Care Quality Commission

Integrated Nursing Homes Limited

The Knolls Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection on 07 December 2017. During our last inspection in February 2017 we rated the service as good. During this inspection the rating changed to requires improvement. The Knolls Care Centre (The Knolls) is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Knolls accommodates up to 56 people in one adapted building across three separate units, each of which have separate adapted facilities. One unit is for people with nursing needs, the second is for people with residential needs and a third smaller unit provides rehabilitation support to people who have been discharged from hospital before they could go home. The service supported some people who live with dementia. At the time of the inspection there were 43 people living at the home.

There was a registered manager in post. 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.

Medicines were administered safely, but stock was not always returned to the pharmacy in a timely manner.

People were supported to access health and social care services when required.

The provider did not have effective recruitment processes in place and some pre-employment checks were incomplete. There were sufficient staff to support people safely. Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff gained people's consent before they provided any care or support to them.

People were supported to have choice and control of their lives. However, checks to ensure people were supported in the least restrictive way possible were not always completed.

There were risk assessments in place that gave guidance to staff on how risks to people could be minimised although these had not been completed for all necessary aspects of some people's care.

Staff supervision was not provided regularly and training to enable staff to support people well was not all up to date. The service had a plan in place to address this.

Some staff were not always kind or respectful to people although others were and we saw some positive interactions during the inspection. People were supported to pursue their interests and, particularly on the rehabilitation unit, were supported to maximise their independence.

Care plans took account of people's individual needs, preferences, and choices and were reviewed regularly.

The provider had a formal process for handling complaints and concerns. They encouraged feedback from people and acted on the comments received to continually improve the quality of the service.

The provider did not have a clearly communicated set of values to underpin the service that were known or understood by staff. The registered manager was prioritising the development of a more person centred culture within the service.

Although the provider had quality monitoring processes in place to ensure they were meeting the required standards of care they were not always effective.

Notifications were not always sent to the Care Quality Commission as required by law.

At this inspection we found that the provider was in breach of some of the regulations 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?

Requires Improvement

The service was not always safe

There were systems and processes in place to safeguard people from harm, although staff had not always responded appropriately when people felt unsafe.

Risk assessments had not always been completed when it would have been appropriate to do so.

The provider's system for safe recruitment was not robust and some checks were not completed. There was sufficient numbers of staff to support people to stay safe and meet their needs.

The provider had policies and systems in place to protect people from the risk of infection. However, some staff did not always follow good practice in relation to infection control.

Medicines were managed safely, although not required stock was not always returned to the pharmacy in a timely manner.

When errors were made by the provider or staff, these were acted on, lessons learned and improvements were made.

Is the service effective?

Requires Improvement

The service was not always effective

Training relevant to the needs of people living at the service had not been completed by all staff to ensure people received effective care from knowledgeable staff.

People were supported to eat and drink a nutritionally balanced diet. However, food was not offered frequently enough to ensure that people were not hungry.

People's needs were not always met by the adaptation, design and decoration of the premises.

People were supported to live healthier lives and had access to health care services and on-going healthcare support.

Consent to care and treatment was sought in line with legislation and guidance.

Is the service caring? The service was not always caring People were not always treated with kindness, respect and compassion. People's privacy and dignity were not always respected. The service supported people to express their views and be involved in making decisions about their care, support and treatment as far as possible. People were supported to maximise their independence.	**Requires Improvement**
Is the service responsive? The service was not always responsive People did not always receive personalised care that was responsive to their needs. A wide range of activities were provided which had been developed in response to people's interests. People's concerns and complaints were listened and responded to, and used to improve the quality of care. Information in care plans in relation to people's end of life needs and wishes did not sufficiently address their personal, cultural or spiritual needs, and did not consider how the service would support family members.	**Requires Improvement**
Is the service well-led? The service was not always well led The provider did not have a clearly communicated vision and credible strategy to deliver high quality care and support. They did not promote a positive culture that was person-centred, open, inclusive and empowering, and achieved good outcomes for people using the service. The provider and the registered manager did not demonstrate a good understanding of regulatory requirements in relation to displaying ratings and submitting notifications to the Care Quality Commission.	**Requires Improvement**

Systems to monitor the quality of the service were not used effectively to ensure that people received a consistently good service.

The people who used the service, the public and staff were engaged and involved in the service.

The service worked in partnership with other agencies.

Care Quality Commission

The Knolls Care Centre

Detailed findings

Background to this inspection

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

The inspection was prompted by an increase in concerning information being received by the Commission. A number of concerns were raised with us and the local authority since the last inspection in February 2017. This included concerns relating to management of specific health conditions, provision of sufficient nutrition and hydration, and the quality of care.

This inspection took place on 07 December 2017 and was unannounced. The inspection team was made up of two inspectors, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection was an expert in the area of care for older people and for people who lived with dementia.

Before the inspection we reviewed the information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send to us. We also reviewed information that had been sent to us from the local authority and members of the public.

During the inspection, we spoke with nine people who used the service, three relatives and friends, the registered manager, two senior managers, the chief executive officer, two nurses, a senior care staff, two care staff, an activities coordinator and one member of the domestic staff team. We also spoke with two visiting professionals.

We looked at the care records for six people who used the service, the recruitment records for two staff employed since the last inspection and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they managed, assessed and

monitored the quality of the service.

After the inspection we spoke with the local authority contracts monitoring team to seek their views about the service.

Requires Improvement

Is the service safe?

Our findings

We observed that some people had stairgates placed across their bedroom doors which had not been identified or assessed as a potential risk to their safety. People's personal evacuation plans (PEEP) had not all been updated to show where a person may need support to leave the building because a stairgate was in place. This could have put the person at risk in the event of an emergency.

The registered manager told us these stairgates had been put in place to restrict access by some people living with dementia who attempted to enter bedrooms without the occupant's permission. There was no evidence that other less restrictive options had been considered before taking this action, which not only restricted the movements of the uninvited visitors, but also those of the person whose room was gated. There was no evidence that a positive and unrestrictive approach to managing such behaviour had been developed. Staff told us that one person who did this was entering bedrooms in the belief that they were tidying up, yet no attempt was made to engage the person in alternative activities that satisfied their need to tidy up and organise.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people about whether or not they felt The Knolls was a safe place to live. One person said, "The home seems alright" and a relative said, "There's nothing unsafe about here." However, a second person said they did not feel safe and described an occasion when another person who lived at the home had entered their bedroom at night. They said, "I woke up one night and [person] was standing over me. I was terrified. I saw [person] this morning. I haven't got over it. I told staff but nobody came back to me. No-one spoke to me about it." They also said, "A lot of noise goes on at night here. It's terrifying to me." This person had not received an appropriate response from staff to support them to feel safe or to protect them from harm in future. We discussed this with the registered manager who told us they would address this situation immediately.

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when needed. Staff had received training in safeguarding people and when asked, demonstrated good understanding of different types of abuse, and the signs they should look for which may indicate that someone could be at risk of possible harm. Staff, including non-care staff such as house keepers, were able to tell us about external organisations they could report concerns to.

There were other risk assessments in place for each person to give guidance to staff on any specific areas where people were more at risk such as falls, nutrition, pressure areas, and mobility including for people supported to move by staff. Where bed rails were in use, there were risk assessments in place to support this. The assessments maintained a balance between minimising risks to people and promoting their independence and choice. They had been reviewed and updated regularly or when people's needs had

changed so that people received the care they required.

The provider had a pre- employment checklist to follow when recruiting staff, but this did not include every check required by law. We checked a sample of staff recruitment records and although most checks to ensure only suitable staff were employed had been completed, some information was missing. For example, the records for one recently employed member of staff contained no application form or details of their work history or education and training. This meant it was not clear whether the person had previously worked with vulnerable adults or children, and there was no record of why they left their previous role. The provider could not, therefore, be sure that staff employed were always suitable.

On the day of the inspection there were enough staff on duty. People we spoke with felt that there were usually enough staff on duty to meet their needs safely. A relative said, "You could always have more, but there are enough staff." However, some people told us that call bell response times were sometimes too long. One person said, Sometimes I wait an awful long time; half an hour (in the daytime)." A second person said, "At night (buzzer answers) are a bit slow. An emergency would be hard luck." On the day of the inspection, call bells were answered quickly and people did not have to wait long for assistance. Call bell logs we reviewed showed this was typical, although we were not able to review the most recent logs because the system was not working correctly. Following the inspection the registered manager confirmed that the system had been repaired.

We looked at staff schedules and noted that each shift was adequately covered and that, where there were shortfalls, agency or bank staff were allocated in a timely way to ensure safe numbers of staff were maintained. The registered manager told us that they had been working hard to recruit permanent staff to the current vacancies, and that they were taking steps to ensure that staff with the right skills and values were appointed. In the meantime, the manager told us they tried to use the same agency and bank staff so that people were supported by staff who were familiar with their needs.

There was an up to date policy regarding the management of medicines which was attached to the medicine trolleys to enable staff to check if required. There were systems in place for ordering, recording, storing, auditing, and returning unrequired medicines to the pharmacy. However, we found some medicines stored in the refrigerator in the residential unit that had been prescribed for a person from the rehabilitation unit who no longer lived at the service. These should have been returned to the dispensing pharmacist but had been overlooked. We also found an inhaler with no name label on it, so it would not be possible to identify who it was prescribed for. This was not good practice and could have led to the medicine being administered to the wrong person.

Medicines were administered by nurses and care staff who had been trained in the administration of medicines. We reviewed a sample of Medicine Administration Records (MAR) and saw that these were completed correctly, with no unexplained gaps. People told us they were satisfied with the way their medicines were managed. One person said, "The nurses keep very strict control over medicines. I've never known them to run out." Staff we spoke with had a good understanding of the medicine administration system. A visiting medical professional told us they had no concerns about how medicines were managed at the service, and they had observed that the staff were efficient and communicated well in relation to people's medical needs.

There was guidance on how nurses and care staff should manage 'as and when required' (PRN) medicines and where people received covert medicines, the correct processes were in place to ensure this was done in the person's best interests and with the consent of the appropriate people.

Although staff we spoke with demonstrated some understanding of infection prevention and control measures, not all staff had up to date training in this area. During the course of the inspection we observed several occasions where staff practice did not uphold good infection control practice. For example, at lunch time staff did not wear gloves and we saw one member of staff tapping a spoon against their hand and then using it to assist a person to eat their meal. This member of staff had just been on a break, removed their coat and immediately went to support someone without washing their hands or putting on gloves. We also noted that food placed in the dining room in advance of lunchtime remained there uncovered until it was time to eat. People who chose to eat in their rooms were taken food on uncovered plates without the use of a tray. This meant that staff had no option but to hold the edge of the surface of the plate.

The service was sufficiently cleaned. Although initially unsure when asked about cleaning schedules, the housekeeping staff we spoke with told us that there was a cleaning checklist for every bathroom and bedroom. This was confirmed by our observations. Communal areas, such as the stairwells were cleaned at least weekly and more frequently if needed.

We saw that the provider had systems in place to support learning from when incidents took place and to use what they learned to make improvements to the service. For example, we saw that where one person was experiencing an increase in falls, the monitoring system was able to identify this increase and the pattern to it, and the manager was then able to make a referral to the falls clinic. This resulted in the person receiving more specialised support to reduce the likelihood of injury from falls in the future.

Requires Improvement

Is the service effective?

Our findings

Detailed information had been sought from people during their initial assessment regarding their food preferences and dislikes, as well as any allergies, specific dietary requirement related to health conditions, cultural or religious beliefs and whether assistance was needed with eating. Care plans took account of this information. People's weight was monitored regularly and where there were concerns about their food or fluid intake, these were monitored .Referrals were made to the GP, speech and language therapists and dietitians where needed.

The feedback we received from people about the food was varied. One person said, "The food is alright." A second person said, "It is good." However a third person said, "The food is awful sometimes, other times not so bad; it depends on taste. It's not cooked well enough quite often. There's plenty of it. It's not always hot because it comes from downstairs." Three people commented that they would like to see more variety in the meals provided, particularly at tea time. One person said, "There are too many sandwiches; bread, bread, bread." We observed that there was a choice of hot meal provided at lunchtime. Food was served warm, appeared to be of a sufficient quality and quantity, and most people seemed to enjoy their meal.

During the morning, one person told us they were hungry, but when asked whether staff would bring them something to eat, they said, "I doubt it." Throughout our visit we observed several people expressing that they were hungry to staff. One person was told by a member of staff, "No you can't have a biscuit now, not until tea time." Another person was repeatedly asking for a slice of cheesecake that had been brought to the unit in preparation for lunchtime. Again, they were told by staff they could not have it and were not offered anything as an alternative. Staff told us that people were offered a biscuit with morning and afternoon tea, but nothing more substantial than this was routinely made available between meals.

During the course of our inspection, some snack baskets containing chocolate and crisps were provided to people, which were eagerly responded to. These had not been on display when we arrived at the service. We spoke with the kitchen manager who was unable to reassure us that people had access to snacks if they wanted them in between meals. The last meal was served at approximately 5pm and when asked if people were offered anything to eat after this, the kitchen manager said that night staff would, "Probably get people something if they asked for it." Some people told us they only ate a slice of toast for breakfast. This meant that during the 19 hour period from 5pm until lunchtime the next day at 12, they only had one slice of toast to eat. We concluded from this that, although people were being offered enough food to prevent them from losing weight and getting unwell, offers of food were not spread out adequately throughout the day to prevent people from feeling hungry.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

The provision of training relevant to the needs of people living at the service had not been completed by all staff and required improvement to ensure people received effective care from knowledgeable staff. For example, training in the management of diabetes, the management of behaviour that challenges and care

planning had not been completed by any staff. There were significant gaps in training in other areas including end of life care, infection prevention and control, and nutrition needs. The training matrix we reviewed showed that training in relation to safeguarding people from abuse, health and safety, moving and handling, and fire awareness was up to date for most staff.

The provider had a policy in relation to the provision of formal supervision within the service. We saw from records, and staff told us, that supervision was not frequent and did not meet with the expectations of the provider.

This is a breach of Regulation18 of the Health and Social Care Act 2008 (regulated Activities0 Regulations.

The provider was aware that the provision of training at the service required improvement, and they had recently delegated responsibility for the coordination of all training to a team leader at the home. They spoke enthusiastically about this new responsibility, and demonstrated a commitment to making improvements to how training was organised to ensure staff were able to attend and complete courses as they became due.

The provider had an induction process for newly appointed staff and staff we spoke with confirmed this had been useful in supporting them to familiarise themselves with their role and the needs of the people using the service.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. We found that where it was assessed as appropriate, DOLS applications had been made to the supervisory body in line with legislative requirements. We saw from records that, where a person was believed to lack capacity to make a specific decision, capacity assessments were completed and best interests decisions were made by the relevant professionals and family members. However, we noted that this process had not always happened when it would have been appropriate to do so. For example, one person who staff confirmed would most likely lack the capacity to make this decision, had a stair gate placed across their bedroom door. No capacity assessment had been completed in relation to this and no best interest decision had been recorded to demonstrate that this action was the least restrictive way of meeting the person's needs. The provider's representative assured us that this would be addressed with immediate effect

People's needs and preferences were assessed prior to them coming to live at the service. The assessments identified people's needs in relation to issues such as eating and drinking, mobility, skincare, personal care, specific health conditions and communication. From this process, a comprehensive care plan was developed to identify each individual need and how staff were to offer support to the person in line with their preferences. Care plans we looked at were detailed and gave clear guidance to staff on how to meet people's needs. We saw that care plans were regularly reviewed and updated when people's needs

changed. Staff told us that they kept up to date with changes in people's needs through reading the care plans and through daily hand over meetings when coming on shift.

The home is not a purpose-built premises and the layout presents some challenges with regard to meeting the needs of people, particularly for those with mobility needs. We could see that the provider had made attempts to address this as far as possible, ensuring access to all levels by the installation of a lift and by ensuring that communal spaces were laid out to take account of people's needs for access. The décor was tired and paintwork chipped in some areas. This resulted in the environment feeling less welcoming and comfortable than it might, had it been maintained to a higher standard. The needs of people who lived with dementia had not been sufficiently considered in the design of the service, and measures to support them to find their way around the service had not been taken. We did note a high number of signs and notices posted throughout the building indicating 'staff only' areas, instructing staff to remember particular care tasks or to lock cupboards or doors. This resulted in the service having the appearance of an institution rather than that of people's long term home.

People were supported to maintain good health. We saw from records that people had support to access health care from community health professionals such as opticians, GPs, chiropodists and district nurses. On the day of the inspection we observed that people were visited by a GP and a district nurse. One visiting professional told us they were impressed with the care people received from the service in relation to their health needs. They confirmed that staff, particularly the nurses, were engaged with other healthcare professionals and communicated well about people's health related needs.

People were consulted and kept informed about their medical conditions. For example we heard a member of staff discussing with one person the treatment they were receiving from the district nursing team. It was clear that the person understood what was going on and the conversation indicated that the treatment provided was effective.

Requires Improvement

Is the service caring?

Our findings

There were mixed responses from people about whether or not staff treated them with kindness, respect and compassion. One person said, "There are all sorts of niggly things. I felt they were crabby to me, especially at first." They went on to say, "One [member of staff] came in when I pressed the buzzer and said sharply, "What do you want now?" I felt awful. I was not feeling well, feeling low and had a cough. I needed a drink." Another person said, "They put you in a box. 'She's possible dementia' and then don't believe (what you are saying)." Some staff are nice, but some are surly. They treat you like dirt – only a couple. Some have grim, straight faces but others are so jolly." A visitor to the service told us, "I asked a member of staff to take [person] to the toilet. I was told [person] uses pads so she can wet herself." This did not demonstrate respect or compassion for people. However, a third person said," [Staff name] is lovely." A relative told us they had confidence in the kindness of staff and said, "Staff are never unkind or rude."

Responses were also mixed about whether or not staff respected people's privacy and promoted their dignity. One person told us, "[Member of staff] catches me in the bathroom or on the toilet every time. They do knock [on the bedroom door] but then they come in and sit on the bed and wait. The bathroom door is open [person's choice], but they can only see my head maybe." Another person said, "Sometimes they knock [on the bedroom door]." However a third person said, "They knock on my door. They shut the door and the curtains [when assisting with care]." We observed several occasions on which staff entered people's private bedrooms without knocking or waiting to be invited in. This did not show respect for people's privacy.

Confidential information related to people's individual care needs was stored in a way that did not protect people's privacy. We saw a number of notices displayed around the open plan nursing stations that contained private and personal information about people. In addition there was information of a similar nature on walls and doors along communal corridors. We saw that some care records were left unattended in a communal lounge, where it was possible for anyone to view them. This did not show respect for people or uphold their privacy.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We observed some good interactions between people and staff and it was clear that there were positive relationships, as well as those reported that were not good. One person told a member of staff never to leave. It was clear the person and staff member had a good rapport and we heard them exchanging friendly banter. The person told us, "If you treat them (the staff) well, they treat you with respect." They later referred to another staff member as 'scatty', but it was clear this was said in fun. A staff member from the nursing unit came to say hello to people and explained they sometimes worked on the residential unit. These were friendly exchanges. Staff were heard providing care and support in a respectful way, explaining what they were doing in advance. However, we did observe that other staff missed opportunities to engage with people. For example, by sitting in the lounge in silence rather than talking to people, or not recognising when a person was trying to attract their attention for some assistance. One person was seen telling a

member of staff that they needed assistance to go to the toilet. The member of staff did not acknowledge this request and walked away from the person without speaking. Fortunately another member of staff responded to the person shortly after this and they were assisted promptly.

We saw people were given enough time to make choices and decisions. For example, one member of staff asked a person if they liked sugar in their tea, and if so, how much would they like. The staff member needed to repeat this several times, but they did so patiently and the person's preferences were met. People were supported to maximise their independence, particularly in the rehabilitation unit, where staff supported people to regain independence following a hospital admission, in preparation for returning to their home.

People were supported to maintain contact with friends and relatives. We saw one person being given a phone handset in anticipation of their relative ringing. Staff explained they rang daily, and the person was clearly anxious to know this was going to happen on this occasion too. Other people were seen receiving visitors.

Requires Improvement

Is the service responsive?

Our findings

We saw evidence that where possible, people and their relatives were involved in the process of developing personalised care plans. Where people could not contribute; the reason for this was recorded. The care plans provided personalised detail about people's assessed needs including their life story, likes and dislikes, and any potential risks, such as falls, wounds, and weight loss or gain.

Daily records and various monitoring charts, such as for food and fluid intake or repositioning were in place to record the care provided by staff on a daily basis when it had been assessed as necessary. There was some duplication regarding the charts, because the night staff completed their own charts. This meant that the 24 hour charts used by day time staff appeared as if they had recording gaps. However, when placed side by side, it was evident that care was provided on a regular basis and other records indicated that people were receiving the right care because their weight was stable and their skin was intact.

We observed that attempts had been made to make some information accessible to people throughout the service. For example we saw a board displayed in reception which showed the date, season, and weather. We also saw a laminated pictorial breakfast menu, although menus for other meals were written on a chalk board in the dining area, which could have been difficult for some people to read. People we spoke with were unable to tell us what they expected to eat for lunch. A representative for the provider confirmed that pictorial menus had been produced for all meals. However, these were clearly not being used, as when asked, staff were only able to produce the one for breakfast.

Some care plans we reviewed referred to picture cards being used to aid communication and we saw that these were being used in the afternoon by one person. However, there was little other evidence of how the service provided different ways to communicate with people when their protected characteristics (age, disability, gender, race, religion, etc.) under the Equality Act made this necessary to reduce or remove barriers.

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We saw some attempts had been made to recognise people's spiritual and cultural needs, although this was largely in relation to the needs of the majority of the people using the service. Therefore, we saw that the home had been decorated for Christmas and various activities related to the season were planned. One person we spoke with commented on how much they liked the Christmas tree in the dining room. However, we found that the spiritual and cultural needs of people who had differing beliefs had not been so well recognised and that one person in particular remained quite isolated and had their dietary needs met by family members rather than the service. Staff told us that this was due to the preference of the person and their family, but there was little evidence to demonstrate continued efforts had been made to provide a service that was acceptable to the person and sensitive to their needs.

We spoke with an activities coordinator who was enthusiastic about their role. They showed us a lot of photographs of people enjoying themselves in a variety of different activities including seeing visiting entertainers, pet therapy, high tea, gardening, flower arranging, baking and a trip out to a MK Dons football game. The activities coordinator also talked about quizzes, exercise classes and cheese and wine tasting

sessions. They said they had weekly planning meetings to decide what activities to arrange and these were provided across five days a week, and over 30 hours for the whole service. In addition to this, they provided one to one time with people who were unable to join in with group activities. During the one to one time they would offer activities such as reading or flower arranging.

A weekly activity planner was on display, as well as a list of other activities that were planned in the coming month. For example, we saw that a carol service was planned for the Sunday after the inspection. On the day of the inspection, children from a local school came to sing Christmas songs during the morning, and people were seen enjoying this. Staff made attempts to engage other people with the activity. One person later told us how much they had enjoyed this.

One person was seen having their hair dried by the visiting hair dresser. Although they did not communicate much in words, they were visibly relaxed and appeared comfortable with the experience. Another person was seen to light up when they saw the hairdresser and walked towards her saying, "You're my hairdresser." It was clear they recognised her and the hairdresser confirmed she visited the home twice a week and had done so for a long time. This was obviously something that added value to people's lives.

The provider's assessment and care planning systems contained information about people's needs and wishes for the end of their life. Some care plans we looked at contained only basic information about this, such as their wishes regarding resuscitation, any identified funeral arrangements, family members to be contacted if the person's condition deteriorated significantly, and where they wished to be cared for. However, the information was minimal and did not sufficiently explore other significant factors. These included the bearing the person's spiritual and cultural beliefs had on their needs and wishes at the end of their life, the support the person wanted from family and friends and how family members were to be supported.

The provider had an up to date complaints policy and procedure and people we spoke with knew how to make a complaint should they find it necessary. One person said, "I would tell them if I was upset about anything." There was a record kept of each complaint received and we saw that each one had been investigated and responded to in line with the provider's policy. This record enabled the manager to monitor complaints and identify actions that were required to make improvements to the service.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, who informed us that they were supported by a clinical lead who was also the deputy manager. However, the deputy manager worked mostly on shift leading the nursing unit, and had only minimal off shift management hours. The manager had regular contact with the senior manager with responsibility for the provider oversight of the service. Following the inspection, however, the provider told us that this member of staff was not, in fact, the deputy manager. They informed us that the member of staff was clinical lead for the nursing unit, and along with leaders of the other two units, had 30 hours of time off rota for management duties.

There were mixed views about whether or not the manager had a visible presence in the home. Most people said they knew who the manager was, but said he was not regularly accessible, spending much of the day in the office. One person said, "I have nothing to do with him." A second person said, "He's always in the office" This view was shared by staff who also said that the manager was not visible enough in the home. However, most staff we spoke with felt they could speak with the manager if they needed to. One member of staff said, "He is so approachable."

The culture within the service was not sufficiently person centred. Environmental issues, such as the signage and locks at the top of doors on the outside of 'staff only' toilets, and an over reliance on notices instructing staff throughout the service, were signs of institutionalised practice, as was the lack of awareness of keeping personal information secure. The perception that people were not to be offered food outside of mealtimes added to the institutionalised culture of the home.

The registered manager was aware of the culture within the service and told us that his primary focus was to develop a more person centred and empowering service. He acknowledged this had been challenging and that there was more work to be done to develop a team with shared and understood values. He said that the key to this had been recruitment and performance management, which were the areas of his work that he had committed the most time to in the first few months of taking up his role. However, opportunities had been missed by both the registered manager and the provider to make easily achieved changes, such as those to the environment or to provision of food to promote more person centred values within the service.

Staff we spoke with felt the provider did not have a clear vision of what kind of a service they wanted to provide. One member of staff said, "I don't think they have a clear values statement or direction to be honest." Another member of staff said that the registered manager was trying to develop the culture of the service, but was not, "given sufficient power from the provider to change things." We concluded from this that the communication from the provider in relation to the organisation's values and the preferred culture of the service required improvement.

There was evidence that the management knowledge of the regulatory requirements needed improvement. For example, when a deprivation of liberty application has been authorised, the provider is required to submit a statutory notification to the Care Quality Commission. We identified three authorisations for which no notification had been received by CQC.

It is a requirement that the rating awarded at the most recent inspection is displayed on the provider's premises. The rating for the last inspection, carried out in February 2017 was not on display at the service. When asked, the registered manager appeared unaware of this requirement. However, this was addressed immediately and the ratings poster was in place before the end of the inspection visit.

There were audit systems in place to monitor the quality of the service. This included audits for medicines, care planning, and infection control. We also saw evidence of regular provider visits to maintain oversight of the service. Although these systems were in place, they had not been used effectively because they had not identified issues found at this inspection. Other systems were available to provide information useful to the management oversight of the service. For example the electronically produced call bell logs. These can be useful in determining staff responsiveness and deployment, and for assessing whether or not staffing levels are adequate to meet people's current needs. We asked to review call bell logs pertaining to the last month but were unable to do this because the system had not been working since early November. This had not been identified by internal or provider audits.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with told us they felt able to contribute to the development of the service through team meetings. We saw from records that meetings for care staff, nurses and team leaders took place regularly and minutes recorded actions that were to be taken and by whom. Processes were in place to cascade information from these meetings to all levels of staff.

People and their relatives were encouraged to share their views about the service and to be involved in making decisions about improvements. We saw that Residents meetings were held to discuss recent events and activities and that people were regularly asked to provide feedback about various aspects of the service. Surveys had been carried out with people, relatives and staff and a report had been developed to show the results and to identify action to be taken as a result.

The service worked closely with other agencies such as discharge planning teams and local hospitals, and GP's and the local authority to ensure as far as possible that care was effective and responsive in meeting the needs and expectations of people. Partner agencies we spoke with were positive about the service and how they worked with people and assisted them to adjust into either living permanently within the home or supporting them to regain their confidence to return back to their own homes.

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 9 HSCA RA Regulations 2014 Person-centred care People's individual wishes and preferences were not met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with respect and their privacy and dignity were not protected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always completed when it would have been appropriate to do so

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Provider and Management oversight was not effective. The provider did not promote a person centred culture within the service and did not have clearly communicated direction or values which underpinned the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff training and supervision was not up to

date