Gateway Housing Association Limited

Pat Shaw House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 23, 24 and 30 August 2017 and the first day of the inspection was unannounced. We told the registered manager that we would be coming back over the next few days. At our previous inspection on 28 and 29 April, and 4 May 2016 we found the provider was in breach of two regulations relating to good governance and notifiable incidents and was rated 'Requires Improvement'. At this inspection we found that they were now meeting their legal requirements, however there were some inconsistencies in the records we reviewed.

Pat Shaw House is a care home without nursing which provides accommodation for up to 38 people across three floors. At the time of our inspection 36 people were living in the home, with 11 on a respite basis which could lead to a permanent placement. People who develop nursing needs have them met by the local community nursing teams. The service does not admit people who are living with dementia but it continues to care for them if they develop the condition once they have moved in.

There was a manager in post at the time of our inspection who had recently completed their registered manager interview process. They were registered shortly after the inspection was completed. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection the service was in a period of transition. A new registered manager was in post who was trying to create a settled environment. People who used the service and their relatives spoke positively about them, and staff felt confident that the appointment could bring a level of stability to the service.

Risk assessments were in place to identify and manage areas of risk to people, which had improved since the last inspection. However, information was not consistent throughout people's care records as some assessments had not been updated. Some records to document the care of people had not been fully completed.

The management of people's medicines were not always in line with legislation and best practice as people's medicines, including topical creams were not always recorded accurately. Medicines were administered and recorded by staff who had received medicines training, with training being refreshed if errors were made. The registered manager was in the process of reviewing their medicines policy.

The provider had reduced the number of agency staff since the last inspection and was still in the process of recruiting to permanent positions. Despite mixed comments from people and staff about staffing levels, the registered manager was aware when extra staff were required and saw they had requested this to help meet people's needs.

People who used the service and their relatives told us they felt safe using the service and all staff had a good understanding of how to protect people from abuse. Staff were confident that any concerns would be investigated and dealt with.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the importance of asking people for consent and the need to have best interests meetings in relation to decisions where people did not have the capacity to consent to their care. The provider was aware when people had restrictions placed upon them and notified the local authority responsible for assessment and DoLS authorisations.

There was an induction and training programme in place to support staff in meeting people's needs effectively. New staff shadowed more experienced staff and had their competency assessed before working independently.

We saw that more regular supervisions were now being carried out since the registered manager had started and staff spoke positively about the benefits of them.

Staff told us they contacted other health and social care professionals, such as the GP, occupational therapists and speech and language therapists, if they had any concerns about people's health. We saw monthly meetings were held to discuss concerns about people's health and well-being.

People and their relatives told us that staff were kind and caring and knew how to support them. Staff understood the importance of respecting people's privacy and treating people with dignity and respect.

Care records had been improved since the previous inspection as they had been audited and were more organised. They included person centred information however there were inconsistencies in the files we reviewed as some people's monthly care plan evaluations had not been regularly updated.

The provider supported people to take part in a range of events held throughout the year. However, people commented that day to day activities were not always available and we observed minimal engagement throughout the inspection.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. Regular residents meetings had started to take place.

We could see that there had been an improved approach to quality assurance since the registered manager had started and audits were in place to monitor the quality of the service, but were not always consistent to monitor the care provided to people. A number of audits to improve the service were in the process of being implemented at the time of the inspection.

The registered manager was aware of their responsibilities in relation to their registration requirements and notifiable incidents, and learning had taken place since the previous inspection.

We made two recommendations in relation to the management of people's medicines and day to day activities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were in place to identify and manage areas of risk to people, however recording of information was not consistent throughout people's care records.

The management of people's medicines were not always in line with legislation and best practice. Medicines were administered and recorded by staff who had received medicines training, with training being refreshed if errors were made.

Numbers of agency staff had reduced since the last inspection and the provider was still in the process of recruiting for permanent positions. Despite mixed comments from people and staff about staffing levels, the registered manager had requested extra staff to help meet people's needs.
The provider took appropriate steps to ensure robust staff recruitment procedures were followed.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm. Staff were confident any concerns raised would be acted upon.

Is the service effective?

Good

The service was effective.

Learning had taken place since the previous inspection and staff were aware of their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). A DoLS log had been introduced to monitor the status of people's applications and when they were due to expire.

People were supported to have a balanced diet, which took into account their preferences as well as medical and cultural needs. Kitchen staff were aware of people's preferences.

People had regular access to a GP and other health and social care professionals, such as occupational therapists and speech and language therapists. The registered manager attended monthly meetings to discuss people's health if their needs

changed.

Staff were positive about the training and support they received to help them to meet people's needs. Staff were now having regular supervision since a new registered manager had been appointed.

Is the service caring?

Good

The service was caring.

People told us staff were kind and compassionate. We saw that staff treated people with respect and kindness, and promoted their dignity and independence.

There was evidence that the service supported people to access independent advocates and relatives were informed if there were changes in people's health and well-being.

People who used the service and their relatives told us they felt they were involved in care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had improved since the previous inspection but monthly evaluations about people's health and well-being were not always being reviewed regularly.

People were supported to take part and be involved in a range of events held throughout the year. However, people commented that day to day activities were not always available and we observed minimal engagement throughout the inspection.

People and their relatives knew how to make complaints and said they would feel comfortable doing so. The provider gave people and relatives the opportunity to give feedback about the care and treatment they received.

Is the service well-led?

Requires Improvement

Not all aspects of the service were always well-led.

There were audits and meetings to monitor the quality of the service and identify any concerns however there were acknowledged gaps as they were in the process of being fully implemented.

The provider had recently appointed a new manager, who had just become registered with the Care Quality Commission at the time of the inspection. They were hoping to provide stable management and develop teamwork.

The provider was aware of their Care Quality Commission registration requirements regarding the submission of notifiable incidents and learning had taken place since the previous inspection.

Pat Shaw House

Detailed findings

Background to this inspection

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

The inspection took place on the 23, 24 and 30 August 2017 and the first day of the inspection was unannounced. We arrived at 5:30am on the first day of the inspection due to anonymous concerns that we had received. We told the registered manager that we would be coming back over the next few days.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience had experience in the care and support of older people in residential, nursing and dementia care services.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included statutory notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 28 and 29 April, and 4 May 2016, which showed the service was rated as 'Requires Improvement'. We contacted the local authority safeguarding adults team and looked at the local authority's recent monitoring report and used this information to support our planning of the inspection.

During the inspection we spoke with 13 people using the service, four relatives and 18 staff members. This included the registered manager, the director of resident services, three team leaders, six care workers, five care assistants, an administrator and a chef. We also spoke with three health and social care professionals who were visiting the service at the time of the inspection. We looked at 11 people's care plans, five staff recruitment files, staff training records, staff supervision records and audits and records related to the management of the service.

Some people living at the service were not fully able to tell us their views and experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us

understand the experience of people who could not talk with us. We carried out these observations during different parts of the day.

Following the inspection we spoke with two health and social care professionals who had worked with people using the service for their views.

Requires Improvement

Is the service safe?

Our findings

The majority of people we spoke with told us they felt safe living in the home and when they were receiving their care. One person said, "It's very good here, I do feel safe and the care is good." Another person said, "I've never seen anybody treated badly. Staff are disciplined and don't put a foot wrong." One person and two relatives felt there were security issues regarding the back gate and how easy it was to open and leave the premises. One relative added, "The back gate in the garden is open to everyone." We spoke to the registered manager about this who confirmed they were aware of the issues that had been raised and had liaised with senior management about ways to make it more secure. They sent us correspondence after the inspection dated 20 September 2017 to confirm that actions were being taken to add locks to the back gates in line with control measures approved by the London Fire Brigade.

We looked at the systems in place for managing people's medicines and saw that medicines were stored securely in a locked room, in locked medicine trolleys and in cabinets in people's rooms on the first floor. Staff completed stock counts for medicines stored in boxes; this helped to make sure people did not miss doses of medicines. Medicines no longer required were stored separately from useable stock. Staff recorded medicine disposals in a record book and the pharmacy signed for receipt of returned medicines. Staff recorded the fridge temperatures daily. However, the maximum and minimum temperatures were not recorded and therefore it was not possible to say if medicines were stored at the correct temperature continuously. Controlled drugs were stored in a separate locked cupboard. When staff administered or received a controlled drug, the records showed the signatures of the person administering the medicine and a witness signature. We did see that there had been no stock checks conducted between the 29 June 2016 and the 25 March 2017 and that weekly stock checks had been started in July 2017. One controlled drug was stored in the medicine trolley and not recorded in the controlled drug book, which is against legislation. Once highlighted to staff the medicine was immediately put in the controlled drug cupboard.

We reviewed 12 medicines administration records (MARs) and saw they were completed accurately and demonstrated that people received their medicines as prescribed. However, staff did not always complete administration records for topical items, such as creams and ointments, and it is therefore not possible to say if these products were applied as prescribed. Staff wrote MARs by hand for people who had did not have a printed MAR supplied by the pharmacy. The handwritten MARs were not always checked for accuracy and signed by a second person. The National Institute for Health and Care Excellence (NICE) recommend that handwritten MARs should be checked for accuracy and signed by trained staff to reduce the risk of errors. We saw one handwritten MAR for a pain relieving medicine that did not state the strength of the tablet to be administered. Five out of 12 MARs did not have the person's allergies recorded. We spoke to the registered manager about this who told us that it was recorded in people's care records, but these care records were not present at the point of administration.

Some people had medicines prescribed to be taken as and when required, for example pain relief and laxatives. On the first day of the inspection, there were no protocols in place to support staff to administer as required medicines to the needs of people. We were told that protocols were being produced and sent to the GP to be checked and signed. The registered manager had liaised with the pharmacy during the

inspection to ask for more specific times to be recorded on to people's MAR charts. We recommend that the provider seeks advice from a reputable source to ensure that best practice guidance is followed to make sure the administration of all medicines, including topical medicines is recorded accurately and the allergy status is recorded on all MAR charts.

The registered manager contacted us after the inspection to confirm that they had spoken with their pharmacist about this and would be working with them over the next three months, with weekly visits to put this in place. We saw correspondence dated 22 September 2017 from the pharmacist confirming that a meeting had taken place and that they would be working with the provider to ensure all guidelines and protocols were being followed. This was part of a pilot study by a GP Care Group in Tower Hamlets to look at the role prescribing pharmacists can play in residential care homes.

People sometimes required medicines to be administered covertly. Staff completed a best interests decision and Deprivation of Liberty Safeguards (DoLS) assessments in line with best practice and care plans stated how to administer these medicines covertly. Staff responsible for administering medicines received medicine training and competency assessments to support them in their roles. One care worker said, "I observed a medicines round during my induction, then took a test and was shadowed to check my understanding." We saw training and competency assessments were refreshed if errors had been found.

We received mixed views about current staffing levels at the service and if they were sufficient to meet people's needs. One person said, "They come in good time when I use the call bell." Another person said, "I think there could be more staff, they are always rushing around." One relative told us that they felt it was stretched at times, however felt it had improved recently. Comments from staff included, "After the last inspection, they added another member of staff at night, which has made a big difference. It is better for us and safer for the residents", "This is one of the busiest floors and we could do with another one working in the morning when people are getting up" and "It will hopefully improve when we get permanent staff. There are days where we are understaffed, however he [the registered manager] does try to resolve it and ensure we arrange cover if we need it." We did see that this had been discussed at the most recent team meeting. A recent local authority monitoring visit had also highlighted at times they felt one of the floors required an extra member of staff to ensure the safety of people in the dining room. We spoke to the registered manager about staffing who confirmed that they were still recruiting for permanent positions and were using agency staff in the interim period. The number of agency staff had reduced since the last inspection and permanent members of staff confirmed this. One member of staff added, "The agency staff are definitely more regular now and people are getting much more used to them." We spoke with two members of agency staff and one had been there for over a year, the other for nearly nine months.

The staffing structure showed that each floor had a care assistant and a care worker, along with one care worker who moved between floors dependent upon the support that was required. It also included a minimum of one team leader on shift at all times. At night, there were four members of staff on shift at all times, with one on each floor and another to float between floors to provide support when required. We looked at the staff rota for the previous four weeks and saw staffing levels were consistent with those as described by the registered manager and the staff we spoke with. Observations carried out throughout the inspection across different parts of the day were noted to be generally consistent for the care provided and we saw examples of staff attending when call bells were activated. We saw correspondence that the registered manager had requested extra hours of support to be authorised for people with higher needs or who required one to one support. For example, one person was supported to get an additional 53 hours of one to one support to help meet their needs.

At the last inspection, we found that risk assessments lacked detail and had conflicting and out of date

information in place which could lead to people not receiving the correct level of care. At this inspection, although improvements had been made and care records had been updated, there were inconsistencies in some of the records we reviewed.

There was a procedure to identify and manage risks associated with people's care. Before people started using the service an initial assessment of their care needs was carried out by the registered manager or another senior member of staff, which identified any potential risks to providing their care and support. A range of risk assessments and screening tools were completed in relation to people's mobility, medicines, behaviour and personal care support needs. Dependency assessments were carried out on a monthly basis covering areas including nutrition, personal hygiene, continence care, emotional well-being, communication and skin integrity.

One person was at risk of falls and skin breakdown. There was a falls prevention plan in place from the NHS and advice had been sought from health care professionals to ensure they were safe. Their skin was inspected daily and reviewed monthly, which showed that a wound was healing with input from a district nurse. Information was in place on moving and handling procedures to avoid causing pain to the person, however the people handling assessment had not been completed. Their falls risk assessment had also highlighted the need to review them weekly but this was not being completed regularly. Another person was at risk of falls and there was information in place on how to reduce this risk and what support should be provided. However, their monthly evaluations had not been updated since May 2017, even though previous evaluations in February, April and May had highlighted poor mobility.

For one person who was recently admitted into the home on a respite basis, they were at risk of pressure sores and needed to be repositioned every three hours. We saw records from the 16 to 23 August which showed a number of gaps and prolonged periods of time where it had not been documented. We spoke to the registered manager about this who acknowledged this as an issue. A visiting health and social care professional had also asked staff to complete behaviour charts to help with their assessment, but they had not been completed. They contacted us after the inspection to confirm this and added that when they raised their concerns with the registered manager, they responded and spoke with staff to ensure they were regularly filled in.

Since the last inspection, there had been an incident at the service which was notified to us, where the outcome of the investigation was that the providers missing person's policy was to be reviewed. We followed this up and saw that people had an updated missing person profile in place, which was personalised and gave guidelines for staff, including additional actions for staff to follow if a person was missing or if they had concerns about their whereabouts.

We found that the provider made sure the appropriate checks were undertaken before staff began work. The staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place to help safeguard people. We saw evidence of photographic proof of identity and all Disclosure and Barring Service (DBS) records for staff were in date. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. A DBS matrix was in place and the provider reviewed these every three years. We also saw that agency staff used had a profile which included their DBS records. The provider asked for two references and people could not start work until they had been received. The registered manager told us that staff were recruited after going through their assessment centre where applicants could be observed in groups and carrying out group tasks, before being short listed for an interview. They said, "We look to see if they have the values for the organisation, look for teamwork and leadership skills."

Staff had received appropriate training in safeguarding and were able to demonstrate how to keep people safe from the risk of abuse. Staff understood how to recognise the signs of abuse and told us they would speak to the registered manager or a senior member of staff if they had concerns about a person's safety and/or welfare. Prior to the inspection, the head of care had told us that they always told staff they could raise any concerns with them, along with providing them with their whistleblowing policy. Staff we spoke with felt confident any concerns raised would be dealt with by the provider. One care assistant said, "I would raise any concerns if I had any. I am confident in the management team that any concerns would be addressed." We saw records that staff had completed safeguarding training recently and that it was scheduled to be refreshed on an annual basis.

Infection control procedures were also observed to have been followed as we saw staff wearing personal protective equipment such as disposable gloves and aprons during mealtimes and when carrying out personal care. There were wall mounted units on each floor containing hand sanitizing gel to help minimise the risk of infection and a team leader was responsible for carrying out weekly hygiene checks, which had recently been introduced. Recent satisfaction surveys highlighted a 100% satisfaction rate for cleanliness within the home. Throughout the duration of the inspection, we found some sluice doors left open and unattended, despite signs saying they must be locked at all times. On the ground floor, the sluice room was unlocked and the door left open. Staff were unable to find the key to lock it. The registered manager immediately arranged for coded locks to be fitted and this was completed during the inspection. We found the sluice door on the first floor was left open on four separate occasions throughout the inspection, even though it had been brought to the attention of the registered manager on the first day. The registered manager followed this up and staff confirmed that they had been reminded to ensure it was locked at all times when not in use.

Good

Is the service effective?

Our findings

The majority of people told us they were happy with the care they received from staff and felt they had the right skills and experience to meet their needs. One person said, "They look after me and they know what they are doing." One relative told us that despite their family member only being there a short time, they were being looked after. One person told us that they felt there were different levels of competence amongst the staff. They added, "Some rush me, some don't. Some know that they're doing." We received mixed views from health and social care professionals who had worked with people at the service. One spoke positively about a member of staff who felt they were fully aware of the person's needs and was able to support them. Another felt there were different levels of competence amongst members of staff and some did not always recognise when people's health had deteriorated.

At the last inspection, we found that staff were not always fully aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as they were unaware that some DoLS applications had expired and there was no evidence of another application having been made. At this inspection, we found that improvements had been made.

The 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 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

We discussed the requirements of the MCA with the registered manager and members of staff throughout the inspection and they demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. We saw records that showed best interests meetings had taken place and when mental capacity assessments had been completed. For example, we saw a best interests meeting had taken place which involved a person's relatives in relation to their care needs and their current placement in the home. The registered manager showed us examples of applications where they felt they identified any potential deprivation of liberty and we saw correspondence from the provider and local authority where applications were followed up. The registered manager had a DoLS log which highlighted people's applications and their current status, which was also in the process of being updated.

Staff told us they made sure they asked for people's consent prior to providing personal care for them and understood the importance of it. People we spoke to confirmed this, one person said, "They always explain what they are going to do. It's like they are asking for my permission and I like that." Another person also spoke positively about this and added, "I've had a positive experience since arriving here. There are certainly no restrictions and I'm free to go out when I want."

We spoke with the registered manager about the induction and training programme that staff received when they started work with the provider. New starters completed a 12 week induction programme which covered a range of policies and procedures, training courses, spending time getting to know people who used the service and having a supervision meeting. The registered manager told us that all staff were in the process of going through the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. Records showed that seven members of staff had completed it, with three being able to assess others. We spoke with one team leader who confirmed this and even though they had not carried out any observations yet, they were looking forward to being involved. The registered manager had a record of each staff member's status and what stages had been completed. They added it was in the process of being completed by all staff and was still a work in progress. Staff confirmed that they had completed an induction programme, including agency staff. One agency care worker said, "I had a one week induction and covered fire safety, the evacuation procedure, was introduced to residents and read their care plans to get an overview of them."

There was a training programme in place that was delivered to staff as part of the mandatory induction within their first two weeks, which was also reviewed on an annual basis. Modules included safeguarding, fire safety, moving and handling, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), medicines awareness and first aid awareness. The registered manager told us that the training programme was in the process of being updated, and we saw further training modules that staff would have access to within their first 12 months with the provider. These were more specific to people's individual needs and health conditions, which included fluid and nutrition, end of life care and falls prevention. We saw that three sessions of fluid and nutrition training had been carried out during the inspection. One team leader said, "A lot of the training has helped us to meet people's needs and I think it has been really good."

We saw records that showed staff had regular supervision and annual appraisals were in the process of being completed. We looked at a sample of records of supervision sessions which showed staff were able to discuss important areas of their employment, which included issues within the staff team, training, medicines and any concerns with people's health and well-being. One member of staff told us that they had not had any supervision from the previous manager and was pleased the new registered manager was putting them into practice. They added, "Mine have gone well, the conversation is two way and it is a good way to find out what concerns there are." A team leader who was responsible for carrying out supervisions said, "They are very important, especially for the new staff. It is important to address any issues in the early stages."

Staff told us they supported people to manage their health and well-being and would always speak with the team leader or registered manager if they had any concerns about a person's healthcare needs. The majority of people were registered with the local GP who visited on a weekly basis. We observed a morning handover on the first day of the inspection and saw concerns from the night shift were discussed and whether the GP needed to be contacted. People's healthcare appointments were also discussed and arrangements made for transport or if they needed to be escorted, which was recorded in an appointments diary. One person said, "I've seen an optician and I can get a taxi to the dentist. In an emergency, the doctor would be here straight away."

We saw information in people's care records where staff had made referrals to a number of health and social care professionals when people's health conditions had changed. This included speech and language therapists (SALT), dietitians, tissue viability nurses and occupational therapists. People's nursing needs were managed by district nurses and we saw that a care home liaison occupational therapist visited on a weekly basis. The registered manager also showed us records of monthly Multidisciplinary Team (MDT) meetings where they discussed any concerns they had about people. MDT meetings involve a group of health and

social care professionals from one or more clinical disciplines who together make decisions regarding recommended treatment and support of people. We saw staff had raised some concerns about a person as their behaviour had started to change, which was discussed at a recent MDT meeting. We saw positive feedback from a health and social care professional who worked with this person that the work the staff had done and support provided had prevented them from being admitted back to hospital.

The home had been awarded a five star food hygiene rating at its last inspection in January 2017, which is the highest rating. The top rating of five means that the home was found to have 'very good' hygiene standards. We saw that this had been an improvement since the last inspection. People told us that they were happy with the food, were able to make their own choices and drinks were readily available. Comments included, "The food is very good and I can always have a drink when I want", "I like it here because of the food" and "The food is good. I'm a vegetarian and they are good with that."

We observed lunch over all floors during our inspection. People had the choice to eat in their room or in the dining room on each floor. We saw that people were given a choice where they wanted to sit and there was enough room for wheelchairs and staff to sit with people and assist them if needed. We observed a calm atmosphere and all staff spoke in a kind and measured tone, with people being able to eat at their own pace. People who required support from staff received it in a caring manner. We saw staff gave verbal encouragement to those who were able to eat independently. One person did not want their meal so a choice of sandwich was offered and made fresh in the kitchen in the dining room. They continued to refuse so the member of staff cut it up into smaller mouth sized pieces, and with gentle encouragement, ate it all, including a dessert afterwards. People were offered help with condiments or asked if they would prefer to add them independently. We did observe that there did not seem to be any portion control in place as people received meal portions of the same size. Two people stated that it was too much and were told to just eat what they could manage.

We spoke to a chef who was able to explain people's different dietary needs, which included halal, kosher, vegetarian, diabetic and those on a soft diet and they told us they were able to order foods as required. They also showed us how kosher food was prepared and how it was kept separate and cooked with kosher allocated utensils and colour coded plates. One person said after speaking with the registered manager about the importance of their kosher diet, they had no concerns about how it was managed. One relative said, "My [family member] has a diabetic diet and it's much better controlled now he/she is here. I've seen the menus and they look OK." Another relative said, "My [family member] had trouble swallowing and they referred her to a SALT, and now he/she has a pureed diet and thickeners."

Good

Is the service caring?

Our findings

People we spoke with told us they were generally happy with the care they received at the service and spoke positively about the staff who supported them. Comments from people included, "The staff pick me up when I'm feeling down and my key worker knows me well", "If I'm talking to the staff, they do listen" and "I can't fault the staff." One relative said, "I do think that they treat my [family member] with respect and as an individual." Two people told us that at times they felt that they were rushed. One person added, "Most of them are alright, but some of them go 'hurry up, hurry up'."

Throughout the inspection we observed positive interactions between people using the service and staff. Staff were observed to be compassionate and interested in the needs of the people when they were supporting them to their rooms or during mealtimes. Whilst observing lunch on one of the floors on the first day of the inspection, one person became quite upset and distressed at the dinner table. Staff were aware of this and responded calmly and positively, reassuring the person that they were OK. After they had calmed down, the person thanked them for their time. We saw this happen again and another member of staff came and sat next to them, chatting with them and offering comfort and reassurance and holding their hand. During the morning handover on the first day of the inspection, we heard that one person was anxious about a hospital appointment they had later that day. The member of staff leading the handover reminded the staff team to be aware of this and reassure them, which we saw throughout the morning. On the third day of the inspection, we observed one person who became quite agitated and aggressive with staff. We saw that staff responded calmly and appropriately in an attempt to deescalate the situation, and were aware of techniques to manage the person's behaviour. On the first day of the inspection it was a warm day and we saw that portable air conditioning units were placed in the communal dining rooms to keep people cool and contribute to their comfort.

Staff we spoke with knew the people they were working with and were able to tell us about the people they supported. At the last inspection, some people had commented that permanent staff knew them better as the agency staff had not had enough time to get to know them. Although agency staff were still being used whilst vacancies were being recruited for, the number of agency staff had reduced and had been more regular since the last inspection. The agency staff we spoke with knew about the people they worked with and how they liked to be supported. One who had worked at the service for approximately nine months, was able to tell us about a person's needs, their medical history and preferred routines, including their habits and preferences. One care worker said, "There is definitely more consistency with agency staff nowadays and it has improved."

People using the service told us they were involved in making decisions about their care and were able to ask the staff for what they wanted. One person told us about their care plan and that they were able to speak with their key worker about it. One relative told us that they felt their family member's wishes about what they wanted to do were listened to and respected. We saw people were supported to access advocacy services. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. We saw one person had visits from an

Independent Mental Capacity Advocate (IMCA) as they lacked capacity and there were no family members involved in their care. The visit recorded that the IMCA felt they were happy living in the home.

People told us staff respected their privacy and dignity. One person said, "They always knock on the door and tell me what they are going to do." One relative said, "They knock on the door when they come in and I can see that my [family member] is always well groomed." We observed staff knocking on people's doors and announcing their presence during our visit. We saw staff treating people with dignity at mealtimes, being very reassuring and patient despite it being a busy period. Staff we spoke with had a good understanding of the need to ensure they respected people's privacy and dignity. One member of staff was able to explain to us in detail how they made sure they respected people's privacy and dignity. They added, "Communication at every aspect of what staff are doing, especially during personal care is so important." One team leader told us how this was discussed with staff during supervision. Information from their most recent customer service satisfaction survey showed positive responses from relatives that felt their family members were treated with respect.

Requires Improvement

Is the service responsive?

Our findings

One the first day of the inspection, we arrived at 5:30am due to anonymous concerns that we had received about people being woken up before their preferred times. All of the people who were up or being supported with personal care were happy and confirmed this, including the relative of one person who was being supported at that time. The registered manager told us that they were flexible with wake up times and since they started had spoken with people about their preferred wake up times and was in the process of putting this information into people's care records. People we spoke with confirmed they were able to choose preferred times to wake up and go to bed. Records sent to us after the inspection also confirmed that an unannounced night visit had taken place in July 2017 to follow up on these concerns. Findings confirmed that no major issues required immediate action.

We spoke with the registered manager and a team leader about the process for accepting new referrals into the home. Since the last inspection, the provider was now accepting people on a respite basis, for short periods of time, with the possibility the placement would become permanent. A team leader told us that they made sure people and their relatives were involved and could carry out assessments in people's homes or at hospital. We saw that new referrals had an initial pre-admission assessment in place, along with a local authority assessment and any corresponding discharge notes from hospital. For two people who had been at the service since 15 August 2017, we saw that their care plan and risk assessments had not been fully completed yet. We spoke to the registered manager about this who told us that they had a two week period in which to get all documents completed. We spoke with one of the relatives who told us that they had to arrange an appointment with the registered manager to bring up some issues they had found since their family member had moved in. They told us that due to a condition, their family member needed a specific daily task to be completed but despite asking staff three times, they still found it was not always being done. We spoke with the relative on the second day of the inspection after they had met with the registered manager. They told us that they felt relieved after speaking with the registered manager and that some action had already been taken. We saw the registered manager had passed this onto a team leader and the relative confirmed that they were being involved in producing the final care plan. They added, "We've booked a date next week to go through everything."

At the last inspection we found that people's care plans were in the process of being reviewed and due to this, found that they were disorganised and it was difficult to tell what information was accurate or the most up to date. At this inspection, although improvements had been made and care records were more organised and had been updated, there were inconsistencies in some of the records we reviewed.

Care records in place were divided into sections which covered people's personal information, care plans and risk assessments and other correspondence, including visits from health and social care professionals. Care plans covered a wide range of areas which included personal hygiene, nutrition and hydration, mobility, social interests, night routines and emotional well-being. Along with this, each person had a dependency profile that covered 25 areas, and was to be reviewed each month, along with individual care plans to monitor people's health and well-being.

For one person, we saw detailed information in place about how they wanted to be supported, with a detailed 'This is me' section, which gave an overview of their life history, family, memorable events, interests and routines. Dependency assessments were reviewed monthly along with monthly evaluations of individual care plans, which recorded how people were and if any aspect of their health and well-being had changed. Another person who wanted to get up and receive personal care at 4am had this recorded in their care plan, which they confirmed with us on the morning of the inspection. We saw that their evaluations were in date and reviewed monthly.

However for one person, we saw that their monthly dependency assessments had not been completed since March 2017. A number of monthly care plan evaluations had also not been completed since April, which included nutrition and hydration, emotional well-being and social care activities. For another person, their 'This is me' section had not been completed at all, despite them being in the home for over three months. Their dependency assessment had not been completed since 7 June 2017, but they were recorded as high dependency. Their emotional well-being care plan was blank. For one other person, their dependency assessments had not been completed since October 2016. We spoke to the registered manager about this who responded immediately by speaking with staff responsible for completing these records. For the majority of records we reviewed, a care plan sign off sheet in people's files, which recorded when plans had been completed and what was outstanding, had not been completed.

The registered manager contacted us after the inspection and showed us correspondence to confirm that they had spoken formally with staff to make sure all care records were brought up to date and that monthly evaluations were reviewed by allocated staff. They also requested weekly reports to be kept updated on their progress.

People were also supported with their specific cultural or religious needs. Two people told us that they were happy with how they were supported to meet their cultural needs in relation to their food and how it was prepared, and that staff respected their faith.

We saw that the service held events throughout the year, including celebrating people's birthdays. At the last inspection we saw that they worked closely with an external organisation that held monthly cocktail parties and saw that these were still taking place. We also saw that the provider had arranged a few one off events throughout the year, which included a summer BBQ, an art project with a local hospice and a wallpaper project, where people could make wallpaper from old photographs. They had also benefitted from a group of volunteers over the summer visiting the home and interacting with people. One care assistant said, "People would play games and go in the garden. It was really good and the residents were really happy." A day trip to the coast had been scheduled to go ahead during the inspection but had to be cancelled due to issues with the accessibility of the transport. It was in the process of being rescheduled. After the inspection the registered manager sent us a few pictures of the events that had taken place over the summer. A relative also visited on a weekly basis for a bingo session.

We received mixed reviews about the day to day activities that were available to people. Although there was a weekly activity schedule in place and people could choose whether to participate or not, we did not always observe them being carried out and throughout the inspection observed people sitting in the dining room with the television on, with minimal engagement. One person said, "I think there are activities, but I can't walk to them. Nobody comes to my room to do anything." One person told us that they were lonely and there was nothing going on. They added, "I used to get taken out but not now." We reviewed this person's care plan and saw that their emotional well-being care plan had highlighted they liked going out to the shops with staff, but the monthly evaluation had not been updated since February 2017. A relative told us that their family member would like to get involved in activities and would join in if there was more going

on. We reviewed this person's care records and saw that their social interests evaluation had not been updated since December 2016. We spoke to the registered manager about this who said he would look into it immediately. We spoke with a care assistant who told us that they tried to get involved with activities for people and would also come in on their day off to take people out shopping or give hand massages. Two health and social care professionals also commented about the lack of participation and interaction people had during the day and felt that it could be improved. We recommend that the provider seeks advice from a reputable source about providing meaningful stimulation and activities for people on a day to day basis to meet their social needs.

People using the service and their relatives said they knew who to talk to if they had any concerns about the service and felt that the registered manager handled complaints well. One person was aware of the complaints process and told us that issues they had been raised had been appropriately dealt with. They added, "He [the registered manager] sorted it out straight away." One relative said, I've never made a formal complaint and anything that I've ever brought up has always been dealt with."

We looked through the complaints and compliments folder and saw that complaints records included details of the event, what action had been taken and if they had been resolved, what the outcome was. Their complaints procedure was a four stage process, with the first three being managed internally with the right of appeal to an independent body as the fourth and final stage. We saw evidence where complaints had led to follow up with staff members and saw complaints were discussed at team meetings. There had been three formal complaints in 2017 which had all been resolved. We spoke with one person who confirmed they were happy with the outcome and how it had been dealt with. We also saw compliments that had been received, from relatives and a health and social care professional. One relative complimented the service after their family member had passed away. It said, '[Family member] enjoyed their time there, I was very reassured by that.'

The provider gave people who used the service and their relatives the opportunity to provide feedback and share experiences about the service they received through resident and relative meetings. We saw a complaint that highlighted there had not been any meetings since October 2016. The registered manager told us that they were trying to hold them monthly and saw that they had taken place monthly since June 2017. We reviewed the minutes of the last three meetings and saw topics discussed included home improvements, activities and events, menu choices and health and safety. For example, fire safety was discussed in response to a recent high profile tragedy of a fire in a London tower block. We saw that this issue had also been highlighted in their quarterly newsletter, where the Chief Executive had written a message to reassure people that as a provider, they were taking additional steps to ensure they were meeting the highest possible safety standards.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the registered manager had recently had their registration interview with the Care Quality Commission (CQC) and became a registered manager after the inspection on 19 September 2017. He had worked for the provider since February 2017, and had been the interim branch manager since June 2017. He was present each day we visited the service and assisted with the inspection.

At our previous inspection which took place on 28 and 29 April, and 4 May 2016, we found the provider had failed to send in statutory notifications to the Care Quality Commission (CQC) as required.

At this inspection we found that improvements had been made. The provider was now meeting the regulation. We reviewed their records of incidents that had taken place since the previous inspection. The provider kept a log of these and was aware and knew under what circumstances to submit a notification to CQC. We saw a table of notifiable incidents located in the registered managers office and learning had taken place since the last inspection.

Since the last inspection, the service had changed the manager on three occasions, which had caused some instability and conflict amongst some of the staff team. Comments from staff included, "Dealing with change can be quite stressful and there are still a few issues with staff. I think teamwork needs to improve but I feel it is slightly improving", "There is still an issue of team politics and it needs to be addressed" and "It can be a bit unsettling working to different ways when management change and we are still recruiting to find the right people. There are some staffing challenges, with cliques and personality clashes, but it has got better." One health and social care professional highlighted that not having a stable manager in place had been an issue and affected communication. The registered manager was aware of these issues and was working to improve the current atmosphere. They said, "There is still a lot of work to do but we are getting there. I'm trying to manage a team and make sure we all work together. Giving staff feedback from the first day of the inspection I think has helped." They told us that team building events were being implemented next month and he had the support from senior management. They added, "I'm hoping it will create a strong staff team and it will cascade down throughout the whole service."

Despite the current situation, the majority of comments about the management of the service were positive. People who used the service and their relatives knew who the manager was and were confident in his abilities. Comments included, "He runs it like a book. When he's about, they move. He's a nice gentleman" and "The place is well organised and I can always talk to the manager." One relative told us that despite an issue they had raised, they felt it was well organised.

Staff also spoke positively about the current management of the service and felt it could bring stability to the service. Comments included, "The new management team are very good, it is a massive change and for the positive", "With management, we need one to settle and build up a good team. Fingers crossed that this time will be good as I'm confident with him in post and he goes the extra mile", If he stays, it can only get better as it has improved and I hope it continues" and "I feel confident as he's done a lot in the short space of time he's been here." One member of staff also spoke positively about the head of care, who supported

the registered manager. They said, "She's open and I feel comfortable talking with her."

The provider had recently carried out their annual satisfaction survey with people who used the service and their relatives to obtain their views of the service. We saw the results from their most recent survey in May 2017, where the provider had worked with NHS students and Health Education England on a project called 'Team Up', which helped develop their survey questionnaires. There were two separate surveys, one for people using the service and one for their relatives. Questions covered areas including complaints, respect, safety, food quality, activities and general satisfaction levels. The provider had compared their findings with their 2015 survey results and the results showed the majority of areas had improved. Negative responses had been highlighted and the provider was in the process of implementing improvements that had been suggested from the 'Team Up' volunteers.

Accidents and incidents were recorded and we saw evidence that when an incident or accident occurred, actions had been taken to minimise the risk of it happening again. There were three records where the action taken had not been recorded, however the registered manager was able to show us what had been done. Actions taken to minimise the risk of repeat events included retraining and supervision for staff or a referral to the relevant health and social care professional. The registered manager told us that where they had found repeat errors with people's medicines, they had arranged further training to address the issue. Since the registered manager had started, he had also reintroduced a monthly analysis to see if there had been any trends.

We saw the registered manager had started to put a number of internal auditing and monitoring processes in place since they started and acknowledged that there would be some gaps in the records we viewed. The registered manager aimed for staff meetings at least every four to six weeks and we saw that this had been done since he had been in post. The previous team meeting to this was held in January 2017. We reviewed the minutes for the last three meetings and saw topics covered included accidents and incidents, staff handovers, fire safety, staffing levels to incorporate hospital appointments and care plan evaluations. We also saw that teamwork was discussed and the importance of working together to create a positive environment.

The registered manager showed us a reporting matrix that was in the process of being completed which gave an overview of each person and when specific records were due for review. This included care plans, risk assessments, Deprivation of Liberty Safeguards (DoLS) applications and medicines reviews. Specific audits of medicines were completed on a monthly basis and reviewed by the registered manager which identified areas for improvement. Medicines errors were reported and investigated and learning from incidents was shared with staff. The provider's medicines policy was dated March 2015 and the registered manager was in the process of reviewing the policy to ensure procedures were in line with best practice. We also saw the provider had worked with the local pharmacy to trial a new process for storing and administering medicines on the first floor to see if it would reduce the number of medicines errors.

We saw records that showed weekly hygiene checks had been implemented which covered infection control and the general cleanliness of communal areas, kitchens and people rooms. Although there were a few gaps since it had started in July, people commented positively about the cleanliness of the home and we observed this throughout the inspection. A range of daily health and safety checks had started since July 2017 which recorded fridge temperatures and fire safety checks. Although we found records had not always been completed, there had been an improvement in recording from July to August 2017. The registered manager acknowledged this and said that they were trying to get the staff team used to carrying the checks out. The provider carried out regular health and safety checks of the building, including weekly fire alarm tests, water temperature checks and mobility equipment, along with annual gas and electrical safety checks.