# Barchester Healthcare Homes Limited

# Westgate House

## Inspection report

178 Romford Road
Forest Gate
London
E7 9HY

Tel: 02085342281
Website: www.barchester.com

Date of inspection visit:
04 April 2018
05 April 2018

Date of publication:
15 May 2018

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

This inspection took place on 4 and 5 April 2018 and was unannounced. The service was last inspected in April 2017. At the last inspection we made 11 recommendations for the service. These were regarding the administration of covert medicines, the administration of topical medicines, supporting people who present with behaviour which may cause harm to themselves or others, recruitment practice, supervision of staff, engaging staff in organisational change, understanding and application of the MCA, menu planning, end of life care, supporting people who identify as lesbian, gay, bisexual and transgender, and activities. We found the service had made improvements across the service however we found recruitment procedures were still not robust.

Westgate House is a 'care home'. 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.

Westgate house provides nursing home care to up to 80 people. At the time of our inspection 79 people were living in the home. The home is divided across three floors. One floor provides specialist dementia nursing care, another provides general nursing care and a third provides nursing care to people with complex nursing needs including tracheostomy care.

There was a registered manager at this service. 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.

Recruitment and selection procedures were not always carried out in line with the provider's policy and procedure and may have placed people using the service at risk of harm by unsafe recruitment and selection practices.

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

Staff told us they received regular supervision and appraisals. However supervision and appraisal records did not always contain sufficient detail to demonstrate what had been discussed. We have made a recommendation about supervision.

The experiences of people who lived at the home were positive. People told us they felt safe living at the home, staff were kind and compassionate and the care they received was good. Staff had a good understanding of their responsibility with regard to safeguarding adults.

People's needs were assessed and their preferences identified as much as possible across all aspects of their

care. Risks were identified and plans in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. Medicines were stored and administered safely.

Staff undertook training and received one to one supervision to help support them to provide effective care. The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests.

People told us they liked the food provided and we saw people were able to choose what they ate and drank.

People's needs were assessed and met in a personalised manner. Care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered manager was approachable and accessible. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and resident meetings.

## 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. Recruitment and selection procedures were not always safe.

Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

Medicines were stored and administered safely.

The home was clean and met infection control requirements.

### Is the service effective?

**Good**

The service was effective. Staff undertook regular training. Staff received regular supervision and appraisals however records did not always contain sufficient detail to demonstrate what had been discussed.

The provider met the requirements of the Mental Capacity Act (2005) and DoLS to help ensure people's rights were protected.

People were supported to eat and drink sufficient amounts and eat nutritious meals that met their individual dietary needs.

People's health and support needs were assessed and appropriately reflected in care records. People were supported to maintain good health and to access health care services and professionals when they needed them.

People's cultural and religious needs were respected. Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

### Is the service caring?

**Good**

The service was caring. People and their relatives told us that they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff

listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

## Is the service responsive?

**Good**

The service was responsive. People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities.

People knew how to make a complaint if they were unhappy about the home and felt confident their concerns would be dealt with appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led. There were processes in place to monitor quality to drive improvements within the service. However, improvements were required to for some of these processes to ensure they were effective in identifying and responding efficiently to address any shortfalls.

People and their relatives told us that the service was well run and they received good care.

The service had a registered manager in place and a clear management structure. Staff told us they found the registered manager to be approachable and there was an open and inclusive atmosphere at the service.

# Westgate House

**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.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placements at the home, the local borough safeguarding team, the clinical commissioning group, and the pharmacist and opticians that provides services to the home. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 4 and 5 April 2018 and was unannounced. The inspection team consisted of three inspectors, two pharmacist inspectors and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 12 people who lived at the home and nine relatives during the inspection. We spoke with the senior regional director, the registered manager, the deputy manager, the head of housekeeping, one head of the unit, five nurses, four care workers, the chef, two administrators and the activities co-ordinator. We also spoke with two people from the clinical commissioning group who visited the home. We looked at 14 care files, staff duty rosters, a range of audits, minutes for various meetings, medicines records, accidents and incidents, training information, safeguarding information, a health and safety folder, and policies and procedures for the service. We also

looked at staff files which included seven recruitment records, three induction records and 14 supervision and appraisal records.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection in April 2017 we made a recommendation as recruitment procedures were not robust. At this inspection we found improvements had not been made.

Staff records showed insufficient information to demonstrate safe robust recruitment practices had been undertaken. For example, application forms did not show key information such as reasons for leaving previous employment and a full employment history had not always been sought. In addition there was no evidence to demonstrate that discrepancies in employment history had been identified, explored and verified before employment commenced. Not all references seen on file were from an appropriate person and some had been requested from previous employers who had not been recorded and identified on the application form. We saw one applicant had been interviewed by a senior management person who had also written a formal reference for that person. This meant the provider could not be assured that employees were of good character and had the qualifications, skills and experience to support people living at the service.

The above issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt the service was safe. One person told us, "I always feel safe." Another person said, "The nurses and carers are near me which makes me feel safe." A health and social care professional told us, "In terms of care delivery, service is safe. This is evident from the skills set required to manage the patients on the second floor, who are complex in the nature of their needs and require competent staff to always be proactive in managing their needs."

The service had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Staff and the registered manager were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise any concerns and would be provided with support from the senior management team and the registered manager. One staff member told us, "I would report straight away to my leading nurse or [registered manager]. You can whistle blow." Another staff member said, "I would inform the manager and take it from there. If nothing done I would go the local authority. I could whistle blow."

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as communication, toileting, moving and handling, falls, choking, medicines, diabetes, nutrition and hydration, and personal hygiene. Each assessment detailed the risk to people and the action needed to mitigate those risks. For example, assessments for people at risk of pressure sores detailed the level of support required and the equipment to be used to ensure risks were minimised. This included recording of turning people and pressure relieving mattresses. One relative told us, "[Relative] got bed sores in hospital. Within three months [since returning to the home] have nearly cleared up. They [staff] kept to a strict regime turning [relative]. We are stunned by the progress." Another relative

said, "[Staff] document everything like when [relative] was turned." Another example included assessments for people who were at risk of choking which showed the service had referred to speech and language therapists for guidance and support. Staff we spoke with demonstrated that they were aware of risks to people and that the guidance had been followed.

Staff demonstrated they supported people with risks while helping them with their personal choices.. For example, one person was at risk of choking. The person had been assessed as needed to be PEG (percutaneous endoscopic gastrostomy) fed. PEG feeding is given when oral intake is a risk to the person. The person refused to be PEG fed and wanted to eat orally. The service sought guidance from a dietician and speech and language therapist and a soft diet plan was put into place. This soft diet plan was monitored by staff and over time the person had increased their weight and had no incidents of choking. Records confirmed this.

Risk assessments were reviewed at least once a month or sooner if people's needs changed. Records confirmed this. Records showed people and their relatives had consented to and participated in these risk assessments wherever possible.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes, actions taken, and lessons learnt were recorded. For example, the home produced a trend analysis report looking at falls and injuries which included time and location of the incident. The analysis report had highlighted a need for additional staff. The service responded by increasing the number of staff and over time incidents had decreased.

The home had in place systems and arrangements for managing medicines which minimised risks. Policies and procedures were in place governing the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Controlled drugs were stored in a controlled drugs cupboard and the keys held securely. Clear records were maintained in the controlled drugs register. Routine checks of stock balances of controlled drugs were undertaken weekly in accordance with the service's policy to ensure the amounts held reflected what was recorded in the register.

All people who used the service had an 'Individual Medication Profile' containing details such as allergies, GP and pharmacy contacts and details of people's preferences in relation to medicines. Additional information was available in peoples care plans to support nurses with the administration of high risk medicines. For example in the case of warfarin a risk assessment was completed and records of INR level, dose and next appointment were maintained. A warfarin flow chart was available to advise staff on action to take in case of side effects of warfarin. Warfarin is a medicine that stops blood clotting.

During the inspection we checked medicines storage, medicines administration record (MAR) charts, and medicine supplies. All prescribed medicines were available at the service and were stored securely in locked medicine cupboards within locked treatment rooms. This assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people using the service. A number of people were receiving their medicines covertly. We saw that this was being done appropriately with the correct documentation in place to support this process.

Current fridge temperatures were taken each day (including minimum and maximum temperatures). During the inspection we saw that the fridge temperature was found to be in the appropriate range. Records confirmed this. This meant that medicines requiring refrigeration were stored at appropriate temperatures.

Staff received competency based training in relation to medicines and competency was re-checked annually. Systems were in place for receiving and acting on medicines related alerts. Staff were able to explain how medicines related errors were managed in the service.

During our previous inspection in April 2017 we found issues with the use of topical creams. During this inspection were saw that there were still issues with the administration of these medicines. Prescribed topical creams were applied by care workers as a delegated action. A delegated action is a process whereby a task is allocated to a competent person but a registered practitioner (in this case nursing staff) retains overall responsibility for the task. We saw that the topical cream administration records used by care workers were not being completed and this was not being identified by the registered nurses who retained overall responsibility for this task. Additionally we saw that although body maps were available in people's folders these were not completed, meaning care workers had no guidance on where to apply the topical creams. This meant it was not clear that people were receiving their topical medicines as prescribed. The registered manager told us after the inspection that care workers had started to record the administration of topical creams and body maps for guidance was now in place.

There were sufficient staff on duty to provide care and support to people to meet their needs. The registered manager told us staffing levels were based on people's needs and recently they had been increased. Staff we spoke with confirmed this. Call bells were answered promptly and care staff were not hurried in their duties. One staff member said about staffing levels, "I think it is very good. Staff are very attentive. There is enough staff." Another staff member told us, "We have enough staff here." A senior staff member said, "I can't thank [registered manager] enough as staffing was terrible but now it is brilliant. We have enough staff."

Most people and their relatives told us there was enough staff to meet people's needs. One person said about the staffing levels, "The manager implemented [increased staffing levels]. It's much better." Another person told us, "There seem to be enough staff." One relative said, "I see a lot of carers and they are regular carers as that's important." However one relative told us, "This weekend there were loads of staff but sometimes there are not enough."

The premises and equipment were managed in a way intended to keep people safe. Regular checks were carried out on hoists, emergency lights, bedrails, alarm systems, windows, water quality and temperature, and fire equipment. Records showed that fire safety checks and drills were done regularly. The service had an in-house maintenance person and a system in place to report and deal with any maintenance issues.

The home environment was clean and the home was free of malodour. The home managed the control and prevention of infection well. Records showed staff had completed training on infection control. Records showed infection control had been regularly discussed in team meetings and supervision. The registered manager told us about and showed us records of a regular infection control audit. Observations during the inspection showed staff wearing PPE for tasks such as preparing food, personal care, serving food and cleaning. One relative said, "The home cleanliness is excellent. [Registered manager] is really onto that. I see the cleaners all the time."

Good

# Is the service effective?

## Our findings

People who used the service and their relatives told us they were supported by staff that had the skills to meet their needs. One person said, "All your needs are met." Another person told us, "You get up in the morning with assistance." One relative told us, "The staff are fabulous. I can't praise them enough." Another relative said, "[Staff] are willing and able."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. An assessment of needs was undertaken at a pace to suit the person. The assessment looked at the person's medical history, mobility, medicines, moving and handling, tissue viability, communication, personal hygiene, toileting, nutrition and hydration, mental health and spiritual and cultural needs. One senior worker told us, "The nurse will start admission. You go to assess the needs of the client." One relative said, "[Registered manager] did assessment at the hospital. [Registered manager] worked with us."

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. One staff member told us, "We have in-house, external and e-learning training. They give you additional training if you want like specialised [training]." Another staff member said, "We have a trainer and she is on top of everything. The training is good." Records showed the training included basic life support, customer care, duty of candour, dementia awareness, dysphagia and chocking, fire safety, food allergies, food safety, health and safety, infection control, manual handling, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and safeguarding adults. Staff also completed training specific to the nursing needs of the people using the service such as catheterisation, tracheostomy care, end of life care, epilepsy, and syringe driver training. The staff files showed that all of the staff had completed the induction programme, which showed they had received training and support before starting work in the home. The registered manager told us they had introduced the Care Certificate for all new staff and records confirmed this. The Care Certificate is a set of standards that social care and health workers use in their daily working life.

Staff told us they felt supported with regular supervision. One staff member said, "[Supervision] every couple of months. Discuss what I can change and improve. If any problems." Another staff member told us, "Supervision is good. I express what I want to do in my job." Staff also told us they received regular appraisals. One staff member said, "I think it was last year. [Talk about] what are your strengths. What you want to achieve. It builds you up and gives you that zeal to do your work." Another staff member told us, "It's about how you have worked over the year. Your weaknesses and strengths, and the training you need to help you."

Supervision and appraisal records did not always contain sufficient detail to demonstrate what had been discussed. We found appraisal records completed by the registered manager were detailed and included personal objectives and goals for the year. However appraisal records completed by other senior staff members were not always as detailed and robust. Also not all annual appraisal records could be found during the inspection, however staff confirmed they did receive an annual appraisal. After the inspection the

registered manager sent us a memo advising that 'constructive appraisal training' was to be held for staff on 16 April 2018. This meant staff development and support was not appropriately explored and recorded through the supervision and appraisal process.

We recommend the service seeks and follows best practice guidance from a reputable source about supporting staff through supervision and appraisal.

Records showed people were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences, likes and dislikes were recorded in their care plan. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored regularly. If there were significant changes they would advise the GP and referrals were made to a dietician. Records confirmed this.

People and relatives told us the food quality and choices had improved since the last inspection. One person told us, "[Registered manager] employed a new chef and food more varied and tasteful." Another person said, "We have two new chefs and they are excellent." A third person told us, "I'm happy with the food." A relative said, "The food is fine. The menu changes to suit the people. If something [relative] doesn't like they change it."

The chef was aware of the people who were on specialised diets and explained the meal preferences for these people. This was reflected in the care plans and displayed in the kitchen. The chef told us that people could ask for alternatives to the food choices for that day. There was a rolling four week food menu in place which included at least two hot meal options. The food for people who were at risk of choking was presented well and blended separately allowing people to experience and taste the different flavours. One person told us, "The food is good. It's chopped up and they feed you." Another person said, "I have a special diet prepared by the chef. It's a salt free diet from the nutritionists. The chef follows the instruction. They will blend about four items separately. You get different flavours." A relative said, "The pureed food is beautiful. They asked what [relative] likes and dislikes. It is nicely presented."

During the breakfast and lunch time period we saw people being offered a range of drinks. Meals were attractively presented and there was a relaxed and calm atmosphere. Staff members chatted with people while they waited for their food to be served. We saw a staff member laughing with a person who lived at the service while the person showed them a video on their mobile phone. We overheard a staff member during the breakfast period offer a person various types of cereal. The person answered, "No, I want egg and bacon." The staff member replied, "Of course." People who required assistance with eating were not rushed and staff talked to them in a gentle and encouraging way. People could choose where they wanted to have their meal.

People in the home were supported to see health professionals when required. A GP carried out a visit on a regular basis and staff identified people who needed to be reviewed. Records were kept in people's care files to show when healthcare professionals had visited the person. This included GPs, podiatrists, dentists, chiropodists, opticians, speech and language therapists and dieticians. One person said, "Anytime I have an appointment [staff] will drive me. They will try and get a doctor on the phone. If urgent the nurse will call emergency services." A relative told us, "We are going to get a physio in." Another relative said, "[Staff] get the doctor in. If I am worried I will speak to the nurse."

The premises, décor and furnishings were maintained to a good standard. They provided people with a clean, tidy and comfortable home. Repairs were carried out in a timely way and a programme of regular maintenance was in place. There was a secure accessible garden for people's use. The home was spacious

and free from clutter. People's bedrooms were personalised. A relative said, "I was told we could do what we liked with the bedroom as it's [relative's] home. All [relative's] photos and plants are in her room. That's important to her." A person who used the service showed us his room and pointed to a large display of personal pictures on the wall. The person said, "My 35 years is on the wall. It feels like my second home." Throughout the dementia unit the service had objects on display that people could touch and hold as part of a sensory experience to stimulate them. The items included a typewriter, sewing machine, dresses, handbags, hats and ties. This meant the environment was decorated to encourage a sensory experience for people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the registered manager was able to explain the process he would follow in ensuring best interest meetings were held involving relatives and other health and social care professionals. The service informed the Care Quality Commission (CQC) of the outcome of the applications. We saw evidence of these principles being applied during our inspection.

Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. People told us that staff members asked their consent before helping them. This consent was recorded in people's care files. One person told us, "When [staff] want to clean me they will always ask me." This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Our observations showed that staff asked people about their individual choices and were responsive to that choice. For example, throughout the inspection we overheard people being asked what they would like to do, different drinks being offered and food choices. One person told us, "I have a choice about when I get up. It's flexible. I can call [staff] when I'm ready."

Good

# Is the service caring?

## Our findings

People and their relatives told us that they were well treated and the staff were caring. One person told us, "Everyone looks after me from the managers to the cleaners. Everyone says hello and takes time to talk to me." The same person said, "I feel [staff] go the extra mile. [Staff] don't do it for the money. They want to help people." Another person said, "Staff are adorable. It's a beautiful home. I love it." A third person told us, "They [staff] are very caring people." One relative told us, "The staff are caring. They are fantastic. The dementia patients are really cared for. [Staff] are really caring and loving and huge interactions with residents." Another relative said, "The staff here are nice. You can have a cup of tea with them." A health and social care professional told us, "Staff are caring and it is reflected on the care that the patients receive."

Relatives we spoke with told us they were kept informed about their family member and were involved in the planning of their care. One relative told us, "I get daily reports from staff. They phone me at home. I am well informed. I have been talking to the staff about the care plan." One person said, "I have a care folder. [Staff] write things in it. My family are involved."

Staff knew the people they were caring for and supporting. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member told us, "Person-centred care is number one. We try and make their environment like their previous home." Another staff member said, "It's good to help people." Staff communication with all residents was warm and friendly, and staff showed compassion when talking about people who lived at the home. Throughout the day we saw staff sitting with people holding their hand, hugging them and giving them a kiss on the cheek.

People's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. Staff we spoke with gave examples how they respect people's privacy. One staff member told us, "If you go to a bedroom you knock and introduce yourself. You respect them as a person as it is their home." One person said, "They [staff] respect my decisions. Saturday is my time and time to myself to collect my thoughts. Staff respect my privacy. They know it is my day." A relative said, "The staff are so patient and they listen."

People's independence was encouraged. Staff gave examples how they involved people with doing certain aspects of their personal care to help become more independent. This was reflected in the care plans for people. For example, one care plan stated, "[Person] is able to wash her face and arms. Staff to remind her to brush her teeth". One staff member told us, "[Person] was confused on how to feed himself. If you hold his hand and show him he can do it himself." Another staff member told us, "If they can wash their face themselves then give them a flannel." One person said, "Some parts of my body I like to wash myself. [Staff] will ask if I want do myself."

People were supported to maintain relationships with their family and friends. Details of important people in each individual's life were kept in people's rooms. Relatives and friends were welcomed to the service. During the inspection we saw family and friends welcomed to the service. One person said, "All the staff make my family feel cared for." A relative told us, "Guests are made to feel welcome. It makes you feel

comfortable."

Good

# Is the service responsive?

## Our findings

People told us they enjoyed living at the home and the care they received was responsive to their needs. One person said, "They [staff] speak to me and listen, especially if I want something." A relative told us, "We have peace of mind that my [relative] is being kept clean. The staff look after me when I come in too. They do all they can."

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. They included guidance for communication, personal hygiene, toileting, mobility, independence, tissue viability, nutrition and hydration, medicines, diabetes, breathing, pain, sleeping, cultural and spiritual needs and hopes and concerns for the future. Care plans were written in a way that reflected people's individual preferences. For example, one care plan for a person with dietary needs stated, "[Person] likes his food cut up in front of him at his table. For breakfast he prefers fried egg, toast with marmalade and a cup of tea." Another person had expressed wanting to start a romantic relationship. Records showed staff had a discussion with this person about exploring dating websites. People's life histories which included the person's likes and dislikes in regard to food, interests and routines were kept in their bedrooms. Records showed care plans had been reviewed monthly or as the person's needs changed. The plans had been updated to reflect these changes to ensure continuity of their care and support. One person said, "Every year [staff] do my care plan and assess me. They ask how I feel about the care and the home and if I have any problems." A relative told us, "My relative's care plan is reviewed with my [relative]." Another relative said, "We have had done a review twice to see how things are. We had a review after [relative] had a fall." Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People had access to planned activities. The home employed a full time and part time activities co-ordinator. Also the home had two activities assistants to support the activities co-ordinators. The activities co-ordinator told us they provided activities every day of the week from 10.00am to 10.00pm. Activities on offer included board games, church services, light exercise, relaxation, music sessions, treasured memory sessions, biscuit decorating, movie night, quizzes, ten pin bowling and one to one sessions. The activities co-ordinator told us, "Residents decide the activities. We have a meeting bi-monthly." People received an activities newsletter every week that listed the activities on offer. Peoples' and relatives' views were mostly positive about the activities. One person said, "We have music, play games, we have a quiz. It's good to be here together."

During our inspection we saw group activities with people. We observed two different reminiscing sessions for people. Both sessions were tailored to people who used the service and were carried out with care and attention. The activity was being run with kindness and sensitivity, involving everyone, and extending challenges to some, and simplifying for others. People with dementia were exploring a range of objects given by staff. We also observed activities with people drawing and playing darts.

People's cultural and religious needs were respected when planning and delivering care. Records showed people had access to spiritual activities and food specific to their culture. One staff member told us, "We

have a church service on a Sunday." Another staff member said, "I have my own religion but when I'm at work I have to respect other religions." Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "I would ask them what they wanted. Are they out and proud? We have information leaflets throughout the home on sexuality." Another staff member told us, "Need to talk to them and ask what they would like to do. Have to respect their beliefs." Training records showed staff had completed equality and diversity training.

There was a complaints process available and this was on display in the communal area so people using the service were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

Most people and relatives knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions taken as a result and the response to the complainant. We found the complaints were investigated appropriately and the service aimed to provide resolutions in a timely manner. One person said, "Have no complaints, and if I have, I sort it out with the [staff]." Another person told us, "I speak to my nurse or manager if I have any problems." A third person said, "Firstly I would speak to the nurse or senior. [Registered manager] has given me her number if problem is very big. It is very rare I complain about something." A relative said, "Anything I have complained about they have sorted." A health and social professional told us, "If I have any concerns, I would raise with the unit manager and the home manager, who would address the issue immediately. They would also give me regular up-dates with regards to any concerns that may have been raised."

At the time of our inspection the home did not have any people receiving end of life care. Records showed staff had received training in end of life care. The registered manager told us the home worked with palliative care teams, a local hospice and the GP when people were at end of life. The service had an end of life policy called "End of Life and Palliative Care Policy" which was appropriate for people who used the service. One staff member said, "I like end of life because I did the course. [Local hospice] always involved. We send them a referral. We make [people] comfortable. We do an end of life care plan. I will call relatives after the person has passed and attend the funeral. We support [relatives]." We saw cards of thanks and appreciation from relatives in relation to the end of life care provided to people who had lived in the home. The cards showed how staff had supported people with kindness.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager, the senior regional director and other managers from the provider's quality teams completed regular audits of the quality and safety of the service. These included audits of care plans and records, medicines records, infection control and staffing records. Records showed these audits effectively identified issues with the quality and safety of the service and implemented plans to address the issues. The registered manager completed unannounced night spot checks on the home. Records confirmed this. Times of the visits varied from 11.00pm, 2.00am and 5.00am. The night spot check looked at general observations, staffing cover, staff appearance and call bells. Although some of the areas we checked had been identified through the provider's audit processes, these did not pick up the concerns relating to recruitment procedures, supervision and appraisal records. This meant that systems were not always effective to monitor and improve the quality and safety of the services provided to people.

The quality of the service was also monitored through the use of annual surveys for people and relatives of the people who used the service. One person told us, "[Staff] are always asking me questions if anything needs improving." The last survey completed was for October 2017. Surveys for people and relatives included questions about staff and care, home comforts, choice and having a say, and quality of life. The registered manager had completed an action plan of issues that were raised and records. The service also completed a staff survey in October 2017. Overall the results were positive. Comments from staff included, "very nice manager, working hard to improve the home and staff training", "best manager ever", and "the best manager I have ever worked with."

People who used the service and their relatives spoke positively about the registered manager and the changes to the service since her appointment. One person told us, "Since [registered manager] has come in she has changed things for the better." Another person said, "[Registered manager] is a godsend. She is an angel. She talks to me one to one." A relative told us, "[Registered manager] is excellent. I have her email and I can text her." Another relative said, "[Registered manager] is interacting more and I can see it in the staff."

Staff told us that they felt supported by the registered manager and deputy manager and that they were approachable and supportive. One staff member said, "[Registered manager] is lovely. She is understanding and listens. She has changed the home a lot like improving the staffing. She is always visible and around." Another staff member told us, "[Registered manager] is young and enthusiastic. She knows the residents and the staff. She is very supportive to me." A third staff member told us, "[Registered manager] has time for everybody. She listens." A fourth staff member said, "[Registered manager] is open and transparent." The registered manager said about themselves, "I am dynamic and believe in a person-centred approach. I've got good listening skills. I can multi-skill, work under pressure and still smile." This was reflected by staff feedback about the registered manager.

The provider regularly implemented innovative schemes to promote and improve staff confidence and recognition. For example, the provider had a staff award recognition scheme for staff member of the month. We saw nomination forms available in the home. The registered manager told us she also provided recognition to staff on a local level. The registered manager said, "I have just had an annual staff ball to

show staff my appreciation. I threw the party and had buffets and professional decorated. [Staff] received awards."

The home held regular staff meetings where staff could receive up to date information and share feedback and ideas. Meetings were held for general staff, head of departments, registered nurses, night staff and health and safety. Topics included were complaints, training, new staff, CQC, supervision and appraisal, care plan reviews, end of life, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), safeguarding and working with the relatives. One staff member told us, "[Management] gives everyone time to express themselves."

Residents and relatives meetings were held on a regular basis to provide and seek feedback on the service. Topics recorded for the meetings included activities, food menu, home maintenance, care plans, complaints, dignity and respect, and care plan reviews. Information about the meetings was on display throughout the home. One relative told us, "I go to the relative meetings every two months."

The home provided quarterly quality reports to the local authority that had placements in the service. Records showed the reports looked at number of safeguarding alerts, deaths, risk assessments, medicines, complaints, infection control, falls, pressure sores, serious incidents, and staffing. The local authority confirmed they received the quarterly quality reports and regular meetings and updates were held with the home.

The home worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us she attended the local older people's forum every quarter to share information. Also the home worked with a national dementia association, local hospice and palliative care teams, national cancer organisation and the local authority commissioning team. A health and social care professional told us, "There is a new management structure in place and [they are] communicating better with our team. We are always informed if there are any changes with the patients that have been placed there."

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<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider did not always check if staff had the qualifications, competence, skills and experience which are necessary for the role to be performed by them. Regulation 19 (1) (a) (b) |