United Health Limited

Bunkers Hill 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

We inspected the service on 14 December 2017. The inspection was unannounced. Bunkers Hill 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bunkers Hill Care Home is registered to provide accommodation, nursing and personal care for 78 adults of all ages. The service can provide care for people who live with dementia, who have physical adaptive needs and/or who have special mental health needs. There were 76 people living in the service at the time of our inspection visit. The accommodation was arranged on two floors and was divided into self-contained units. Two of these that were called Bluebell and Honeysuckle were on the first floor. They were reserved for people who needed nursing care and who lived with dementia. The units on the ground floor were called Primrose and Jasmine. They were used to accommodate people who only required residential care.

The service was run by a company who was the registered provider. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

At the last inspection on 10 September 2015 the service was rated, 'Good'.

At this inspection the service was rated, 'Requires Improvement'.

We found two breaches of regulations. This was because the registered persons had not suitably assessed risks to the health and safety of people who received care and treatment. In addition, they had not done all that was reasonably practical to reduce such risks. Furthermore, the registered persons had failed to suitably assess, monitor and improve the quality and safety of the service in the carrying on of the regulated activities. This was because quality checks had had not always resulted in shortfalls in the service being quickly put right. In addition, the arrangements used to consult with people and their relatives about making improvements in the service were not robust. You can see what action we have told the registered persons to take at the end of the full version of this report.

Our other findings are as follows. Sufficient care staff had not always been deployed and some background checks had not been completed before new care staff were appointed. However, nurses and care staff knew how to keep people safe from the risk of abuse including financial mistreatment.

Suitable arrangements had not always been made to enable people to receive effective care. Nurses and care staff did not consistently use national guidelines by seeking people's consent for the care and

treatment they received. In addition, some parts of the accommodation were not designed and adapted to meet people's needs. However, there were arrangements in place that were designed to assess people's needs and choices so that care was provided to achieve effective outcomes. In addition, nurses and care staff had received training and in practice they knew how to provide people with the assistance they needed. This included ensuring that people had enough hydration and nutrition to maintain a balanced diet. Furthermore, there were arrangements to help people receive a coordinated care when they moved between different services and people had been supported to receive on-going healthcare assistance.

Nurses and care staff had not always been given all of the resources they needed to provide people with a service that consistently promoted their dignity. However, people were supported to express their views and be actively involved in making decisions about their care as far as possible. In addition, people's privacy and independence were respected. Furthermore, confidential information was kept private.

People did not always receive responsive care and treatment including having information presented to them in an accessible manner. In addition, people had not always been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. Furthermore, records did not show us that complaints and concerns had been properly managed and resolved. However, suitable provision had been made to promote equality and diversity. As part of this the registered persons recognised the importance of appropriately supporting people who chose gay, lesbian, bisexual and transgender lifestyles. Furthermore, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

The registered persons had taken a number of steps that were designed to develop the service's ability to comply with regulatory requirements. In addition, the registered manager promoted a positive culture in the service that was intended to achieve good outcomes for people. Care staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns. A number of measures were in place to promote the financial sustainability of the service. Furthermore, the registered persons were actively working in partnership with other agencies to support the development of joined-up care.

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.

The registered persons had not suitably assessed risks to the health and safety of people who received care and treatment. In addition, they had not done all that was reasonably practical to reduce such risks.

Suitable arrangements had not been made to ensure that sufficient numbers of suitable staff were always deployed in the service to support people to stay safe and meet their needs.

Background checks had not always been completed in the right way before new care staff were appointed.

Nurses and care staff knew how to keep people safe from the risk of abuse including financial mistreatment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Nurses and care staff did not consistently use national guidelines to promote positive outcomes for people by seeking consent to care and treatment in line with legislation.

Parts of the accommodation were not designed and adapted to meet people's needs and expectations.

Arrangements were in place that were designed to assess people's needs and choices so that care was provided in a way that met their expectations

People were helped to eat and drink enough to maintain a balanced diet.

Nurses and care staff had received training and had most of the knowledge and skills they needed.

There were suitable arrangements to enable people to receive coordinated care when they used different services.

People had been supported to receive on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Nurses and care staff had not been given all of the resources they needed to always provide people with care that promoted their dignity.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People's privacy and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always received personalised care that was responsive to their needs including their need to have information presented to them in an accessible way.

Some people were not regularly offered opportunities to pursue their hobbies and interests and to take part in a range of social activities.

Records did not fully confirm that people's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Suitable arrangements had not been made to assess, monitor and improve the quality and safety of the service.

The registered persons had taken a number of steps that were

designed to develop the service's ability to comply with regulatory requirements.

There was a registered manager who was promoting an open culture in the service.

Care staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns.

Arrangements had been made to enable the service to maintain its financial sustainability.

The service worked in partnership with other agencies to promote the delivery of joined-up care.

Bunkers Hill Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons continued to meet 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 14 December 2017 and the inspection was unannounced. The inspection team consisted of three inspectors, a special professional advisor and an expert by experience. The special professional advisor was a nurse who had a detailed knowledge of delivering clinical services in residential care settings. An expert by experience is someone who has personal experience of using this type of service.

During the inspection we spoke with 17 people who lived in the service and with four relatives. We also spoke with the clinical lead nurse, a nurse, a senior member of care staff and five care staff. In addition, we spoke with two activities managers, two housekeepers, the head housekeeper and laundry manager, one of the chefs and the administrator. The registered manager was not present in the service and so in their absence we met with the deputy manager. We observed care that was provided in communal areas and looked at the care records for 10 people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, 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 speak with us.

After the inspection visit we spoke by telephone with a further two relatives.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living in the service. One of them said, "Yes, I'm pleased I chose this place as I feel safe here because I know I've got staff around me all of the time." A person who lived with dementia and who had special communication needs smiled and patted the hand of a member of care staff when we asked them about their experience of living in the service. Relatives were confident that their family members were safe. One of them remarked, "I think that the care here is very good. All of the staff are kind and they take care of the residents. That's the case even if they're short staffed on some days and a bit rushed."

However, we found that the registered persons had not suitably assessed risks to the health and safety of people who received care and treatment. In addition, they had not done all that was reasonably practical to reduce such risks. This included shortfalls in assessing, reviewing and monitoring the provision that needed to be made to ensure that good standards of hygiene were maintained in the service. This was because the carpet and three of the armchairs in one of Honeysuckle's lounges had not been kept clean and as a result did not have a fresh fragrance. In addition, we were concerned to note that two people sitting in this lounge had not been supported to wear clean clothes. Their clothes were stained with spilt food and furthermore they had not received all of the assistance they needed to maintain their personal hygiene.

We also found that some of the arrangements used to prevent avoidable accidents were not robust. An example of this was a person who lived with a medical condition that increased the risk of them experiencing falls. Records showed that suitable steps had not always been taken to responsively monitor the person's medical condition at times of day when it was most likely to contribute to them falling. A further example was a person who was not promptly provided with the correct mobility aid they needed even though they were at immediate risk of falling.

We found that the arrangements followed to ensure that lessons were learned and improvements made when things had gone wrong had not always been robust. Records showed that in the period since our last inspection visit a number of accidents and near misses had occurred in the service. The accidents had usually involved people having falls as a result of which they sustained minor injuries. When these incidents occur it is important to establish what has gone wrong so that action can be taken to reduce the likelihood of the same thing happening again. However, records did not clearly demonstrate that accidents and near misses had been carefully examined. In addition, we noted examples of action not being quickly taken to prevent accidents from happening again. An example of this was a person who had experienced a very high number of falls during a short period of time resulting in them sustaining an injury that required them to be admitted to hospital. These shortfalls had reduced the registered persons' ability to consistently promote people's health and safety.

Some of the arrangements used to manage medicines were not robust. We examined a number of the records nurses and care staff had created each time they had administered a medicine. Two of these records had not been completed accurately to fully assure us that the people concerned had received all of the medicines prescribed for them. Furthermore, another set of records had not been created in the right

way. This was because handwritten amendments had been used to update the details about the administration of a medicine without a suitable check being made that the changes made were correct. We were also noted an example of a person receiving a time-sensitive medicine on the wrong day. We raised our concerns with the deputy manager who assured us that steps would immediately be taken to address our concerns. This was so that lessons could be learned to ensure that medicines were consistently administered in the right way.

All of these shortfalls had reduced the registered persons' ability to consistently deliver safe and harm-free care.

Failure to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce such risks was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In their Provider Information Return the registered persons told us that they had carefully established how many care staff and other members of staff needed to be on duty. They said that they had taken into account the number of people living in the service and the care each person needed to receive. However, the documents that related to these calculations were not available for us to see and so we could not establish how robust the registered persons' assessment had been. In addition, three people told us that on some days the service was short staffed resulting in them having to wait too long for assistance. Summarising this view a person remarked, "There's always at least one nurse on duty but they can be down a care worker on a shift. When this happens the other ones are flying about and you'll have to wait which isn't good if you want the toilet."

We examined records that described how many care staff had been on duty on each shift for the period 1 November 2017 to 13 December 2017. We noted that 11 shifts for care staff had not been filled. Therefore, on these occasions the service had not been resourced with care staff to meet the minimum requirement set by the registered persons. The deputy manager said that most of these occasions had been caused by care staff being absent from work at short notice so that it had not been possible to make alternative arrangements to cover the shifts. In response to our concerns they assured us that the registered persons would reassess how many care staff needed to be on duty at any particular time. They also told us that more robust arrangements would be made so that all care staff shifts could be reliably filled in the future.

We examined the procedure used by the registered persons when recruiting two new members of care staff. Records showed that there were shortfalls in the checks that had been completed. We noted that in each case the registered persons had not obtained a suitably detailed account of the applicants' employment histories. This shortfall had reduced the registered persons' ability to determine what background checks they needed to make. In addition, in relation to one of the applicants some of the required checks had not been completed. Although other security clearances had been received to show that the applicants did not have relevant criminal convictions, we concluded that the registered persons had not taken all of the steps necessary to assure themselves of the applicants' previous good conduct. We raised our concerns with the deputy manager. They assured us that no concerns had been raised about the performance of the two members of care staff in question since they had been appointed. They also told us that the arrangements used to appoint new members of staff would quickly be strengthened to address each of our concerns.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed that nurses and care staff had completed training and had received guidance in how to protect people from abuse. We found that nurses and care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told

us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. In addition, we noted that the registered persons had established robust and transparent systems to assist those people who wanted help to manage their personal spending money. This included the service's administrator keeping an accurate record of any money deposited with them for safe keeping and an account of any funds that were spent on someone's behalf. This arrangement contributed to protecting people from the risk of financial mistreatment.

Requires Improvement

Is the service effective?

Our findings

People were confident that the nurses and care staff knew what they were doing and had had their best interests at heart. One of them said, "The staff here are very good to me and they help me lots with things every day and they don't mind doing it either." Relatives were also complimentary about this matter. One of them said, "I certainly do think that the staff are very good. It's good to know that there's always a nurse on duty if they're needed."

However, we found that national guidelines had not been consistently used to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. This was because some of the arrangements used to implement the safeguards contained in the Mental Capacity Act 2005 (MCA) were poorly organised and recorded. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the Mental Capacity Act 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that suitable arrangements had not always been made to obtain consent to care and treatment in line with legislation and guidance. Records showed that the registered persons considered it necessary for people or their representatives to give written consent to each part of the care that was provided. However, when we examined 10 elements of the care provided for three people we found that none of the relevant documents had been signed to indicate that consent had been obtained.

We also noted that the registered persons recognised that it was necessary to complete specific assessments when a person lacked the necessary mental capacity to make decisions about important things that affected them. This is necessary to enable key people in a person's life ensure that decisions are always taken in their best interests. However, when we examined the provision that had been made for three people we found that the arrangements that had been made were inconsistent and poorly recorded. In particular, we noted that no assessments had been completed for most of the care provided for two of the people although we were told that they should have been undertaken. We also noted that some of the assessments that were in place had not been reviewed as frequently as the registered persons' said was necessary. These shortfalls had reduced the registered persons' ability to ensure that they sought consent to care and treatment in the right way.

Furthermore, there were shortfalls in the arrangements the registered persons had made to ensure that care

was always provided in a lawful way by obtaining deprivation of liberty authorisations when necessary. We were told that the necessary authorisations were in place in relation to each of the three people in question. However, records were only available for two of the people and these showed that one of the authorisations had expired. We were concerned to note that no records at all were available to show that an authorisation was in place for the third person. In addition, when we asked a nurse and three care staff about this matter they all assumed that authorisations were in place for the people concerned. They considered this to be necessary to validate the way in which the people's care was being provided. This was because the level of care and supervision involved necessarily resulted in each person's freedom being appreciably restricted. Although in practice the three people were receiving care in the least restrictive way possible, shortfalls in the arrangements used to obtain and use authorisations had reduced the registered persons' ability to ensure that people who lived in the service only received lawful care.

We found that some people's individual needs were not fully met by the design and adaptation of the accommodation. This was because suitable steps had not been taken to support people who lived with dementia to find their way around their home. In Bluebell and Honeysuckle little had been done to signpost different areas of the units so that people knew where they were and could be as independent as possible. Although signs were fitted to bathroom and toilet doors these were very small and did not use easy-to-understand graphics that are often helpful for people who live with dementia.

We were also concerned to note that little had been done to distinguish each person's bedroom door so that there was less risk of them entering the wrong room. Although the doors were painted in different colours this provision had not been further developed by displaying photographs and other personal keepsakes to help people recognise their bedroom. In addition, we saw people mistakenly entering other people's bedrooms and care staff told us that this regularly occurred in the service.

However, other aspects of the accommodation were well appointed. People were able to move about their home safely because there were no internal steps. There was sufficient communal space in the dining room and in the lounges. In addition, most areas of the accommodation were well decorated and comfortably furnished.

We found that arrangements were in place that were designed to assess people's needs and choices so that care was provided in a way that met their expectations. Records showed that the registered manager had established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources. Records also showed that the initial assessments had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager carefully asking people if they had particular expectations deriving from cultural or ethnic identities about how their close personal care should be provided and who should deliver it.

We saw that care staff were able to promote positive outcomes for people who lived with dementia. This included occasions on which they became distressed and needed assistance to keep themselves and other people safe. We noted that when this occurred care staff followed the guidance in the people's care plans so that they supported them in the right way. An example of this was a person who was worried because they could not clearly recall what social activity they were due to attend later on in the day. The person was becoming anxious, loud in their manner and physically assertive. A member of care staff recognised that action needed to be taken to keep the person and others around them safe from harm. We saw the member of care staff gently reminding the person that after lunch they were going to attend a musical session with one of the activities managers. We noted that this information reassured the person who was pleased to go to the dining room in time for lunch.

Records showed that new nurses and care staff had received introductory training before they provided people with care. For care staff who did not have a recognised qualification this training involved completing the Care Certificate. This is a nationally recognised training scheme that is designed to ensure that care staff are competent to care for people in the right way. In addition, nurses and care staff had also received on-going refresher training to keep their knowledge and skills up to date. We found that nurses and care staff knew how to care for people in the right way. An example of this was nurses knowing how to correctly complete clinical tasks to support people to safely manage medical conditions. Other examples were care staff reliably assisting people who were at risk of developing sore skin or who needed help to promote their continence.

People told us that they enjoyed their meals. One of them remarked, "The food's okay actually for such a big place and we get more than enough" A person who lived with dementia and who had special communication needs smiled broadly when we used sign assisted language to ask them about their experience of dining in the service. We were present at lunch time in two of the units and we saw that people were offered a choice of dishes which were well presented.

We also found that people were being supported to eat and drink enough to maintain a balanced diet. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. We also noted that nurses and care staff were making sure that people were eating and drinking enough to keep their strength up. In addition, the registered manager had arranged for some people who were at risk of choking to have their food and drinks specially prepared so that it was easier to swallow.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. In addition, the service had prepared a 'hospital passport' for each person. These documents contained key information likely to be useful to hospital staff when providing medical treatment. Another example of this was care staff offering to accompany people to hospital appointments so that they could personally pass on important information to healthcare professionals.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dietitians.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they received. One of them remarked, "The staff are very good to me and I have no problem with them at all." Relatives were also confident that their family members were treated with compassion and kindness. One of them remarked, "I call to the service at least twice a week and I have always seen staff being kind and caring. If there was anything wrong I'd have seen it but I've never had any concerns."

However, we found that nurses and care staff had not been fully supported to deliver the caring response they wanted to provide. When we were present in Bluebell and Honeysuckle we observed a number of occasions on which care staff were rushed and as a result were task focused. This included people receiving care without care staff speaking with them at all. Remarking about this a person said, "They are very short staffed. Staff don't have time to talk with me. I can feel very low and down and there is no one spare to talk to."

We were also concerned to observe an occasion at lunchtime when a member of care staff seated themselves between two people so that they could assist both of them to dine at the same time. This resulted in neither of the people receiving the dignified or responsive assistance they needed in order to enjoy their meal. Furthermore, we noted examples of care staff speaking over people while they were providing care. On one of these occasions two care staff chatted about the shifts they were due to work over the Christmas period as if the person for whom they were was not present. All of these shortfalls reduced people's ability to enjoy the experience of living in the service.

In addition, three people told us that they were not satisfied with the arrangements that had been made to assist them to get up in the morning. All of them remarked that they felt obliged to agree to night staff assisting them to get up at a time much earlier than they would otherwise choose. One of them said, "There's a definite routine here and you have to sort of fit in. The night staff need to get some people up to help the day staff because they're so rushed. But if you're up by half past six it's a long wait until breakfast and then it's a long day after that." Another person said, "There isn't always enough staff. The night staff wash me at 7.00am and after the wash I go back to sleep. Sometimes staff come to wash me before I am ready." A third person complained to us saying, "Night staff get you up and showered round-about 6.00am to 7.00am."

However, we also witnessed other examples of people being treated with kindness and being given emotional support. An example of this occurred when we saw a member of care staff sitting with a person in their bedroom where they were both watching a quiz show on television and answering the various questions. Another example was a member of care staff reassuring a person that they would look in the laundry to check that one of their garments had not become mislaid.

Furthermore, nurses and care staff were considerate and we saw that a special effort had been made to welcome people when they first moved into the service. This had been done so that the experience was positive and not too daunting. The arrangements had included asking family members to bring in items of a

person's own furniture so that they had something familiar in their bedroom when they first arrived.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who could support them to express their preferences. Records showed and relatives confirmed that the registered manager, nurses and senior members of care staff had encouraged their involvement by liaising with them on a regular basis. In addition, the service had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People's privacy was respected and promoted. We noted that nurses and care staff recognised the importance of not intruding into people's private space. Bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw nurses and care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

People could speak with relatives and meet with health and social care professionals in private if this was their wish. In addition, we noted that nurses and care staff were assisting people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

People said that care staff provided them with all of the assistance they needed. One of them remarked, "The staff help me from first thing in the morning until last thing at night. They're lovely to me." Relatives were also positive about the amount of help their family members received. One of them commented, "I can see with my own eyes how well cared for my relative is. I've no complaints at all about that."

However, we found that people had not always received personalised care that was responsive to their needs. This included their need to have information presented to them in an accessible manner. Records showed that nurses and care staff had prepared a care plan for each person. These were intended to describe the care each person needed and had agreed to receive. However, little had been done to present information in a user-friendly way for people who lived with dementia by using multi-media tools such as graphics and colours. This oversight had increased the risk that people would not be fully involved in the process of recording and reviewing the care they received.

Nevertheless, records confirmed that people were receiving most of the care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing, keeping their skin healthy and promoting their continence.

The activities managers told us that it was important to offer people a wide range of opportunities to pursue their hobbies and interests and to enjoy taking part in a range of social activities. We were told that this involved both inviting people to attend regular small-group activities and offering them one to one support. During the course of our inspection visit we saw a number of people joining an activities manager in one of the lounges to sing some favourite old-time tunes. However, we did not see people being given one to one support to enjoy individual activities and this may have reduced their ability to become involved in social events. We looked at the records of the activities undertaken by two people who lived with dementia and whom we had observed to be withdrawn. They showed that in the period from 1 September 2017 to 13 December 2017 there had only been five occasions when each of them was recorded to have received individual support from a member of staff to engage in an activity.

We found that the arrangements used to listen and respond to people's concerns and complaints were not robust. We were told that people had been encouraged to feel free to raise any concerns they had so that they could be used to develop the service. However, we noted that the complaints procedure that described how people could go about raising issues was not user-friendly. It was a formal typewritten document that was difficult to read because of the small print it used. Furthermore, little had been done to explore ways of developing more accessible versions of the document using multi-media tools to engage the interests of people who lived with dementia.

We were told that the registered persons had received 20 complaints during the course of 2017 but this figure did not match the records that had been kept by the registered manager. Therefore, we could not be certain how many complaints had been received. We were also concerned to note that the records which were available were incomplete. As a result they were not sufficiently detailed for us to be assured that each

complaint had been properly investigated and quickly resolved.

However, we saw that suitable provision had been made to acknowledge personal milestones. An example of this was people being helped to celebrate their birthdays in a manner of their choice. This usually involved the chef baking them a special cake. Another example was person who had been supported to invite members of their family to the service in order to celebrate their wedding anniversary. Furthermore, we were told that people had been enabled to share in community events. An example of this was people being helped to put their name on the electoral roll and being supported to cast their vote if they wished to do so. Another example was people being helped to take part in raising funds for national charitable events such as the poppy appeal on Remembrance Sunday.

We noted that nurses and care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. In addition, the deputy manager was aware of how to support people who had English as their second language, including being able to make use of translator services. Furthermore, documents showed that the registered persons recognised the importance of appropriately supporting people who choose gay, lesbian, bisexual and transgender lifestyles. This included being aware of how to help people to access social media sites that reflected and promoted their lifestyle choices.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. We noted that the registered persons had made the necessary arrangements for the service to hold 'anticipatory medicines'. These are medicines that can be used at short notice under a doctor's guidance to manage pain so that a person can be helped to be comfortable. Records showed that the registered manager had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. We also noted examples of nurses and care staff kindly supporting relatives at this difficult time. This included making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance.

Requires Improvement

Is the service well-led?

Our findings

People considered the service to be well run. One of them said, "I think it's pretty much run in the right way as the staff are here and we get what we need." Relatives were also complimentary about the management of the service. One of them remarked, "I think overall it's well managed. If I have a problem I just have a word with the manager who's very helpful and whatever it is gets sorted."

However, we found that people who lived in the service and their relatives had not been fully engaged and involved in making improvements. We were told that people and their relatives were invited to regularly meet with one of the activities managers to suggest how the service could be improved. These were called 'Our Voice' meetings. However, we were told that in practice most of the people who lived in Bluebell and Honeysuckle were not able to attend these meetings because of their special communication needs.

The activities managers said that it was important for a record of these meetings to be circulated in the service so that everyone knew what had been discussed. They also said that it was important for people to receive a copy of a 'You Said-We Did' document to let them know what was going to be done to implement any suggested improvements. However, we noted that the record of the most recent meeting and a You Said-We Did document had not been made available for people to see. We looked at written information that was available for the Our Voice meeting that had been held in June 2017. Although we noted that a 'You Said-We Did' document had been prepared we found that the arrangement was not well organised. The document itself was not written in a user-friendly way to support access by people who lived with dementia. Furthermore, when we checked one of the improvements that was said to have been made we found the information to not be correct. This referred to a person who wanted to lock their bedroom from the inside at night. The document said that this could be done by asking care staff for a key. However, when we checked the lock in question we found that there was no provision for the mechanism to be operated from the inside even with the use of a key.

We were also told that people were regularly invited to complete a questionnaire to give feedback on their experience of living in the service. However, we also found that this process was not well organised. This was because the questionnaires were not presented in a user-friendly way and there was no organised system to analyse the results and act upon them.

In their Provider Information Return the registered persons told us that it was important to operate robust quality checks to ensure that people reliably received safe care. However, we found that quality checks had not always been completed in the right way. This had reduced the registered persons' ability to effectively identify and quickly put right problems in the running of the service. These shortfalls in the completion of quality checks had resulted in the persistence of the concerns we have described earlier in our report. These issues included oversights we noted in the prevention of accidents, management of medicines, deployment and recruitment of staff, the seeking of consent, the promotion of people's dignity, the provision of social activities and the resolution of complaints.

Failure to suitably assess, monitor and improve the quality and safety of the services in the carrying on of the

regulated activity (including the experiences of people receiving those services) was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, there was a registered manager in post. In addition, nurses and care staff told us that they were committed to promoting a positive culture in the service that was focused upon achieving good outcomes for people. Furthermore, records showed that the registered persons had correctly told us about significant events that had occurred in the service.

We also found that the registered persons had taken a number of steps to develop the service's ability to comply with regulatory requirements. We were told that the registered manager and deputy manager had subscribed to a number of professional websites in order to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give registered persons information about important developments in best practice. This helps registered persons to be more able to meet all of the key questions we ask when assessing the quality of the care people receive. Furthermore, we saw that the registered persons had suitably displayed the quality ratings we gave to the service at our last inspection.

We found that a number of systems were in place to help care staff to be clear about their responsibilities. This included there being a nurse and senior members of care staff who were in charge of each shift. In addition, arrangements had been made for the registered manager and the deputy manager to be on call during out of office hours to give advice and assistance to care staff should it be needed. Furthermore, nurses and care staff had been invited to attend regular staff meetings that were intended to develop their ability to work together as a team. This provision helped to ensure that nurses and care staff were suitably supported to care for people in the right way.

Nurses and care staff told us there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered persons if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

We found that the registered persons had made a number of arrangements that were designed to enable the service to learn and innovate. This included all members of staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles.

Records showed that the registered persons adopted a prudent approach to ensuring the sustainability of the service. This included operating robust systems to balance the service's income against expenditure. This entailed the registered persons preparing regular updates about how much money had been spent and how much was left for the remainder of the financial year. These measures helped to ensure that sufficient income was generated to support the continued operation of the service.

We found that the service worked in partnership with other agencies. There were a number of examples to confirm that the registered persons recognised the importance of ensuring that people received 'joined-up' care. This included operating efficient systems to manage vacancies in the service. We saw that the registered persons carefully anticipated when vacancies may occur so that they could make the necessary arrangements for new people to quickly be offered the opportunity to receive care in the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to suitably assess risks to the health and safety of people who received care and treatment and had not done all that was reasonably practical to reduce such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to suitably assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activities (including the experiences of people receiving those services).