Bupa Care Homes (CFHCare) Limited

Copper Hill Residential and Nursing Home

Inspection report

Church Street
Hunslet
Leeds
West Yorkshire
LS10 2AY

Date of inspection visit:
09 February 2016
16 February 2016

Date of publication:
22 April 2016

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?	**Good**

Summary of findings

Overall summary

The inspection took place over two days, on 9 and 16 February 2016. The first day was unannounced, which meant the service did not know in advance we were coming. The second day was by arrangement.

At the last inspection in August 2015 we found the provider had breached one regulation associated with the Health and Social Care Act 2008. This was in relation to medicines administration.

We told the provider they needed to take action and we received a report in September 2015 setting out the action they would take to meet the regulations. At this inspection we found the service had followed their action plan and improvements had been made with regard to this breach.

Copper Hill is a large home, spread across six separate units located on the outskirts of Leeds city centre. It provides residential services, nursing care services and dementia care services for a maximum of 180 people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accurate and up to date records in relation to people's care and treatment were not always maintained. Health care and treatment of people who used the service did not always meet their assessed needs and people were not consistently provided with meaningful and stimulating activity. You can see what action we told the registered persons to take in relation to each of these breaches of the regulations at the end of the full version of this report.

Overall, people said there were enough staff to meet their or their family member's needs. However, we noted that at times, people who used the service had to wait for periods of time for the support they needed such as assistance with meals.

There were systems in place to record accidents and incidents and monitor for any patterns or trends. However, we found on one unit two incident reports that had not been completed in full or followed up to show what action was taken in response to them.

The premises and equipment were well maintained to ensure people's safety. However, improvements to the environment were needed to assist people who lived with dementia to promote their freedom and independence.

People told us they felt safe and well looked after at the home. Staff had a good understanding of

safeguarding vulnerable adults and knew what to do to keep people safe. Staff were recruited appropriately in order to ensure they were suitable to work within the home. They were provided with training to develop their knowledge and skills. However, not all staff were able to demonstrate their knowledge and skills in how to support people living with dementia.

There were policies and procedures in place in relation to the Mental Capacity Act 2005. Staff were trained in the principles of the Mental Capacity Act (2005), and could describe how people were supported to make decisions; and where people did not have the capacity; decisions were, in the main, made in their best interests.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity. Overall, their choices and preferences were respected and they were supported to make their own decisions whenever they could do so.

People told us they enjoyed the food and got the support they needed with meals. However, some improvements were needed to ensure the meal time experience was positive for all people who used the service.

There were systems in place to ensure complaints and concerns were fully investigated. People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning and improvement.

People were not put at risk because systems for monitoring quality were effective. Where improvements were needed, these were addressed and followed up to ensure continuous improvement.

The registered manager was supportive of people who lived in the home and the staff who worked there. They listened to what people had to say and took action to address any issues they had.

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.

Accurate and up to date records in relation to people's medication were not always maintained.

People told us they felt safe in the home. Overall, there were sufficient staff to meet the needs of people who used the service.

Recruitment practices were safe and thorough and staff knew what to do to make sure people were safeguarded from abuse. However, systems in place for incident reporting were not fully effective.

Is the service effective?

Requires Improvement

The service was not always effective.

Health, care and support needs were assessed. However, they were not always met by regular contact with health professionals.

Overall, people enjoyed their meals and were supported to have enough to eat and drink. However, the meal time experience was not a positive experience for everyone who used the service.

Legal safeguards were followed to ensure that people's rights were protected.

Is the service caring?

Good

The service was caring.

Staff and the management team had developed good relationships with the people living at the home and there was a relaxed atmosphere in the service. People told us they were well cared for.

Staff understood how to treat people with dignity and respect and were confident people received good care. They were polite and respectful and treated people as individuals.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The range of activities provided were not stimulating or meaningful for all
people who used the service.

Systems were in place to manage complaints appropriately.

Care plans reflected the needs of people as individuals.

Is the service well-led?

Good

The service was overall well- led.

The management team motivated staff to provide a good standard of care.

Systems for monitoring quality were effective and used to drive improvements in the service.

People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning and improvement.

Copper Hill Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 over two days, on 9 and 16 February 2016. The first day was unannounced; the second day was by arrangement.

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

We also reviewed all the information we held about the home, including previous inspection reports and statutory notifications. We contacted the local authority and Healthwatch. We were not made aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted health and social care professionals who were familiar with the service, no concerns were raised by them.

At the time of our inspection there were 103 people living at the service. During our visit we spoke with 12 people who used the service, 10 visitors, 21 members of staff, the registered manager, the area manager, the clinical services manager, the head of care and the area trainer. We spent some time looking at documents and records related to people's care and the management of the service. We looked at 13 people's care records and 19 people's medication records.

The inspection was carried out on the first day by four adult social care inspectors, an inspection manager, a

specialist advisor in governance, a specialist advisor in dementia and a pharmacist specialist. On the second day of the inspection one adult social care inspector returned to the service to complete the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service in August 2015, we found medication practice was not consistently safe. This was a breach of Breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in February 2016 we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above. However, further improvements were still needed to ensure medication records were completed fully and accurately.

Medicines storage was safe and secure. Controlled drugs (medicines which are more liable to misuse and therefore need close monitoring) were stored securely. Registers were in place to record the handling of controlled drugs and these were in order. We saw documentation to show fridge temperatures were recorded daily but there were inconsistencies in documenting whether the thermometer had been re-set in line with the home's policy to ensure medicines were stored at the correct temperature.

We found that recording of variable doses of medicines was sometimes inconsistent and this had not been identified on the audits we saw. For example, one person was prescribed paracetamol; one or two tablets when needed. The Medication Administration Record (MAR) did not show when one or when two were administered. Another person was prescribed senna; one or two to be taken at night as and when necessary (PRN). We saw their MAR showed on one occasion that the dose had not been recorded. On every other occasion we looked at, the dose was recorded, the number given and reason for refusals documented. We also saw some stock balances of medication had not been recorded properly when a person transferred from one unit to another. This could lead to medication running out if the stock balance was incorrect.

There were comprehensive PRN plans in place to support staff to administer when required medication but these were not in place for all people whose records we looked at. We brought this to the attention of a unit manager who agreed there had been an oversight for a person who used the service who had recently been admitted. They told us; "This is an omission, I'll put one in now." We also found on another unit that the PRN care plan was not on the unit for staff to refer to. We discussed this with the head of care and were provided with a copy of the PRN care plan which was detailed and gave good guidance for staff to administer the PRN medication.

Topical medications were administered safely and staff were trained to do so. Topical MAR charts were in place for staff to sign when they had applied any creams or other topical medicines. Body maps identified the parts of the body creams were to be applied to. Some people were prescribed pain relief patches and we saw body maps were in place to ensure site rotation at the recommended intervals to prevent skin damage.

We found that medicines ordering and stock control was not always appropriate and this was leading to unopened medications being unnecessarily wasted and re-ordered for people who used the service. This did not follow NICE guidance on the safe management of medicines in care homes. NICE guidance states 'Before disposing of a medicine that is still being prescribed for a resident, care home staff (registered nurses and social care practitioners working in care

homes) should find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.' On the second day of our visit we discussed this issue with the registered manager and head of care. They said they had identified a problem with the ordering and supplying pharmacy and had now rectified this, with the introduction of a new service level agreement, to make sure there was no unnecessary waste in the future.

Some people had their medicines administered covertly. This is where a best interest's decision has been made that a person should receive medicines without their knowledge in food or drink. We found the appropriate processes had been followed and correct documentation was in place for these people in most cases but that documentation was not always reflective of the way medication was currently given for one person. This could lead to inconsistencies in administration.

We saw there were systems, policies and procedures in place to ensure medicines were now managed safely overall. However, we concluded our evidence showed a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as accurate and up to date records in relation to people's care and treatment were not always maintained. You can see the action we have told the provider to take at the end of this report.
We looked at training records in relation to medication which showed training and medication competency checks were up to date for staff. People told us that they received their medication on time. One person told us, "I always have my tablets on time." Another person said, "I get my medication when I need it, never miss my medication." However, one relative said they had complained as they were left in a position of supervising their family member to take their medication. The unit manager was aware of this and said it had been an oversight.

We received mixed views on staffing levels from people who use the service and their relatives. Overall, people said there were enough staff to meet their or their family member's needs. Comments we received included; "As far as I can see there are loads of staff", "The staff are always there, they help me. I am never waiting for anything" and "Staff always around if you need them." However, a relative said, "If something crops up where staff have to go it feels there is not enough staff, it takes three at a time and they can be thirty minutes which is quite a while."

We discussed staffing levels with the management team and were told they used a dependency banding tool on admission to make sure they had the correct staffing levels to meet people's needs. They said this was reviewed regularly to ensure they had enough staff on each unit. Some unit managers were fully aware of the banding system and were aware staffing levels were determined by people's needs and could be flexible according to individual needs. However, one unit manager told us they were not aware the level of people's needs influenced staffing ratios.

Our observations showed there were, overall, sufficient staff to meet people's needs and keep them safe. However, we identified on one unit there were risks people may not be supervised properly at all times. We were told some people required three to one support to meet their needs and at times there were only three staff on duty on this unit. We discussed this with the registered manager who said they would monitor the situation and would be increasing the staffing levels as occupancy in this unit increased.

We saw there were systems in place to record accidents and incidents and monitor for any patterns or trends. We saw a number of people had fallen and a falls toolkit had been introduced to monitor when and where these falls had occurred. We saw actions had been taken to prevent re- occurrence of falls. However, on one unit we found two incident reports had not been completed in full or followed up within the service to show how the incidents had been responded to. We informed the head of care who made arrangements

for this to be done as a matter of urgency.

People who used the service said they felt safe at the home. One person told us; "Definitely, I feel safe here, and I can put my head down on my pillow and sleep all night." Another person said, "I am safe here they look after me." We saw people looked comfortable and at ease with staff. Staff confirmed they had received training in safeguarding vulnerable adults and could name various types of abuse people may be at risk from in a care home setting. They described what they would do if they had any concerns. They said these would be reported to the unit manager in the first instance, then escalated to the registered manager if necessary. One staff member said; "I would report it immediately, even if you think it is nothing, still report it, I tell carers this also." Staff said they felt confident any concerns would be acted upon. Staff also told us they were aware of the whistleblowing policy and knew how to report concerns outside of the service if they needed to.

We saw a safeguarding vulnerable adult policy was in place and staff had received training on safeguarding vulnerable adults. There was a safeguarding log which identified when safeguarding incidents had occurred and the outcomes from those incidents; with actions taken to prevent re-occurrence. We also saw a 'Speak Up' policy was in place which identified what staff should do if they saw anything that concerned them. They were able to give information confidentially through a freephone voice mail, email, or write using a freepost envelope.

Risks to people who used the service were appropriately assessed, managed and reviewed. We saw risk assessments for areas such as falls, pressure care, bed rails and diabetes within people's care records. These gave clear instructions to staff to enable them to support people safely and they had been reviewed regularly. Staff showed a good awareness of the hazards people who used the service faced and were able to describe the management plans in place to minimise the risk of harm.

We saw a non-physical restraints policy was in place. The area manager said each person was assessed on the management of their care and the use of non-physical restraint if necessary.
Some staff told us about the training they had received in supporting people who displayed behaviours that challenged others. This training was called Management of Actual and Potential Aggression (MAPPA). The staff told us how they intervened when people become anxious as soon as possible so that behaviour did not escalate. One staff member said, "We support [name of person] when agitated either in the quiet lounge and do something one to one, or leave them alone, we judge it on the day by sitting and talking to them to see what they want." Staff could explain that at times they had to physically intervene in the person's best interests, but this was a last resort. When staff did intervene physically they told us they would use 'safe holds' to restrain the person to keep them and others safe from harm. The unit manager told us they analysed all behaviours seen monthly to look for patterns and trends and to reduce further incidences.

Appropriate recruitment checks were undertaken before staff began work. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable adults. We looked at the recruitment process for ten members of staff. We saw there was all the relevant information to confirm these recruitment processes were properly managed, including records of Disclosure and Barring Service checks. We saw enhanced checks had been carried out to make sure prospective staff members were not barred from working with vulnerable people. We discussed recruitment with the area manager and were told a recent recruitment drive had resulted in a number of vacancies being recruited to. The area manager said there were eight nurses and 12 carers due to commence in the next few weeks. They said this would reduce their reliance on agency staff and give more flexibility in the home to providing consistent staff.

We looked at various areas of the home including communal lounges, dining rooms and bathrooms. We

also looked at some people's bedrooms which were clean, tidy and personalised. We found the home was maintained well and looked in a good state of repair. There were no malodours. There were systems in place to make sure equipment was maintained and serviced as required and staff were able to respond to emergencies such as fire. One staff member said, "They test the alarm every week and we have a drill every six months. We also get training in fire evacuation."

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they received health care when they needed it. They told us they regularly visited the opticians and their GP came to the home weekly. One person said, I was in pain so I pressed by buzzer, they [staff] came straight away. They look after me well." We saw in people's records they had received regular support from healthcare professionals such as dentists, chiropodist and opticians. Where needed GP and specialist hospital services visits were also documented. Referrals had been made to access therapy support and advice for eating and drinking and moving and handling.

However, we found for some people, their health needs were monitored but no action had been taken in response to the findings which could lead to health needs being missed or overlooked. For example, blood sugar monitoring occurred for people who had diabetes but there was not always a plan in place to support staff with what to do if results were not in the recommended ranges. For one person, the pulse rate was being recorded daily prior to administration of a medication, however there was nothing in the care plan to assist staff with making a decision to give this medication based on the pulse result. We discussed these concerns with the unit managers who said they would ensure GP appointments were made and relevant care plans put in place.

Staff told us what they did to monitor the health needs of people who used the service. For example, staff said, pressure ulcers were monitored according to skin integrity and according to the person's identified needs. However, we saw for one person it had been identified they needed to see a dentist due to broken teeth. This had been identified 27 days prior to our inspection and no action had been taken. We reported this to the unit manager and head of care who could not explain why this had occurred but assured us a referral would be made.

People were supported to go to hospital in an emergency and a hospital transfer form was completed to ensure essential information about the person's health and personal details was transferred. This document did not contain individualised information about the person and how they liked to be supported which means their preferences and needs could be overlooked.

We concluded the evidence above demonstrated a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.
People told us they enjoyed the food provided by the service; and always had plenty to eat and drink. Comments we received included; , "Can't moan about the food, they ask you what you want. The food is lovely", "The food is passable, enough to eat and drink" and "Food could not be better now we have the new chef." People said the food, snacks and drinks were in plentiful supply. One person said, "You can order all you want from the kitchen." We saw drinks and snacks were offered to people throughout the day. People said if they had raised any concerns about the food, this had been addressed with the chef. Two relatives told us they did not think the food was suitable for their family member. We discussed this with unit managers who said they would meet with the relatives to try and resolve this.

We observed the lunch time meal in three units. We saw the staff brought people into the dining area and were respectful and kind towards them as they did this. Food looked appetising and we saw visual menus were available, though we did not see staff using these to assist people to make choices at the time of the meal. Menus were chosen in the evening the day before, but staff still explained the choices on the day to people in case their preference had changed. Some people ate their meals in their rooms and we saw staff take these on trays. Plates were covered to help ensure the food stayed warm.

We saw some positive interaction around meal times by staff chatting to people and assisting with cutting peoples food up where required. Generally the assistance was patient and respectful, with staff speaking with the person and offering encouragement and explanation of what they were eating. Staff asked if people were ready for more. However, we saw on a number of occasions on one unit, staff had to break off from assisting to attend to people in other parts of the open living/dining room which meant people's meal time support was interrupted. We also saw people were given support to eat while sat in front of a loud and distracting television. The meal time experience was not a positive one for these people. On another unit we saw one person waited 20 minutes to be supported with their meal and in this time their food became cold. Staff did not re-heat the food when they came to support them.

People were weighed regularly and nutritional assessments were completed to identify any risks. We saw nutrition and weight management policy was in place and catering staff were aware of the nutritional needs of people who used the service. There was a four weekly menu which showed a varied and balanced diet was available to people. We saw through the comments at the 'residents meetings', where problems had been identified, actions had been put in place to resolve the problem. For example, we saw a comment that on one unit the plates were cold and the action was to ensure all plates were heated before food was served. Another person requested more tea cakes which had been subsequently ordered.

Staff showed a good awareness of people's dietary needs. Staff were able to tell us who needed thickener added to food and drinks to prevent choking and could tell us about allergies and intolerances and whose diet needed to be modified to protect them from these risks. One member of staff said, "It's not just allergies; it can be a religious need that means someone has a different diet."

Staff were trained to meet the specialist needs of people living with dementia. Staff said they had undertaken training called 'Person first, Dementia second'. They described this training as "Learning about person centred support for people living with dementia. Working as a multi-disciplinary team with the person and their families." Another staff member said, "It helps us learn to see the support from the resident's perspective, to see the person not the illness and all staff get this." However, on one unit, a senior staff member did not demonstrate good knowledge of the needs of people living with dementia. They were unable to show how they would demonstrate best practice in this area of care.

We looked at the environment on two of the units providing specialist care for people living with dementia. Some areas were 'dementia friendly'; they were well lit to reduce the risk of falls and some of the walls on the corridors were decorated with memorabilia pictures and there was a recess in a wall that had a very interesting feature on items from the past. However, we concluded the environment would benefit from some improvements to enhance the lives of people living with dementia. We saw all bedroom doors were painted the same colour and had very little detail to distinguish between them. This could be confusing for a person to recognise their room. The toilets did not have contrasting coloured seats which would help them to be seen well. We discussed improvements to the environment with a unit manager who said the provider was aware of the need to improve the environment to be more dementia specific.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. We saw that a number of DoLS applications had been made to the local authority and these were being monitored to ensure they were up to date. We saw a DoLS policy and procedure and a Mental Capacity Act policy was in place to guide staff.

Staff we spoke with were able to talk in general terms about DoLS, and understood it was a safeguard put in place to protect vulnerable people. Some were not certain who did or did not have a DoLS in place, but said they would look at a care plan if they needed to know. One staff member said "We know people are here against their will/choice but if the doors are open they are at risk of harm, we need DoLS to ensure we are acting in their best interests." Staff were knowledgeable about the MCA, and understood people may have varying capacity. One member of staff said, "It's up to people what choices they make, if they have capacity." Another said, "There is an assessment of capacity in the care plan. People can have it in different ways." A third staff member said, "Never assume people don't have capacity, always give people choice."

Mental capacity assessments were completed for people who used the service in relation to multiple issues or decisions. Where people did not have capacity in specific areas a best interest decision record was in place. However, on some occasions this was not the case. For example, we saw people were recorded not to have capacity in relation to taking their medication but no best interest document could be found in their care records. The head of care agreed to attend to this oversight.

Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions. We saw staff worked in a way that empowered people to make choices about their everyday lives, for example what food they wanted, what activity they wanted and where they wanted to go. We saw people were in control and staff respected people's choices. For example, one person had woken early and been supported to dress and eat breakfast, but they then chose to return to bed for a lie down and staff supported this without question. We saw, however, on one unit, people who used the service had two hourly night checks carried out and on another unit, people who chose to take a rest during the day kept their doors open. There was no evidence people had consented and agreed to this intervention and lack of privacy. We discussed this with the relevant unit managers for their action. We saw a consent policy was in place and staff were expected to gain consent before carrying out any care or treatment.

Most staff told us they felt well supported and they had regular supervisions and appraisal to discuss their role. We looked at a sample of the supervision documents and saw the headings on the form gave opportunity for staff to raise concerns, managers to provide feedback and for actions plans to be developed for individuals. We noted most supervision meetings were task or instruction focussed and did not show evidence of how staff were supported to develop in their role. However, staff we spoke with said they did feel encouraged and spoke of training they had been supported to complete. Another staff member said "Gives me feedback if I'm not performing how I should be. Helps me to improve. Get good positive feedback since [name of unit manager] has taken over."

Staff said they received a good induction which had prepared them well for their role. The induction consisted of five days classroom training and shadowing (working alongside experienced staff) on the unit. One staff member said "I felt confident following the induction, it was more organised than previous employer and I was not thrown in the deep end."

There was a rolling programme of training available and staff told us overall, they felt they received the training they needed to meet people's needs and fulfil their job role. We noted there was no specific training for activity organisers. However, shortly after the inspection, the registered manager informed us of a course all activity organisers were to undertake that was specific to the provision of activity.

The training records we looked at showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date. Training included safeguarding, moving and handling, mental capacity act, fire safety, infection prevention and control, food safety and medication awareness which included annual competency checks for non- nursing staff who administered medication. We were told the provider's policy did not include nursing staff for annual competency in medication awareness; this is not in line with NICE guidance on the safe management of medicines in care homes. NICE guidance states 'Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines.' Following the inspection we spoke with the registered manager about this and they confirmed they would ensure nurses also received an annual competency check and they would make sure the provider was made aware of the NICE guidance on this.

We also saw there was specialist training provided to meet the needs of individuals who used the service. This included diabetes, first aid, stroke awareness and end of life care.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the staff; they said they found them kind and caring. One person said, "They're a happy lot [staff]. They welcomed me here from the first time I came." Another person said "Yes sound as a pound here, staff are nice." Another person told us "Staff very good can't fault them." A relative told us; "People get well looked after and are included like one big family, we are welcome anytime of the day." Another relative said, "You don't feel you're in someone else's home it feels like my mums home. I take mum on short walks around the grounds and there is plenty of places to sit." We received negative comments from one relative regarding the conduct of staff. This was brought to the attention of the unit manager and the registered manager and we were assured it would be investigated.

We observed many warm and friendly interactions between staff and people who used the service. Staff knew people well which meant they could anticipate their needs well. People said staff supported and encouraged them to do things for themselves. They also described ways in which they felt staff treated them as individuals and knew their preferences. For example one person said, "They always knock on my door and ask if they can come in.They ask me what I want, get a list so I can choose, they [staff] know what I like." "They support me in the shower and always ask me if I need help with anything." Another person said "Staff knock on my door most of the time before coming in." This meant people were treated with dignity and respect.

Most staff we spoke with demonstrated they knew the people they were supporting. They could tell us about likes and dislikes and what people's care needs were. However, on one unit we saw a staff member had been provided to deliver one to one support for a person whose behaviour challenged others. They had not been fully briefed on the needs of this person and said they did not know how to support this person should they display behaviour that challenged others. We brought this to the attention of the unit manager who said they would address this on the day of our visit to make sure the staff member was fully aware of the person's needs.

Staff were overall, encouraging and supportive in their communication with people. We saw staff listened to people when they were communicating by lowering their stance so eye contact could be made. Staff did not leave the person until they understood what the person wanted or that they had reassured them. We saw one person who had communication difficulties wanted a certain programme on the television; staff were patient and went through a process of elimination to find the right programme. This showed compassion.

We saw people looked well dressed and well cared for which is achieved through good care standards. For example, we saw people were wearing jewellery, some people had their nails painted and hair was nicely styled. This indicated staff had taken the time to support people with their personal care in a way which would promote their dignity and in line with the people's preferences. Throughout our inspection, we saw staff respected people's privacy and dignity. They were thoughtful and sensitive when supporting people with personal care.

Staff we spoke with said they provided good care and gave examples of how they ensured people's privacy and dignity were respected. Staff told us how they closed people's doors and curtains during personal care, how they knocked and sought permission before going into people's rooms. We observed these positive practices during the inspection. Staff were trained in privacy, dignity and respect during their induction and showed a good understanding of this. Comments we received included; "Treat them as if they are your own family member. At the end of the day, they are someone's relative" and "This is their home. You want to make people feel comfortable and feel at home, help them do the things they like to do." Each unit in the service had a Dignity Champion. Dignity Champions were expected to demonstrate good practice and challenge any bad practice with regards to respecting people's dignity at all times.

Staff told us how they encouraged independence for people. They spoke of the ways they would do this, for example, one staff member said, "If a person can hold the cup but not put it to their mouth we will hold the cup with them to drink, it is support with the person not for the person." Staff also told us of people who liked to access the community independently and how they supported them to do this and maintain community links.

Overall, people who used the service and their relatives were involved in developing and reviewing care plans. Relatives told us they felt involved and informed about their family member's care. One relative said they were always informed if there were any changes to their family member's care needs. We saw one person who used the service had signed their own care records and stated they did not wish their care needs to be shared with their relatives and this was respected. We saw in care plans people's life histories were recorded and this helped staff to get to know people well. We heard people chatting about the past and encouraging people to maintain their hobbies and interests. For example, a person known to like puzzles was supported with that hobby during the inspection. We did however see some people had care plans in place which did not show evidence of their or their family member's involvement or if this had been attempted.

The registered manager was aware of how to assist people who used the service to access advocacy support and spoke of how they had done this. We saw information was on display in the home on a local advocacy service people could access if they wished.

Requires Improvement

Is the service responsive?

Our findings

We looked at provision of activity in the service to see if person centred activities were available to people who used the service, if they were provided with stimulation and able to maintain hobbies and interests. There was an activities co-ordinator for each unit in the service. We saw a wellbeing and activity handbook was in place which identified the role and aims of the activity co- coordinator.

On the day of the inspection the activities co-ordinator on one unit had escorted a person to hospital following an emergency. They did not return until late afternoon. We observed activity levels during the day were low and were told there was no other staff member available to cover the activity co-ordinators role. Staff interaction was mainly task based and there were long periods where people received no interaction or stimulus provided by staff. People remained seated for long periods. Two televisions were on in different parts of the lounge, but we did not observe staff asking people what they wanted to watch and people did appear to be watching. There was also music on throughout the day and we did not observe people being asked what they would like to listen to. We looked at the activity records in three people's care plans on this unit. The care plans contained information as to the person's hobbies and interests, however we did not see these reflected in the activities they had taken part in. For example, a person whose interests were listed as 'Watching TV, films, fishing, Judo' had recently participated in bingo, dominoes, a quiz and a manicure. A person whose interests were documented as, 'Films, stamps, and history' had participated in bingo, gentle exercise and a quiz. We also saw activity records frequently showed gaps where no activity was recorded. We found on this unit, there was an activity plan for the week but this was very simple and repetitive. It did not appear to provide stimulation and meaningful activity. For example on the day of our visit, the advertised activities were; Breakfast, TV and radio, Pamper time (foot spa), Lunch and activities, card bingo.

On another unit we found activities were meaningful and arranged to suit the needs and interests of the people who used the service. There was an activity co-ordinator who supported the unit with various activities people would enjoy. An activities sheet was present and on display at the time of our inspection. Staff said they offered and encouraged activity based on the person's known likes and dislikes. People told us they enjoyed the activities on offer they told us, "I like watching the queen on the television, we all do." Another person told us," I would join in the activities if I wanted to there's a lot to do." Records were available which showed people who used the service were involved in a range of activities. These included trips out to local places of interest. We saw from the records people participated in a wide range of activities from 'quiz in the lounge', 'film afternoon', 'sing a long', 'play your cards right' and jigsaws.

We spoke with the activities co-ordinator in another unit who told us activities were based on people's individual needs. We saw in this unit, people were supported with one to one activities.
We observed someone doing art work and were told they had started this new hobby since they moved in. They had also recently written letters and cards to friends and family and enjoyed this achievement. Another person had an interest in bingo and was supported to attend a local bingo facility. Staff told us that following their Person first Dementia second training they were looking to change the approach towards activities by 'meaningful moments' being created when completing everyday tasks with people. However, we saw no evidence of people being supported to take part in activities of everyday living such as making a

cup of tea or a snack.

In another unit we saw some people enjoyed group activities and we saw a lively game of bingo during our visit. People from another unit also participated which meant relationships across the service were promoted. One person we spoke with was very pleased winning biscuits and bubble bath. Another person and their family member told us how they were supported to do gardening in the summer and tend to house plants in the lounge. We looked at the records in relation to activities for some people on this unit who had complex needs and did not enjoy group activities. We found they had little time spent with them on a one to one basis. One person told us they felt socially isolated because of this. For another person records showed that in the main the person spent time in the lounge watching TV and did not receive any one to one support in the period we looked at.

We concluded people were not consistently provided with meaningful and stimulating activity and this was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report. Records showed people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit. This information was then used to develop individual care plans.

We looked at the care plans of people who lived in the service to see how well care was planned on an individual basis to match people's needs and preferences. The care plans we saw contained all the information needed to care for each individual well. The care plans were comprehensive, relevant and detailed. They had health and care needs described and they contained descriptions of how the person wanted support to be delivered. This made them person centred. They had been reviewed regularly and where people's needs had changed they had been updated. We saw people's preferences and choices were recorded and person centred information such as what brand of toiletries a person liked to use, why and what effect not using it would have on their skin was included.

The people we spoke with confirmed they received person centred support. One person told us they were supported to have a bath by the same person each week and this was their preference.

On one unit we looked at the six monthly review document which had sections to record an up to date view of a person's care and support needs and outcomes of that support. The unit manager we spoke with said they discussed in detail at the review meeting all of these areas. However the documents we looked at were sparsely completed and did not provide a record of what was discussed. The review document did not list the actions agreed at review by the people present which means there was a risk people's needs could be overlooked. The unit manager said they would be reviewing the paperwork to show a better record of what was discussed.

Overall, staff showed an in-depth knowledge and understanding of people's care, support needs and routines and could describe care provided for each person. Staff showed good awareness of people's needs and backgrounds. One staff member described the life history of two people who used the service. This included the people's working lives, their families and where they came from. Life histories help staff understand people as individuals.

Staff told us the care provided was person centred. One staff member said; "Everyone's an individual. [Name of person] likes a bath first thing in the morning." Staff told us they encouraged people to remain independent and to do their own care under supervision. They said they asked people what clothes they would like to wear each day and if they wanted their make-up, nails and hair doing and the men were asked

if they would like a shave each day.

Health professionals we contacted told us they felt staff understood people's needs well. Comments included; 'The nurse I spoke to had a sound understanding of my client's needs.
When I visited the staff seemed to be caring for the clients well. The RGNs (Registered nurses) had a good working knowledge and was very insightful into my client support needs' and 'In my opinion I have found that [name of unit manager], and her staff have the knowledge and skills to deliver good end of life care to their residents.'

There were systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. We saw the complaints policy was available and on display in most units we visited. We spoke with people who used the service and one told us, "I don't have anything to complain about, if I did [family member] would complain, they know how to complain as well." Another person told us, "No complaints, would complain if I needed to the staff or manager." A family member raised some concerns with us during our visit and we saw the unit manager responded appropriately to these concerns. One person who used the service told us they would like to see practice change following the raising of concerns. They said they felt in some circumstances although they were listened to, the issue had not been resolved. We followed this up with the registered manager who said they would contact the person to see how to resolve their concerns.

There was a complaints log maintained which had information on each complaint and the outcome and actions taken as a result of the complaint. We saw all complaints were discussed at the weekly senior management meeting and at the relevant unit at the daily handover in order to prevent re-occurrence. We saw one relative had complained about the lack of activities for their family member. We saw staff had spoken with the relative to explain what activities were available and how they were managing the behaviour of their family member in the context of activity choice and participation.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a clinical services manager, a head of care, unit managers and a team of registered nurses and care staff. People who used the service who we spoke with were familiar with their unit managers and said they would speak to them if they had any concerns. One person told us, [unit managers name] will listen to you if you need anything [unit managers name] will help you." Another person told us they were appreciative of the support from the unit manager and that of the registered manager.

Staff said they felt well supported in their role. The staff said more senior managers were visible in the units and they felt able to go and see them if they had any issues. Staff spoke positively about unit managers and said they had a good relationship with them. Comments included; "[Name of unit manager] is good at their job", "[Name of unit manager] is always approachable", "[Name of unit manager] is who I always go to, they were really nice when I had to discuss my personal circumstances" and "If I've got any problems I go to [unit manager] feel well supported by [unit manager]."

We observed a unit manager leading their team during our inspection; particularly seeking support for people who used the service and directing staff to meet people's needs and routines. We found overall that unit managers were knowledgeable on the individual needs of people who used the service and demonstrated they managed the unit well. However, on one unit we found leadership and knowledge of the unit was lacking. We discussed this with the registered manager who said this had been identified and the appropriate support was being given. We saw documentary evidence of this.

Overall, staff told us that they felt listened to and their ideas and suggestions discussed at team meetings were acted upon. Staff said they met regularly for team meetings and minutes were available. One staff member said; "At staff meetings we are able to give our point of view and if any issues are raised it gets put into place." However, another staff member couldn't remember when the last team meeting was that they had attended. We saw that although team meetings were held on the units there was no consistency on how often these were held. The area manager said it was expected they were held at least quarterly. We saw each of the units had held staff meetings but each at different times within the past four months. For example one unit's last meeting was held in June 2015, three others had held meetings in November 2015 and one unit in December 2015. This meant there were risks that staff's views were not consistently sought.

We saw on the whole, staff worked as a team by communicating well and showing an understanding of their role. Staff described teams that were supportive and worked well together. Comments included; "Good team, everyone knows what they are doing" and "I love my job, and love my residents, [Name of unit manager] will tell us if things need doing." However, when we asked how the service could improve, one staff member told us all staff needed to 'pull their weight' and there were not enough consequences for staff who didn't.

We saw a weekly senior management meeting was held with all of the unit managers. There was a documented agenda where falls, tissue viability, infections, safeguarding, nutrition and medication where

regularly discussed. Staff rotas and skill mix on the units was also occasionally discussed. There was an expectation the unit managers cascaded information from these meetings to the daily handovers on each of the units. In addition to this, a daily meeting of all heads of department took place. One unit manager told us they got great benefit from meeting daily during the week to go through day to day issues and improve communication in the service.

People who used the service and their relatives were asked for their views about the care and support the service offered. People we spoke with were aware of the 'residents meetings'. One person told us, "I am not interested though in the meetings. I am happy with what I do at the moment." Families told us they felt involved in the running of the unit and staff communicated really well with them when needed. We saw 'residents meetings' were held quarterly. Areas covered included news related to the care home and provider, housekeeping, catering and activities; we saw representatives from each of the units were present at the meetings. We noted there was positive feedback from people who used the service. For example 'The food had improved since the new chef was in place'.

We saw a recent survey (September 2015) on people's satisfaction with the home showed an overall 88% satisfaction. Included in the survey was staff, food, being treated as individual, activities, building and surroundings, own room and communal rooms. Some of the comments from people who used the service and their relatives were 'Overheard staff talking behind people's backs'. The response from this comment was that staff were to be educated to behave in a professional and respectful way at all times. We saw this information had been passed to staff through the staff meeting on one of the units in order to improve the service and prevent re-occurrence of this issue. Positive comments included 'We are very pleased with the care' and 'The food has improved since the new chef has been here'. We saw a service action plan had been put in place following the survey and were told this would be monitored by the registered manager to ensure the service was continually improving and responding to what people wanted.

We found the service quality assurance systems were embedded into the culture of the service to ensure continuous improvement. Audits were carried out across areas such as medication, infection control and care plans. We saw information on actions that had been taken as a result of these audits, for example on one of the units a PRN medication protocol was not in place for a person who used the service. We saw this had been subsequently resolved and a protocol had been put in place. A quality assurance metric was in place. This consisted of a monthly return which was sent to head office, from which a monthly report was generated to identify any patterns or trends. The areas covered included detailed information on complaints, accidents and incidents, pressure ulcers and infections. Unit managers also reported the numbers of people who had weight loss, bed rails, referrals to safeguarding and DOLs and the number of people cared for in bed.

We also saw a monthly home review was carried out by the area and quality manager. A number of areas were reviewed on these visits including first impressions, quality assurance, and observation of units, care charts and wound management. Each area was given a pass or fail and if an area failed then an action plan with timescales was put in place to ensure improvement. The head of care said more monitoring had been introduced to ensure improvements in the service which included increased walk arounds by the management team and unit managers working alongside staff to ensure/model good practice. The head of care spoke about how the vision and values of the service were understood by staff. They said this started with a thorough induction for staff where the standards expected of them were outlined and this was then supported by regular meetings with staff, staff supervision and keeping staff well informed on the important issues that affected the service such as the outcome of complaints or safeguarding investigations.

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 did not take formal enforcement action at this stage. 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 The care and treatment of people who used the service did not always meet their assessed needs and people were not consistently provided with meaningful and stimulating activity.

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 People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records associated with medication management were not always maintained.