Advinia Care Homes Limited

Parklands Court 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 15 May 2018 with a return announced visit on 17 May 2018. There has been a change of ownership and this will be Parklands Court Care Home's first inspection since it was registered under the new provider, Advinia Care Homes Limited, in November 2017.

Parklands Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Parklands Court is purpose built and consists of six separate, single storey buildings: Collins, Samuel, Harrison, Marlborough, Elmore and Clarendon. The Clarendon unit was closed at the time our visit. The service is registered to accommodate up to 163 people providing nursing care to older people living with dementia and people who require rehabilitation and palliative care. At the time of our inspection there were 104 people using the service. Parklands Court is currently subject to a restriction on admissions imposed by the local authority and clinical commissioning group. This was imposed prior the registration of the new provider but has remained in place.

The home manager was not yet registered with CQC but told us it was their intention to apply. 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.

It was recognised the service is undergoing a major transformation. The governance systems had only just started to be implemented and had not been consistently effective at ensuring good working practices were constant across all the units. They were not always effective in ensuring all people received a good quality of service. The manager had worked closely with partner agencies to monitor and improve the quality of the service and where shortfalls had been identified, they were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences. People who used the service, most relatives and staff were confident in the new leadership of the service.

Full information about CQC's regulatory response to issues and concerns found during inspections are added to this report after any representations and appeals have been concluded.

Risks to people had been assessed and processes were in place to reduce the risk of avoidable harm. However, staff members' working practices were not consistent across the service because we saw unsafe techniques were used to move people. Where risks were identified, we found that staff members were not always provided with the relevant information in people's risk assessments to keep people safe. Risks associated with peoples' nutrition were not always managed effectively. People told us they received their medicines appropriately, but some people did not receive timely pain relief because the staff had not

identified that people were in discomfort.

People told us they felt safe and staff understood their responsibility to raise concerns regarding potential abuse. There were processes in place to ensure the premises and equipment was checked to maintain people's safety. People were protected from the risk of infection. There were systems in place to investigate incidents and share learning when things went wrong.

There were not consistently sufficient numbers of staff employed to meet people's needs across the service. Employment checks had been undertaken on staff to ensure they were suitable for their roles. Staff received limited supervision and appraisals, but told us they felt supported by the management team to carry out their roles. Staff members were aware of the provider's policies to prevent discrimination and promote equality and diversity at the service.

Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making. Mental capacity assessments and best interest's decisions were applied to show what decisions people were being supported or asked to make in relation to their care. Applications had been submitted to deprive people of their liberty, in their best interests. People were offered choices and staff sought people's consent for care and treatment. People were supported to make as many decisions themselves as practicably possible.

People received sufficient amounts of food and drinks they enjoyed and their nutritional needs were met. We saw evidence that people were being supported to access healthcare professionals when required. Relatives told us the communication from the service was good at keeping them informed about their family member's care.

People received care and support from staff that had received training but their working practices and knowledge demonstrated that the training provided was not always effective. Some staff members were attentive and supported people promptly but this was not consistently practised across the all units with some staff lacking the skills and knowledge to support people who lived with dementia. The units were not suitably tailored to meet the needs of people living with dementia. This had already been recognised by the new provider and work was in progress to address this. Plans were being drawn up to modernise and re-develop the service to meet the specific needs of people who lived with dementia.

People told us that the staff members were kind and caring. We saw many positive interactions but this was not constantly practised by all staff across the service. People were generally supported by staff that respected their privacy and dignity and promoted their independence.

There were dedicated staff members to support people to participate in social activities and in things they liked to do. People and relatives were confident any concerns or complaints would be appropriately responded to. There were processes in place to ensure people would receive appropriate care at the end of their lives.

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 most people received their medicines on time, some people had not received their pain relief in a timely way.

Techniques to transfer and move people were not always safe. Risks to people were monitored and reviewed. There were some discrepancies with the frequency of reviews and some risk assessments were not consistently completed which meant there was not always clear guidance for staff on how to safely care for people.

Although people and staff reported there was sufficient numbers of staff, from our observations, this was not consistently practiced across the service. People were safeguarded from the risk of abuse because there were appropriate processes in place and staff members were aware of their responsibilities to keep people safe.

Medicines were stored safely and people were protected from the risk of infection and cross contamination.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff that had received training, but there was some room for improvement in relation to staff members' knowledge of dementia and managing behaviours that challenge.

Risks associated with people's nutrition were not always managed effectively.

People needs and choices were assessed to ensure staff were provided with the information required to support people effectively.

People had access to a range of healthcare professionals to support their needs.

The provider had recognised the service required improvement with the living environment to ensure it was adapted and suitable for people living with dementia.

Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and these were being consistently followed.

Is the service caring?

Requires Improvement

The service was not consistently caring

Although people told us staff were caring, we found that staff working practices were not constantly practiced across the service. People were sometimes left in an undignified condition and staff did not always recognise these situations.

People told us their visitors were always made welcome.

People were supported with their independence, where possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not consistently reflective of their current needs, which placed people at risk of not having their needs met appropriately.

There were daily activities to support people's interests and hobbies but this was not consistent a across the service.

People and relatives were aware of the complaints policy and how to raise any
concerns they had.

The provider was working towards implementing the Gold Standards Framework to support people at the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

The provider's quality assurance processes had not been effective at ensuring all people received safe and consistent care across all the units. The systems had not identified the issues we found at this inspection and improvement was required to ensure all people received high quality standard of care.

Statutory notifications about notifiable incidents had been submitted.

Most of the people living at the home and their relatives were confident the new provider would make the necessary improvements.

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

The inspection was prompted following concerns received from partner agencies and members of the public that included but is not an exhaustive list:

-□Neglect
-□Allegations of abuse
-□Infection control
-□Insufficient staffing numbers
-□Lack of training/supervision for staff

CQC was aware of safeguarding investigations, complaints and injuries sustained by people living at the home. As a result of the number of concerns notified to us, over the short period of time since the home was re-registered with the new provider, we explored aspects of people's care and treatment during the inspection. This included reviewing current risks to people and the action taken by the provider to mitigate those risks. We examined the likelihood of any impact on people living at the home and whether the provider was in any breach of their legal requirements.

This inspection took place on the 15 and 17 May 2018. The first day was unannounced with an announced second day. On day one of the inspection, the team consisted of five inspectors, two specialist advisors and two experts by experience. The specialist advisors were nursing practitioners with experience of working within a dementia setting. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service. On day two of the inspection, the team consisted of one inspector.

As part of the inspection process we looked at information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including

serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. We also received information from the Clinical Commissioning Group they held about the service and reviewed the Healthwatch website, which provides information on health and social care providers. This helped us to plan the inspection.

We used a number of different methods to help us understand the experiences of people who lived at the home. We spoke with 19 people, 17 relatives, three health care professionals, 17 staff members that included nursing, care, kitchen and domestic staff. We spoke with the five unit managers, the home manager, the clinical lead, quality manager and head of property. We also spent time observing the daily life in the units including the care and support being delivered. As there were a high number of people living at the service who could not tell us about their experience, we undertook a Short Observational Framework for Inspection (SOFI) observation. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.)

We sampled records of 16 people including care files, risk assessments, nutritional information and medication records to see how their care, treatment and medicine was planned and managed. Other records looked at included seven recruitment files to check suitable staff members were recruited. The provider's training records were looked at to check staff were appropriately trained and supported to deliver care that met people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received a number of concerns and complaints from partner agencies and family members regarding the safety of people living at the home. We took into consideration the complaints and concerns when conducting this inspection and explored aspects of people's care and treatment. This included reviewing current risks to people and the action taken by the provider to mitigate those risks. We examined the likelihood of any impact on people living at the home and whether the provider was in any breach of their legal requirements. We asked people living at the home and their relatives if they felt the environment was safe and we reviewed the provider's processes and practices to ensure people were safeguarded from the risk of avoidable harm and abuse.

Staff told us what signs they would look for in a person to indicate if they were in pain, discomfort or distress and protocols were in place; however we saw there was not consistent practice throughout the different units. On the first day of the inspection, we saw two people displayed behaviours that indicated they were anxious. We reviewed their care files and noted for one person they had not received their pain relief gel for six days. It was prescribed by the GP for application three times a day and this had not happened. We spoke with the unit manager, they explained there was an instruction from the provider that any medicines dispensed with 'as directed' pharmacy labels had to be referred back to the GP for a detailed written instruction on how the medicine or cream should be administered and until this new directive had been received, the gel had ceased to be used. When we checked with the home manager and other unit managers, it was clear there had been some break-down in communication. Requests had been submitted to GPs for clearer directives; however, no other pain relief for people had been provided. The person we saw did not have the ability to verbally tell staff they were in pain. Nevertheless, it was clear from their behaviours and facial expression that they were in distress. Their care plan stated, 'administer medications as prescribed, analgesia for pain management may reduce anxious episodes.' When we asked nursing staff about the person's behaviours and why they were anxious, we were told 'it's just their dementia.' Staff had not recognised the person was distressed.

A second person was seen to be in discomfort. We asked the unit manager if the person had received their pain relief. We were told they were due their pain relief at a suitable time to follow the manufacturer's guidance. We asked the manager 30 minutes later if the pain relief had been administered and found it had not been given because the person was no longer in pain. From our observations this was not the case, the person's facial expression, grinding of their teeth and crying out clearly showed they were in some continuing distress. Two nursing staff that were in close proximity to the person took no action to ease this anxiety until our intervention. Again, staff had not recognised the behaviours as distress. We contacted partner agencies to raise our concerns and spoke at length with the senior management team. Calls were made to the out of hours GP and urgent referrals were made to the appropriate agencies.

We had received information of concern that the repositioning, moving and transferring of people was not consistently safe and had, on occasion, led to injury. The service was undergoing a significant transformation due to a change of ownership and this had led to some discrepancies with the completion of some care plans and risk assessments. However, staff members spoken with were generally knowledgeable

of risks to people and explained how they would ensure people were safeguarded from the risk of avoidable harm. One staff member explained, "[Person's name] is at risk of choking, they eat fast and doesn't always chew, we give them a little spoon as this helps to limit the amount they eat." Another staff member said, "We have lots of people at risk of falling and in wheelchairs, which means we use the hoist. We make sure there are always two of us and each person on this unit has their own sling."

We reviewed a recent incident that involved a person who sustained an injury whilst being transferred with a hoist and we found the provider had taken appropriate action. It was noted on four units that safe moving and transferring of people had been practiced. However, on Marlborough we saw two incidents that indicated poor practice. One person being moved whilst sitting in their recliner chair was seen to have their left leg dragging across the floor. The staff member had not ensured the person's legs were safely off the floor. A second person was being moved using a hoist, we heard them cry out 'it's hurting', whilst staff did try to reassure the person they were safe, staff had not ensured both legs were clear of the lounge chair. Whilst lowering the person, their legs started to rest on the lounge chair and became trapped underneath them causing the person to cry out with pain. The staff immediately stopped the transfer, repositioned the person's legs to ensure they were now clear of the lounge chair and continued with the manoeuvre. Though these two instances had not caused the people any harm it showed there was a requirement to review the staff members moving and handling training. We discussed our observations with the management team. Additional training has now been arranged for staff.

People, relatives and staff we spoke with told us they felt the environment across the service to be safe. Three people told us, "People are safe here;" "I've never seen anything of concern," and, "If anyone was in any danger or if I saw someone in distress, I would tell the nurse or manager." Staff explained how they would identify if a person was in distress and the process they would follow. Comments included, "Any concerns we have been told by the managers to report it and if no action was taken I would go external and contact CQC or safeguarding." Staff we spoke with also referred to the provider's 'whistle-blowing' policy or 'Shout up.' We saw this information was displayed throughout the site for easy reference. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. We saw that when necessary the home manager had raised concerns about people's safety with other agencies in order to protect them from the risk of harm. We reviewed each of the incidents with the home manager and found that they had worked closely with partner agencies, had acted promptly and implemented action plans where appropriate.

We spoke with nursing staff and reviewed how medicines were stored and found they were stored safely. Some medicines were prescribed on a 'when required' basis and required written information to support staff on when and how these medicines should be administered. Where information was available to the staff in the form of a protocol we found the information was sufficiently detailed to ensure that the medicines were given in a timely and consistent way by the staff. We found that where people needed to have their medicines administered directly into their stomach through a tube, the provider had ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely. We looked at how Controlled Drugs were managed. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that the Controlled Drugs were being stored securely.

We had received information of concern from partner agencies and members of the public about the effective deployment and numbers of staff employed by the provider to ensure people were kept safe. We had been told due to staff vacancies there was a dependency to use agency staff and this had meant people's needs were not consistently met. We asked people, relatives and staff about the levels of staff employed throughout the five units and received mixed responses. Comments from people and residents

across the units included, "There seems to be enough staff and they work extremely hard," "Sometimes I am kept waiting for my care but the staff do their best," "There are enough staff around most of the time; you can soon find someone to ask if there is a problem. Sometimes there are less staff at weekends, which can cause some delays." We were told by people there were enough staff on the units during the day but at night there could be more staff on duty. On Marlborough unit there were 23 people living there at the time of our visit. Staff confirmed to us there were two care staff and one nurse on duty at night. We checked one person's daily records where they were required to have 30 minute checks to ensure they remained safe. The 30 minute checks had been introduced because the person was at serious risk of self-harm. However, entries in the records, made by staff, showed this was not the case. The records showed the person had become increasingly anxious and there was not sufficient staff on duty to provide the person with the additional support they required. An additional staff member from another unit had been brought across to sit with the person. We noted from the records, the person was not assisted to bed until the early hours of the morning. These entries demonstrated there were not sufficient staff members on duty that night to meet this person's care needs effectively. It was not clear to us how the provider calculated how many staff were needed to ensure all people's care needs were met. We raised our concerns with the home manager and they agreed to immediately increase staffing levels by one care staff member. They gave us their reassurance a full dependency review of all residents' needs and risks to confirm staffing numbers, in the long term, would be completed.

Dependency level assessment of people is critical to determining staffing levels. We recommend that the service explores the relevant guidance on how to ensure safe staffing ratio's in the home are monitored, maintained and updated whenever there is a change to either the permanent staffing, number of people within the home or changes in peoples' support and care needs.

We checked seven staff members' recruitment records and found the provider's recruitment practices were sufficient. Pre-employment checks were completed, including a Disclosure and Barring check (DBS) before staff started to work for the provider. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.

We had received information of concern about the cleanliness of the service. People and relatives spoken with explained they were satisfied with the cleanliness of their rooms and had no complaints. People told us, "My room is cleaned daily and my sheets are changed weekly, more often if they need it," and "In my bedroom, the cleaners come in and get it [furniture] all out and clean top to bottom." The provider had been working to an action plan with partner agencies to address some hygiene deficiencies. We found there were cleaning schedules in place and infection control auditing and monitoring tools were been used. Aprons and gloves were available for staff to use when providing care. People were offered hand wipes to sanitize their hands at mealtimes and we noted where there had been any spillages, these were cleaned up quickly by domestic staff. There were no unpleasant odours. We looked at the laundry area and found it was organised. We also observed the kitchen area was clean and suitable to prepare food.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and most of the relatives felt staff had the knowledge, skills and training to support people safely. Two relatives told us they felt staff would benefit from additional training to support people living with dementia. One relative explained, "In [person's name] care plan the doctor has said they need to be kept in a quiet environment as loud, sudden noises can upset them." Our observations supported this view. We found Marlborough unit to be very noisy and staff were not seen to understand that loud noises could have a detrimental impact on people. People had been placed in close proximity to each other that caused some to shout at each other or become anxious and call out. This was exacerbated with a small kitchen area and the banging and clattering of kitchen equipment. We noted a radio playing music in one person's room was so loud it could be heard in the corridor. We spoke with the home manager about our observations and it had already been identified that some staff would benefit from additional dementia training. We saw that action had already been taken and appropriate training was arranged.

Some of the people we spoke with told us they had been involved in the assessment and planning of their care and support needs. One person explained, "I have been involved in discussions about my care." Relatives we spoke with confirmed they were consulted regarding their family member's needs. Care files we looked at showed evidence to support that elements were individualised for people. We looked at how people's needs and choices were assessed at the point of admission to the home to ensure the service could meet the needs of individual people. Where appropriate, there was equipment in place such as walking frames that supported peoples' independence.

Prior to the inspection we had received concerns that people that required support to eat did not always receive it. We found the meal time experiences for people differed from unit to unit. For example, laid tables with placemats, tablecloths and condiments were not consistently used throughout the units. One staff member told us the tables could not be laid because 'people would pull them off'. Plates that divided pureed food into separate sections were not consistently used across the units. One staff member told us, "I wouldn't eat it, the moulds are not used and food is pureed together, it doesn't look appealing." There were mixed responses from people about the quality of the food. Comments included, "The food is very good, there's a list with lots of food choices. I have no complaints," The food is so-so. I don't know about any choices, I have what I'm given. I have a full cooked breakfast very day," "The food isn't bad, I like a good breakfast, then I just have a sandwich," and," The food is so good I can't describe it. There is more than enough food." We saw some people choose to remain in their rooms or the lounge areas and staff took their food to them and ensured it was appropriately covered to keep it warm and protect the food from contamination. The kitchen staff explained they were in the process of developing a 'local menu' that would include sourcing foods from the local area. They told us if someone did not like the food they were offered they prepared a different meal for them. The kitchen staff knew the number of people with special dietary needs.

We saw staff members were rushed in Marlborough and Harrison units and staff did not always have time to sit and support people who needed support to eat. For example, on Marlborough, one person was offered a drink by a staff member, they took a sip but the staff member left them immediately to attend to other

people. We saw the person did not attempt to drink from the beaker again for two hours. We did not see another staff member offer the person any additional fluid during this time. We checked the person's care file and it said the person was to be encouraged and supported to drink fluids. One relative told us, "[Person's name] doesn't eat a lot of food because they do not get the help; staff rely on relatives for additional support." We noted a number of relatives did visit at lunch time to support their family members to eat.

We looked at whether the provider was responsive to changes in people's weight. Where appropriate, we saw referrals had been made to appropriate professionals for people that were at risk of choking or losing weight. For example, to the Speech and Language Therapist (SALT) or GP. We checked the care file for one person who had lost a considerable amount of weight in three months. We saw that a SALT assessment had been completed and the person had been seen by a dietician. We were told by a staff member that weekly weights should be in place for those at high risk of losing weight. We found the person's weight record had been incorrectly completed which meant they were not on weekly weights and not monitored as closely as they should have been. The records evidenced significant weight loss overall from the last six months but there was no indication the dietician had been asked to review the person again, or the GP informed of the weight loss. We discussed our concerns with the home manager who ensured appropriate referrals were made and immediate action taken.

All the staff we spoke with were complimentary about the training they had received. The provider had taken steps since acquiring the service to ensure all staff received training around safeguarding people, health and safety, fire safety and infection control. Staff spoken with told us they felt they had the skills and knowledge to complete their role. Whilst the staff had not all completed the Care Certificate because the previous provider had their own training programme, the home manager explained it was their intention to eventually introduce the Care Certificate for staff. The Care Certificate is an identified set of induction standards to equip staff with the knowledge and skills they need to provide safe and effective care to people. We saw from the staff training records we reviewed that new staff members had completed an induction that included shadowing an experienced staff member and having their competencies to complete the job reviewed, before being signed off.

There were processes in place to support staff communication between themselves and with other organisations. Each day there was an 11am meeting on each unit where clinical issues were discussed and staff had an opportunity to raise any concerns they may have about people. The 'handovers' we saw were detailed and signed by staff to say they had read them. One staff member told us, "We have daily handover from [staff member name] they tell us if there have been any changes in people or if the doctor is coming, [staff member name] keeps us informed of any changes all day." We saw the manager had introduced a weekly meeting for unit managers and the clinical lead. This meeting was detailed, the manager asked for an overview from each unit manager concerning emerging risks to people, new infections, any clinical issues or concerns that the provider needed to be made aware of. We saw the manager and clinical lead had regular communication with partner agencies that provided additional healthcare to people and commissioned services to ensure people received consistent support.

People had been supported with their health, care and support needs and records we looked at demonstrated that people had access to local health care services. For example, the GP, dentist, the optician, podiatrist and psychiatrist. Staff spoken with explained how they supported people with the healthcare needs. One staff member said, "We do know most of the people but when someone new has come in, it's important to read their care files so we know what we need to do for them." We saw from reviewing people's care files that health care professionals visited regularly, one person told us, "The staff will get the doctor for me if I need it". During our inspection, we saw a number of different health and social

care professionals visit people to assess their health and wellbeing.

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 saw most staff sought people's consent before completing certain tasks and offered people choices. For example, choice of drinks at different times of the day. Where people were deemed to lack the mental capacity to consent to some of their treatment or care, we found mental capacity assessments had been completed and evidence supported decisions had been made in peoples' best interests.

Prior to the inspection we had received concerns people were being locked in their bedrooms and unlawfully restrained. We spoke with the home manager about the concerns. We were told there had been occasions when some bedroom doors had been locked but this had been done with the consent of the families because they did not want other people going into their relative's room when it was unattended. We were also told that some bedrooms had been locked at night to keep people safe. These actions were not in line with the Mental Capacity Act and following the provider's investigation into the allegations; appropriate action was taken to ensure people's rights were protected. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked the service was working within the principles of the MCA and if any conditions on authorisations to deprive a person of their liberty were being met. There were a number of people that had been deemed to lack the mental capacity to consent to their being at the home or their care and treatment. Applications to lawfully restrict them from leaving had been submitted to the supervisory body.

Requires Improvement

Is the service caring?

Our findings

While most staff members were seen to be kind and caring, this was not consistent practice throughout the units. One person could be heard to be very anxious and was crying out. We checked on the person and found a staff member was present in their room but standing at the person's side not providing any words of comfort or reassurance to the person. We saw on two separate occasions in one unit staff refer to people in the third party. For example, one staff member brought a person into the dining area and asked another staff member, "Where do you want them?" At no time had the staff member tried to engage with the person to ask them if they had any preference where they wanted to sit. We discussed our observations with the management team who were upset and disappointed but gave us their reassurance that additional training would be arranged for staff members.

People we spoke with thought staff were kind and caring. Comments from people included, "The staff are good to me," and "The staff are kind, I couldn't ask for better care." Relatives we spoke with told us, "The staff make it a home from home for us they care for us like they care for [person's name]," And "[Person's name's] care is usually very good, the staff are kind." We saw most staff were polite with people and patient, with some very caring and positive interactions with people. For example, one staff member was supporting a person to eat their lunch. The staff member spoke kindly to the person, offering lots of encouragement with comments, 'just try this,' 'you're doing really well, you've nearly finished' and 'shall we try just a little bit more.' However, we also observed staff were very busy on two of the units, with limited time to sit and talk with people, this led to staff missing opportunities to interact with people more. For example, one person was clearly anxious and distressed and had been calling out for help. Staff had occasionally gone up to the person and tried to offer some reassurance but it had not eased their anxiety. One staff member then sat down with the person and gently stroked their arm and spoke in a low, gentle tone. The person immediately became less anxious and was visibly calmer. However, after five minutes, the staff member had to leave to attend to other people and the person started to cry out again.

People we spoke with told us staff respected their privacy and dignity. One person told us, "They knock my door, even when it's open." Staff addressed people by their preferred names and we saw staff knock on bedrooms doors and call out to the person. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. Although, this was not consistent on all the units. For example, it had been noted on one unit that bedroom doors were open and some people were in a state of undress and could be seen by visitors as they walked past the bedroom. This was not dignified for people and it was brought to the attention of the unit manager, who took immediate action to attend to the issue.

People we spoke with told us they were involved in decisions about their care and support needs. One person said, "I talk about my care and feel they [staff] listen to me." Another person told us, "Staff listen to me when they can but they are so busy." One staff member told us, "I ask people where they want to sit and if I am giving an intimate service to people I ask them what makes them comfortable." Another staff member said, "I will sit down with people, listen and talk with them, it's my job." People were supported to be independent where possible. We saw staff support people to self-mobilise when they wanted. Care files

contained information for staff on how they were to support people to become independent with personal care. Although it was noted in some of the care files we looked at where the question asked 'what can people do for themselves' there was more emphasis on what people could not do.

Our discussions with staff we spoke with demonstrated to us they knew people well. They were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people, they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. However, we had seen that this was not the case with all staff where signs of distress and anxiety had not always been identified and attended to in a timely way.

We did see that most staff were friendly in their approach to people and they laughed with people. People who were independently mobile had their walking frames close to hand and those spoken with considered themselves to be able to be independent for getting up and doing as much as possible for themselves. The bedrooms we were invited into were individualised with pictures and personal belongings that were important to the person. One person told us, "I love my room." A relative said, "[Person's name] has a nice room."

People told us that their family members were made to feel welcome. We saw there was a constant arrival of visitors. Everyone we spoke with told us there were no restrictions when visiting. A relative told us "I visit every day." We found people living at the home were supported to maintain contact with family and friends close to them.

Staff we spoke with knew how to prevent discrimination and promoted equality and diversity at the home. Staff were aware of the individual wishes of people living at the home that related to their culture and faith. Care files contained information about people's personal histories, albeit limited information in some cases, people's preferences and interests so staff could consider people's individual needs when delivering their care. Most staff spoken with respected people's individuality and diversity and understood how people's past experiences could affect their responses now. We found that people were given choices and whether they had any special dietary requirements in association with their spiritual, religious or cultural beliefs and whether they joined in with any religious ceremonies or celebrations. The home manager told us the provider created an inclusive environment and whilst they were not formally aware of anyone living at the service who identified themselves as being Lesbian, Gay, Bisexual or Transgender, (LGBT) all relationships were respected and people encouraged to be open and comfortable within a safe and supportive environment. One staff member explained how they assisted one person with clothing they felt comfortable and happy with and staff supported them with their choice of hair colour and make up.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us they were involved in developing their care files. One person said, "Most of the staff know me well and understand my needs." A relative said, "They [the provider] involve us in [person's name] support needs, they ring me at home, I know what's going on and I see they [staff] look after [person name]." The care files we reviewed recorded details about peoples' individual needs, their past lives, interests and dislikes. A relative explained, "I can see the care files at any time to look in if needed." A staff member told us, "When I first started I wasn't told everything for example one person has a sensory loss. I was unaware and I didn't know what their hand movements meant, for example was it the sign of aggression. I read the care files to understand what their needs were. Whichever person I support, I will go to the care file to make sure I know how to support them. I found it very useful for the person with sensory loss because it told me all about their needs." Another staff member said, "We have a handover, we meet in the office to discuss the needs of the residents and we are told about changes to care plans." Unit managers spoken with confirmed staff received a verbal and written handover, which was a new system introduced. The staff had access to people's care files and when care or support needs changed and confirmed it was discussed at each handover to ensure people continued to receive the correct level of care and support. We spoke with two visiting professionals who told us that generally the information they needed was contained within the care files and staff were willing to help and provided any information they required if not found in care file.

The care files we looked at had been reviewed, which suggested people's care needs were being reviewed on a regular basis, therefore changes within people's care needs would be addressed in a timely manner. Although overall, care files were individualised and daily care notes where completed as required, we could not see how the provider had involved people living with dementia in the planning of their care and support. We saw there was good input from family members with them making a number of decisions about their family member's care. We spoke with the home manager about what the service could do to try and involve people more in the development of their care file. This was an area that required some improvement.

We spoke with people and observed how staff supported them with their hobbies and interests. People's experience of how they were supported varied dependent on which area of the home they lived. One person we spoke with told us, "I prefer to sit in the lounge for company but most of the people here are sleeping in their chairs, so there is no one to talk to. I have my own television in my bedroom but staff tell me I have to reduce the volume, if I have to reduce it any further I can't hear it and may as well switch it off. My family visit and I have my own mobile phone. I don't like to join in activities but I like to watch others. I can't go out on my own so you have to wait until staff are available to take you. You have to wait your turn." Our own observations on Marlborough unit on the first day of our visit, showed there was no stimulation for people, there was loud music playing, there were no age appropriate books, games or soft toys to act as a distraction for people. However, on the second day of visit, this had slightly improved. We did see the service had a sensory room that people appeared to enjoy.

We saw one person was cuddling a toy cat sat in a basket and when stroked, made a sound which we could see made the person smile. A staff member was sat with the person and encouraged them to stroke the cat.

Some other people were sat opposite watching and we could see they were smiling as they watched. There were patio doors which led to an outside area where we saw one person was sat outside in the sunshine. We spoke with the person and they told us they were 'very happy.'

Most of the responses from people and relatives we spoke with were positive about the provision of activities across the service. We were told by some people they were taken out by staff into the community. However, we found this was restricted to one or two people at a time due to the limited availability of staff to take people. People's care files we looked at included information on their hobbies and interests. There were 'activity plans' in place that detailed how people living at the service spent their time. On the first day of our visit, Harrison unit had a singer booked to entertain people, unfortunately they had double-booked and were unable to attend. People had been brought across from other units for this singing event and so to ensure they were not disappointed, the staff improvised and managed to put on an afternoon of singing and dancing that everyone who attended had enjoyed. A relative told us, "[Staff member name] is very good, there is the royal wedding celebration organised, people are taken up to town to the shops. We had ponies visit the home and they have the chickens grown from chicks." Another relative said, "I've seen staff take people out and seen other people join in the activities, I can't fault it." On Samuel unit there was a 'tuck shop' that provided a small selection of knitted clothes, gifts (photo frames), sweets and crisps for people and visitors to purchase.

We spoke with one staff member who told us they tried to hold one to one sessions with people that were cared for in bed. They showed us a personal notebook where they were recording notes which room they had visited and where they needed to visit. The activities staff tried hard to engage with most people across the service. A relative told us, "Sometimes [staff name] comes in to read to [person's name], they like poetry." The provider had demonstrated they were actively trying to engage with people to encourage social interaction.

People and relatives we spoke with told us they knew who to and how to complain if they had any concerns or issues about the service. One person said, "I am aware of the complaints process, not formally used it but would speak up about my concerns." Comments from relatives included, "I have no complaints about the care [person's name] receives and I see nothing here that concerns me." "I'm happy with the general standard of care, if I'm not happy with something I can speak to the care assistants." We reviewed the complaints the provider had investigated. The analysis of the complaints was thorough and where appropriate, action had been taken and measures put in place to reduce the risk of reoccurrence. We saw where complaints had been upheld, the provider accepted responsibility where things could have been better and had apologised.

We were told the provider would be introducing the Gold Standards Framework (GSF) for the provision of end of life care (EOL). This was not in place at the time of our inspection. We were told there were a small number of people who were said to be on EOL. However effective EOL planning was not consistently demonstrated throughout the service. We saw there was a section within the care file that referred to EOL planning but the information contained within these sections were lacking in detail or were not completed. Staff members acknowledged further work was required and attributed the lack of evidence of planning was due to the provider's success in improving and maintaining people's health. A number of relatives we spoke with confirmed their family member's health had improved since moving into the service. The home manager and clinical lead confirmed the provider's goal was to work to the GSF to make sure people's wishes were sought to ensure that EOL was dealt with in a dignified and respectful manner.

Requires Improvement

Is the service well-led?

Our findings

The provider had been working to an action plan to implement improvements from monitoring visits completed by other agencies, for example the Clinical Commissioning Group (CCG) prior to them being registered as the service provider. They had taken steps to introduce a more robust monitoring process however; we found the current processes had not ensured consistent good practice across all the units.

The deployment of staffing was individually managed by each unit manager. There was no overall management process looking across the entire site to ensure there was sufficient staff on duty to meet people's needs. For example, on Marlborough, the unit manager explained they were short staffed with five care staff on duty, when there should be six. On our arrival to the service, we had witnessed the unit manager trying to find emergency cover. They were heard to say, "I have asked all the managers and they have refused to send anyone over." We did see an additional staff member arrive to Marlborough but this was to support with the lunch time session; once the lunches had finished, the staff member returned to their respective unit. We had been told that agency staff or staff from other units would cover unplanned absences at short notice; however this was not our experience at the time of our inspection. This meant there was a lack of oversight across the units and the processes currently in place to ensure the cohesion of unit managers to support each other with unplanned absences required improvement.

In one unit we found a number of people were at high risk of developing sore skin and required the additional support of a pressure relieving mattress. We found that people had been assessed at risk of developing sore skin and risk assessments had been completed and available in their care files. We checked the weight recorded for one person against the setting for their mattress. The correct setting should have been between two and three; it was set at seven which was too high. If a mattress setting is too high, this can further agitate certain conditions. Audits and checks had not identified this. This was brought to the attention of the home manager. Immediate action was taken to check all mattress settings on the unit, where they were found to be incorrect and re-set. The home manager introduced a new monitoring and recording process to ensure mattress settings were correctly monitored.

During our observations it had been identified that a number of calls bells were out of reach of people. One person we spoke with told us, "I can't reach my buzzer so I shout for help." Audits and checks made on peoples' rooms had not identified this. We raised the matter with the home manager. They confirmed this had not been drawn to their attention before but have introduced additional checks to ensure people can reach and press their alarms for assistance. The home manager also confirmed people who remained in their rooms and did not have the mental capacity to press an alarm, were regularly checked by staff. The records we looked at confirmed this to be the case.

There was evidence to show there were discrepancies when it came to providing regular supervision for staff. One staff member told us, "We do have supervision but we haven't had one for some-time." The home manager explained it was identified staff had not been receiving supervision. This was in the process of being addressed and supervisions were being arranged. One staff file showed since their appointment in February 2018, the staff member had not received any supervision. The manager explained, the person had

been supported by other staff members and had at no time requested any additional support from them. They continued to tell us that when additional support was offered, the staff member had refused. However, there was no information in the staff member's file to corroborate this.

We found people living with dementia had not always benefitted from the same level of service as people who had mental capacity to make decisions about their care and support. For example, the dining experience for people and access to social interaction differed from unit to unit. Where good practice was found, this was not always repeated on other units. For example, staff taking the time to sit and speak with people to ease their anxiety. We found the provider's systems to monitor the quality and safety of the service, had not always been used effectively to implement or sustain improvements, where shortfalls had been identified. This was evident for some of the shortfalls we found during this inspection, for example monitoring pressure relieving mattress settings and management of some people's pain relief. Audits had failed to evaluate staff knowledge when training had been completed. For example, as an outcome from a complaint, additional training had been introduced around Sepsis. However, on speaking with some nursing staff to check their knowledge, it was apparent this training had not been effective. Systems in place on Marlborough unit to effectively record the amounts of fluid and food intake for people at risk of weight loss had required improvement. This was because records for one person had been incorrectly calculated and the significant weight loss had not been acted upon within a timely manner and appropriate referrals being made to professionals.

We found risk assessments and care files had not been consistently and accurately completed and on occasion had contained incorrect or missing information about people. Information relating to peoples' care and support needs was spread across three or more areas making information difficult to locate, duplicated and contributed to information being incorrect or missing. The recording and evidencing of wounds required some improvement. We saw from additional care files there was evidence of a wound care plan that included photographic evidence to monitor healing. However these pictures were not being consistently updated within peoples' care files. It is good practice for regular photos to be taken to identify potential improvement or deterioration within the wound.

We have considered the provider has recently taken ownership of Parklands and inherited processes that were already in need for improvement. However, the oversight of all the units was not consistently practiced and each unit was currently working independently of each other. This meant the audit processes had not been effective at identifying the issues we had during our inspection and this was a breach of Regulation 17 Good governance.

Other systems the provider had in place had been affective at improving the quality of the service. We saw the home manager had worked closely with the local authority and CCG to monitor and improve their performance. The provider conducted regular checks to monitor the service and we saw that where areas for improvement had been identified, action plans had been developed to address concerns. These were monitored to check if actions had been effective.

The manager understood their regulatory responsibilities and the home's latest inspection ratings were displayed appropriately. Records we looked at showed the provider had notified us of incidents and events they are required to do so by law. We saw evidence to support the service had worked in partnership with other organisations, stakeholders and healthcare professionals and had reviewed incidences in order to identify how the service could be improved.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the

care and treatment they received. The manager was able to tell us their understanding of this regulation and we saw evidence of how they reflected this within their practice. Where issues had been found, the provider was receptive to feedback, had been open and transparent with their views and plans for developing and improving the service.

At the time of our inspection the service had not held regular 'residents or relatives meetings.' The home manager confirmed it was their intention to re-introduce meetings. However, people and relatives we spoke with explained they had attended meetings in the past. One relative explained, "We have had meetings but I tend not to go." A number of relatives had told us the communication from the provider could be improved. For example, the closure of one unit had raised some concerns, one relative explained, "We were given about three weeks' notice that Clarendon would close but then it happened really quickly, it could have been communicated to us better." Another relative said, "The new regime is better, but the managers need to be more dementia aware." Another relative told us, "There's no feedback forms, they [the provider] expect you to tell them, they do sort problems out."

Staff we spoke with told us the management team were approachable and if they had concerns regarding the service and they would speak with them. Staff we spoke with commented "The managers are very good," "I have confidence in the new provider and feel, in time, there will be improvements." "I feel supported by the manager, always gives support when needed, there is lots of work to do and a long way to go but I can see an end." The home manager had a clear vision and set of values which most staff understood. Staff said the management team were always available and there was a clear call out policy if staff needed support out of normal working hours.

The provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems had not been consistently effective at ensuring good working practices were constant across all the units within the service. They were not always effective in ensuring all people received a safe and good quality of service.

The enforcement action we took:

We have issued a warning notice