishes if they declined. Families and friends were made welcome in the service and there were unrestricted visiting hours each day.

People knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been managed. People had access to complaints forms if needed and the manager had investigated and responded to the two minor complaints that had been received in the past six months.

The manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We saw from recent audits that the manager was making progress in improving the quality of the service.

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

Some aspects of the service were not safe.

The recording and administration of medicines was not being managed appropriately in the service.

We found the level of cleanliness in the service was satisfactory, but the infection prevention and control practices within the service did not follow best practice.

There was sufficient staff on duty to meet people's needs and there were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults procedures.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Improvements to the number of staff completing essential training had been made, but further work was required to improve the number of staff receiving regular supervision.

People had access to adequate food and drinks, but this was not always well recorded by the staff. People were seen by the dietician or the Speech and Language Therapy (SALT) team when appropriate. People who spoke with us were satisfied with the quality of the meals, although one or two said they could be better.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People gave us a mixed response when we asked them if staff were caring and supportive. Some were very positive in their

feedback, but others were more reserved and indicated that their care was satisfactory depending on who was on duty. This was being looked at by the manager.

End of life care within the service was not appropriately recorded, although we saw the care and support being delivered to people was in accordance with their wishes and needs.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans did not clearly describe their needs. We saw no evidence to suggest that people were not receiving the care they required, but judged that the care provided was not well recorded.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs. Staff encouraged people to join in with social activities, but respected their wishes if they declined.

People knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been managed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Record keeping within the service needed to improve. We saw evidence that care plans, risk assessments, food / fluid charts, turn charts and end of life plans were not always accurate or up to date.

The manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We saw from recent audits that the manager was making progress in improving the quality of the service.

Meadowbeck

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 May 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector on day one and one ASC inspector and an Expert-by-Experience on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the City of York (CYC) Contracts and Monitoring Department and CYC Safeguarding Team. We asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the manager and the regional manager. We also spoke with eleven staff members and then spoke in private with four visitors and six people who used the service. We observed the interaction between people, visitors and staff in the communal areas and during mealtimes. We looked at the environment of the service and spent time chatting to people in their bedrooms and the communal areas.

We spent time in the office looking at records, which included the care records for three people who used the service, the recruitment, induction, training and supervision records for four members of staff and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. Comments included, "Yes, I know no one can get in, there is always someone walking around and checking on me," "Feel safe, staff about and building is safe" and "Yes, from the care you get".

Visitors we spoke with said they felt their relative and other people using the service were safe in the home. One visitor said, "The staff I have met are competent, using the hoist, all done correctly" and they added that both their relatives using the service used the hoist for baths and never had any problems. Another visitor told us, "The staff I see have the right skills" and added, "Yes, I feel the hoist is used correctly."

Although the majority of people felt safe in the service, we spoke with two people who both complained to us that a member of staff had been, "Rude, abrupt and didn't listen to them when carrying out moving and handling tasks." Further discussion with them resulted in the manager taking immediate action to safeguard them from the risk of harm. In liaison with the local safeguarding team, the manager began an internal investigation.

The registered provider had policies and procedures in place to guide staff in safeguarding of vulnerable adults from abuse (SOVA). The manager described the local authority safeguarding procedures, which consisted of phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about whether a concern required investigation. Discussion with the local council's safeguarding and commissioning teams prior to our inspection indicated they had no concerns about the service.

Checks of the safeguarding records held in the service showed that there had been a total of nine instances in the last year when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with four staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident the manager would take any allegation seriously and would investigate it. The staff told us that they had completed SOVA training in the last year; the training records we saw showed that 87% of staff were up-to-date with safeguarding training and where staff required refresher training or updates the training officer for the service had booked them onto courses in 2016.

We looked at the systems in place for medicines management. We reviewed the medication administration records (MARs) for the ground floor unit and looked at storage, handling and stock requirements. We found that appropriate arrangements for the safe handling of medicines were not always in place.

The provider information return form sent to CQC in April 2016 said that there had been 14 medicine errors made by staff in the last 12 months. During the inspection we saw that regular checks of medicine stock and

records were carried out by the staff and any discrepancies were reported to the manager and investigated. We looked at records of 'near misses' where medication errors had been noted and action was taken to prevent reoccurrence happening.

Discussion with the manager indicated that they were taking action to improve staff practices with regard to medicine management. We saw evidence that the manager had carried out face-to-face meetings with staff to discuss their poor practice and medicine errors / lessons learnt had been discussed at staff meetings. Checks of the records showed that where the same staff made repeat mistakes then support, retraining and medicine competency sessions had taken place. We saw documentation that indicated four staff had completed their competency checks and five staff were going through this process. Discussion with the manager also showed that disciplinary action would be taken if staff practice did not improve. We saw evidence that personal development improvement plans were in place where needed. The last audit in May 2016 showed that there continued to be medicine errors taking place despite the actions taken by the manager. One of the errors in May 2016 referred to poor practice by an agency nurse. The manager had reported this back to the agency appropriately.

We saw that agency nurses received an induction to the service before starting their first shift. The induction process for the trained staff included the medication system. Given that some of the medication errors picked up by the service involved poor practice by the agency staff, this indicated the induction was not sufficiently in-depth to reduce the risk of harm to people who used the service. This concern was discussed with the manager and regional manager who said they would review the induction documentation.

Medicines were stored securely and the nurse on duty held the keys. Controlled drugs (CDs) were regularly assessed and stocks recorded accurately. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature.

Medicines were administered by the nurse on duty. We asked people who used the service if they understood what they were taking their medicine for and one person told us, "I always count my tablets but I don't know what they are for." Other people said, "No," "I think I know" and "I just take them." This indicated that people were not always kept informed about their treatment.

Transdermal Application Records (body maps) were used to help ensure pain relief patches were used safely by ensuring they were applied to different areas of the body. We observed that one person had their patch applied to the same skin areas more frequently than recommended. This increased their risk of skin irritation from this medicine.

Topical medicine charts were in use for the application of external use creams and lotions. However, we found that instructions for use of these medicines were vague or not recorded on the charts and staff were not signing when they administered these. This meant we could not be certain that these were being administered appropriately and as prescribed.

We asked people who used the service if they received their medicine on time, if creams and lotions were applied regularly and how easy was it for them to ask for pain relief. People told us, "I get my medicines at a regular time, I don't need pain relief" and "I have creams on my legs and arms twice a day, but this is not done every day – can't remember if it was done yesterday". Other people said, "It varies when I get them, I don't take pain relief, and no creams," "I never need painkillers or lotions" and "Yes on time, I do ask for pain

relief and I get it" and "Creams done daily."

We noted that the stock balance of one medicine was less than what the records documented. When we checked with the staff we found that they had not counted the medicine when it was received and therefore could not be certain that the correct amount of medicine had been received from the pharmacy. This practice did not follow the registered provider's medicine policy and procedure.

This is a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found the level of cleanliness in the service was satisfactory, but the infection prevention and control practices within the service did not follow best practice. We saw no evidence of an infection prevention and control audit being carried out within the service and there was no annual statement of infections. These documents would demonstrate how effective the registered provider was at maintaining high standards of cleanliness / hygiene and managing infections within the service.

Discussion with the manager indicated that these records were not in place, although they did begin an audit following the first day of our inspection. We were given records to show that the housekeeper completed an audit of cleaning every two months and cleaning schedules were filled in by the domestic and laundry staff on a daily basis. Bedrooms and communal areas were cleaned daily and a set number were deep cleaned each week. Records were kept of the carpet cleaning taking place and all staff had access to ample supplies of aprons and gloves. Sufficient numbers of ancillary staff were on duty each day to ensure the service was kept clean and hygienic.

We recommend that the service consider current guidance on infection prevention and control and take action to update their practice accordingly.

Checks of the records held in the service showed that a dependency level tool was used by the manager to calculate the staffing levels required to meet the needs of people who used the service. We were given a copy of the tool used to calculate staffing levels in May 2016 and the manager said it would be reviewed as people's needs changed or numbers in the home went up or down. Agency staff usage in the service was reducing and in the last week before our inspection only two day shifts and one night shift had needed agency cover.

At the time of our inspection there were 47 people using the service, 10% of which were people who needed residential care and 90% required nursing care. When we asked people who used the service and relatives if there were enough staff on duty we received a mixed response. Some felt there were enough on duty but others said there were times they were short staffed. People told us, "There are never enough staff; the call button is answered usually within five minutes, but I don't use it at night" and "Some days there are no activities but I read." "Not enough staff at mealtimes" and "Most of the time; I am always looked after". "Yes, the call bell is answered in a few minutes." Relatives said, "Yes, staff are always about," "Yes, lots of activities and [Name] is getting involved" and "Yes, always somebody there." One visitor told us, "At times" and added that, "Mealtimes they seem short staffed."

We looked at the rota sheets for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rota sheet. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of nurses, care staff, ancillary workers, administrator, activity co-ordinator, catering staff and maintenance personnel. Staff told us, "We can be

short staffed if there is sickness. Weekends all okay" and "Enough staff, had more but now a few empty beds so less staff needed." "We have a few empty beds so levels okay at all times."

We looked at the recruitment files of four members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks without unnecessarily restricting people. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents that showed what action had been taken and any investigations completed by the manager.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment used in the service. These records showed us that service contract agreements were in place, which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm and the nurse call bell, moving and handling equipment including hoists and slings, the lift, portable electrical items, water systems and gas systems. There was also an electrical wiring certificate in place that showed the electrics were checked every five years. Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

The manager spoke with us about the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were kept in the nurse's office and were up to date. Fire drills were completed with the staff every month and the last one was held in April 2016.

Requires Improvement

Is the service effective?

Our findings

The majority of people reported that the service delivered effective care, but two people raised concerns about staff skills in moving and handling. Two people said, "Some staff are competent, but I am independent" and "Staff definitely have the skills for the job; I can move myself or they assist me, all okay." A third person told us "I do have confidence in the staff, apart from the one last night, they hurt me when they 'dragged' me up the bed" and a fourth person said, "Some of them are okay, I feel safe when being moved from my chair to wheelchair," but they added that one member of staff had been in a rush and had grabbed their arm causing bruising. We followed up these concerns with the manager who took appropriate action to identify the staff and initiated safeguarding procedures.

Staff used established, evidence-based strategies and techniques to support people. For example, care staff were trained in the use of the DICE (Describe, Investigate, Create, Evaluate) tool for communication in people with dementia. This is a four-part tool used as an empowerment strategy to help caregivers reduce the instances of or anxious behaviour in people with dementia. From looking at records we saw staff used this tool to support people in specific areas of need such as personal hygiene, continence, mobility, tissue viability, nutrition, breathing and pain management. Staff were also trained in the use of non-violent intervention techniques to manage and support people with aggressive or violent behaviour that challenged. Discussion with the manager indicated that no person using the service currently had this type of behaviour and that restraint techniques were not used or necessary at the time of our inspection.

Discussion with the manager indicated that since they started to manage the service in March 2016, the level of staff training had improved. We were told that the registered provider had allocated one of their in-house trainers to work 40 hours a week with staff to improve the training statistics to an average of 85% completion rate. This was due to reduce to 20 hours a week from June 2016 as the majority of staff had completed their training. We looked at the training records of four members of staff. We found staff had up to date training in infection control, moving and handling, food safety and allergies, the Mental Capacity Act (2005), safeguarding and fire safety. Drug competency training was being delivered to all the trained nurses. Staff were also trained in the 'Barchester Footsteps' programme; a targeted study programme to help staff support active ageing and reduce the risk of falls. We spoke with two members of senior care staff who were starting out on their 'Care Practitioner' training, which took place over nine months and involved six months of 'shadowing' a qualified nurse. The training included additional sessions on medicines management, tissue viability, observations of medicine rounds and working practice on taking charge of a unit.

The manager showed us the induction paperwork completed for staff in their first three months of employment. We found that the registered provider used the 'Care Certificate' induction that was introduced by Skills for Care in April 2015. Skills for Care is a nationally recognised training resource.

Information from the provider information return form indicated that the service had a new supervision and appraisal system that had been introduced to manage staff performance and quality care outcomes. We found evidence during the inspection that some appraisals and supervisions had been completed, but further work was needed to ensure all of these were brought up to date. The training plan we were given to

look at indicated that the current level of compliance with supervision was 46%. The manager and in-house trainer were aware of these statistics and were supporting senior staff to make sure these figures improved quickly.

People were able to talk to health care professionals about their care and treatment. All individual health needs, visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). We asked people who used the service what happened if they did not feel well and they told us, "It is easy to ask the staff if I need the GP or someone like the chiropodist," "I can see a Doctor when they think I should" and "I have not needed a Doctor so far." One person told us "A nurse comes to give me my insulin three times a day."

Visitors told us that everything concerning their family member's health and well-being was actioned and provided and they were involved in decisions regarding the health and welfare of their relatives. One visitor told us, "Yes, there are good communications; if I have a question the staff will find the answer." Another visitor said, "All family is involved with [Name's] care, sister mainly." Other visitors said, "Yes, if [Name] has any falls I am always informed; happy with falls assessments" and "Yes, kept informed, carer has a chat and tells me how [Name] is."

From looking at care records and speaking with staff, we found people had regular access to multidisciplinary healthcare professionals. This included regular visits from a GP, district nurse and the Speech and Language Therapy (SALT) team. Staff used the Malnutrition Universal Screening Tool (MUST) to monitor people for malnutrition. We saw this tool was used alongside choking and swallowing risk assessments to provide a comprehensive overview of each person's nutrition needs. People were able to eat their meals wherever they wanted, such as in the privacy of their bedroom.

However, not all care records were being updated by staff appropriately. For example, food and fluid charts and 'turn' charts were not always being completed when people were moved in bed or given fluids to drink. We carried out observations of three people whose care we looked at in-depth during our inspection. We found them to be adequately hydrated, given mouth care as needed and they were clean and comfortable in their beds. This indicated the issue was more one of poor recording than poor care. Following our feedback to the manager on day one of our inspection, we found a distinct improvement in the frequency of recording on day two. We have reported a breach of regulation with regard to record keeping in the well-led section of this report.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Records showed that 11 people who used the service had a DoLS in place around restricting their freedom of movement. Documentation was completed appropriately by the manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

Staff had completed training on Mental Capacity awareness during the last year and were aware of how the DoLS and MCA legislation applied to people who used the service and how they were used to keep people safe. We saw evidence in the care records that the service had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions.

People who spoke with us said they were very satisfied with the communication between themselves and the staff. They told us that staff asked for their consent before carrying out care tasks and that they consulted them about their care. Visitors told us they had involvement with capacity / best interest matters saying, "I have Power of Attorney for [Name]," "My sister is the appointee" and "My older brother has Power of Attorney". A Power of Attorney is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and / or finances) on behalf of a named person.

The manager told us that they had introduced a menu group, which was to be held the week after our inspection. This was to give people a forum to air their views and opinions about the meals and the menus within the service. The activity staff were taking the meeting lead initially and meetings would be held monthly. This was decided in response to the feedback from people's satisfaction surveys.

People who spoke with us were satisfied with the quality of the meals, although one or two said they could be better. People said, "The food is very good, always two choices and if not liked I get something else," and "I could do better with one hand tied behind my back, but good choice, most of the staff know my likes." One person told us they told their key worker they had a dream about eating pancakes and as a surprise the chef made them some and they had these with sugar and lemon. Other people commented, "Very nice, all of it, always a choice and hot, staff seem to know what I like" and "I always enjoy pasta, food is pretty good and choices."

We spoke with the Chef who said all food was prepared on site. They got a list of likes / dislikes from the nurse when a person arrived, and they showed us a file in the kitchen with every person's dietary requirements. A sheet accompanied the food each day so staff knew what to serve to whom. Diabetic foods included low sugar jellies, fresh fruit and an artificial sweetener was used in some cooking. The kitchen was open 24 hours a day, and food was always available. The chef advised us that there were two choices always at meal times, then a further menu if these were not liked, which included omelettes and jacket potatoes.

We saw people were supported to eat and drink sufficient amounts to meet their needs. We saw that cold drinks were provided in a number of people's bedrooms and people received snacks and drinks mid-morning and afternoon. Observation of the lunchtime meal showed that the food was presented very well. We saw that people were shown the meals available and asked what they would like to eat. Everyone was provided with a hot or cold drink and sauces / condiments were offered and given. People chatted to each other and staff so there was a relaxed and enjoyable atmosphere in the dining rooms. Staff moved around the service offering support to people as needed. We overheard staff asking if people wanted help with cutting up their food and people were asked if they would like more to eat and this was given where requested. The food looked appetising and most people said the food was very good and that they really enjoyed mealtimes.

Requires Improvement

Is the service caring?

Our findings

People gave us a mixed response when we asked them if staff were caring and supportive. Some were very positive in their feedback, but others were more reserved and indicated that their care was satisfactory depending on who was on duty. We asked people if they felt staff had the right approach to care giving and they responded, "Some do, one keeps fetching me bags of crisps or a book" and "The majority of them do, I feel I am only a number." Other people said, "Yes, basically all very caring" and "Yes, barring one." We asked people how well the staff communicated with them and they told us, "If they are doing anything for you we have a chat and I understand them" and "They don't chat with me." People also said, "All the time, we have a laugh" and "If they are not very busy they will offer me a cup of tea and have a chat then."

We asked staff if they had enough time to give personalised care to people and they told us, "Not really time to do one-to-one care, we try to spend as much time as possible, we talk to them," "We talk when I get them up, put to bed and at meal times" and "We develop a care plan, make it person centred, keep care plans up to date - find out their likes and dislikes." We observed two occasions during the day when staff responded immediately to people's requests for items of clothing and assistance with moving and handling. This was done willingly and respectfully.

We spent time talking to staff and the manager about the different perceptions that people had about their care. Discussion with the staff indicated that there were some problems within the staff group, saying there was a lack of teamwork at times and some poor staff attitudes. Staff told us that they thought some staff were lazy and others had conflicts of personalities making it unpleasant to work with them. However, on a more positive note staff also recognised that the manager was making many positive changes in the service and said their strong leadership was gradually changing the staff working practices for the better. The manager was able to show us how they were using supervisions, staff meetings and personal development improvement plans to change the quality of care being given and promote a continuous care system within the service.

We looked at the end of life care for one person who was using the service. This individual had been seen by their GP recently and all medicines except for pain relief had been discontinued. The registered provider's policy and procedure for end of life care was quite specific about the records of care to be used and procedures to be followed. However, we found the staff were not following the policy and procedure with regard to record keeping and we have written more about this under the well-led section of this report. Discreet observation of this person showed that they were receiving appropriate care, including mouth care, as they were no longer eating or drinking. We saw that they were clean, comfortable and settled in their bed and staff were checking on them regularly. Staff said that they had arranged for this individual to see their local clergy as asked for by their representative, but this had not been documented.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people on end of life care.

The registered provider had a policy and procedure for promoting equality and diversity within the service.

Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. Staff also supported people to maintain relationships with family, friends and other people in the community.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. Two people who used the service did not have English as their first language and we saw that families were involved in translating information to and from the service users and staff. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People were able to move freely around the service, some required assistance and others were able to mobilise independently. One person told us, "I am very independent and if I need help I ask." We saw that people and staff had a good rapport with each other. Observations of people in the lounge, dining room and around the home indicated that individuals felt safe and relaxed in the service and were able to make their own choices about what to do and where to spend their time.
Visitors had mixed feelings about how much support was given to people to maintain their independence. One visitor said, "No, I don't think staff do enough. I would prefer more encouragement for mobility." Other visitors told us, "Staff are patient with [Name], encouraging, the girls very nice" and "Yes; [Name] can eat independently."

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the manager. People told us they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for themselves or had a member of their family who acted in this capacity for them. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

We found that people who used the service were dressed in clean, smart, co-ordinating clothes. Their hair was brushed and many had been to the hairdressers, including the males. Fingernails and hands were clean and well cared for and gentlemen were clean-shaven (if that was their choice). People told us that they could have a bath whenever they wished and they were confident that staff respected their privacy and dignity at all times. People told us, "I don't have a bath / shower (by choice)" and "Yes, I am grateful for their help, they assist me with personal care and I am comfortable with this." One person said, "Most of the time it is okay, but I am not happy if staff are dealing with me and someone needs something else." They explained to us that occasionally staff would knock on their door to ask staff assisting them a question. Visitors also told us, "Yes, the staff knock on doors, they are very patient when giving personal care" and "Yes, when we are here they ask us to leave the room if [Name] needs attention."

Care files included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. This showed that people and their relatives had been involved in assessments and plans of care. Not everyone using the service remembered they had a care file as one person told us, "I have a care file but I don't go through it" and three other people said "No idea." We saw evidence in the care files that families and people using the service were involved in the monthly care reviews so had the opportunity to input to their care and support.

Requires Improvement

Is the service responsive?

Our findings

The service was not responsive around some aspects of care. We found that people's care plans did not always clearly describe their needs. We saw no evidence that indicated people were not receiving the care they required, but noted the information about people's person centred care was not well recorded. Please see the well-led section of this report for the action taken regarding records.

We looked at three care files during the inspection. We found that these contained a lot of old notes and personal information from up to six years previously, which should have been filed away by the staff. The old information made it difficult to see what people's current needs were. One file had its care plans updated in May 2016, but another should have been updated when the person went onto an end of life pathway the previous week; the information in this file was largely irrelevant to the care currently being given to the individual. This was discussed with the staff on duty and the manager on day one of the inspection. On day two we were given a basic overview of the current end of life support and care that was being provided for this person, but the paperwork did not meet the standards of end of life care documentation as described in the registered provider's 'End of Life' policy and procedures. We made a recommendation regarding this in the Caring section of this report.

We looked at two care files that contained a care plan for wound care being carried out by the qualified nursing staff. The information about the actual wounds was detailed and descriptive and staff had recorded each time the wound was redressed. We found that staff made appropriate referrals to the GP and the community tissue viability nurse when needing advice or guidance about the wounds. Discussion with the unit manager indicated that new wound care plans had been introduced and they were able to tell us about what type of dressings were being used and the action taken to prevent further damage. However, when we went to speak with one person who had pressure damage to their feet, we found staff had tightly tucked the bed clothes under the mattress meaning additional pressure was being put onto their toes and heels. The unit manager quickly loosened the bedding and assured us they would speak to the staff as their actions could have caused this person pain and further damage to their feet.

All three people whose care files we looked at required regular pressure relief delivered by the staff in the form of three to four hourly turns of their body whilst in bed. Our observations of people showed that those who remained in bed presented as clean, comfortable and cared for. Our checks of the 'turn' charts showed that these had not always been completed appropriately. We noted that for one person who was assessed by the staff as at high risk of pressure damage, their chart showed they always remained on their back. When we asked the unit manager about this, they said the person was not compliant with being moved onto their sides to relieve the pressure on their sacrum. We looked at the person's care file and found that this non-compliance with pressure care was not documented in their care plan and had not been risk assessed.

Visitors were asked what input they had to their relative's care plans and we were told, "When [Name] originally came in, but these have not been reassessed," "Care plans were discussed initially, [Name] has put weight on" and "No, I don't have any input but other family members do." We checked the care files and saw that people's needs were being reviewed and we saw evidence that people and families had been involved

in the monthly reviews of care. The information in the records indicated that the majority of people and relatives had input to discussions around care and support.

The home employed two activity co-ordinators to carry out daily sessions of social activities and events. We saw that the day's activities included Scrabble and Dominoes and the hairdresser was also in the home (they came in two days a week). In the afternoon we saw four people sat in the ground floor dining room playing dominoes with the activity co-ordinator present and chatting; they were still playing at 15.40, and the activity co-ordinator also had two other people playing a quiz game.

One of the activity co-ordinators showed us leaflets that they circulated which listed the weekly activities on offer. They said they had access to transport for two weeks a month and they took four people out twice a week. Activity sessions included group and one-to-one activities including reading and hand massage, there was a singer in once a month and a church service every month for all denominations.

We asked people if they enjoyed the activities in the home and what things they took part in. One person told us, "Board games and I won a cup last week for dominoes." Three other people said they did not take part in activities through choice. This indicated that people were able to have choice over what they did to pass the time when in the service. We saw that staff encouraged people to join in, but respected their wishes when they declined. Visitors were mainly positive about the social side of the service, for example one visitor said, "There is usually something on every day and they involve [Name]," but another person said, "Would like them to get out occasionally but never asked, and would like any dementia friendly ones for mum-in-law."

Everyone we spoke with said their family and friends were made welcome in the service. One person said, "They come and have a coffee and a biscuit" and another told us, "My daughter comes every day." We saw there was a drinks station in the entrance hall and people and visitors were able to help themselves to a hot drink and fresh baking throughout the day. Visitors told us there were no restrictions on the visiting hours and that staff were friendly, kind and welcoming."

People who used the service told us that they felt they had some choice and control over their care and that their disabilities and diverse needs were taken into account by the staff. For example, one person told us, "Yes I am in control and independent." Another person said, "I seem to be, no complaints."

People knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been dealt with. Comments included, "I would tell the manager, but I don't know who that is at present - no complaints," "I would tell any of the carers if I had a problem - no complaints - not needed to" and "I would speak with the Nurse in charge, I know they would listen." Visitors and relatives were equally confident in using the complaints system saying, "I would go to the nurse in charge of the floor, but I have had no complaints," "We have met the manager so would go again to them, or nurses, but no concerns" and "I would go to the manager, no complaints."

We saw that people had access to complaints forms in the entrance hall if needed. Checks of the complaints folder showed the manager had investigated two complaints in the last six months. Both complainants had received a written response to their concerns and the issues were now resolved.

Requires Improvement

Is the service well-led?

Our findings

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and health / social care professionals who spoke with us or gave us written feedback. Everyone said the culture of the service was open, transparent and sought ideas and suggestions on how care and practice could be improved.

Staff spoke to us about the management and leadership in the service. They said, "They are good, [The manager] is trying to better things, and it is improving" and "It is better than before, they are trying their best." One staff told us, "It would be nice if we had consistency, changes are made then someone else comes in and changes are made again - no complaints, we feel we have the skill mix organised now."

The service had been without a registered manager since March 2016. Active recruitment had taken place and the regional manager said that a new manager had been appointed and would be taking up their post in June 2016. In the meantime, a peripatetic manager had been in the service on a daily basis and we saw evidence of the hard work they had put into the service, to make improvements, during our inspection.

Record keeping within the service needed to improve. We saw evidence that care plans, risk assessments, food / fluid charts, turn charts and end of life plans were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm.

For example, one person was on an end of life approach to care and support; however, their care file had not been amended to reflect this. Staff were able to discuss their care with us and checks on the person indicated they were being cared for appropriately. Another person required full support from staff to eat and drink, but did drink well according to staff. Checks of their food and fluid intake chart showed that between 6 May 2016 and 14 May 2016 their fluid intake for the day had dropped from 1200 millilitres to 240 millilitres of fluid. Their care plan said they should be taking at least 1875 millilitres of fluid a day, but staff had not taken any action in response to the information being recorded. This indicated they were not monitoring this person's health appropriately. Discussion with staff and observation of the individual indicated they were adequately hydrated, but staff were not recording the fluids being given to the person each day.

We saw that the manager completed a month end report to the registered provider. This showed they analysed risks within the service and reported on these to the registered provider. Monthly audits were also completed and those for April 2016 showed that any issues were put onto action plans and dealt with by the manager through staff meetings, supervisions or face to face discussions. However, there remained some areas of the service that could be improved. These included infection prevention and control, medicine management, staff supervisions, record keeping, staff practice with regard to moving and handling people and end of life care. These have been discussed throughout this report. The manager was aware of most of these issues and was working towards continual improvement through increased staff training, development and where necessary staff disciplinary action. When we discussed concerns during the inspection, the manager took immediate action to rectify things and ensured staff were made aware of the

changes needed.

This is a breach of Regulation 17 (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw that the manager was promoting a more visible staff presence within the service; the manager told us this was in order to move away from the previous 'laissez-faire' culture where there was a practice of leaving things to take their own course, without interfering. Evidence was seen that the service was inclusive, open, proactive and keen to develop its staff and their potential. For example, senior care staff within the service were being promoted and received additional training to become 'Care Practitioners'. When their training had been completed, they would have the skills to manage and run the units under the supervision of the nurses. The manager was committed to improving communication in the service by the introduction of 'Stand up' meetings that were attended by the heads of departments each day and information from these was filtered back to the staff teams. These took place on one of the units at 10:30am daily.

People were aware of what was going on in the service and said they saw the manager most days. They told us about the resident meetings that they could attend if wished, although many did not bother. People told us how they kept up to date with things and said, "I find out everything on the grapevine and staff chat," "Yes, from everyone chatting" and one person said, "I know as much as I want to." Visitors told us, "Know of meetings but none done, I was asked to do a survey but didn't" and "Relatives meeting last week, don't feel the need to go, and no surveys." One visitor said they did not know of any meetings or surveys.

Discussion with the manager and checks of the records kept in the service showed that there had been one resident and relative meeting held since March 2016, although the manager said they planned for these to be held monthly. Eventually they hoped to develop an independent chair for the meetings to enable people to speak freely and take more control of some aspects of their lives. We saw that staff meetings were held once or twice a year, with more regular meetings for the different units and unit managers / heads of departments.

We asked for a variety of records and documents during our inspection. We found these were easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to maintain an accurate, complete and contemporaneous record in respect of each person using the service. Including a record of the care and treatment provided to the person using the service and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)