HC-One Limited

Brooklands Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Brooklands Care Home provides nursing and personal care for a maximum of 63 people, some of whom may be living with dementia. Accommodation consists of single occupancy rooms situated in four units over two floors. At the time of our inspection 46 people were using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We undertook this unannounced inspection on the 1 and 2 August 2017. The last full inspection took place on 20 and 21 June 2016 and although no breaches in regulations were identified we rated the service 'Requires Improvement' for two of the five key questions and rated the service 'Requires Improvement' overall.

During this inspection, we found some concerns regarding quality monitoring which had resulted in shortfalls not identified through the audit programme or when shortfalls were identified, timely action had not been taken to address these. Examples included gaps in care plans, supplementary charts for recording food and fluid intake and records to support consent to care.

There was some inconsistency with the application of mental capacity legislation. Some people had assessments of capacity and records about the restrictions they had in place, but this was not consistent throughout the service. One person was subject to low level physical interventions which had not been agreed or assessed as being in their best interest.

People had care plans in place, however, we found these were not always person-centred and missed important information regarding how staff were to care for them. This meant that important care could be missed.

You can see what action we told the provider to take regarding the above three areas at the back of the full version of the report.

The CQC had not received a notification of an incident which affected the welfare of a person who used the service. On this occasion we are writing to the provider to address this shortfall.

We received a mixed response from people who used the service, staff and visiting relatives with regards to staffing levels at the home. There were occasions when people were not supervised appropriately and staff reported being over stretched at times during shifts and unable to spend time with people. Some relatives considered staff were not visible enough and some people felt they had to wait at times for care. We have made a recommendation that the provider reviews the number and deployment of staff on shifts.

Staff were recruited safely which ensured employment checks were in place prior to new staff starting work. Staff had received training in how to protect people from the risk of harm and abuse. There were also policies and procedures for additional guidance. Staff knew what to do if they had concerns but some staff were not aware of the external agencies they could raise these with.

Generally, there were safe systems in place to manage risks to people's health and safety although the area director took action during the inspection to ensure one person's risk of falling was reviewed and action was taken to better protect their safety.

People had access to community health professionals for advice and treatment. Staff knew when to consult these professionals although the guidance provided was not always followed consistently.

Staff completed assessments of people's nutritional needs and monitored their weight. They referred people to dieticians when required. We saw the menus provided people with a choice of nutritious meals. People told us they liked the meals provided for them and staff were flexible if they wanted an alternative to the main menu choices each day. During the day, we observed people were served drinks and snacks between meals. We found improvements could be made with some people's accessibility to drinks on the nursing unit.

People told us staff had a kind and caring approach. We saw people's privacy and dignity was respected and observed many positive interactions between staff and the people they cared for. Staff knew how to promote people's independence and need to make their own decisions.

We saw people were encouraged to participate in a range of activities at Brooklands and in the community. Relatives told us they could visit at any time and we saw staff supported people who used the service to maintain relationships with their family.

Medicines were managed safely and people who used the service received them as prescribed. People told us their medicines were administered to them in a timely way.

Records evidenced that staff received appropriate induction, training, supervision and support, which enabled them to feel skilled and confident when supporting people who used the service.

Staff, people who used the service and their relatives, told us the manager had an open-door policy and was available to speak with them when required. There was a complaints procedure on display in the service and it was included in information given to people. Staff knew how to manage complaints and people spoken with felt able to raise concerns. There were systems in place to enable people to share their opinion of the service provided and the general facilities at the home.

We found the environment was clean and safe, and equipment used was serviced regularly and maintained on a day to day basis.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Although staff were recruited safely there were times when people were not adequately supervised and staff were overstretched to meet people's needs in a timely way. We have made a recommendation to review staffing levels and deployment of staff.

Staff had received safeguarding training and knew how to protect people from the risk of harm and abuse. Aspects of the risk management of people's health and safety were inconsistent.

There were effective systems in place for managing medicines and the control of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There had been inconsistent application of mental capacity legislation and deprivation of liberty safeguards, which meant best practice guidelines, had not always been followed when people lacked capacity to make their own decisions. However, we found staff were clear about how they gained people's consent to day to day care and support.

People were supported to eat a healthy, balanced and nutritious diet. They had access to a range of healthcare professionals but the guidance provided from professionals consulted was not always followed consistently.

Staff received training, supervision and support which provided them with the skills and abilities to carry out their roles effectively.

Is the service caring?

Good

The service was caring.

The staff approach when supporting people was observed as

kind, patient and caring.

People's privacy and dignity was respected and staff supported people to maintain their independence skills as much as possible.

Private and personal information was kept confidentially.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people's care plans did not provide sufficient guidance for staff in how to meet their needs and in the way they preferred.

There were activities, outings and entertainment for people to participate in. Those people spoken with told us they enjoyed these.

There was a system in place for managing complaints. People who used the service and their relatives told us they felt able to raise issues with staff and these would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems for quality monitoring required strengthening in order to identify all shortfalls and support effective improvements.

Staff told us the manager and deputy manager were approachable and would listen to any concerns they had.

There were regular meetings for staff, people who used the service and their relatives to raise issues, provide feedback, and share information about the home.

Brooklands Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 August 2017 and the first day was unannounced. The inspection was led by an adult social care inspector who was accompanied on the first day by a second inspector and an expert by experience who had experience of supporting older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the provider, which gave us information about how incidents and accidents were managed. We also contacted the local authority safeguarding team, care management and contracts and commissioning team about their views of the service.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including meal-times.

During the inspection we spoke with twelve people who used the service, twelve of their relatives and six health care professionals. We also spoke with the area director, manager and a selection of staff; these included the two qualified nurses, a nursing assistant, four care workers, the activity co-ordinator, the cook, the maintenance person, a housekeeper and a laundry assistant.

We looked at eight care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as medication administration records and monitoring charts for food, fluid, weights and pressure relief. We looked at how the service used

the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the building and checked the environment.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found some concerns about the deployment of staff and how the staffing levels were calculated. We were given assurances that the staffing levels within the service would be assessed and changes would be made as required. In April 2017 we received concerns about insufficient staffing levels during the night at the service and these were passed to the area director to look into. We received confirmation from the area director that the numbers of staff on the day and night shifts had been reviewed and increased.

At this inspection we received mixed feedback from people who used the service and their relatives about staffing arrangements. Comments included, "Staffing appears tight sometimes", "Not enough on during the day", "Some days there are just not enough staff seen about", "Staff seem good but there's not enough of them; we can wait ages to get in and even then don't see many about probably because they are so busy and then I have to try and find someone to let me out; weekends are so much worse", "Some of the young ones are a bit rough rushing to get to the next one" and "Lots of the staff are really good, but you have to wait such a long time when you press your buzzer."

The area director confirmed they had made improvements with the configuration and layout of the four units, which included the placement of people with nursing needs on one unit on the first floor and a reduction to the size of the dementia unit. Although staff acknowledged having the nursing clients on one unit was an improvement, the unit comprised of two separate corridors (one with secure access) and this impacted on staff deployment. We identified times during both days on the nursing and dementia units when people were not adequately supervised. For example, on the dementia unit people were left unsupervised when the two staff on duty were assisting a person with their personal care. Similarly on one of the nursing units, on both days, we found there was no member of staff present for up to 10 minutes and in communal areas on each unit people were left unsupervised at times; this was usually when staff were on their break. On the first day we also observed visitors experienced delays with staff letting them in the building. This improved on the second day when the area director based themselves in the administrator's office and could see the entrance door and respond better to visitors.

We found staffing levels were formally calculated based on the number of people and their dependency. The manager told us people's care needs were assessed each month and the home's staffing levels were reviewed in line with people's dependency. We asked how the layout of the home factored into the staffing calculations as people's accommodation was in four units over two floors, and the manager could not confirm this was taken into account.

At the time of the inspection there were 46 people (one person moved out on the first day) and levels of seven care staff, a nursing assistant and a nurse were provided in the day and a nurse and four care workers at night. Rotas showed that the numbers of staff had been maintained by the use of bank staff, staff working additional shifts and agency workers. There were occasions when the planned number of staff were not on duty and the manager explained this was due to short notice absence and all efforts had been made to provide cover where possible, including asking staff to stay late and arrive early for duty.

Comments about staffing levels from staff included, "The residential unit is okay but we need more staff on the nursing unit, every person requires help from two staff", "We know we leave people unsupervised at times, but all the other units are so busy we don't like to ask for help" , "Staff are very tired with covering extra shifts and this affects morale", "Often we can't spend the time with people we want to" and "Some shifts are better than others, especially if we have a lot of agency staff."
We recommend the provider reviews the number and deployment of staff to ensure there are sufficient and consistent numbers of staff available.

People felt the care and support they received from staff helped keep them safe. One person told us they felt safe having staff check on them during the night. Relatives spoke of staff ensuring people had any walking aids within reach and encouraging their family members to use these. One relative told us, "A lot of people need to use the hoist to help them move and staff are very competent in using this. Staff reassure people and explain what they are doing. People look safe and not worried." We saw people received safe and caring support when being assisted to transfer with the use of a hoist.

Risk assessments were completed to guide staff in how to keep people safe and minimise the risks associated with specific activities of daily living. These included areas such as falls, pressure damage, nutrition, swallowing difficulties and the use of equipment such as bedrails. People who had been assessed as being at risk of developing pressure ulcers were provided with suitable equipment to reduce the risk and we saw that this equipment was being used as specified in people's care plans. Records were in place which evidenced care had been provided in accordance with the care plans. For example, re-positioning charts were in place for people at high risk of developing pressure ulcers and these had been completed. There was low incidence of pressure damage.

Generally we saw accidents and incidents were investigated and appropriate action was taken to prevent their re-occurrence. However, we found one person was not always protected from the risk of falls. Their care records showed they had experienced a high number of falls in the last six months, many in their own room. Although we found a referral had been made in June to the falls team for assessment and in July a referral had been made to the community mental health team, there were no risk management strategies on the falls risk assessment and a lack of a care plan detailing how staff should manage this risk, especially when the person was in their bedroom alone. A sensor alarm had not been considered, which would alert staff if the person fell in their bedroom. Nor had the provision of a bedroom nearer to the lounge where staff could monitor the person more closely. We discussed these concerns with the area director who took immediate action to arrange an urgent care review meeting and to consult with relevant agencies and the person's relative to arrange a best interest meeting. This was to consider the person moving to a bedroom nearer to the lounge, the provision of a low rise profiling bed and a sensor alarm to better support the person's safety.

There was a policy and procedure to guide staff in how to safeguard people from the risk of harm and abuse. Staff completed safeguarding training and in discussions were familiar with the different types of abuse and the signs and symptoms which may alert them to concerns. Two care workers were not fully aware of the appropriate agencies they could refer concerns to and the area director confirmed they would follow this up. All staff were aware of the provider's whistleblowing policy and the designated telephone line to enable staff to confidentially raise concerns regarding poor practice at the service. During the inspection a safeguarding officer from the local safeguarding team visited to look into some concerns about the quality of care a person had received at the service in recent weeks. The safeguarding officer confirmed that the majority of concerns raised were being passed onto the manager to investigate as part of their complaints procedures. We will report on this during our next inspection.

There were two dedicated medicines rooms and we found medicines were stored securely and the storage facilities were clean and well organised. Suitable arrangements were in place for the storage of specific medicines that required cooler temperatures and checks were carried out on a daily basis to ensure the manufacturer's guidance was adhered to. Controlled drugs were stored safely in line with current best practice. Records and discussions with staff evidenced the management of stock control in the service was consistent and safe.

Medication administration records we reviewed were complete and contained no gaps in signatures. All 'as required' medicines were supported by written instructions which described the situations and presentations when these medicines could be given. We saw where people were prescribed pain relief patches, records stated the date and time of application and removal of the patch. A person who used the service told us, "Oh yes, they come round as regular as clockwork with my medicines."

We found staff were recruited safely with full employment checks in place prior to them starting work at the service. These included an application form so gaps could be explored, references, an interview and a disclosure and barring service (DBS) check. This included a police check and assurance that the potential candidate had not been excluded from working with adults at risk. Qualified nurses had an additional check to ensure they were registered and there were no conditions on their registration to practice.

We found the environment was safe and equipment used was checked and maintained. People who used the service and their relatives considered the standards of cleaning at the service were good. A relative told us, "The home has an excellent cleanliness regime, no odours." We found the environment was clean and tidy. There were systems in place to prevent and control the spread of infection. Work was in progress to refit two of the sluice areas in the service. We found the laundry was well-managed.

Requires Improvement

Is the service effective?

Our findings

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. We found the application of MCA was inconsistent. Whilst we found some people had capacity assessments and decisions made in their best interest recorded when they lacked capacity, others did not. Some people had restrictions in place such as bedrails. However, their capacity to make these decisions had not been fully assessed and the decision to provide them had not been discussed and recorded as in their best interest and as the least restrictive option for people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the provider was working within the principles of the MCA for some of the people who used the service. Applications for DoLS had been submitted to the local authority and two had been authorised. We found one person demonstrated anxious and distressed behaviour especially during personal care tasks requiring the use of holding techniques by staff. There were no records of any discussions with the person's relatives and relevant professionals that this practice was the least restrictive and in the person's best interests. Although a DoLS application had been submitted, the application had not included this information and the placing authority had rated the application as medium risk and not yet completed the assessment. This meant the person may be deprived of their liberty unlawfully.

Not working within the principles of MCA and DoLS is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

We saw people being asked for consent and to make choices over every day matters throughout our visit. One person told us, "Yes, the staff always ask me about my care." Another person said, "They [staff] don't take my life from me, they assist me, they say, 'Is it alright if I do this or that?' before helping me." Relatives told us they had observed staff consulting their family members about bathing, clothing, care, meals and activities. One staff member told us, "We should always assume people have mental capacity until proven otherwise and help them to make their own decisions." Another member of staff said, "Even though we know people's needs and preferences really well, each time we provide support we always ask them about their care first."

People's care records generally evidenced they had access to a range of community healthcare professionals when required. One person's relative raised a concern to us about the delay in arranging a dentist to visit their family member. We passed this on to the nurse who confirmed they had experienced problems in arranging the visit, but were following this up and would let the person's family know. Records were made of when the professionals visited and what treatment or advice they provided. In most cases we

found the guidance provided was followed. One person had been recently assessed by the community mental health team (CMHT) due to their levels of anxiety and behaviour which challenged the service. Staff had been directed by the CMHT to monitor the person's behaviour throughout the day and night and complete a detailed record of their observations. However, we found staff had not completed the monitoring record provided, which could mean a delay in the person receiving treatment. The monitoring record was put in place during the inspection and staff completed this.

Health professionals told us they were kept informed of issues and staff were willing to assist. Their comments included, "Staff ensure patients are in their rooms for any treatment. They seem to have a good rapport with patients and are knowledgeable about their specific needs" and "The service has massively improved." A GP told us they were generally happy with the delivery of care at the service. They said staff communicated well with the surgery and followed treatment programmes but they considered nursing staff could have a more pro-active approach at times.

People were supported to have regular hot and cold drinks and we observed most people were provided with jugs and glasses of water and juice. However, on the nursing unit lounge on both days of the inspection, we found staff had not ensured some people were provided with drinks so they could help themselves. Checks on people's fluid intake records showed they were generally well completed. However, we one found one person's fluid intake records showed their optimum fluid target was often not achieved and there was no evidence staff had put measures in place to monitor the person's intake throughout the day to see if the person was on track to meet the target. These issues were mentioned to the area director to address.

We found people's nutritional needs were met. People were complimentary about their meals and the quality of the food. Their comments were, "Meals are very good", "Sometimes I have a salad, they do nice ones here" and "I love the puddings, the cooks are very nice and come round and check we have what we want." Relatives also gave us positive comments about the meals. One person said, "Meals, choice and nutritional values all good and catered for very well." We observed the lunchtime meal service in different units on both days; we saw this was a calm experience and people who required assistance received this in a patient way. The meals provided looked well-prepared and well-presented and people enjoyed them. People were offered a choice and second helpings were available for those who wanted these. The menus were seasonal and developed by the provider. The cook was able to show how they met people's individual meal preferences and gave examples of one person requesting liver and another kippers and curry.

People's weight was monitored each month and if there were any concerns about someone's weight change they were weighed more frequently. Dieticians were involved when required and staff were aware of the referral system. The cook explained how they catered for diabetics and prepared fortified foods for people who were at risk of losing weight. They also provided soft and textured diets for people with swallowing difficulties. The cook had information about people's needs, preferences, diets and allergies and said they were informed each day by the senior staff on duty if there were any changes involving people they needed to be aware of. Checks of food intake records showed staff were not consistently recording people's support and intake in relation to snacks. The area director took action during the inspection to amend the format of the record to prompt staff to record when people had eaten snacks between meals.

We saw from records and from discussions with staff, that they had access to induction, training, formal supervision meetings, appraisal and on-going day to day support. There was a range of courses, including clinical training for nurses, which enabled staff to gain knowledge, experience and confidence when supporting people who used the service. Staff confirmed the training was essential to their roles and appropriate for their development needs. Staff also told us their training was kept up to date and they were reminded when they were due any training updates. They said, "We have access to a wide range of training.

I've had a lot of clinical updates recently" and "There have been improvements with the quality of training courses, the dementia one was really good."

We found there had been some adaptations to support the needs of people who used the service. For example, there were grab rails in corridors, toilets and bathrooms and raised toilet seats. There was some use of contrasting paint colours, photographs on doors, memory boxes and pictorial signage to provide orientation for people living with dementia. The service had undergone a redecoration and refurbishment programme in 2016. An on-going renewal programme was in place and the estates manager visited the service to discuss improvement work and timescales. Relatives told us they considered the home was well decorated and comfortable. One relative told us, "[Name of person] has been given a large room which suits them because of all their equipment. They've helped us make it as homely as possible though and put up lots of pictures and photos."

Good

Is the service caring?

Our findings

People who used the service told us staff looked after them well and treated them with dignity and respect. They said their privacy was maintained. Comments from people included, "Thumbs up, brilliant, I couldn't be in a better place. I choose to be in my room most of the time but they fetch me for dinner with the others which I enjoy", "It's not like home but it's nice - a good substitute" and "I like it here and my family come most days. Staff are very kind and obliging, I'm well cared for."

Relatives told us staff had a caring approach but some commented about the lack of time the carers had to spend with their family members. Comments included, "Very kind and caring staff, though not always the time to give the residents", "All the staff I've met have always been kind and generally couldn't help enough- just the odd time when they are obviously rushed", "The care is very good and [Name of person] always looks clean and well-cared for" and "I cannot praise the staff enough; they have all been so kind and compassionate. They have given me peace of mind and I'm confident the quality of care is maintained when I leave."

Although we saw staff were very busy and over stretched at times we observed staff tried very hard to meet everyone's requests for care and support. We observed positive staff approaches and interactions with people who used the service. Staff displayed warmth and empathy towards people. Some people were very frail and we observed staff explaining what they were doing and gently encouraging them to eat and drink. One staff member said, "Try and eat a bit more, I've brought you one of your favourites - chocolate mousse."

Staff told us they enjoyed working at the service and they found the work they did rewarding. They spoke about people they cared for with fondness and respect. Staff had a good knowledge of people's life history and told us they enjoyed talking with people about topics such as their family and any jobs the person may have had. We saw staff communicated well with people and chatted with them about the local area, their interests and families.

Staff were aware of equality and diversity issues and had received training. They were aware of people's individual wishes and beliefs. One person was supported to meet their religious needs by attending regular services and receiving visits from church elders.

Brooklands operated a 'Resident of the Day' scheme. Each person in turn was given special treatment for that day, such as having an individual choice of activity, their room being deep cleaned and the chef discussing menu preferences. This was designed to promote wellbeing and a sense of being special.

The staff also made the effort to ensure they supported people to enjoy special occasions. One person who used the service was celebrating their 80th birthday on the day we visited. The dining room had been decorated with banners and they had a celebratory tea in the afternoon. We observed how happy they were when staff sang Happy Birthday and gave them a hug. The following day another person had a birthday party with their extended family and great grandchildren, which they all enjoyed.

We observed staff treating people in a respectful manner and that people's dignity was upheld. For example, when staff needed to talk with people about their personal care, these conversations were held discreetly. We saw staff respected people's privacy and dignity when needed, for example helping someone to move to their room to see a healthcare professional and ensuring a person had their legs covered and clothing adjusted when being hoisted. Staff always knocked on people's doors and waited to be invited into their room. The layout of the building and people's accommodation ensured that their right to privacy could easily be upheld. Visitors were able to come to the home at any time and stay for as long as they wished to.

End of life care was provided and staff had received training in how to support people as they neared the end of their lives. A Macmillan nurse told us there were good systems at the home for end of life care support. They said staff regularly made referrals and had a collaborative approach. They also said they had a good relationship with the care and nursing staff. A relative we spoke with praised the staff for the excellent end of life care they were providing for their family member. They described how very kind, caring and supportive the staff had been to all the family during this time.

Information was available about local advocacy services. The manager told us that that one person had recently used an advocate to support them with decision making. There was information displayed in the service so that people knew how to contact an advocate if they wished to. Advocates are trained professionals who support, enable and empower people to speak up.

Requires Improvement

Is the service responsive?

Our findings

People had assessments of their needs completed, including risk assessments, prior to and following admission to the service. Staff used these to write care plans of how best to support people. Although some people had informative care plans, we found some of them lacked guidance for staff on how to support people in an individual way, some had not been put in place to support specific areas of need and some had not been updated when people's needs changed.

For example, one person had developed a health condition in recent months which was currently being investigated by their GP. Their health need was not detailed in a care plan and there was little evidence of how this was monitored and when staff should report concerns. Two people had anxious and distressed behaviours which could be challenging for staff and others. Although care plans had been put in place, these did not guide staff in how to support both people in a consistent and person-centred way to help alleviate their distress. One of these two people had sustained an injury from a recent fall and although daily records showed the person was experiencing pain and staff had contacted the person's GP for stronger pain relief, when the person refused to take these, there was no evidence staff had considered administering the person's pain relief covertly. There was no pain assessment tool or care plan put in place to support the person's pain management, nor was there a detailed plan of care to provide staff with clear directions around the action to take to reduce the person's risk of falling.

We also found a person's care plan did not contain sufficient information about their nutritional and hydration needs and risks and the assistance they now required. Although the care plan directed staff to monitor the person's dietary intake we found this was not being completed. Another person with a learning disability and very limited verbal communication did not have the phrases they used or understood detailed in their communication care plan. This meant staff may not have been able to communicate with the person effectively.

Not ensuring people's needs were accurately and consistently assessed, care planned and met in a person-centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

Some relatives said they had had been involved in planning their family member's care and support as they were unable to do so themselves. One relative told us they had spent time over the first few days of their family member's stay at the service discussing the care they needed and that staff had taken this on board and made every effort to ensure their preferences were upheld. They also said they were kept informed of any changes.

Most people who used the service said they had a range of activities to participate in. Some told us they had enjoyed a recent trip to the coast for an ice cream which they enjoyed. Two people told us they enjoyed the quizzes and Bingo sessions. One person told us they appreciated that the activities person had taken them to see their husband in hospital. Another person told us they preferred to sit in the entrance area and watch people coming and going. They told us they were bored at times, although when we saw the activities

person tried to encourage the person to join in with activities, they refused. We observed staff engaged with the person when they went past and stopped to talk when they had time.

Relatives made positive comments about the activities provided. They told us, "Mum chooses whether to join in with the entertainment provided", "[Name likes the music and staff talking to him", "The activities organiser is lovely and there's always something arranged for people to join in with" and "They [people who use the service] enjoy trips out occasionally and sometimes have therapy dogs which are enjoyed; they [staff] are always decorating the place for seasonal times which is good."

The activity coordinator had developed a weekly plan of activities that provided people with one to one support and a varied range of group activities, trips and entertainment. People could also access religious services which were held regularly at the service. The activity co-ordinator told us they enjoyed their role and this was evident in discussions and our observations of the support they provided during the inspection visit. On the first day in the morning, we saw people participating in chair based exercises on different units and then in the afternoon a memory-drama workshop was held by an external charity as part of a 12 week programme. On the second day we observed a musical entertainment session in the lounge and the activity co-ordinator provided individual one to one time on each unit with people including sensory support and music. The activity co-ordinator told us they had ordered more sensory equipment for people living with dementia or those with a learning disability. We saw people chose to spend time in different areas of the service; some people visited other units to participate in activities and one person went to a local shop with the activity co-ordinator. People who enjoyed spending time outside were assisted to sit in the garden and appropriate shade and sun screen was provided. The garden was attractively decorated with bunting from the recent national care homes open day and BBQ they had held.

The provider had a policy and procedure for managing complaints. The complaints procedure was available to people and relatives and a copy was provided upon admission to the home. We saw that when complaints were received they were investigated and responded to appropriately. An electronic device was available in the entrance area of the home for people and visitors to record their opinions of the service. This device was linked to the provider's quality team.

People we spoke with and their relatives told us they knew how to make a complaint or raise concerns and would have no hesitation in making a formal complaint if the need arose. Comments included, "My concern was addressed immediately with a good outcome", "I have raised concerns with the manager and it has been dealt with on the same day, excellent" and "Initially items like spectacles went missing from their [Name of person's] room but that has been resolved." One person told us, "Yes, I don't hesitate to let them know if I have concerns" and added "I have to keep on top of them to make sure it's dealt with though."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection there was no registered manager in post, which meant the well-led domain could not receive a higher rating than 'requires improvement.' We also identified some minor shortfalls with the quality monitoring programme. The manager was recruited just before our last inspection in June 2016 and registered with CQC in October 2016.

There was a formal comprehensive quality monitoring system in place and regular audits had been undertaken, but we found aspects of the programme were not effective in identifying issues in the service or whether they were addressed in a timely way. We found shortfalls in the quality of the care records which had not been identified through the audit programme. These shortfalls also included records which supported consent to care, and although some of these had been identified by the manager as an area for improvement they had not been fully addressed. We also found one person was subject to low level physical interventions which had not been agreed or assessed as being in their best interest.

An assessment of each person's dependency levels was completed each month to support the calculation for the staffing hours needed in the service. This did not take into consideration the configuration of the building and the four different units situated over two floors, and provide assurances the staffing levels and deployment were adequate. Other aspects of the quality programme such as 'resident of the day' and the manager's daily walk around checks had not been carried out or fully completed in recent weeks.

We had concerns about effective recording within the service. Where staff had been directed to complete monitoring records in relation to people's behaviour or food intake, we found these had not always been completed. We also found the recording of monitoring charts for fluid intake was inconsistent. There was no system in place for overseeing the recording of fluid intake at regular intervals throughout the day to ensure those people at risk were on track to reach their optimum hydration levels.

We found one person had recently experienced a fall and sustained an injury. This incident was recorded in the person's daily records which detailed an incident form had been completed. The incident form could not be located and the manager confirmed the information had not been entered onto the incident monitoring system. This meant the incident was not included in the analysis or factored in any action planning and lessons learnt.

Not having an effective quality monitoring system meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

Despite the shortfalls in quality monitoring, mainly in relation to records, there were other areas of the service which had been improved or maintained through quality monitoring such as medicines management, staff training, infection prevention and control, health and safety and catering. The area director and the provider's quality inspection team also completed visits to carry out quality monitoring audits. The area director had completed a recent spot check visit at night and the findings had been positive

overall. The manager completed a monthly audit report on a clinical governance system which included falls; pressure sores; weight management; accidents; hospital admissions and infections; and any other incidents which occurred during the month. Incidents were monitored for trends so that methods for reducing incidents reoccurring could be identified.

The manager told us there were some changes to the management and administration team taking place. The deputy manager had recently resigned and was working their notice and a new deputy had been appointed. The administrator had recently left and recruitment was also underway for that position. People, their relatives and staff spoke favourably of the manager and indicated they felt there had been improvements since their appointment. Comments from people and their relatives included, "I think the home is well-managed. If I've mentioned anything, it's been sorted. The manager and all the staff are always very approachable. [Name of person] is really happy, settled and well-looked after here. I have a lot of confidence in the management", "Everything appears to run smoothly", "Certainly there have been improvements with the environment and décor", "It is a very nice home. There have been lots of improvements since this manager has come." One person told us the manager was always available but they felt improvements in leadership could be made around staff management.

Meetings were held each month for people who used the service and relatives in order to gain their input and views of the quality of the service. We noted that action had been taken in respect of people's suggestions. For example, the places to visit on outings and also that relatives were now accompanying their family members on trips when requested. The manager held a 'surgery' one evening each month for people or their relatives to meet them and discuss any aspects of care or the service, although records showed few people chose to attend. People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found the results of recent resident surveys in June 2017 were generally positive about the service, 60% of people had rated the service overall as Good and 40% had rated the service as Excellent.

There were meetings and shift handovers to ensure staff had up to date information about issues affecting the service and people who lived there. A 'flash' meeting was held every day at 11am by the manager with senior staff to discuss any current issues, changes and urgent matters. This meant that staff were kept informed of any immediate needs. Staff meetings were held on a monthly basis. Minutes from meetings showed mixed attendance levels although staff confirmed they could see the records of the meetings. Staff we spoke with were generally satisfied with the management of the service. Comments included, "I have confidence in the manager, they work well with everyone" and "It is okay working here. Things are getting better. The manager is supportive; she listens and will always help out."

Information about the provider's values and ethos around kindness in care were clearly displayed in the entrance area. When we asked staff about these values their knowledge was limited. Most staff were also unaware of any staff incentives and care awards and considered they were not available anymore. We mentioned this to the area director who confirmed they would follow this up.

We had received notifications when people had serious injuries, applications for deprivation of liberty safeguards had been approved or when people had died. However, we found there had been one occasion when the CQC had not received a notification of a safeguarding concern about an incident that had occurred between people who used the service. Although we were satisfied that appropriate action was taken to keep people safe, it is important we receive timely notifications for these incidents so we can monitor their numbers and check with the manager how they are supporting and protecting people. Not notifying us of incidents which affected the safety and welfare of people who used the service is a breach of

Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the provider reminding them of their responsibility regarding notifications to CQC.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used the service did not consistently have their needs assessed, or care planned and met in a person-centred way. Regulation 9 (1) (a)(b)(c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when people were unable to give consent because they lacked capacity. Also they had not always consulted with the local authority and provided sufficient information when there was the possibility some people met the criteria for a deprivation of liberty safeguard Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems or processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated fully. There were shortfalls in recording systems. Regulation 17 (1) (2) (a)(b)(c)(f)