Solehawk Limited

# Ashton Court Care Home

## Inspection report

376 West Road
Newcastle Upon Tyne
Tyne And Wear
NE4 9RJ

Date of inspection visit:
31 July 2018
01 August 2018
02 August 2018

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## Ratings

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

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

# Summary of findings

## Overall summary

Ashton Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Ashton Court Care Home accommodates 42 people in one adapted building, across four floors. There were 34 people using the service at the time of our inspection, including some people living with dementia.

This unannounced comprehensive inspection took place on 31 July and 1 and 2 August 2018. This meant that neither the provider nor the staff knew we would be visiting the home.

This was the first inspection since the provider registered with the CQC.

The previous registered manager of the service had formally de-registered with CQC in June 2018. A new manager had been employed and supported the inspection process.

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.

People who used the service and relatives told us staffing was not adequate to run the service safely, particularly the first floor and other floors during certain times of the day. During the inspection we confirmed this to be the case. However, the regional manager confirmed they had increased staffing levels in the 1st floor of the service and provided a 'floating' (additional) member of staff to cover during break times and other busy times.

Medicines management had areas which needed to be improved, including timing of administration, disposal and recording. Staff had received training in medicines and competencies had been completed.

We could not always confirm if people were supported to have maximum choice and control of their lives and that staff supported them in the least restrictive way possible. Although documents showed consent was gained. Other issues demonstrated that people were at risk of receiving care and treatment which was not lawfully consented to, for example, lasting power of attorney documentation was not always in place to show those authorised to act on people's behalf's. Applications had been made for Deprivation of Liberty Safeguards (DoLS), where it was considered that people would be unable to keep themselves safe if they were to leave the home unaccompanied, however, the service was not clear on the number of people who had been authorised until they liaised with the local authority after our inspection.

Whilst there was evidence that some of the shortfalls we identified had been highlighted through audits and checks, we noted the issues were still on-going in some cases.

Staff were knowledgeable about the safeguarding process. Accidents and incidents were recorded and monitored to determine if any trends were occurring.

Risks to keep people and staff safe were managed, although we did find some gaps. Health and safety checks on the building and equipment were regularly carried out and we were told that in a recent visit from the fire service they were happy with fire safety. We noted that personal emergency evacuation plans needed to be updated, but the manager was going to address this.

Recruitment processes were undertaken, including pre-employment checks. However, we have made a recommendation in this area as the provider had not always followed best practice in reference requests.

Staff training was mostly up to date. Staff received regular supervision and the manager was working to ensure that annual appraisals were completed. New staff completed an induction and had opportunities to shadow more experienced staff.

Feedback about the food on offer was positive. Where required, people were not always provided with a visual choice so they could decide what they would like to eat. Where people needed support to eat, this was given in a dignified way.

People had access to a range of healthcare professionals to maintain their health and wellbeing. Referrals and appointments had been made with GPs, podiatrists and district nurses. Any advice had been built into care records.

Most care plans in place were person-centred and included details about people's life histories and what was important to them. People's individual needs were assessed and care plans were put in place and reviewed regularly. However, we did find some care records that needed improved and the manager was already in the process of reviewing these.

People told us staff were friendly and caring. They told us they were treated with dignity and respect. We saw that regular staff knew people well, and we observed positive interactions between people and the staff who supported them. Relatives told us they were welcome to visit at any time.

There were activities planned within the service, however the manager was in the process of reviewing these.

Complaints had been responded to in line with the provider's policy.

Feedback about the management team was positive. Staff described the current management team as supportive. Meeting took place for staff and residents/relatives alike. Minutes were recorded which showed feedback was sought and opportunities for discussion were given.

The service had built links with the local community, including church groups and local schools.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, consent and good governance. You can see what action we told the registered provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Medicines were not always managed in a safe manner.

Staffing was not adequate during the inspection, particularly on the 1st floor. The provider put in place additional staff to resolve this.

People told us they felt safe. Staff had completed safeguarding training and told us they would report any concerns.

Recruitment processes were in place but we have made a recommendation in this area in relation to reference requests.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff did not have complete records or understanding of which people were supported with consent or those subject to a Deprivation of Liberty Safeguard authorisation.

People told us staff were knowledgeable and were able to meet their needs.

Staff felt supported and received supervisions and yearly appraisals were being conducted.

People were complimentary about the food.

People were supported to access a range of healthcare professionals.

### Is the service caring?

**Good**

The service was caring.

People told us staff were kind and compassionate. People were treated well, with dignity and respect. People's right to privacy was promoted.

Staff knew people very well and had built friendly relationships. Visitors told us they were made to feel very welcome.

## Is the service responsive?

Good

The service was responsive.

Care plans were generally detailed with information about how staff should provide care and personalised support to people.

The service provided activities but the manager was in the process of reviewing these.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance system covered a range of areas. However, whilst it had identified some of the shortfalls which we found during this inspection, they had had not been fully addressed.

The last registered manager had not been in place since June 2018, but a new manager had been appointed. People spoke well of the new manager and staff described them as supportive and responsive.

The home had built links with the local community.

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

This inspection took place on 31 July and 1 and 2 August 2018 and was unannounced.

The inspection was carried out by an inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service. This included looking at statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We contacted the local authority safeguarding and commissioning teams, Healthwatch, the local fire authority, care home infection control team, tissue viability nurses and used any comments to support our planning of the inspection. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services.

We asked the provider to complete 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. We used this information in our inspection planning.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Throughout the inspection, we spent time in the communal areas of the home observing how staff interacted with people and supported them. With consent, we looked in four people's bedrooms.

During the inspection, we spoke with sixteen people who used the service and six relatives.

We spoke with the manager, the provider's regional manager, a visiting director, two registered nurses, one

senior care worker, six care workers, the maintenance person, a member of domestic staff, one of the cooks and the administrator. We also spoke with one community nurse and one district nurse. We contacted a GP and three local authority care managers. We used their comments to support our judgements.

We reviewed six people's care records, twenty medicines administration records. We looked at five staff personnel files, in addition to a range of records in relation to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

We looked at the arrangements for the management of medicines, including observations of medicines being administered. We looked at the timings of people's medicines and although some people received their medicines at the time prescribed, others did not. One staff member told us (and we heard) they set their alarm to remind them to give people their Parkinson disease related medicines. However, this was not the case for everyone. We found people who required their medicines to be given 30-60 minutes before food were receiving breakfast and then being given medicines.

Thickeners were found in an unlocked dining area cupboard. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. There was a previous alert issued to care homes regarding the death of an individual due to swallowing thickeners directly from the container. We brought this immediately to the attention of staff, but then the following day, we found the container of thickeners back in the same location.

On one occasion staff had left medicines with a person who required staff to oversee their administration, and on another occasion, we found medicines had been left on top of the dispensing trolley while staff dealt with another matter and left them unattended. Although no one came to any harm, we spoke with the manager who said they would address these issues.

Staff had not seen the medicines policy and confirmed this with us. One nurse said, "I will have to get a copy of that." We noted that completed medicines competencies refer to the medicines policy being followed and this included for the staff who had not seen the policy. We also noted that on a recent visit from the medicines optimisation team (clinical commissioning group support team for medicines) that the medicines policy was not available to them. This visit occurred at the beginning of May 2018.

We found that PRN (as required medicines) protocols were not always in place. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and how often people require additional medicines such as those for pain relief. The manager had already started the process of updating these records, although they were not all in place at the time of the inspection.

There were separate administration records for topical medicines. Topical medicines are, for example, creams or ointments applied to the body. We found these were not always fully completed or had the full details of where and how staff should apply the medicine in question. The manager told us they would address this and ensure correct paperwork was in place.

Medicines which were no longer required and due for disposal were not stored in a tamperproof container and in line with NICE guidance. NICE is an organisation called The National Institute for Health and Care Excellence. They provide national guidance and advice to improve health and social care.

We observed staff administering medicines carried portable home phones with them during this period and often stopped to take phone calls into the service. This is particularly dangerous as can lead to mistakes in

administration. We brought this to the attention of the manager who agreed and said they were making arrangements for this to cease, along with the purchase of red tabards to alert everyone not to disturb staff while administration of medicines is taking place. Overall, medicines were not managed as safely as they should have been.

Risks were assessed and where possible, actions were identified for staff to take to mitigate issues occurring. For example, we saw risks had been considered within the records we viewed for risk of falling, use of bed rails, diabetes, moving and handling and mobility. Risks had also been reassessed regularly or when an incident had occurred. We found a number of bed rail risk assessments had been completed incorrectly. We also found that a number of other risk assessments were not always in place or had not been fully completed. For example, one person was at risk of choking. However, their risk assessment had details of a normal/soft diet, where as their care plan detailed a fork mashable diet. Another person had no risk assessment in place in connection with their medicines to ensure they were able to receive them safely.

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

People, relatives and some staff thought that there was not enough staff. One person told us, "There are occasions when there is no staff around and you feel abandoned. The other day three of us waited for staff to go to bed, but it didn't occur quickly, we were left sitting." Another person said, "Yes, they need more staff. There can be delays in waiting for staff." A third person told us, "When the staff have their breaks it leaves one of them…it's not enough."

Relatives we spoke with confirmed that there were not enough staff and comments included, "There is definitely not enough staff, especially on the middle floor from what I have seen"; "It is hard to find staff sometimes when you need them, but it's not because they are skiving, it's because the two staff on duty are usually seeing to someone in their room" and "I spent 10 minutes one day looking for someone."

We reviewed staffing rotas for the four weeks prior to our inspection. We found that the staffing ratios described and calculated by the manager had been met. There had been a number of occasions where, due to staff sickness the service had one less staff member than planned and this was the floating staff member who would have covered breaks and any additional need across the service.

Our observations concurred that the service was short of staff particularly on the first floor which accommodated people who lived with dementia. We saw people left unattended in lounge areas, including when hot trolleys were in the vicinity. We timed the response for call bells activations on a number of occasions and found they often were for extended periods of time as staff were busy elsewhere. During a morning visit we found one person suffering from a seizure and no staff were available in the area as both staff on duty were assisting another person in their bedroom. We aided the person and called staff to support them. Due to lack of staff, this placed the person at risk of harm.

We spoke to the manager about our concerns and later they confirmed that an additional staff member had been agreed for the 1st floor and they would have a 'floating' (additional) member of care staff who would cover staff breaks etc. We also discussed staff breaks with the manager and they said they would review this to ensure that staff were not leaving together which meant the 'floater' could not cover appropriately. The manager also assured us they would look into unattended hot food trolleys and call bell answering times. We spoke to a relative after we had completed the inspection visit to the service and they confirmed that additional staff were now in place.

The use of agency staff continued to be an issue, however, the provider had recruited a number of staff and were waiting for employment checks to come through in order for them to start in their roles. The provider had a recruitment process in place, including completion of an application form, interview process and employment and identification checks taking place. We reviewed five staff personnel records and the new managers records. Disclosure and Barring Service (DBS) checks had all been carried out. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. The provider had not always applied for appropriate references in all cases as per Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They later confirmed that references had now been sought from the member of staff we had highlighted. Registration of nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC).

We recommend the provider review their recruitment procedures in line with best practice.

People told us they felt safe at the service. Comments included, "Yes absolutely (feel safe)"; "Yes, I feel safe here and they look after me well. It's the best I've felt living here"; "Well there's nothing happened here to make me feel unsafe"; "I'm safe but I've never liked it. I don't know if it's the room or if it's in my head" and "Yes, I do (feel safe), but we did have a little bit of an upset last week when we had a burglar."

We were made aware that there had been a break-in recently. The provider had updated security measures and was in the process of placing further measures in place to prevent a reoccurrence. We were told by staff that people living at the service had discussed safety measures in their regular meetings and looked to raise awareness amongst the people who lived there. One person confirmed, "At our last meeting [residents] we spoke a lot about safety due to the recent break-in we had."

Relatives told us they thought their family members were safe and comments included, "Yes, she's safe but I know she'd like to come home" and "I have no worries about safety at all. I would not let them live here otherwise." One relative told us, "I know about the break-in, honestly, these people have got no heart…I believe they have changed things around so it does not happen again."

Staff had undertaken safeguarding training about how to recognise and respond to any concerns. The staff we spoke with knew what to do in the event of any concerns they may have had. One staff member said, "No problem reporting anything like that…would not even hesitate." Safeguarding records showed appropriate referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

Accidents and incidents were monitored. We saw accidents and incidents records were completed promptly after they had occurred, and were reviewed by the manager. The system prompted the manager to consider if staff had acted appropriately, if any further action was required and if any other agencies required to be notified, such as the local safeguarding team, or CQC. Records showed details of investigations and outcomes and any lessons learnt.

The local fire authority had just visited the service and we were told they were happy with fire safety arrangements. Certificates in relation to health and safety for the premises were in place and up to date. For example, electrical installation, lift and fire safety records. The service also had a range of risk assessments for the building and the environment. These included moving and assisting equipment, water temperatures and emergency lighting testing. These were reviewed on a regular basis to ensure they were up to date. We saw that personal emergency evacuation plans (PEEPs) were in place. PEEPs are used to support emergency services with information about individuals who may need to be evacuated from the service should an

emergency arise, like a fire or flooding. We noted that some of the forms had no information in relation to people's capacity (for example, if a person was living with dementia), which is a crucial piece of information in which to prepare emergency services when an evacuation is needed. The manager said they would add this information as soon as possible.

Staff maintained the cleanliness of the main building as we saw it was clean and tidy and we observed staff wore protective equipment, such as gloves and aprons appropriately. We found no issues with infection control procedures.

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.

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).

The service did not have clear documentation to confirm which people were restricted under a DoLS authorisation. We checked whether the service was working within the principles of the MCA. Some people who used the service did not have capacity to leave the home unaccompanied, as it was considered that they would be unable to keep themselves safe. We saw applications had been made to the local authority for DoLS authorisations. However, when we liaised with the local authority on the number of people who had an authorisation in place, the numbers of people were not the same as the service had. We spoke with the manager about this, who said they would contact the local authority to confirm the information they held was correct. We found that staff did not have a working knowledge of who was subject to a DoLS when we asked. For example, one staff member told us that one person was not subject to a DoLS authorisation, when in fact they were. We also found that handover paperwork did not include the correct details of which people were subject to a DoLS authorisation.

The service did not have copies of Lasting Power of Attorney (LPA) documentation. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. Without copies of documentation, staff could not be assured the right people were being involved with decisions about people's care and treatment. We brought this to the attention of the management team during feedback.

We saw that CCTV was used in some communal areas of the service, however, we were not shown any evidence to confirm this had been discussed with people living at the service or their relatives or had been consented to.

Where people did not always have capacity, assessments and best interest decisions were in place. However, we saw variance in how well these had been completed. We saw several capacity assessments which were not decision specific. For example, one person's assessment discussed whether they could make decisions about their care, safety, treatment, welfare, health and wellbeing. One of the principles of the MCA is that a person's capacity must be assessed in terms of making a specific decision.

Although documents showed consent was gained. Other issues demonstrated that people were at risk of

receiving care and treatment which was not lawfully consented to.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed before they moved into the home to make sure the staff were able to care for the individual and had the necessary equipment to ensure the people's safety and comfort. People's needs and plans of care were reviewed and updated monthly to ensure they contained relevant information. Some records had not always been updated regularly, but staff were aware of this and were spending time reviewing these.

Staff received an induction based around The Care Certificate. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. The provider used a booklet to monitor the completion and the service had started to use this. Agency and bank staff also received an induction and records and discussion with staff confirmed this. One member of bank staff said, "I have had a full induction. I came in to shadow and meet people while doing medicines. I was shown care records. It covered the building and health and safety. I have also had training to complete on line.

People and relatives told us staff were skilled and knowledgeable to meet people's needs. One person said, "There is new staff here and they are doing a fantastic job, especially in comparison to the previous nurses" One relative said, "The staff seem to be well trained, although not sure about the agency staff." The service's training matrix showed care workers had received training such as nutrition, moving and handling people, health and safety and medicines training. We confirmed this was correct by cross referencing the information with individual staff records and discussions with staff. There were a few staff who were due training but this was being addressed.

We noted chair exercises were undertaken with people who lived at the service. We found no training available to staff to undertake this safely. The manager confirmed they (manager) had received training in this area and would ensure that this was addressed before any further exercises took place to maintain people's safety.

Training supported information within care records as they described to staff how they should carry out each person's care. For example, staff received face to face practical training in the moving and handling of people. Within each person's record were details, such as, how many staff were required and the details of any equipment needed to support the person to get in and out of bed, or into a chair. During our inspection we saw people being supported to move as per their care plans and with staff showing the utmost care during the process and communicating with people throughout. During one moving and handling procedure, one person said, "Nice day today" and smiled throughout, showing they were totally relaxed in the safe hands of staff.

Staff told us they had opportunities for support sessions, including supervision and yearly appraisal. The new manager was working their way through staff appraisals and supervision sessions had taken place and were planned for the future from records we viewed. Staff told us the new manager was responsive, listened and supported them. One staff member said, "They have been very good since they started, feel supported yes."
People and relatives, we spoke with told us they thought the service was effective. People told us, "We get good support I can tell you that. I'm hoping to improve my mobility while I'm here, I've noticed the carers helping people to walk and get motivated which is good, but I can't as I can't see. I've heard them mention

an exercise class I'd like to do that"; "I have been here about 10 months now and my health has improved considerably" and "I have everything I need here, it's not home, but it does what it says on the tin."

Handovers from one staff shift to another took place in the morning and late evening. We sat in on two verbal handovers with no written record being kept. We noted that not all staff attended handover, including agency staff. This meant that crucial information may not have been handed over. The manager showed us the written documentation which should be completed at each handover and confirmed that all staff should attend. The manager said they would look into this to ensure that all handovers were fully recorded and confirmed they had already spoken with senior staff. We noted that the written handover format was detailed with a picture of the person, snapshot of their health issues and would have provided a good source of information; which would be particularly useful for agency staff. It also included staff signatures to confirm staff had attended and had reviewed the information available to them.

People's comments regarding the food and refreshments available at the service were positive. People's comments included, "The meals are ok thanks"; "The food is nice, I've never had anything bad" and "No problems with the meals. They are normally very nice. Some people complain about the temperature though." There were a small number of less positive comments made, including, "They're alright except for sweets as I'm diabetic and they keep coming up with things like mousse and it's no good. They seem to ignore the question of fat with my diet which is important. I think there could be more variety now and then."

One person living in the community who visited the home on a daily basis told us, "I come for my lunch here every day, it was very good of them; they didn't have to, but the manager said it was ok. I have a full three course (meal)." We asked if they get a choice and they confirmed they did.

Each person was given a choice of what they would like to eat and asked for their preferences the day before, which was recorded and sent to the kitchen. During meal times we noted that some people living with dementia were not shown the choice of meals plated up, which we had been told by the cook and the manager should have occurred. Menus were available with picture format to support people in deciding what they would like to eat. One person told us, "I don't eat a lot, I have a small appetite, I can't really eat things like beef because of my teeth. I do eat a lot of jelly and custard, I only eat two meals a day but that's my choice." A 'resident' representative told us, "Yes, I speak to the cook daily about feedback from the residents, for example one lady mentioned she likes peas pudding so I spoke to the cook about her having a little extra on her sandwiches. The cooks are always happy to help."

The kitchen contained a variety of fresh and dried produce, including full fat milk, cream, cheese and fresh meat and vegetables. An assortment of freshly cooked meals were prepared daily, including cooked breakfasts and hot and cold choices at other meal times. Fortified drinks were provided and a range of other refreshments throughout the day. Mid-morning and afternoon snacks were prepared outside of regular meal times and these consisted of a selection of fruit, cakes and biscuits. People we spoke with confirmed this was usual. One person said, "We get lots of snacks with the tea trolleys, it's not just because you're here!" One relative commented that their family member did not have a choice of brown bread as they thought none was available. We checked the kitchen and other storage and found brown bread in use. We spoke with the manager about this and they said they would ensure that everyone was offered a choice of bread, but said that this should be happening now anyway.

We noticed that some people were placed at dining tables and then had to wait an excessive amount of time for food and drinks to be served to them. For example, two people waited more than 20 minutes for a first course to be served at lunch time on one floor, while on another floor, one person waited 20 minutes for

their main course to be served after finishing the soup starter. The cook told us, "Meals should be served as soon as they arrive." We spoke with the manager about this who said they would speak with staff.

People were supported with their meals and drinks if that was required as part of their care regime. We observed a number of people being supported at meal times, and this was done in a non-rushed fashion. People received meals in various forms as required, including for example, soft or pureed. One person preferred pureed meals and said, "I have it like that for swallowing." Their records confirmed this to be the case. When we checked records held within the kitchen for people who were on special diets, including those people who were diabetic, we found the information was not always up to date. When we checked care and medicine records we noted that some people were recorded as being diabetic but this information was not passed on to kitchen staff. Although we did not observe any of those people receiving inappropriate foods, this posed a risk. We brought this to the attention of the manager who said they would address this immediately.

People's care records showed details of referrals to, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. The service received weekly calls from a GP and community nurse, this ensured that any issues with people's health were addressed straight away. A community nurse told us, "It a proactive approach and endeavours to reduce hospital admissions, which it does." One person told us, "I saw the GP not that long ago. I had a right bad cough. I am okay now."

Visitors to the service were greeted by a staffed, comfortable reception area during day time hours. We found staff working in the area to be extremely positive and visitors we spoke with commented, "Makes such a difference when you have a cheerful, smiling face to greet you" and "[Name of staff] is always helpful and asks how things are going."

The service had been adapted to the needs of the people living there. There was good clear signage throughout the service, for example, using pictures as well as colours to assist people to use bathrooms. The service was relatively new in structure and facilities were aimed to be accessible for those less mobile, including people who used wheelchairs. Storage was very good in the service with separate storage facilities for example, hoists and other moving and handling equipment. Hairdressing and cinema facilities were available for people to utilise.

Memory boxes were in place outside of bedrooms where people lived with dementia. Some of these still needed to have items of memorabilia placed in them to support people to further recognise their bedrooms.

Outside was an enclosed garden for people to walk, however we found this to be in need of maintenance as it was overgrown with weeds and some of the shrubbery was growing over walkways. People we spoke with told us the area needed addressed. The providers advertising literature described the gardens as 'beautiful' which we found they were not. One person said, "We have plans to put a bird table out there." One relative told us, "They (provider) have a lovely water fountain at the front in the car park…that should be round the back for [person's name] and others to see when they look out. Definitely needs some work done out there." We spoke with one of the directors of the about the garden area and he said he would look into this and said, "Our guests are important and this will be addressed." We will follow this up at our next visit.

The service had large viewing windows, particularly on one side of the building and we observed that at night anyone looking in from outside could see the corridors and there was potential for people's dignity to be compromised. Staff told us that a film had been placed on the windows so that people could see out but

no one could see in. This was not the case. We brought this to the attention of the manager, regional manager and director. The director immediately contacted their architect and asked them to resolve this issue.

Good

# Is the service caring?

## Our findings

We witnessed on a number of occasions people looking distressed and staff approaching to provide reassurance and helping people to calm down. People and relatives thought that care staff were kind, compassionate and went the extra mile. Although they felt agency staff did not have the same interaction as permanent staff and did not know the people who lived at the service as well.

People's comments included, "I like all the staff here, I love it here, I like my physio, I'd like to have more exercise though. I like that my husband can come and see me, I'd go mad if he couldn't"; "I'm well looked after, and the staff are smashing"; "The staff are very good to me, I know I can speak to anyone of them here, they let me speak to them, they are always friendly to me" and "The usual staff are lovely, but some of the stand ins (agency staff) don't know me and I don't know them…it's not the same." One person told us, "I feel looked after most of the time. Night staff can be hard. Last night [two agency staff] were on and I was told I couldn't do this and that but this got sorted for me, but I didn't want to go to bed with people on who couldn't understand me, and I couldn't understand them. The others [permanent staff] are very good though."

The provider acknowledged that agency staff had to be used while they recruited into various posts, however, they saw this as a short term measure and said new staff would be in post soon. The manager said, "Its not ideal to use agency and we all know that, it won't be long before posts are filled though."

One person explained how kind Maintenance staff had been and said, "I do get involved, my personal hobby is bird watching. They bought me a bird feeder, so I can go out daily and feed the birds. I was given a huge bird feeder so I'm working with [maintenance person] to make a frame for it so it can go outside the lounge. He does it with me and puts things in the trees for me. I'd say I probably see him daily."

Relatives told us, "I think the staff are all friendly and [person] speaks well of them, she's always smart and clean and they're always happy to help"; "She's well cared for and I cannot fault the staff. We all get on ok they seem pleasant" and "All in all the staff are good, it's the agency staff that just don't know everyone and don't seem to do as good a job."

Healthcare professionals told us that people who lived at the service were happy with staff and their caring natures. One professional told us, "Residents appear happy with staff. They seem caring." They continued, "Staff always make time for you and if you ask, they are always helpful." Another healthcare professional said, "Staff seem to be involved and know residents. Residents, not commodities and they tailor the care to personalities and it's not forced." Another professional said, "I have never come in and thought concern – not here. There is a good energy."

Staff supported the people who lived at the service by raising funds. For example, we saw advertised in reception that one staff member was about to complete a paraglide to raise money for the 'residents' fund which would provide additional entertainment (for example) for the people who lived at the service.

Throughout the inspection we saw permanent staff knew people who used the service well. Staff greeted visitors when they arrived at the home. Relatives told us they were welcome to visit whenever they wanted to. In conversation with us, staff were knowledgeable about people and their needs. People seemed relaxed in the company of the staff. We saw an activity taking place with care staff and the activity coordinator and people were laughing and enjoying the interaction.

One person who was unable to communicate verbally, was supported regularly by care staff. We saw them having positive days and less positive, but throughout, staff tried to interactive with them. On the positive days, smiles were evident and the person was clearly enjoying the companionship of the staff around them, which included holding the persons hand to show affection.

People's privacy and dignity was upheld. We saw people looked well groomed, wearing clean clothes. One person said, "They always shout through and knock. They are very good at making sure I feel comfortable and respecting me. You know what I mean…It's hard to relax when staff are seeing to you (providing personal care), but the staff are very good at making you feel at ease." One relative said, "Staff always knock and ask us to leave when they are helping [person's name] with the toilet or changing them."

People were encouraged to be independent. People's care records set out what tasks people could manage themselves and detailed that staff should prompt people to maintain these skills, for example by washing their own face and hands whilst staff supported them to bathe. We observed that staff supported people to be independent where they could. For example, over lunch we saw staff ask people if they would like condiments and handed people the containers to use themselves. We also overheard one staff member encourage a person by saying, "Let the baby look out of the window while you have your dinner." The person used a doll as a comforter and this was their 'baby'.

Staff were respectful when speaking with people. For example, we heard staff calling people by their preferred name and listening and giving people the time to explain, before responding and not interrupting the person before they had finished explaining.

People were supported to express their views and be actively involved in making decisions about their care and how the service was operated. 'Resident association' meetings took place every two weeks for the people who lived at the home. This allowed people to get together and discuss any changes they would like to see and discuss positive changes that had happened. A person had been appointed to chair the meeting and they had taken the lead of minute taker and promoting the meetings within the home. The chair confirmed that they also fed back suggestions to the manager. For example, they said, "One resident had fallen so we discussed having pendant alarms for those who can get around. The manager does respond, and she does listen." Relative meetings also took place but some relatives said that they had not attended and one said, "We just see the manager if we need to discuss anything."

Care records had been written with input from people who used the service and their relatives. People told us, "They asked me loads of questions when I first came and last night the activities coordinator came and asked me questions about what I'd like to do. She said she'll get back to me when they start things up" and "I was asked my likes and dislikes and made a care plan."

Information was provided to people in service user guides about what they should expect from the service. Noticeboards contained information, for example, about the provider, how people could access various community events and services, including church services in the area.

At the time of our inspection we were not made aware of any person accessing an advocacy service. The

manager told us they would make a referral if they identified anyone who would benefit from this type of service. Information relating to independent advocacy services were available on information notice boards. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

# Is the service responsive?

## Our findings

Care plans were varied in how detailed they were. Most had been written in a person-centred way, including specific information about the person and providing guidance for staff to follow to provide the person with consistent care. For example, a care plan relating to one person's moving and handling care detailed how many staff they needed to move them safely and how it should be completed with particular equipment needed. Another person had a very detailed diabetes care plan in place, including what actions staff should take in cases of emergency. However, we did find one person who had recently suffered a form of seizure had no care plan in place for staff to follow. We spoke with the manager about this and the matter was addressed straight away. We also found some other care plans which contained incomplete detail, for example in relation to their capacity.

Care plans were not always kept on the floor which the person lived. They were stored between two offices on different floors. This made it difficult to locate a particular person's care record when required. The manager agreed that the current storage system was overly complicated and would address this.

We saw, and the manager confirmed that care records were in the process of being reviewed to ensure all information was relevant and up to date.

Some people were at risk of developing damage to their skin. Preventative pressure relieving measures were in place for those people who required them. We checked people's equipment and saw each was on the right setting for the person's needs. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin, and staff regularly checked the equipment settings to ensure they were working efficiently. One person had pressure damage and the treatment plan was clear and evidenced the progress which was being made to improve the damaged skin.

People and relatives had the perception that staff were responsive to their (or their family members) needs. One person said, "I'm well looked after. No complaints from me. A relative said, "I believe they (care staff) respond well." However, during our inspection we saw staff were not always available within communal areas. We heard call bells were responded to, but sometimes after an extended period of time. We have dealt with these issues within the safe domain.

Daily records were kept for each person. These contained a summary of support delivered and any changes which had occurred, including when people were being cared for in bed and at risk of deteriorating skin integrity. If people needed support to eat and drink, additional documentation to record re-positioning at regular intervals and their food and drink intake were kept. We saw these were well maintained.

The service provided end of life care to people with terminal and life limiting conditions, although at the time of the inspection, no one who lived at the service was receiving end of life care. One person told us, "Yes, I was involved [in care planning] and now I'm currently making me end of life plan which is a good thing to have in place." Other people had the choice of producing end of life care plans should they have wished to for future use.

Staff had worked with people and health care professionals to ensure future plans were in place should emergency situations arise. Correctly registered Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were in place. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly and is signed off by a suitably qualified healthcare professional. We saw that emergency health care plans (EHCP) were in place for some people. An EHCP is a document that is planned and completed in collaboration with people and a health care professional to anticipate any emergency health problems.

People and relatives had mixed views on activities available in the home. One person said, "I love going out in the garden, but we need it done properly, that's something [manager] said she'd sort. We watched a good film last week about Jonny Cash. The activities coordinator is marvellous, she always looks after us and does our nails. I think everyone likes her. There's not loads to do but there is a choice"; "She [activity coordinator] used to do my nails but when I've asked her lately she says she's been busy. I spend all my time in here [bedroom]. I don't like being in the lounge. I'm not a mixer" and "Sometimes there is nothing to do."

On one of the inspection days, the activity coordinator went around at breakfast time asking people if they would like to come to the cinema room at 2:30pm to watch a movie. They brought the movie with them and explained to each person what it was about. One person said, "Oh, I like him, I want to come."

The activities coordinator told us, "A lot of the residents are new so I'm still working out what kind of things they like. [People living with dementia] can be hard to get them motivated so I do armchair exercises. They all seem to like quizzes and bingo, the men tend to like their movies, but they don't have to wait till movie day. I'm happy to put one on any time for them. We recently done a coffee morning where relatives could come, and donations go back into resident's funds which pays for entertainers." They also said, "I have a four-weekly planner which doesn't have to be final, I will change it to the resident's preferences. I've also started doing photograph books of the activities. The staff come in and get involved too they are quite supportive, they're a good team. I help them, and they help me."

Varied activities had taken place, but people told us that, "The amount of activity on offer varies, depending if the activity coordinator had taken someone (person) out. We saw this in practice during our inspection, where limited stimulation was available because the activity coordinator had taken one person out of the service. We spoke with the manager about this and she said that she had recognised this and was reviewing activities across the service.

Large printed versions of various documentation was available as required. We were also told that interpreters had been used in the past when one person's first language was not English.

There had been seven complaints formally registered with the provider. All the people we spoke with told us they would make a complaint if they had any concerns. One person said, "I am able to say if I have had any problems, they have always been sorted out; nothing major." A relative told us "I have complained before and they dealt with it. I was happy with the result." Complaints had been recorded and the manager had followed the provider's policy in response to formal written complaints and any concerns which had been raised verbally. Where necessary the manager had carried out investigations in response to complaints including reviewing records and taking statements from staff.

Requires Improvement

# Is the service well-led?

## Our findings

Overall, we saw people's care records were detailed and specific. However, we noted a number of examples where they were briefer and needed to be re-written in order to provide staff with important information about people's needs. Capacity assessments did not always follow the principles of the Mental Capacity Act 2005 in being decision specific. Diet notifications to the kitchen were not up to date. Care plan audits were carried out regularly but had not always addressed these areas of improvement.

A range of audits and checks were in place, including those undertaken by the manager and the regional manager. Whilst we could see that areas for improvement throughout the quality assurance systems were noted, and action plans created and worked towards to address these areas, they had not fully corrected the shortfalls we identified during this inspection, for example, regarding medicines, record keeping already noted and staffing issues.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection a registered manager was in place who had been responsible for the service initially when it first registered. They had applied to cancel their registration. The previous (last) registered manager had formally de-registered with the Care Quality Commission (CQC) in June 2018. The new manager had been in post for approximately four weeks and had started the initial process of applying for their DBS check in order to register with the CQC.

Feedback about the leadership of the service was positive. People told us the management team were friendly and had a visible presence in the home. When we asked people about the new manager they told us, "Yes, she is very supportive. Since the new manager there have been a lot of changes, much better and all for the good"; "Yes, she's very approachable and a very nice woman, she's the kind of woman that gets stuff done"; "Its recently changed but she hasn't been to see me, she wouldn't recognise me on the street" and "She seems very approachable and pleasant." Although some people told us they did not know the manager and had not met them.

Relatives told us of the manager, "Yes (met them) and she's made it very plain I can go to her at any time"; "I have spoken to her a couple of times since she arrived. She seems to listen and take notice" and "I had to speak with her a couple of weeks ago, she seemed nice and sorted things out."
Staff told us the manager had been supportive and the service had improved since they had started working there. They said, "She lets me get on and do my own thing, but I can approach her any time if I have any problems"; "I feel better with the manager, she seems nice and approachable" and "I have lots of time for her, she has listened to me and acted on my suggestions." Staff told us they enjoyed working for the provider and liked their job.

The manager appeared open and transparent. During the inspection, the manager displayed openness and transparency, including towards the evidence we presented to them and were proactive in their response to

our findings. The manager and regional manager showed a commitment to making changes and improvements within the service as did the director we met.

We saw from a copy of the statement of purpose (SOP), information needed to be updated. A SOP for a business describes what they do, where they do it and who they do it for. If you apply to the CQC to carry on any of the activities we regulate, you must include a SOP as part of your application. It must include the services aims and objectives. The SOP referred people to contact the CQC if they were not happy with a complaint, whereas this should refer people to the ombudsman for adult social care services. We asked the provider to refer to the CQC on line guidance and the manager said this would be updated to ensure the SOP was accurate and fully up to date.

The service had an emergency contingency plan in place. This ensured that the service would carry on operating in the event of an emergency, including lift failure, power cuts or flooding for example. We noted that the document needed updating with the current manager details.

Incentives and benefits were available for staff members, including staff discount and childcare vouchers schemes. Awards for providing good care or going the extra mile at the service were also available, with nominations being received from people, relatives or other colleagues. Displayed in the reception area was details of staff who had recently won awards and staff confirmed this to be the case and that they had received a cash reward for these too as well as the certificate.

Surveys had been sent out to people who lived at the service and their families. Out of the surveys returned (approximately 35% return rate) the majority of the comments received back were rated as good or excellent with others as fair. There were a small number of ratings classed as poor by people, including for example, dissatisfaction with the laundry service. An action plan had been put in place to address the issues raised. No one we spoke with raised any issues currently with their laundry. The manager told us they were monitoring responses and working with the chair of the resident association to ensure no issues remained.

Meetings had taken place with staff from the service, including full staff meetings and flash meetings with heads of departments. These had included discussions around various topics, including staff morale, policy and procedures, holidays and handovers. We noted that actions from previous meetings was not always carried forward to ensure completion. Staff were noted as having made comments and being part of the meeting process.

The service had built links with the community. Staff had organised various community groups to visit the service, including church groups and school children to take part in singing and other activities.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not always ensured that consent was provided correctly or legally before care and treatment was provided.<br><br>Regulation 11 (1)(2)(4)(5) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not ensured that medicines were always managed safely. Risks to people had not always been fully assessed and mitigated for.<br><br>Regulation 12 (1)(2)(a)(b)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had systems and processes in place to monitor the service provided, however these had not always addressed the issues we found during the inspection.<br><br>Regulation 17 (1)(2) (a)(b) |