Limetree Healthcare Limited

Limetree Care Centre

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

Summary of findings

Overall summary

We inspected Limetree Care Centre on 2nd, 3rd and 4th July 2018. The inspection was unannounced. This meant that the provider and staff did not know we were coming.

Limetree Care Centre is a nursing home providing care and support over three floors for up to 92 older people, some of whom were living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the previous inspection in April 2017 the home was rated "Good" in all areas. However, we received information of concern from relatives and other agencies that the service had begun to show signs of poor management, leadership and governance and was not always able to ensure delivery of high-quality, person-centred care for people, which prompted this inspection. We found that on this inspection the service did not meet some of the required standards relating to safety, providing effective and responsive care and in the management and leadership of the service.

The service did not have a registered manager in post at the time of the inspection. A new manager had been recruited and was going through the process of registering with the Commission. 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.

There were not always sufficient numbers of suitably qualified and experienced staff to provide the necessary care and treatment to people.

People's health and nutrition were not always monitored effectively. Fluid and nutrition charts were of variable quality, as were records of people's weight changes.

People did not always receive personalised care that was responsive to their needs. Care plans did not fully reflect people's interests and background. The quality of and frequency of activities was variable and staff did not spend much time in meaningful interaction with people.

The service was not always well-led by a consistently good management team. The service had a high number of incidents and accidents and was engaged in an improvement programme with the local authority. This, together with the areas of concern identified during this inspection meant that the service was not always able to ensure delivery of high-quality, person-centred care for people.

The service carried out suitable pre-employment checks to ensure safe care for people.

Staff knew their responsibilities to protect people from potential harm and abuse and how to report this.

There was a garden which people and relatives commented positively about, and which we saw was being well used on the hot summer day.

Staff we spoke with confirmed that they had attended Mental Capacity Act (MCA) training and were able to tell us about the principles of the MCA, acting in people's best interests and how they applied these in their work with people.

People at the home were treated in a kind and compassionate manner which respected their privacy and afforded them dignity. Relatives spoke positively about the staff. Relatives also commented that they could visit at any time and that they could trust the staff.

Staff addressed people according to people's wishes. We observed staff treating people with kindness and compassion, speaking quietly and gently to people and it was clear that staff knew people well. We saw notices on doors when personal care was being given, which ensured people's privacy.

The service had a complaints policy and procedure. The policy included timescales for responding to complaints and details of how people could escalate their complaint if they were not satisfied with the initial response from the service. People using the service and their relatives told us they knew how to complain if they needed to. People told us that since the new manager had arrived they could speak to her and that they felt things had changed for the better in regard to open communication.

The provider had already begun to act on the above issues. A new management team had been recently brought into place and the manager was going through the process to be registered by CQC.

A team of external support for the service was already active, working with the manager and staff with the aim of improving things.

The work carried out to date by the senior leadership and management team received positive comments from people, relatives and staff. Staff told us they felt the changes being introduced were positive and it made them focus on their job better.

Records and information were securely stored, and there were plans on how to evacuate people in case of an emergency.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this 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.

There were not always sufficient, suitably experienced and competent staff available to meet people's needs at all times.

Medicines were managed safely. Records associated with the safe management of people's medicines were available and completed.

Staff recruitment procedures ensured that people were not put at risk from unsuitable staff. There were procedures in place to protect people from the risk of abuse and staff were aware of these.

Is the service effective?

Requires Improvement

The service was not effective in some areas.

People's nutritional and hydration needs were not always monitored and recorded effectively.

People were able to make choices about their care and the service operated in line with the Mental Capacity Act 2005.

Staff received appropriate training and supervision.

Is the service caring?

Good

The service was caring.

We observed kind and caring interactions with people and visitors and people spoke positively about the care provided.

People told us the service was caring and staff treated them with respect and dignity by offering care and support discreetly. People were supported to remain as independent as possible.

The service enabled people to maintain links to their beliefs and religious practices and there was good multidisciplinary working

between the home and other agencies.

Is the service responsive?

Requires Improvement

The service did not always provide care that was responsive to individual needs.

Care plans did not always contain sufficient information to help staff provide personalised care and the home lacked a range of quality activities and meaningful interactions between staff and people.

There was a complaints process and people using the service and their relatives said they knew how to complain

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not have effective quality assurance and governance systems to assess, monitor and improve the quality and safety of the services.

People's views had not been consistently sought or used to make improvements at the service.

People using the service and their relatives told us they felt that the new management team and recent changes had had a positive effect on the running of the home.

Limetree Care Centre

Detailed findings

Background to this inspection

We carried out this inspection of Limetree Care Centre under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 2nd, 3rd and 4th July 2018 and was unannounced. The inspection team consisted of three inspectors, one specialist advisor on medicines and nursing care and two experts by experience. An expert by experience is someone who has had experience of receiving care, or knowing someone who is receiving care. The experts by experience had experience of looking after people with dementia.

Before the inspection we reviewed information we held about the service. We looked at notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern.

The provider was asked to complete a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with 22 people who used the service, nine relatives, three professionals and one visiting volunteer. We observed care and support being delivered in communal areas of the home and the interaction between staff and people.

We spoke with the manager, chief executive officer and quality director, as well as with 11 other staff, including nurses and care workers.

We looked at the care files for 45 people using the service including care plans, risk assessments and care and treatment records. We looked at medicines records of five people. We reviewed the training matrix for all staff. We looked at the minutes of team meetings. We checked various policies and procedures including

adult safeguarding procedures. We reviewed quality assurance and monitoring systems at the service.

Requires Improvement

Is the service safe?

Our findings

People told us that staff were mostly kind and helpful but that they were often too busy to take much time. One relative told us that her relative was "lonely" and that it was often difficult to "get hold of staff who had the time to discuss things with you."

We saw that the effectiveness of the home's staff provision when delivering safe care and support to people, depended upon the time of day and the particular floor. The third floor had people who required the highest level of nursing and dementia care and support and had a corresponding higher number of staff. However, there were many people who were bedbound and or required the support of two staff.

It was unclear how the provider assessed the number of staff required. There was a general staff deployment of two nursing staff plus six care staff on each floor during the day. At night there was one nurse plus three care staff. However, this staff deployment did not go beyond a generic staff-resident ratio and there was no indication that staffing levels were considered on the basis of regularly reviewed dependency levels of people or the needs of people who were bedfast.

There was a high use of agency staff on the third floor and there was no process to designate permanent staff from other floors, who knew people better than agency staff.

The impact on people of the current staffing arrangements was varied across floors. The numbers of notifications from the home over the 15 months leading up to the inspection had a high level of accidents that had been unwitnessed by staff, incidents between people which required intervention by staff and cases where people had managed to leave the home unnoticed or enter the home unchallenged.

These incidents were managed poorly. The registered manager ensured that appropriate notifications were sent to the CQC and the local authority safeguarding team. However, there was little evidence that senior management had used these incidents as opportunities for learning and improvement. They were treated as isolated incidents and, as a result, senior management failed to identify patterns of behaviour or shortfalls in their management which could have reduced the number of incidents.

During the inspection we saw other examples of the negative impact on people. Some people waited long periods before being seen and some areas of the home were not as hygienic as could be, for example wet floors in people's rooms were not attended to quickly. There was variable quality across floors regarding risk assessments, records and checks on people (such as falls, repositioning and hourly checks) and staff not having time to have meaningful interaction with people other than carrying out care-related tasks.

The failure to ensure sufficient numbers of suitably competent and experienced staff were deployed to meet people's needs at all times was a breach of Regulation 18 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service carried out suitable pre-employment checks to ensure safe care for people. Staff were required

to provide two satisfactory references, photo identification and to undertake a criminal records check before they started working with people. Staff told us, and records confirmed that interviews and employment checks had been carried out prior to starting work.

Staff knew their responsibilities to protect people from potential harm and abuse and how to report this. One staff member told us, "I know I can speak to the nurse in charge, or I can speak to the manager. If I was still unhappy I could report things to social services."

There was a safeguarding policy and procedure in place. Because of concerns over the high number of reported incidents and accidents that had occurred over the previous 15 months the home was working closely with the local authority on an improvement action plan. In addition, there was an embargo on the home preventing new admissions until the local authority was satisfied that improvements had been made to keeping people safe.

The newly recruited manager was also working in collaboration with the local authority and an internal quality improvement team to improve the quality of risk assessments. During the inspection we found the accuracy and quality of risk assessments carried out on people to be variable.
For example, we saw that one person had been assessed as being at high risk of falls but there was no guidance to staff regarding what support should be given. In another example one person's care records recommended in one section that the person could stand up to be transferred from chair to bed, but in another section stated that they required a hoist.

One person who was being assessed in respect of diabetes had several gaps in their records where no tests had been entered.

Discussions with the manager and internal quality team were positive. They acknowledged that improvements needed to be made and that the local authority social services team had included these areas in its request for an action plan from the home.

We were satisfied that the home was working to improve these areas, with the support of their quality team and local authority. However, it was an ongoing process which, at the time of inspection required further improvement.

However, we also saw good examples of assessments of residents' risk of pressure ulcers, including the use of body maps where necessary. We also saw evidence of residents who had developed pressure ulcers being referred for specialist advice from a tissue viability nurse (TVN). Pressure relieving equipment was available and in use. The registered nurse told us that it was easy to obtain pressure relieving mattresses and cushions for wheelchairs, but more difficult getting pressure relieving cushions. We saw evidence of residents having repositioning charts in place, but there again, this was variable throughout the home. This indicated that there was the potential for good practice to exist and of the importance for this to be consistent.

Staff told us how they would deal with an outbreak of norovirus or clostridium difficile. Stool samples could be taken and sent for testing. All infectious or potential infectious outbreaks were reported to the manager and regular updates given. Laundry services in the home were informed and they used appropriate measures to control the spread of infection for laundry and waste.

There was sufficient personal protective equipment available, for example, gloves and aprons. Staff could wash their hands in individual resident's rooms and we observed staff washing their hands. There was little

hand sanitiser available on the three units. We also observed housekeeping staff cleaning the clinical areas, which appeared clean and maintained.

Medicines were managed safely. The home used a local pharmacy as the provider for their medications. The general stock cupboards on each unit were checked and found to be in good order. This included controlled drugs. There were no open medication boxes or bottles in the cupboards and the medication checked were found to be in date. The cupboard was opened by a key.

Medicines records had an up to date staff signatory list in each folder, which included regular agency staff. Staff carried out daily and weekly audits. We observed cream application charts, patch application charts, insulin record charts including blood glucose recordings and pain assessment charts.

The Registered Nurse carrying out the medication round wore a red 'do not disturb' tabard which minimised distraction and therefore the risk of making mistakes.

Requires Improvement

Is the service effective?

Our findings

People's health and nutrition were not always monitored effectively.

Food charts were completed for some people, particularly those who had been identified as having lost weight. Different methods of recording food eaten at mealtimes were in place. On the second floor it appeared that the amount of food eaten at meal times was recorded on the electronic system and that on the ground and first floor they used paper records.

On one occasion we observed that someone who had been left a meal tray had not been helped with her meal and this was two hours after lunch had been served.

Staff told us that except for one person there weren't any people with swallowing difficulties or who required PEG feeding. There was no care plan for the person with swallowing difficulties and we only observed two weights recorded since admission, back in February 2018. We saw one example of where a speech and language therapist (SALT) had visited a person and suggested a follow up within a short time scale, but there was no evidence of the follow up having taken place.

There was a mixed picture in terms of monthly weights being taken and recorded. We saw some good examples on the ground and first floors where weights were completed and on the ground floor where good evidence of weekly weights being taken and recorded. On the second floor we noted that weights weren't always recorded on admission and one person whose weight hadn't been recorded for five months.

There were very few night time entries of people being offered or given fluids, or notes about whether people had passed urine during the night.

The failure to ensure effective monitoring and recording of people's nutrition and hydration was a breach of Regulation 14 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime practice on the second floor. Although there was a high level of staff on this floor, prior to and during lunch, the dependency and behavioural needs of people, coupled with the tasks staff had to do to prepare the room for lunch, meant that the experience was chaotic.

Staff were laying tables five minutes before lunch, at the same time as people were coming in to be served and who needed support with finding a table. The staff had to focus on serving meals rather than making it a pleasant experience for people. One visitor referred to it as being "like school dinners." There was no clear direction for staff who seemed unclear of their specific duties. This meant that staff spent a lot of time forming in a queue to pick up people's lunches rather than supporting them to eat and enjoy their meals safely.

On the other floors, there was a more positive and relaxed lunchtime experience for people. In addition, people on all floors were offered a choice of meals. Drinks, including tea, water and juice were available

throughout the day and we observed these being provided to people. We saw that people were offered snacks of fruit, cake, biscuits throughout the day.

Menus were available to people on all floors with the menus running on a four-week cycle. The menus were displayed in the lounge and dining areas. People were encouraged to sit in the dining area for their meals. Those who couldn't leave their rooms were assisted with their meals and we observed this happening.

Special diets were catered for by the kitchen, for example diabetic people. We saw evidence of people being referred to, and seen by, dietitians. Nutritional supplements were available for people.

People and their relatives had positive things to say about the food. One person told us, "We have a lot of variety and Caribbean food. It's not the same as you would cook at home…but then it never is." Another person said, "I really like the food, but then again, I eat anything that they give me…I eat well." A relative told us, "My [relative] has always had a good appetite. He does eat well here."

Staff told us that they received training and this was confirmed in records. Training encompassed the 'Care Certificate Common Standards' and included dementia awareness, safeguarding, fire training and evacuation, manual handling, first aid, infection control and health and safety.

The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

In addition, some staff had taken further qualifications in Qualifications and Credit Framework (QCF) to levels 2 and 3.

An electronic training plan was in place which the manager said was helping to track people's training and remind people of any refresher or updates required.

Staff meetings included an opportunity to identify further training needs. Bi-monthly supervision sessions and annual appraisals were partly used to identify any gaps in training.

Training and supervision formed part of the home's overall improvement plan. Staff told us that since the arrival of the new manager things had improved with regard to training and supervision.

The home had communal lounges and dining rooms on each floor. However, although the home described itself as being able to provide specialist dementia services, there was little evidence in the home's design or adaptations which could be described as "dementia-friendly", or would assist people with dementia to move around the service easily.

All the corridors, bedroom and bathroom doors, and flooring were of a similar colour. There were no visible cues, signage or forms of colour coding which might help people know in which direction they were going, for example to the bathroom, lounge or dining room, or to recognise their own room. However, we saw that a few people's bedrooms had personalised signs on the doors which provided a sense of individuality. Many of the people we observed were independently mobile and would have benefitted from better signage, decoration and adaptations to the premises to help promote people's independence and avoid potential distress to people who became disoriented.

We discussed this with the manager and senior management team. They reiterated their commitment to providing specialist dementia care and informed us that, as part of the ongoing improvement plan and building works, these issues would be considered in the development of the home.

Apart from the dementia-related aspects of the premises, the home was clean and free from odours, with spacious rooms and lounges and free of hazards to people who were moving about.

There was a garden which people and relatives commented positively about, and which we saw was being well used in the hot summer day. The garden had suitable seating and shelter and the door to the garden was open and accessible to people living on the ground floor although not to people on the upper floors without staff assistance.

The garden was benefitting from upgrading and the person in charge of the project spoke passionately about wanting it to be a space that people used and not merely a decoration to look at from bedroom windows. Part of the upgrade project was the design of flower and vegetable beds which would be raised to enable people in wheelchairs to make use of them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made to the supervisory bodies at the time of the inspection, following a mental capacity assessment. Where DoLS had been authorised, the service was complying with any conditions applied to the authorisation. The service followed the requirements of the DoLS.

Staff confirmed that they had attended MCA training and were able to tell us about the principles of the MCA, acting in people's best interests and how they applied these in their work with people. One staff member told us, "You don't just start doing things to someone. You have to ask and check. Not just because it's right, but because if you just suddenly start doing something to someone with dementia and they don't know what's happening they get frightened." The staff member went on to mention personal care as an example.

We saw good examples of multidisciplinary referrals being made to a number of other health care professionals, for example, GPs, speech and language therapists, tissue viability nurses, physiotherapists social workers and dentists. However, frequency and regularity of visits or bookings was variable across the floors.

Good

Is the service caring?

Our findings

People at the home were treated in a kind and compassionate manner which respected their privacy and afforded them dignity.

Relatives we spoke with said "Staff are lovely, they keep me up to date with my relative's care and are very helpful." and "Staff are very nice and they attend well to my relative, she is given choices even though she finds it hard to choose."

Relatives also commented that they could visit at any time and that they could trust the staff.

Staff addressed people according to people's wishes. We observed that staff affectionately called one person by the title `mamma' which she responded to smiling, and interacted positively in response. The person told us that they liked being called mamma, and that she was "everyone's mamma".

We observed staff treating people with kindness and compassion, speaking quietly and gently to people and it was clear that staff knew people well. We saw notices on doors when personal care was being given, which ensured people's privacy.

Other interactions between staff and people were positive and showed care and compassion. We saw a care worker sit next to someone who was becoming distressed and ask if they wanted to move from the area. When the person said "No", the staff member remained and talked in a calm manner and used some therapeutic touch to reassure the person.

The service sought to meet people's needs in relation to equality and diversity. This was included in people's care records and care plans. Staff knew about people's cultural backgrounds and told us how they supported them by providing specific meals and observing religious and cultural practices. Staff completed equality and diversity training.

People told us that staff were nice. One person told us, "It's a helping place." Another said, "The staff are very nice." A relative said, "It's more important that there is good care – and there is."

However, there were also comments and observations which indicated that staff were rushed and not always able to take as much time as they might have wished, or to notice when someone was needing help.

One person said, "If I didn't know how to do it for myself, I don't know what would happen." Another told us, "If you get naughty they [staff] can shout at you. But they're right, if you're naughty."

We observed one person who repeatedly unbuttoned and re-buttoned the front of their dress, which had buttons from the neck to just below the waist. She was struggling to re-button her dress and called out and waved her arms attempting to get the attention of staff. A member of the housekeeping staff passed very close by and would have been able to see or hear the person. However, the staff member appeared to be

totally oblivious to being called, and continued to walk past with no acknowledgement of the person and therefore did not alert care staff who could have intervened.

We recommend that managers build into their training and supervision the importance of all staff being attentive to the needs of people, regardless of their role.

People's independence was promoted and risks associated with their independence were assessed, for example in relation to their mobility, mental capacity and ability with self-care. This enabled the service to develop a care plan which aimed to provide care whilst maximising people's choice over their daily lives.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs.

People who could voice an opinion were mostly complimentary about staff kindness. However, they were critical of the range of activities to participate in the home, and the lack of meaningful entertainment available. They were also critical of the way planned events, such as outings were cancelled at short notice.

One person told us that they enjoyed the exercise session held on Thursdays, but missed the walks with staff outside the building, which appeared to have just stopped. Another told us, "There isn't much to do here but they do have a church service which I always go to." Another said "I don't do anything all day. There's nothing to do, is there?"

Another person queried the meaning of the "resident of the day" and felt that it did not achieve its stated purpose of providing the opportunity for the person to have a special day devoted to doing things that meant a lot to them. One person also commented that the advertising of activities often looked good but did not actually happen a lot of the time.

One person said that if they had one wish it would be continuity of staff. Another person said that more encouragement could be given to relatives to take up volunteer roles.

People's care plans contained sections titled "This is me" regarding people's work, family, hobbies and interests. Gathering this information from people and their relatives of their past meant the care provided could be focussed on them as individuals. However, we found that these sections tended to contain scant information. In one floor of the home we looked at seven care files and saw that only one had the 'This is Me' section completed.

During the inspection we observed that much of the home's advertised services and events (as stated on their website and brochure as a "flagship service", as well as within the home) lacked substance and did not happen as described.

For example, we saw that activities during the day were of a varying standard and appeared to lack preparation or design. In one lounge we saw four people. One was asleep. The television was on with no sound, and a radio was on in the same room with sound. There seemed to be little thought given to either the activity or the dependency level of the people in the lounge.

We also observed a singing session where the staff member was sitting next to a fan which was very noisy, and people unable to hear properly.

In other parts of the home, there appeared to be facilities available such as books. However, these were in bookcases in corners of lounges which were inaccessible to people. The area advertised as a "bar" was nothing more than part of a lounge with some wall decorations.

In effect, the stated descriptions of facilities and activities appeared to be exaggerated and in reality were not as exciting or available as people may have been led to believe .

In other aspects of care, the home was not as responsive to people's needs as they could be. This was reflected in little things that together impacted negatively on people and their ability to have care that was individual and which responded to their needs.

Examples included clocks in people's rooms not being at the right time or noise from different sources all being heard together, such as TV, radio and other people shouting in distress or agitation.

Other examples included events which indicated a need for further staff training or general leadership. For example, we saw one person who was asked repeatedly what they wanted for lunch. The person stated clearly that all they wanted was a glass of juice. The staff member suggested a meal, then a different meal. The person said again they wanted juice. The staff member then asked the person to point to what they would like. The man pointed to the picture of juice. Then another member of staff joined in and told the person in a loud, clear voice, that they should eat something. The man repeated again, this time in a very annoyed manner, that he wanted juice.

The result was that this episode took over five minutes and developed into a situation that left the person in an angry mood. The staff did not do anything about their supposed concerned over the person's lack of interest in food. It was neither recorded nor monitored and therefore, even from a staff perspective it was difficult to see how this provided a responsive approach to the person's needs.

In another lounge we saw a staff member ask someone if they were ok, because the person was shouting. The person told staff to go away. The staff member noticed that one of the person's slippers had come off his foot and, without saying anything to the person, reached down and took hold of the person's ankle to put the slipper on. This caused the person to react in a surprised and angry manner, which in turn caused the staff to respond, telling the person not to be rude, which caused even more anger in the person concerned. The staff member then left the scene, whilst the person was still in an annoyed state.

The lack of useful and meaningful personal details in people's care plans such as "This is me", the lack of conscious, meaningful interaction between staff and people and the general shortage of meaningful activities that related to people meant that staff were not always able to respond to people's needs confidently and appropriately, whilst giving due regard to their mental capacity or ability to communicate.

This was a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the manager and leadership team at the home. They were open and honest about the challenges facing them as they implemented the action plan in conjunction with the local authority. They were able to show us that they were aware of the concerns regarding suitable arrangements to provide appropriate opportunities, encouragement and support to services users, as noted in the local authority's remedy notice. They stated their determination to improve in this area.

The manager was able to show us examples of work currently in progress. In addition to the work currently underway in the garden, the home had also begun to roll out a programme to deliver internet access via wi-fi to the home for people and relatives. Increased outings in the summer weather had taken place, and an initiative whereby a pen-pal scheme was being set up between the home and local primary schools in order to "bring together different generations to share experiences and life stories".

The manager had already begun to improve the frequency of meetings for people and relatives, and provided us with examples of dates set. The home management team had also recruited more permanent staff to the home and were planning to involve people in the recruitment process.

In the home, we saw a good example of an activity that demonstrated that, when done well and with the needs of people in mind, could be popular and run smoothly. This was a religious service on the ground floor. This was well attended, and was led by the church group but with staff available for support. People were given the opportunity to read passages from the Bible, to lead prayer, and request hymns they liked. We noted the impact this service had on people's emotions and how competently staff responded to this by gentle and caring interaction with people.

The service had a complaints policy and procedure. The policy included timescales for responding to complaints and details of how people could escalate their complaint if they were not satisfied with the initial response from the service. People using the service and their relatives told us they knew how to complain if they needed to.

In the months prior to this inspection CQC had received complaints from people about the quality of care in the home. These complaints were made because people had felt the home had not responded adequately to complaints made directly to the management of the home. People told us that since the new manager had arrived they could speak to her and that they felt things had changed for the better in regard to open communication.

The management team were aware of the need to provide accessible information that met people's different needs. Information was available to people in different formats such as large print or photographic symbols if required to enable people to make decisions about their care and support.
The home didn't have anyone receiving end-of-life (EOL) care at the time of our inspection. However, we saw that there were procedures in place to receive people. Referrals came directly from the hospital and already known to the hospice EOL care team. On arrival, the person's EOL care would be reassessed and discussions take place with the person's relatives. Assessments included the person's DNACPR, medicines and daily living routines. Other agencies would be involved, specifically around syringe drivers and involve the local hospice if support was needed.

Provision was made for families to stay with the person and meals would be provided by the kitchen for family members.

Staff told us that there was an EOL care e-learning module for staff to undertake and that training was carried out by St Christopher's Hospice. We also saw evidence of thinking and looking ahead information for EOL care on people's care plans.

The care home used the Abbey pain assessment score. This is a tool which helps staff recognise and measure whether someone is in pain, for example, from being moved or transferred. We saw evidence of people on, or who had been, on a pain chart and appropriate medication prescribed and given. We also saw an example of a pain care plan in place.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led by a consistently good management team.

The reason for bringing this inspection forward, approximately one year ahead of a date normally scheduled for a service previously rated "Good", was the concern expressed by relatives and other agencies that the service had begun to show signs of poor management, leadership and governance and was not always able to ensure delivery of high-quality, person-centred care for people.

This was illustrated by the number of notifications received by CQC from the service about accidents and incidents, and the concern expressed by the local authority and relatives about poor safety and care in the home.

The service had a high number of incidents involving interactions between people living in the home, ranging from arguments and altercations to people wandering into other people's rooms. Whilst this was a result of the severe dementia and emotional condition of people who were living in the home, the management team had not been strong enough to develop strategies which enabled staff to respond adequately to these behaviours.

Other incidents, such as unwitnessed accidents and people leaving the home unnoticed were also of a sufficient number to raise concern over the management of the service.

Complaints by relatives were made to CQC. Normally these were the result of people not having had their complaints to the service resolved, or in some cases, not even responded to.

The local authority had recently implemented a "Remedy Notice" on the service, which requested the service to provide an action plan to address concerns over care and management of the home, and an embargo was placed on new admissions to the service.

At the time of inspection we noted that the local authority Remedy Notice was still in place and that the service was being monitored with regard to the admission of new people. Insufficient time had passed for the home to be able to demonstrate the improvement required. This, together with the shortcomings found during this inspection in the areas of safety and responsiveness of the service meant that the service was not yet consistently well-led.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had already begun to act on the above issues, which was good to see. A new management team had been recently brought into place and the manager was going through the process to be registered by CQC.

A team of external support for the service was already active, working with the manager and staff with the aim of improving things. The main areas identified for improvement were the culture of the home, openness and accuracy of audit information reported to senior management.

For example, previously all audits had been carried out as required, such as monthly care audits and bi-monthly manager feedback, yet somehow the audits did not reflect the reality as experienced by people and staff.

The new manager and regional director were committed to rectify this. The Chief Executive Officer also stated her commitment to supporting the management team.

The management team were supported by a quality director, an external inspector, business support, activities support and training support. In addition, the home was going through a refurbishment programme which aimed not only to modernise the look of the home but also to improve how dementia-friendly it could be. Improvements to care planning and the call bell system were also planned, and we saw examples of these. The management team had already begun a recruitment drive to reduce the dependency on agency staff and the manager had reintroduced a schedule for holding relative and people meetings as well as carrying out surveys to collect people's views on the service.

The work carried out to date by the senior leadership and management team received positive comments from people, relatives and staff. One relative told us they were "delighted with the changes". One person told us, "Yes, I know there is a new manager. She's very nice and she listens to you."

Staff told us they felt the changes being introduced were positive it made them focus on their job better. One staff member said, "The manager will come and be with you on the floor, not just be behind a desk. She knows what she's doing. It's good."

Records and information were securely stored, and there were plans on how to evacuate people in case of an emergency.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care that was responsive to their needs. Care plans did not fully reflect people's interests and background. The quality of and frequency of activities was variable and staff did not spend much time in meaningful interaction with people. (Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's health and nutrition were not always monitored effectively. fluid and nutrition charts were of variable quality, as were records of people's weight changes. (Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not always well-led by a consistently good management team. The service had a high number of incidents and accidents and was engaged in an improvement programme with the local authority. This, together with the areas of concern identified during this inspection meant that the service was not always able to ensure delivery of high-quality, person-centred care for people. (Regulation 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of suitably qualified and experienced staff to provide the necessary care and treatment of people. During the inspection we saw that some people waited long periods before being seen and some areas of the home were not as hygienic as could be (for example, wet floors in people's rooms were not attended to quickly). Staff did not always have the time to have meaningful interaction with people other than carrying out care-related tasks, and important checks and assessments were not carried out in a consistent manner. (Regulation 18(1)