Barchester Healthcare Homes Limited

Stamford Bridge Beaumont

Inspection report

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Date of inspection visit:
08 November 2016
10 November 2016
24 November 2016

Date of publication:
16 January 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This inspection took place on 8, 10 and 24 November 2016 and was unannounced.

Stamford Bridge Beaumont is a care home which offers nursing and personal care for up to 107 people. The home is situated in Stamford Bridge, which is situated in the East Riding of Yorkshire, close to the city of York. Accommodation is provided over three floors in a Georgian listed building and purpose built extension. The home is divided into five main areas with three of these being used to support people with dementia. At the time of our inspection there were 80 people using the service.

The service is required to have a registered manager, and at the time of our inspection there was no 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. The previous registered manager for the home had recently left, and a unit manager was fulfilling the role of 'acting manager' for the home, until a permanent manager was appointed. Another member of staff was also 'acting up' as the deputy manager for the home, whilst the appointed deputy manager was completing a six month secondment post at another home. This meant we were unable to rate the key question, 'Is the service well-led?' any higher than requires improvement.

At our last inspection in July 2015 the registered provider was not meeting legal requirements in relation to the safe management of medicines. At this inspection we found that practice had improved and the registered provider was now meeting legal requirements. Medication was appropriately stored, administered and recorded on medication administration records. Staff responsible for the administration of medication received training and any medication errors were appropriately investigated.

The registered provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. Some people, staff and relatives raised concerns about staffing consistency and staffing levels, especially at weekends and when there were staff absences at short notice. Staff told us that whilst there were always sufficient numbers of staff to meet people's basic care needs, on some days it was difficult to find time for social interaction on a one to one basis, when there was unexpected staff absence and insufficient time to arrange replacement cover. We have made a recommendation about this in our report.

People's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm. The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and concerns were appropriately reported. Staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns.

Staff completed a range of training to help them carry out their roles effectively, and there was a schedule

for refreshing this training when it was required. Staff received supervision to support them in their role.

The registered provider sought consent to provide care in line with legislation and guidance. Staff had completed Mental Capacity Act (MCA) training and were able to demonstrate an understanding of the principles of the MCA.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that the registered provider had supported people to access healthcare services where required, such as GPs, speech and language therapists, chiropodists and the local nurse practitioner.

Most people were satisfied with the quality of meals available and told us they got sufficient to eat and drink. Two relatives raised concerns about the availability of sufficient support for people who required assistance and encouragement with meals and drinks. We observed people being offered choice and support where required. People's weights were monitored and action taken where people had lost weight.

The majority of people and visitors told us that the staff were kind and caring. However, some people's comments suggested there was some inconsistency at times. We observed that on occasion the support provided by staff was functional and task focussed, but we also observed many other examples of interactions that were very warm, positive and friendly. People told us that staff respected their privacy and dignity. Support was provided to meet people's religious and cultural needs.

The registered provider completed care plans which contained detailed information about people's needs and preferences; these were regularly reviewed by staff to ensure they reflected people's current needs. Most staff were also able to demonstrate a good understanding of people's needs and preferences. The registered provider employed activities co-ordinators and there was a range of leisure and social activities available to people.

There was a complaints procedure in place and records were held of formal complaints that had been raised and addressed. However, we found that some people had raised concerns informally and did not feel these had been resolved to their satisfaction. Not all people we spoke with told us they would feel comfortable raising concerns. Opportunities to encourage people to give their views, in resident's and relative's meetings for instance, had not been consistently available across the home. We have made a recommendation about this in our report.

There was a quality assurance system in place, which included the completion of a range of regular audits. This enabled the registered provider to identify issues and measure the delivery of care. Whilst most issues identified in audits were addressed, we saw some examples where action had not been taken promptly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were systems in place to ensure that people received their medicines safely.

Some concerns were raised about the consistency of staffing levels at the home and we have made a recommendation about this in our report.

There were systems in place to protect people from avoidable harm. Risks to people were appropriately assessed and managed.

The registered provider used a robust recruitment process, to ensure that people were supported by staff who were considered suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and regular refresher training.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People had access to healthcare services, where this was required, in order to maintain good health.

Is the service caring?

Good

The service was caring.

Most people told us that staff were kind and caring and we observed mainly positive and friendly interactions between staff and people who used the service.

People's privacy and dignity was respected, and people were provided with support to practice their religious beliefs, where

they wished to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and detailed care plans were developed to enable staff to provide personalised care. Most staff demonstrated an understanding of people's individual needs and preferences.

There were systems in place to manage and respond to complaints and concerns, but some people told us concerns they had raised had not been resolved to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager for the service, so the home was in a period of transition until a new permanent manager was appointed. Feedback about the temporary management arrangements for the service was positive.

There was a quality assurance system in place. We found examples which showed that quality audits led to improvements being made, but there were also some occasions where actions identified had not always been promptly addressed.

Stamford Bridge Beaumont

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 inspection took place on 8, 10 and 24 November 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and two experts by experience on the first day of the inspection and one adult social care inspector on the second and third days.

Before our visits took place we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from East Riding of Yorkshire Council's safeguarding team. Prior to our inspection we received some information of concern about care at the home, including staffing levels and consistency of staff, medicines management, support with nutritional needs, communication and leadership. We therefore brought forward our planned inspection and have reported on our findings in relation to these areas as part of this report.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with 13 people who used the service, 10 relatives and visitors and a visiting healthcare professional. We also spoke with three care staff, three nurses, a care practitioner, an administrator, the acting manager and the regional manager. We looked at six people's care records, 20 people's medication records, four staff recruitment files, staff training files and a selection of records used to monitor the quality of the service. We also carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves.

Good

Is the service safe?

Our findings

We asked people using the service if they felt safe living at Stamford Bridge Beaumont, and their comments included, "I feel very safe, the staff are very friendly. I don't have any worries about the staff. I always find them helpful," "We have been very well cared for here" and "I feel very safe because I get help to get about. My [relative] is very assured that I am safe and getting the right level of care." Other people told us, "I feel safe" and "I feel very safe; it's the way I'm looked after. The staff are very helpful and look after me." One person raised concern that they could not use their call bell easily and had to shout to get staff attention when needed. We checked their care file and saw that this had been risk assessed.

At our last inspection on 20 July 2015 we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to medicines practice at the home. This was because although the home had made some improvements since the previous inspection we conducted in February 2015, further improvement was still required. Prior to our inspection a concern had also been raised with us about a recent medication error that had occurred at the home. We therefore looked again during this inspection at the systems in place to ensure people received their medication safely.

The registered provider had a medication policy. Staff responsible for the administration of medication had received training in medicines management and were assessed for their competency. People's care files contained information about the support they required with their medicines. The information was detailed and reviewed each month, to ensure it was reflective of people's current needs.

We looked at a selection of 20 people's medication administration records (MARs). We found that these were appropriately completed, to show that people had received their medication as prescribed. Two people's MAR sheets were missing, but we were advised this was due to a recent changeover in medicines and would be addressed straightaway. No medication had been missed as a result of this. We checked the stock balance for a number of medicines and the stock held tallied with the stock level recorded on the MARs. There were protocols in place for people who were prescribed medication for use 'when required'; these protocols gave clear instruction to staff when and why the person may require this medication and records were completed when people received them. We found one example, on the first day of our inspection, where a staff member had recorded that a medicine for use 'when required' had been given, but had not promptly documented why. The staff member was able to explain to us why the medicine had been given, but acknowledged that they should have recorded the reason it had been given straightaway.

Medication was appropriately stored. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were stored safely and records were accurately completed. We discussed with the manager an issue in relation to the storage of some drugs that were awaiting disposal and this was addressed on the first day of our inspection.

We also observed medication being administered and spoke with staff about various aspects of medicines management, including training and competency checks. Staff demonstrated a good level of understanding. We found that where medication errors had occurred these had been appropriately investigated. One investigation was on-going at the time of our inspection.

We spoke with a community pharmacist who routinely visited the home and conducted independent audits of the medicines practice at the home. Their feedback about the systems and practice at the home was positive and they showed us examples where recommendations they had made in previous audits had been acted on.

This showed us that systems and practice to ensure people received their medication safely had improved since our previous inspection, and the registered provider was now meeting legal requirements.

We spoke with people who used the service, relatives and staff about the availability of sufficient staffing to meet people's needs safely. Staff told us that there were always sufficient numbers of staff to meet people's basic care needs, but that on some days when there was unexpected staff absence, due to sickness for instance, it was difficult to find time for social interaction on a one to one basis. They told us it was not always possible to get additional staff cover at short notice, and this put a strain on staff at times. One staff member told us this was a particular issue at weekends.

There were mixed views from people using the service about whether there were sufficient numbers of staff to meet people's needs. Comments included, "Staffing is generally not too bad. Weekends can be an issue and there is quite a lot of agency staff," "I think there are enough staff. I always feel as if I can ask for things and they will always help me" and "There's just the right amount of staff." Others told us, "At this time of year, there always seem to be staff off and agency staff come in. Sometimes they are good," "I get frustrated with the changes in staffing. I like continuity of staff" and "I feel as if they could do with extra staff, because sometimes I have to wait. There are only two [in this unit] on a night but they always come eventually if I need them."

Comments from visitors were again mixed. Two visitors we spoke with were concerned about staffing levels, particularly when there were staff absences and at the weekends. They felt this impacted on the care their relatives received as it meant there were less staff to monitor people's well-being and ensure their needs were promptly met. However, others visitors did not raise concerns about staffing levels.

During our inspection the atmosphere in the home was calm and staff generally responded to people's needs in a timely manner. The registered provider used a dependency level assessment tool to assess the level of staffing required in relation to the needs of people living at the home. We looked at rotas for the last four weeks and these showed that where there were identified shortfalls in the number of staff required to fill the rota agency staff were used. Rotas also showed that the registered provider employed a range of ancillary staff, such as domestic, kitchen and activities staff, which meant that nurses and care staff could concentrate on the delivery of care to people.

After the second day of our inspection we received information which suggested that additional care staff may have been called in on the first two days of our inspection, thus not representing the typical staffing availability at the home. We therefore returned for a third day to explore this further. We found that whilst additional management support had been called to support with the inspection on the first day, there was no evidence that additional care staff were available on the first two days of our inspection. The staff on the planned rota reflected the staff who were present in the service, apart from one carer who was absent due to sickness on the third day of our inspection. The atmosphere in the home on the third day was consistent

with the first two days of the inspection. Staff were used flexibly across the units of the home to take account of one less carer than planned on the rota on the third day, and this ensured people's needs were met.

We spoke with the manager about the concerns that were raised with us about staffing levels, and they confirmed that there had been some issues with individual staff attendance and action was being taken to address this with those involved. They also told us that on occasions, where there had been staff absence at short notice, if they had not been able to find additional cover they had been required to move staff between units to ensure staffing levels were maintained on the units where there were people of highest need and risk. This was because they assessed that some other units were still able to operate safely with one less staff member if required. The regional manager told us that they monitored the use of agency staff via weekly reports sent by the home, and that although the home used agency staff, they did not feel that the amount used was excessive when considered alongside the statistics for other homes. They also told us a number of new staff had been offered positions and were going through the process of recruitment checks.

Whilst it was evident that action was being taken to ensure there was sufficient staffing, including an on-going recruitment campaign, use of agency staff and booking additional contingency staff on occasions, the feedback we received from staff, people and visitors showed that further work was still needed, to ensure on-going consistency of staffing levels on all units.

We recommend that the registered provider takes action to ensure that sufficient numbers of staff are consistently deployed in order to meet people's needs promptly.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. Staff received training in safeguarding vulnerable adults from abuse as part of their induction training, then regular refresher training thereafter. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Records were maintained of all safeguarding concerns, and these were appropriately reported to the local authority, where necessary. We found that where the behaviour of people who used the service had impacted on others using the service, specialist support had been sought from a dementia advisor, to support staff in appropriately managing any incidents and meeting people's needs.

Staff were aware of the registered provider's whistleblowing policy, which enabled them to report issues in confidence and without recrimination. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

The registered provider completed risk assessments in relation to people's needs. These included assessments in relation to falls, moving and handling, skin integrity, continence needs and the use of call bells. The Malnutrition Universal Screening Tool (MUST) was also used to assess people's risk in relation to malnutrition. Risk assessments were reviewed monthly. Personal emergency evacuation plans (PEEPs) were in place, to show the assistance people would require to leave the premises in the event of an emergency.

We observed staff following safe moving and handling practices throughout our inspection. Staff told us that the availability of additional stand aid hoists would be helpful as there was only one per unit at the time of our inspection.

We saw that records of any accidents or incidents were completed by staff and reviewed by the manager to make sure appropriate action had been taken in response to any incidents. The manager recorded

information about accidents and incident's on the registered provider's electronic clinical governance system, so that data could be analysed in order to identity patterns and action required.

We looked at documents relating to the maintenance of the environment and servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked and serviced at appropriate intervals. This included alarm systems for fire safety and fire extinguishers, gas installations, lifts and hoisting equipment and the call bell system. We saw that actions recommended in a report of a recent electrical wiring check were planned for completion. Maintenance staff also conducted portable appliance tests on portable equipment. These environmental checks helped to ensure the safety of people who used the service.

The registered provider also had a business continuity plan detailing how they would ensure people's safety and comfort in the event of an emergency, such as a fire or flood.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references, identification checks and registration checks for nursing staff. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The acting manager was also aware of the requirements in relation to nursing revalidation. Revalidation is the new process that all nurses in the UK will need to follow to retain their status with the Nursing and Midwifery Council (NMC). The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of all workers.

The registered provider had an infection prevention and control policy and cleaning schedules were in place to ensure the home was clean and hygienic. We discussed with the manager about some minor infection control issues we identified, such as a clean mop head which we found left on a table in a dining room. One specific area of the home was also malodorous and the manager told us that they had plans to replace the carpet in this area. However, most of the home was clean and well maintained. The manager regularly walked around the home to check on practice, and this included looking out for, and addressing, any cleaning issues identified or any areas of the home which were unsafe or untidy. We saw records of 'floor observations' completed by a training manager, which showed that the home monitored staff practice in relation to infection prevention and control.

Good

Is the service effective?

Our findings

We asked people who used the service if they felt the staff were sufficiently skilled and experienced to care and support them to have a good quality of life. People told us, "I feel staff have the right skills and if they don't know the answer they would ask" and "I feel the staff look after me and listen to my needs." Two people we spoke with together told us, "The care here is very good. Sometimes the beds don't get made but we don't complain… We have one or two favourites [staff] but no-one we have any complaint with. We think staff have the right skills… We know some staff aspire to improve themselves and undertake extra training." One person suggested that some staff were not consistent in how they re-positioned them, as some were less gentle than others. Another person said that some of the staff were, "Too young to have the life skills to help older people."

We saw records that showed us that all staff completed an induction when they started in post. Staff completed training as part of their induction and shadowed other care staff, usually for a week, until they were assessed as ready to work independently. The induction training covered topics such as; fire, infection prevention and control, moving and handling, safeguarding vulnerable adults, Mental Capacity Act and Deprivation of Liberty Safeguards. Staff also completed a variety of other training via e-learning. The registered provider's induction programme covered the requirements of the Care Certificate. The Care Certificate is a set of standards that social care and health workers work to. It is the minimum standards that should be covered as part of induction training of new care workers.

Staff completed regular refresher training and the manager was able to monitor when staff were due to complete refresher training, as records were held electronically. We saw from these training records that the majority of staff were up to date with their training. The manager advised us that reminders had been issued to relevant staff where any training was overdue, making it clear that completion of the training was a requirement of their role.

Staff told us, "I feel the training is quite good, and gives me the skills and knowledge to do the job" and "I had a thorough induction, completed a competency check for medication and have completed my essential training." As well as carers, senior care staff and nurses, the registered provider also employed care practitioners at this service. Care practitioners provided an enhanced senior care role and were able to deliver certain clinical aspects of people's care, delegated to them by qualified nurses. Two senior care assistants had completed the qualification required to become a care practitioner and a further one was part way through the training. A care practitioner we spoke with told us about the training they had undertaken for the role and explained that they worked three days per week on the management and administrative side of the role and the other two days a week on direct care delivery. They confirmed they had completed mentoring and leadership training in order to develop their skills in managing staff.

We saw evidence of staff supervision. The registered provider's policy was a minimum of six supervision meetings for staff per year. Records showed us that there had been some gaps in supervisions earlier in the year, but these had improved throughout the year and staff were receiving regular supervision. We noted that many of the current month's supervisions were due around the time of our inspection, and the manager

told us they had plans to ensure these were completed, so that the regularity of supervision meetings was maintained. This all showed us that people received care from staff that had the knowledge they needed to carry out their roles.

We looked at whether people received adequate support with eating and drinking. Care files contained a section about people's nutritional needs, including information about the type of diet required and any food preferences. We saw that where relevant, advice from specialists, such as speech and language therapists, had been obtained for people and instructions followed. Food and fluid intake was monitored for people assessed at high risk due to their nutritional needs or weight loss. The manager completed a nutritional report each month which was to monitor people who had lost weight or were at high risk of malnutrition, and the action taken in relation to this.

We asked people their views about the variety and quality of the food available at the home. Their comments included, "I like my full cooked breakfast every day and there's lots of choice for dinner and tea" and "There is usually a choice of food and at dinner time I like to go to the dining room to see my friends for company. I like to have breakfast in my room, I have toast and tea." Other comments included, "There is very good choice and I have recently asked for a soft diet because of my teeth. I like to have my lunch in my room" and "The meals are very good and there is always a choice. I mostly go to the dining room. I sit with my friends and chat!" One person was less satisfied with the quality of the food and told us, "The food has improved slightly but you get an awful lot of fish." Another felt their pureed food was poorly presented and looked unappetising. The acting manager told us they would continue to monitor the quality and presentation of all food.

Two visitors told us they were concerned about whether their relative got sufficient support with eating and drinking, because they had witnessed food being taken away uneaten or had found their relative appeared thirsty when they arrived to visit them. We made observations throughout our inspection to monitor if people who required support with eating and drinking received adequate encouragement and assistance. We noted one occasion where two people had drinks on tables nearby them after lunch, for over half an hour, but staff did not offer them assistance or encouragement to take a drink. We also saw that some people who were cared for in bed had jugs of juice in their rooms but these were not within their reach. The manager confirmed that some of these people required assistance with drinking, due to a choking risk, and it was therefore not appropriate for the drinks to be left within reach. They also told us they would remind staff to continue to be vigilant with offering regular drinks. We saw examples throughout our inspection where staff offered drinks and snacks, including a hot drinks trolley which was circulated mid-morning and mid-afternoon and people were offered a choice of beverage.

We observed mealtimes in different units of the home and saw that people could eat in the dining room or in their own bedroom if they preferred. The dining rooms were light and airy and tables were laid with cloths, cutlery and condiments. People were shown the menu and offered a choice from the two starters and two main meal options available. People were also offered a choice of drinks. The food looked hot and appetising. Staff offered assistance to cut food where required, and cleared used plates quickly. They asked people if they were ready for their next course, before bringing it. We observed some people eating independently in their own rooms, and staff were available to assist others where required.

People received support to maintain good health and access healthcare services. We saw evidence in care files that people had received support from healthcare professionals where required, such as GPs, speech and language therapists and chiropodists. Staff at the home also regularly consulted a local nurse practitioner for guidance, when they had concerns about people's health or well-being. Care files also

contained instructions where people needed specific assistance to maintain good health, such as support with pressure care.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care files contained mental capacity assessments, and where relevant, information regarding DoLS authorisations that were in place. People had been involved in decisions about their care, where they had the capacity to do so. There was also evidence that where people lacked capacity to make a specific decisions, a decision had been made on their behalf in their best interests, involving relevant professionals and family where appropriate. Records were held which showed if a person had a Lasting Power of Attorney (LPA), and if so, whether this was for finance and affairs, for health and welfare or for both.

Staff had completed MCA training. They were also able to demonstrate an understanding of the principles of the MCA, and the importance of gaining consent before providing care to someone. This showed us that staff sought consent to provide care in line with legislation and guidance.

The environment in the home was spacious and appropriate to people's needs. Some areas of the home were being decorated at the time of our inspection. We noted that the walls and door frames in this unit of the home were in the process of being painted in very similar colours and there was therefore not much visual contrast to indicate where the doors were. Having a colour contrast can help some people with dementia or visual impairments to orientate themselves and distinguish shapes more easily. The acting manager checked the redecoration plans, which showed more of a colour contrast, so they told us they would discuss this further with the regional manager to ensure the finished decoration would be in line with dementia friendly design principles.

Good

Is the service caring?

Our findings

Most people who used the service spoke positively about staff at the service, describing them as kind and caring. Comments included, "Staff do care for us," "Staff are very kind. I cannot fault the girls. Some of the night staff are exceptionally kind, including the male staff" and "Staff are quite caring." Others told us, "I feel staff care for me as a person and always call me by my name" and "Staff are kind and treat me respectfully". One person however indicated to us that there was some inconsistency; "Some are excellent, some are abrupt" and their relative told us that the person also found it insensitive when staff had talked about inappropriate aspects of their personal lives in front of them. Another person was very positive about how caring staff were, but said that they were busy, so did not always have time to sit and chat.

The majority of relatives felt staff were caring in their approach and their comments included, "All staff have a lively, positive approach. Much better than [my relative]'s previous home," "The staff seem nice," "Staff are caring and treat people appropriately" and "They are all nice people here." Feedback from two relatives however suggested some inconsistency; one comment included, "Some of the staff are angels but about 20-30 percent aren't as caring. For instance, the other day when I came in two staff were watching television and my [relative]'s hair hadn't been combed." We discussed the feedback about the inconsistency of staff approach with the acting manager who told us they would monitor this, including completing daily 'walkarounds' of the home to observe practice and address any concerns.

Throughout the inspection we observed staff with people who used the service. We saw many examples of warm, friendly and positive interactions. For instance, we saw one member of staff chatting and laughing with a small group of people. When some of the people from this group requested a cuddle from the staff member, they were happy to oblige and it was evident that this made people very happy. When the staff member left the room we overheard people discussing the staff member and saying they were, "Special that one, so lovely." We saw other staff chatting to people about things of interest to them, such as a magazine one person enjoyed and their families. One staff member talked to someone about places they had travelled to abroad and listened with interest to the person's views on different countries. We also saw carers respond very positively when one person became particularly anxious and distressed. The person was becoming agitated by the verbal instructions and reassurance from staff, so the carers adapted their approach by singing and encouraging the person to join in. The person visibly relaxed and began to engage with staff. This diffused the situation, to the point that the two staff were able to guide the person to where they were going, all three singing together with linked arms.

Whilst the majority of interactions were warm and friendly we did observe some occasions where interactions were more task focussed. For instance, during a mealtime on one unit of the home, although staff were polite, offered choices and responded to requests from people, there was less friendly chatter than in another unit we observed, making it a less sociable experience. On another occasion a member of agency staff was asked to monitor three people in a communal lounge. The staff member sat and observed, to ensure people's safety, however, they did not attempt to speak to people whilst they were sat in the room with them. Therefore, some opportunities to promote people's social and emotional well-being were not always consistently taken. We spoke with the acting manager about this, who agreed to monitor this and

encourage all staff to maximise opportunities for social interaction where appropriate.

Staff gave us examples of how they promoted people's independence and encouraged choices, including with food, clothes and particular aspects of people's care. We observed staff offering choices and responding to requests throughout our inspection. Care files gave instructions to staff on how to promote people's independence wherever possible. For example, in one care file we viewed there were specific detailed instructions to staff about which elements of personal care tasks the person could do for themselves and which tasks the staff would need to assist with. We saw from care files that people had been involved in decisions about their care, where they were able to do so. We also saw that staff recognised and considered people's preferences where the person was unable to express these themselves. For instance, one person's file stated, '[Name] has no preference about the gender of staff who assist [them], although they previously preferred female staff so this previous preference should be maintained where possible.' Detailed information about their choices and preferences in relation to clothing, bedtime and morning routines was also recorded and available to staff.

We found there was detailed information about people's communication needs in their care files, including the impact of sensory impairments and the support required from staff in relation to this. Staff also provided us with examples of how information was made available to people in a format that met their needs, such as one person who received large print newspapers.

Two people who used the service had an advocate at the time of our inspection and information was available to others about local advocacy services. Advocates help to ensure that people's views and preferences are heard.

Discussion with staff indicated that there were people using the service that had diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. The registered provider's initial assessment of people's needs included people's needs in relation to gender sexuality and relationships. Care files also contained a section in relation to people's cultural, spiritual and social values. Staff told us how they met people's spiritual needs. This included a weekly church service which was held at the home, and we saw this was attended by many of the people who used the service. A memorial service was also being planned, to enable people who used the service and relatives/visitors (and former visitors) to come together and remember people they had lost. We found that some people also had regular individual visits from a priest or vicar, where they had expressed a wish to. Staff were also knowledgeable about the specific end of life care needs in relation to one person's faith.

People told us that staff maintained their privacy and dignity, including when providing support with personal care, such as bathing and washing. One person told us, "I'm treated with dignity and conversations are private" and a relative told us, "Staff do all they can to respect [my relative]'s dignity; they always ask me to leave if they have to change their clothes." Throughout our inspection we saw that staff knocked on people's bedroom doors before entering and ensured doors were closed when providing support with personal care.

Requires Improvement

Is the service responsive?

Our findings

Before people started to use the service their needs were assessed. This assessment involved the person, relatives and staff. The assessment covered a range of areas including people's communication needs, personal hygiene and dressing, mobility, moving and handling, tissue viability, nutrition and hydration, mental state and cognition and social needs. 'Life histories' were completed to give staff a greater knowledge about people and their strengths and preferences.

Care plans were then developed on the basis of this assessment. We found care plans were very detailed and provided staff with the information they needed to deliver care in the way the person wanted. There was comprehensive information about people's needs, the support required from staff, and people's individual preferences. We found staff reviewed care plans monthly or sooner if people's needs changed significantly in the meantime.

Staff completed monitoring records in relation to specific issues, such as food and fluid intake and re-positioning to prevent skin pressure damage. We found these monitoring records were generally well completed and indicated people's support was provided in line with their care plans.

Staff we spoke with were knowledgeable about people's needs. If was apparent from our observations during the inspection that some agency staff were less familiar with people's needs and preferences and required additional instruction from other staff. The registered provider booked regular agency staff, where possible, to improve consistency.

Staff told us, and we saw, that changes to care plans were communicated to staff in daily handover records. However, one relative told us that changes that had been agreed in meetings or discussions were not always communicated effectively between staff. We also saw comments within care review meeting records where another family had expressed concern about internal staff communication. Staff we spoke with in one unit of the home acknowledged that there was a risk with the current system that staff who were not on duty for several days could miss information from previous days handover records. Therefore, they told us they were planning to introduce an additional communication book that staff would be required to read. This showed that improvement was required in regard to staff communication and the consistency of information handover systems.

The registered provider employed dedicated activities co-ordinators and a range of activities were provided every day. On the first day of our inspection we observed a chair exercise class taking place. Eight people took part in the class and appeared to enjoy the activity. A church service also took place on the second day of the inspection. Planned activities were advertised around the home.

People told us, "I like to play scrabble. Two volunteers occasionally come in and play with me," "I sometimes go to the church service" and "I don't take part in many activities. I'm quite happy in my own company." This person indicated they were aware that activities were available. A relative told us, "They [staff at the home] are excellent at social activities. They have pat dogs and ponies that come to visit."

This showed us that there were a range of activities available to people.

There was a complaints procedure in place and a system to record and respond to complaints. Records showed that four formal complaints had been received in the year prior to our inspection. The registered provider had investigated and responded to these complaints. We were told that other minor concerns, raised informally, had been received and responded to over the course of the year, but the registered provider was not able to show us any records held in relation to these so it was not possible to determine what action had been taken in response.

Some people and relatives told us they knew how to raise a complaint and would feel comfortable doing so. Their comments included, "We would go to the lead nurse in this section" and "I've never had to complain but would go to the manager if I needed to."

However two visitors told us that when they had raised concerns in the past, these had been acted on for a few days, then the problems had started reoccurring again. For instance, one person raised a concern about their relative's nail care, which they told us had been addressed initially but then had reoccurred. We saw on our visit that the issue was still unresolved. The second visitor told us that issues they had raised were not always serious in nature, but indicated that the lack of a consistent, sustained and well communicated response to their concerns was an on-going frustration.

A third visitor raised some concerns with us about the care of the person they visited and had a number of queries about the care package, which could have been clarified with clear communication from the staff. The visitor told us they had not raised their concerns formally, because the person they visited had asked them not to, due to being worried about the consequences of raising a complaint.

Although there was no evidence to suggest that people's care was affected by raising concerns or complaints, it was apparent that not all people and visitors felt confident about raising issues.

People and visitors who raised these concerns were all from the same unit of the home. We found that no relative's meetings had been held on this unit recently. A meeting planned for March 2016 had been cut short and a meeting planned for July 2016 had been cancelled due to the management and staffing changes. One person whose relative had raised concerns about their care had not had a six monthly care review meeting involving the family for over 18 months. Whilst the family spoke to staff regularly, the opportunity to meet and formally discuss the plan of care may have helped to prevent concerns escalating. In other units of the home some relatives and residents meetings had been held during 2016.

This showed us that the registered provider could be more proactive and consistent about encouraging people's views and opinions and ensuring that concerns were consistently addressed. For instance, relatives and residents meetings would have provided further opportunity for people to feedback on the service provided and for staff to reassure people they could raise concerns in confidence.

We recommend the registered provider takes action to appropriately record and respond to all concerns, ensure that staff are consistent about addressing issues and provide consistent opportunity for people to share their concerns and experiences.

The regional manager told us they were committed to ensuring people felt able to raise concerns and felt that people or relatives could approach the management at any time. The acting manager also told us they were in the process of developing a newsletter for relatives, to keep people informed, and that they planned to hold a meeting for relatives early in 2017.

Requires Improvement

Is the service well-led?

Our findings

The service is required to have a registered manager, and at the time of our inspection there was no registered manager in post. The previous manager had left two weeks before our inspection, and there was an acting manager in place, who was managing the home until the registered provider appointed a permanent manager. The deputy manager for the service had also recently taken up a secondment opportunity at another of the registered provider's care homes, so there was also a temporary acting deputy manager for the home. The acting manager and acting deputy had been unit leads at the home, so were both familiar with the home and the registered provider's policies and systems. The lack of a registered manager meant we were unable to rate this key question any higher than requires improvement.

When we spoke with people about the management of the service the feedback was generally positive. One person using the service told us, "Yes, it's very well managed. Staff are friendly and listen to you. I think this is because the manager does their job well" and "It feels well managed but they are sometimes short staffed." Feedback from visitors was mixed. One relative told us they did not feel there was strong visible leadership within the units on a day to day basis, but another told us, "I think the unit is well led." One relative felt that communication about the management changes had been poor.

One staff member told us, "[Acting manager] is fabulous, has an open door and is very supportive" and another told us they were surprised by the good support they had received from the staff team and management since starting in their role. However, one staff member told us there was inconsistency in the leadership approach of senior care staff on the units, as some directed carers and trusted them to "Get on with the job" but others did not. We discussed this with the acting manager who told us that they were aware that some staff had different leadership styles, and that a focus of their priorities moving forward would be to improve consistency of approach across the whole home.

The acting manager told us they kept up to date with best practice and legislation via updates from the registered provider, training courses and updates from the Independent Care Group. They discussed this information with staff and told us they also intended to relay key information in memos to staff.

We found that staff meetings were held periodically through the year, for nurses, senior care staff and carers. We reviewed staff meeting minutes and saw that these included reminders to staff about a variety of practice issues, including medication, infection control and record keeping, as well discussion about topics such as training, team work and communication. The acting manager was unable to locate any staff meeting minutes for one unit of the home for 2016. They told us that meetings had taken place with staff on that unit during the year, but did not know where the minutes had been stored, as they had been filed by the previous manager. A staff meeting had been held on that unit two weeks before the start of our inspection but the minutes had not yet been typed up, so we were unable to view them. The lack of records for meetings on this unit meant that staff did not have access to the information provided or agreed at the meeting to refer back to if they needed it, and the registered provider was unable to check that agreed actions had been completed.

The registered provider conducted annual satisfaction surveys and participated in 'Your Care Rating' which is a survey conducted and published by an independent market research company. The results of the most recent survey, for 2015, were available on the internet and in the home. 12 people responded to this survey. Results were generally positive, but there were some less positive responses in certain questions, such as the handling of complaints. The findings from our inspection suggested this was still an issue.

The registered provider had a quality assurance system and conducted a range of monthly audits. These included audits in relation to medication, accidents and incidents, care plan reviews and nutritional reports. 'Floor observations' were also recorded, to monitor practice within the units. The acting manager submitted information from audits on to the registered provider's electronic clinical governance system each month, so that patterns could be analysed and checks conducted in order to ensure appropriate responsive action was being taken where required. This also included reporting on falls, any pressure wounds or choking incidents. In addition, the regional director completed quarterly quality audits and an internal regulation team conducted periodic unannounced visits to the home to evaluate practice in relation to regulatory standards.

We found that appropriate action was usually taken in response to issues identified in audits. For example, concern about the regularity of staff supervisions had been identified in audits, and this had improved throughout the year. Other specific actions, such as a requirement to update the servicing certificates for an extractor fan and the call bell system, identified in an audit in April 2016, had also been addressed promptly. However, we found examples where the registered provider had not always completed actions identified. For instance, in an audit in April 2016 it was identified that the kitchen floor needed replacing, and we were told that this had not yet been replaced.

There were other occasions where the registered provider had not been prompt to address other issues raised in relation to the environment and equipment. For example, the dishwasher on one unit of the home had been broken since September 2016, and this had not been replaced when we started our inspection in November 2016. A new one was purchased after our inspection. The carpet in one specific area of the home smelled strongly of urine and needed replacing. The acting manager was taking action to address this at the time of our inspection, but the process had taken several weeks due to requiring approval for the expenditure request and being required to try other methods of cleaning the carpet first. Plans to improve the courtyard area of the home, discussed at a relatives and residents meeting in July 2016 had not yet been completed, due to on-going work to get quotes and funding.

This showed us that systems were in place to monitor and review the delivery of care and the quality of service that people received, but there were occasions where the quality assurance system had not resulted in prompt action being taken to rectify issues and improvement was required in this area.

Policies and procedures were in place, and based on up to date legislation and guidance. We asked for a variety of records and documents during our inspection. We found these were generally well kept, easily accessible and stored securely, although there was some information that the acting manager was unable to locate, due to being new in post, such as records of informal concerns raised and staff meeting minutes.