Anchor Trust

Madeleine 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 05 and 07 September 2017 and was unannounced on both days. At the last inspection on 08 and 09 June 2015, we found that the provider had met all the legal requirements of the Regulations we inspected.

Madeleine House is a residential care home providing accommodation and personal care for up to 41 people, some of which were living with dementia. The home also provides short stay interim beds (EAB) for people discharged from hospital, who may require further assessment of their care and support needs before returning to their own home or another care home. At the time of our inspection 40 people were living at the home.

It is a legal requirement that the home has a registered manager in post. 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.

At our previous inspection in June 2015, we found that for the questions is the service safe, effective, caring, responsive and well-led, we rated the provider as 'good.' At this recent inspection, we identified areas of the service that required some improvement.

Systems in place to monitor and improve the quality of the service were not consistently effective in ensuring people received a good and continually improving quality of service. The audits had not identified the issues we found. They had not always been consistently applied to ensure where shortfalls had been identified, they were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences.

Staff were trained to identify signs of abuse and supported by the provider's processes to keep people safe. However, staff did not always follow the provider's own safeguarding procedures when unexplained bruising or marks were noted on people's bodies. Potential risks to people had been identified and appropriate measures had been put in place to reduce the risk of harm, although the information contained within some risk assessments was not always effectively communicated to staff. People were supported by sufficient numbers of staff but they were not always effectively deployed around the home. People were supported to receive their medicines as prescribed. Although protocols to support staff on when to administer medicine that was required on an 'as and when' basis were not consistently in place.

Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making. However, mental capacity assessments and best interest decisions were not always applied consistently to clearly show what decisions people were being supported or asked to make in relation to their care. Applications had been

submitted to deprive people of their liberty, in their best interests; therefore, the provider had acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We saw staff treated people as individuals, offering them choices whenever they engaged with people. Where people had the capacity to make their own decisions, staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible.

People spoke positively about the choice of food available. People were supported to eat and drink enough to maintain their health and wellbeing, although the overall meal experience required some improvement. People were supported to access health care professionals to maintain their overall health and wellbeing. People's health care needs were assessed and regularly reviewed. Relatives told us the management team were good at keeping them informed about their family member's care.

People and relatives told us that 'some' staff were kind, caring and friendly and treated people with respect, although there were occasions when people's dignity was not maintained. People were relaxed and were supported by staff and the management team to maintain relationships that were important to them. There were activities that provided opportunities to optimise people's social and stimulation requirements although they were not always suitable for those living with dementia. People and their relatives told us they were confident that if they had any concerns or complaints they would be listened to and matters addressed quickly.

The provider's recruitment processes were robust and ensured the necessary security checks were completed to make sure persons employed by the provider were safe and appropriate to provide care and support to people living at the home.

People and relatives had received satisfaction questionnaires to comment on the quality of the service being delivered. The management team had started to put in place systems to gain feedback from people living at the home, relatives and visitors through group meetings. People, their relatives and staff told us the management of the home had improved with the arrival of the new registered manager.

People felt they received care and support from care staff that had the skills to meet people's needs. Staff received supervision and appraisals, providing them with the appropriate support to carry out their roles.

We found one breach in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always safeguarded from the risk of harm because staff had not reported possible safeguarding issues to the manager and had not always followed the appropriate safeguarding procedures.

Risks to people were assessed and managed appropriately but information provided by health care professionals was not always followed by staff.

Although there were sufficient numbers of care staff to provide care and support to people, there were times of the day when the deployment of staff meant people were not always responded to in a timely way.

People received their medicines as prescribed.

The provider's recruitment processes ensured people were supported by appropriate staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments did not consistently identify what decisions people were being asked to make, or supported to make, in relation to their care.

People received care and support from staff that were trained and knew people's needs.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

Although people were supported to receive food and drink, the overall dining experience for people required some improvement.

Staff supported people to receive medical attention when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider had not ensured that the service was always caring. They had not ensured that people were consistently kept safe and that staff were effectively deployed to meet people's needs.

Peoples' dignity was not always maintained.

People' independence was promoted where possible.

People made decisions about their care with support and guidance from staff and were supported to maintain contact with relatives and significant people in their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People spent time completing social activities they enjoyed but the activities were not always person centred and did not always suit those people living with dementia.

People and their relatives were involved in planning and agreeing their care and received care that met their individual needs.

People were confident that their concerns would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the service but they did not always ensure shortfalls were identified and appropriate action plans put in place to reduce risk of reoccurrences.

There was a new registered manager.

People were generally happy with the service they received.

Madeleine 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.

This unannounced inspection took place on 05 and 07 September 2017. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor on the first day and one inspector on the 07 September. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia.

As part of the inspection process we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people. We had received a number of concerns from partner agencies that related to keeping people safe and from risk of avoidable harm. We looked into these concerns as part of our inspection.

We spoke with 10 people, five relatives and friends, the registered manager, the district manager, eight staff members and one health care professional. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at records in relation to nine people's care and medication records to see how their care and treatment was planned and delivered. Other records looked at included three staff recruitment files to check staff were recruited safely. The provider's training records were looked at to check staff were suitably

trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in June 2015 we rated the provider as 'good' under the key question of 'Is the service safe?'. At this inspection we found that some improvement was required. People we spoke with told us they felt safe living at the home. One person said, "I feel 100% safe, the carers make me feel safe and the doors and windows are locked." Another person explained, "I feel safe here because everyone has to sign in and out". Another person told us, "If I felt unsafe I would go to the girls in the office, they are approachable." A visiting health care professional had told us they had not seen any unsafe practice being carried out by staff. Staff we spoke with explained how they would report any suspicion of abuse and the signs they would look for that could indicate a person was being abused. One staff member said, "We check for bruising and you could tell if something was wrong if you noticed someone was cowering from a member of staff." Another staff member told us, "If people suddenly became withdrawn and quiet then that could be a sign that something is wrong." All the staff we spoke with were aware of how to report suspicions of abuse explaining they would raise concerns with their team leader or the management team.

Although all the staff we spoke with told us they would report any changes in peoples' behaviours, suspicious or unexplained bruising, we found this was not routinely happening. This meant that although people we spoke with told us they felt safe, we found that staff had not always recognised that certain injuries should have been reported under the provider's safeguarding procedures. For example, one care plan we looked at included body maps that detailed a number of unexplained marks and bruising to the person but we found the incidents had not been notified to the registered manager. We discussed our findings with the registered manager and district manager who raised a safeguarding for the person to ensure what had been found could be investigated thoroughly.

We had received information of concern regarding a number of incidents which had taken place that related to altercations between people living at the home. We found the incidents had been correctly reported and investigated with appropriate measures put in place to reduce risk of reoccurrence.

We saw that individual risk assessments were completed, for example, to assess people's risk of falls, developing sore skin, nutritional risk and moving and transferring. The assessments were updated regularly and there was a record of the actions to be taken to reduce the risk of harm to people. We saw people being moved safely using a hoist and staff used appropriate moving and handling techniques that ensured people were transferred safely. However, on the first day of our inspection site visit, we had observed one person, who was at risk of swollen legs, had remained in the same seated position for five hours. We saw on the person's file there were instructions to encourage the person to elevate their legs. This was not seen to have happened during our visit. We shared our observations with the registered manager and on the second day of our visit, although the person declined, staff did try to encourage the person to stand. We were also told that during the night the person would become more active and walk around the home. We saw from the person's facial expressions and their body language they did not appear to be in any discomfort.

We looked at three staff records to check their suitability to work with people living at the home. We found staff had completed the appropriate pre-employment checks that included an up to date Disclosure and

Barring Service (DBS) check prior to their employment. The DBS check can help employers to make safer recruitment decisions and reduce the risk of employing unsuitable staff.

We received mixed responses from the people, relatives and friends we spoke with concerning the numbers of staff on duty to support people. Comments from people and relatives included, "There are enough staff and at night time, but they are always busy." "At times, there is no staff in the lounge to look after people." A health care professional we spoke with said they thought staff were 'rushed off their feet.' The new registered manager had increased care staff numbers in an attempt to address concerns. However, one staff member we spoke with said, "There's not enough staff, the extra staff doesn't always happen, but when we do have that extra one it is more organised." We talked about concerns with the management team. The registered manager explained how staffing numbers were monitored and confirmed with us the concerns raised by staff would be discussed them in supervision and team meetings.

Our observations around staffing numbers showed alarm activations were responded to in a timely manner. However, it was noted on both days of our inspection visit, staff were seen to be standing around in small groups talking amongst themselves or sat in a small office located within the main dining area. This was confirmed by people and relatives we spoke with, as a regular occurrence. One relative explained, "Some staff are sitting in the office too long and not hands on. I don't think that they are doing their job when residents are left unattended in the lounge." We discussed with the registered manager our observations and the conversations we had with people. The registered manager explained she had already identified this as an area that required improvement and gave her reassurance that it would be addressed with all staff.

We had received information concerning a number of medicine errors that had occurred at the home. We had also been told of an occasion when medicine had been unaccounted for. The appropriate authorities had been notified and an investigation was conducted. We observed the administration of medicines and found that staff were routinely interrupted. Interruptions to staff when administering medicine to people can lead to errors in the administration and recording of what medicine is given to people. We saw that following the medicine errors there had been a change to the way some medicines were stored. The registered manager confirmed the competencies of staff had been checked and relevant training put in place.

People we spoke with told us they had no concerns with the administration of their medicine. One person said, "They [staff] never forget to give me my medicine." Another person told us, "I get my medicine when I need it." During our visit we saw medicines were locked away. Processes were in place for ordering and supply of medicines. We checked nine medicine administration records (MAR sheets) and conducted a medicine audit which showed medicines in stock balanced.

We found with one person's record for topical patch (pain relief) application, the body map did not indicate the site of application when the patch was rotated. This is important to ensure the patch does not remain on the same site and make the skin sore. Guidance for staff on when to administer 'when required' medicine to people were not consistently in place. However, when we spoke with staff, they were aware of the behaviours of people that could indicate the person was in pain and required their medicine. Guidance would help support new and agency staff to identify when a person required their medicine. The registered manager immediately started to review their guidance to ensure they were accurate and in place.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in June 2015, we rated the provider as 'good' under the key question of 'Is the service effective?' We found at this inspection improvement was required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. We checked the provider was working within the principles of the MCA and found that improvement was required.

We found on the mental capacity assessments we reviewed, the decisions to be made were almost identical and therefore not always individualised to the person's circumstances. The best interests decisions we saw did not always state the benefit to the person and why it was in their best interests. We discussed with the registered and district managers the need to improve the completion of mental capacity assessments and the best interests process to ensure assessments were decision based and time specific.

People we spoke with told us staff asked for permission before carrying out any care or support and could make decisions about their care and support. One person said, "Staff do ask if I am happy with what they are doing." Another person told us, "I make my own decisions on how I spend my day." One member of staff said, "I always ask people what they want and make sure I give them a choice." Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "It depends on the person, I could just ask and they'll understand but others you might have to show them things and explain it more slowly so they can understand."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw applications had been made to authorise restrictions on people's liberty in their best interests in order to keep them safe. One staff member told us, "There is a list of people who have a DoLS. Some people (living at the home) can't make their own decisions so we (staff at the home) will have to make a decision in the best interests of the person." Another staff member said, "We hold best interests meetings and involve the family, the doctor and if there is one, a social worker, to talk about what is best for the person." Although some staff were not always able to give a clear reason why some people were subject to a DoLS, they did identify who could be at risk if some restrictions were not in place, in the person's best interest's, in order to keep them safe from risk of harm.

People we spoke with told us they were satisfied with the food they received. One person said, "The food is very good and I'm a fussy eater." Another person told us, "The food is fairly good and we have choices, would be nice to see a menu on the table though." However on the first day of our inspection site visit, we found the overall dining experience could be improved. For example, we saw there were gravy boats on

each table but people were not asked if they wanted gravy or encouraged to pour it themselves. One person had not eaten their meal which had been on the table for 40 minutes. A staff member sat with the person and tried to assist them to eat it. The person refused to eat what would have been a cold dinner. The staff member was heard to say to the person "You prefer soup don't you?" The soup was later bought to the person and they ate it. We noted there was a high number of staff in the dining area, however we saw that there were times staff were standing around in a small group when they could have been supporting people more effectively. This was discussed with the registered manager and on day two of the inspection site visit, there was an improvement with staff walking around the tables, offering people gravy and support for those that required it. We saw that people did have access to drinks throughout the day and if people asked for a drink, staff would fetch them.

People's nutritional needs were assessed and there was information in people's care plans about their nutritional preferences. We found, where appropriate, referrals had been made to the GP in respect of the weight loss. We saw that additional support was sought from speech and language therapists (SALT) where people had difficulty swallowing their food. We found the provider had also sought advice from dieticians and staff would add additional calories to people's food. For example, the use of cream instead of milk. We saw one person who was at risk of choking required thickener to be added to their drink to reduce the risk of choking. The amount of thickener to be added was one scoop for each 100mls of fluid. However, it was noted when the staff member was adding the thickener to the person's drink they were unsure if the glass size was 100ml or 150ml. This meant the drink may not have been correctly thickened and could have had the potential to cause the person to choke when they drank it. We discussed this matter with the registered manager who assured us they would address the matter directly with the staff member.

People we spoke with told us they were regularly seen by health care professionals, for example, the GP, tissue viability nurses, optician, podiatrist or dentist. Relatives we spoke with had no concerns about their family member's health needs. One person said, "The doctor comes out once a week." We saw that healthcare professionals completed visiting records with instructions for staff. This supported people to maintain their health and wellbeing. However, we were told by a visiting health professional that 'sometimes' staff had not carried out instructions left by them which had led to some people's skin becoming sore. This had been identified by the registered manager and training had been put in place for staff to care for people with sore skin to ensure correct pressure relief and appropriate barrier creams were consistently applied.

People spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "I think that the staff are skilled and are here when I need them." Another person told us, "You can ask anything of the staff and they will do it for you." Staff we spoke with told us they had received training to support them in their role. One staff member said, "We have a lot of training, I've recently completed training in health and safety, dementia, fire prevention, it was all interesting. We have face to face training from trainers outside the home, it's good." Another staff member told us, "The training is pretty good, they [the provider] is on you if you haven't done it [training]. The training is varied some on line through E-learning and some face to face and practical, we do have a lot of training." Staff also received training to support them to complete the Care Certificate. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. Staff we spoke with confirmed they had recently received supervision from the new registered manager. Staff we spoke with told us they felt supported by the new registered manager and that they would speak with them if they were concerned about anything.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in June 2015, we rated the provider as 'good' under the key question of 'Is the service caring?' At this inspection we found the service required some improvement. People and relatives we spoke with were generally positive about the staff. One person told us, "The staff are very caring, there was a person who took a dislike to me, they [staff] reassured me." A relative we spoke with said, "The staff are very caring, they know how to look after mum." We saw some positive interactions between some staff and people living at the home. However, we did observe that at times staff missed opportunities to interact with people more. For example we observed a number of people were sat at one dining table. Staff would walk past them or seat other people at the table without speaking to those already seated. A number of people and relatives we spoke with explained how they would 'often' see staff members standing in small groups talking or sitting in the office when they felt staff could be supporting people. One person told us, "The staff don't talk to you." A relative we spoke with said, "Some staff are open to improvement." We discussed these observations with the registered manager. They had already identified the issues through their own observations and explained to us what action they intended to take.

People we spoke with told us they felt involved in decisions about their day to day care and support needs. One person said, "If I don't want something, I tell them [staff] and they listen." Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people, they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. We saw that people were encouraged to walk, where possible and others were encouraged to transfer, with support from staff, from their wheelchair to a lounge chair. Another person told us, "I choose what I do with my time."

People we spoke with told us staff maintained their dignity. One person told us, "I like to do my own personal care and staff will sit and discreetly wait close by when I am having a bath or shower to make sure I'm ok." However, we saw that one person had spilt a drink on their trousers. Although the person was approached and spoken with by four members of staff, it was not noticed the person's trousers were wet. It was not dignified for the person to be left sitting in wet trousers. Eventually after a considerable length of time, a staff member did notice and encouraged the person to go with them to change their trousers. We discussed this matter with the registered manager. Although we saw that staff were kind, they were not always as vigilant as they could be and this was an area for improvement.

People we spoke with told us staff were considerate and respected their privacy. One person told us, "I prefer a female carer and this is respected." Another person explained, "Some of us [people living at the home] have our own bedroom keys so we can lock our rooms." Staff addressed people by their preferred names and knocked on people's bedroom doors before entering. Some people chose to have their bedroom door open or closed and their privacy was respected. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity. Our observations overall, demonstrated that staff were friendly and they laughed with people and supported people to move around the home safely. This was carried out with care ensuring people moved at the pace suitable to them.

Everyone we spoke with told us there were no restrictions when visiting. One person told us, "Family and friends can visit at anytime." There were separate rooms and areas for people to meet with their relatives in private. We found people living at the home were supported to maintain contact with family and friends close to them.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in June 2015, we rated the provider as 'good' under the key question of 'Is the service responsive?' At this inspection we found some improvement was required. We had received information from partner organisations that the initial admission assessment of people's care was not robust. This had led to a number of people being moved from Madeline House to other homes in a short length of time which could cause people distress. Prior to the registered manager's appointment, the assessments were not as robust as they should have been. This had led to a number of admissions being accepted only to later find the people had required higher care needs than originally assessed for and the staff were unable to meet these needs. We discussed the assessment process with the registered manager. They explained the improvements they had made. This included the registered and deputy manager conducting initial assessments, with the intention to provide additional training and support to senior care staff.

There were mixed opinions from people and relatives we spoke with about their involvement in the planning of people's care and support. However, we found that care plans were reviewed and there was evidence to support input from people and their family members. We found that when there were changes to a person's health this had been identified and recorded in the care plans and showed the involvement of health care professionals when needed. Staff we spoke with were knowledgeable about people's needs and risks associated with their care and were able to give examples of personalised care and how they managed difficult situations. For example, when people became upset and angry. All the staff we spoke with told us that they received updates in changes in people's needs in handovers between staff at shift changes and would also read peoples' care plans.

People and relatives we spoke with told us they were satisfied with the home. One person told us, "I have never had to raise a concern or complaint." Another person said, "If I wasn't happy here I would leave but I would speak to the manager first." One relative we spoke with explained, "I did raise a concern but it was dealt with quickly." We reviewed the complaints file and saw there had been a small number of complaints made since our last inspection. The new registered manager told us complaints and concerns were taken seriously and would be used as an opportunity to learn and improve the service. We saw the complaints the new registered manager had dealt with had been investigated and resolved to the satisfaction of the parties concerned. However, there was no process in place that could identify trends to ensure the service could be improved upon and reduce the risk of any reoccurrences and this required some improvement.

A new activities co-ordinator was in post and we could see they were passionate about their role. They were keen to develop and improve activities for people. They explained about a number of initiatives they had introduced. For example, there were people living at the home who were visually impaired. We saw the staff member had arranged 'talking books' that were updated with news items and events on a regular basis. One person told us, "We do have activities and people come in to entertain us." Another person explained how they attended a 'Monday club' that had been arranged for them. We saw that some people were supported to participate in social activities, for example, a new 'pen pal' scheme. This had recently been introduced where people wrote letters to other people living in one of the provider's other homes. One

person told us how exciting it had been for them to write to their 'pen pal.' We saw people were encouraged to sing, although it was noted on the first day of our inspection that the television and music were playing at the same time and the environment was noisy.

During the two days we were on site, we saw there was a lot of effort put into providing activities for people. One person said, "They [staff] would take me to the shops if I ask," Another person said, "I enjoy doing crosswords and I get a paper everyday." At the time of our inspection site visit, the provider's website stated Madeleine House worked in partnership with the provider of activities for older people. However, we noted there were different activities taking place around the home but found the same people were involved. Although we did not find evidence of activities suitable for people living with dementia taking place at the time of our inspection visits; we could see the new activities co-ordinator had started to put plans in place for people living with dementia. This included reviewing their life histories to develop and personalise activities for them.

The home had a large, accessible garden to the side of the property that people could access. We heard one person ask if they could go to the park. The staff member replied, "If you want," but the person was not supported to go out in to the garden or for a walk. We heard the person ask to go to the park on a number of different occasions during our visit. We saw only a small number of people access the garden. We were told by staff that families used the garden to take their relatives out when they visited and if the weather was fine.

We asked staff how people's cultural and spiritual needs were being met. One staff member told us, "[Person's name] likes to go to go to church but is unable to go anymore so I have arranged for a church service once a month." Staff we spoke with confirmed they had received training on respecting people's equality and diversity needs, which included people from the Lesbian, Gay, Bi-sexual and Transgender community (LGBT).

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in June 2015, we rated the provider as 'good' under the key question of 'Is the service well-led?' We found at this inspection the service required some improvement.

Since the last inspection, the home has had three registered managers. The latest registered manager had been in post for just three months. This had led to some inconsistency in the management of the home. The registered provider had a responsibility to ensure that there were effective systems in place, during the transitions between registered managers, to make sure the service people received remained consistently effective and safe. This was not always the case. Although we had found that the provider had some systems in place to monitor the quality and safety of the service and that some of these had been used effectively to identify areas for improvement. For example, we saw that the provider had identified their initial assessment process had required some improvement and had already taken steps to correct this. However, we also found that some of the quality monitoring systems had not always been used effectively to implement or sustain improvements made and where shortfalls had been identified. This was evident for some of the shortfalls we found during our inspection.

We found medicine management processes including the medicine auditing systems required improvement. For example, we saw that staff administering medicines were constantly interrupted by other staff members, this was irrespective of staff wearing distinctive red tabbards that clearly showed they should not be disturbed. These interuptions could lead to incorrect dosage of medicine being administered and inaccurate recordings of medicine given. The provider's own internal processes had not identified these constant interruptions as an area for improvement. We also found a controlled medicine patch and a bottle of medicine were unaccounted for. The provider's audits had failed to identify the medicines were missing and were unable to provide a satisfactory explanation as to where the medicines might have gone. We found that the provider had increased the number of staff members on duty, however, their processes had failed to ensure the effective deployment of staff to ensure people's needs were consistently met in a timely manner. Although staff had been trained to identify signs of abuse, the provider's processes had not identified that staff had not always followed the safeguarding procedures when unexplained bruising or marks were noted on people's bodies. The provider's processes had not identified that activities offered to people living at the home, were not always suitable for those living with dementia.

We have taken into account the new registered manager had already started to take some action and had been conducting their own audits to determine where the shortfalls were. We saw that following our feedback, the registered manager had responded by attending to some of the shortfalls. However, we explained that this was a reactive rather than proactive response and improvements needed to be made to the monitoring of the quality assurances processes.

Collectively, this demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to implement effective quality monitoring systems and processes in place to ensure they were compliant with the requirements of their registration and that the safety and quality of the service being provided to people was maintained.

It is a legal requirement that organisations registered with the Care Quality Commission (CQC) notify us about certain events. We had been notified about significant events by the provider.
It is also a legal requirement for a registered manager to be in place. At the time of this inspection visit, there was a registered manager in place therefore, the conditions of registration were met.

People and relatives we spoke with were complimentary about the quality of the service. We found the atmosphere of the home to be calm and relaxed. Everyone knew who the registered manager was and told us that they could speak with them whenever they wished and that they were visible around the home and approachable. One person told us, "I know who the manager is and they are approachable." A relative told us, "The manager is approachable and seem to know what they are doing." We had been told by some staff that in the past, staff had been set in their ways and opposed to change and that this had influenced the working practices of some newer members of staff. However, all the staff we spoke with told us there had been an improvement in the running of the home since the new registered manager's arrival. Comments made by staff included, "We need to change the culture of the home and I think [registered manager's name] is just the person who can do this." "[Registered manager's name] is easy to talk to and will get an apron on and help. She will sit with us and comes to help us straight away, I like that." "The home is so much more organised, we have been shown the correct procedures and I get so much support from her [registered manager]." "I love working with [registered manager's name], I enjoy my job, I'd go to [registered manager's name] they seem really nice, fair and will listen to the staff."

People and relatives we spoke with said they were asked to provide feedback about the quality of the service. We saw this was in the form of resident and relative meetings and feedback questionnaires. We saw there had been some resident/relative meetings but they had not been particularly well attended. One relative told us, "There are relative's meetings but no one turns up." However, people and relatives we spoke with all told us if they had any feedback or concerns to raise about the home, they felt confident to approach the management team. One person told us, "The manager is a lovely lady and if I had any problems I'd tell her."

Staff members we spoke with told us the management team were approachable and if they had concerns regarding the service, they would speak with them. The provider had a whistle-blowing policy that provided the contact details for the relevant external organisations for example, CQC. Staff told us they were aware of the provider's policy and would have no concerns about raising issues with the provider, manager and deputy manager and if it became necessary, external agencies. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to a person's safety), wrong-doing or some form of illegality.

It is a legal requirement that the overall rating from our last inspection is displayed within the home. We found the provider had displayed their rating as required. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider was working in accordance with this regulation within their practice. We also found the provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.

This section is primarily information for the provider

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 17 HSCA RA Regulations 2014 Good governance The provider's quality assurances processes required improvement to ensure the service provided a safe and effective environment for people living at the home.