Roseberry Care Centres GB Limited

Alexandra View 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Alexandra View is owned and operated by Roseberry Care Centres GB Ltd. It is a large three storey residential care home situated in the Southwick area of Sunderland. The service is able to provide accommodation, nursing care and support to 62 older people, most of whom have physical and/or mental health conditions, including people who live with a form of dementia. At the time of our inspection 58 people used the service.

The service had a 'Time to Think' unit on the ground floor. This was a unit commissioned by the local authority with accommodation for 10 people. The unit was used mainly by people who needed more recovery time but were fit enough to leave hospital and this prevented a delayed discharge. Other people were on a short term placement to give their family carers a period of respite. It was also a unit where people could come and experience the care home before making a commitment to reside there on a permanent basis.

This inspection took place on 21 and 22 June 2016 and was unannounced. We last inspected this service in March 2014, at which time we found them to be compliant against all of the regulations that we inspected.

The manager of the service had been in post for one week and had begun the progress to become the registered manager. 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.

Medicines were not managed in line with safe working practices. We reviewed medicines in three treatment rooms and found issues with the storage and disposal of medicines. The temperature of the treatment rooms was not monitored and subsequently the room temperature was too hot meaning medicines and nutritional supplements were not being stored in line with the manufacturer's guidelines. We also observed broken and disorganised storage facilities and flooring which needed replaced. Medicine administration records were found to be accurate and well maintained.

Checks on the safety of the home were routinely carried out by on-site maintenance staff as well as by external contractors where necessary. Action had not been taken to address potential risks with some electrical systems, although the provider gave assurances the systems were safe and the work was to be undertaken in August. Personal emergency evacuation plans were in place.

There were policies and procedures in place to ensure the smooth running of the service. These included a safeguarding policy which staff told us they understood along with their responsibilities towards protecting people from harm or improper treatment. Relatives of people living at Alexandra View Care Centre told us they thought they relations were safe. We found staff were following procedures which enabled them to provide safe, good quality care. We found some issues with regards to record keeping which we discussed with the manager and regional operations manager. For example, accidents, incidents and complaints were

recorded but there was no evidence of thorough investigations, actions or outcomes.

Staff recruitment was safe, however we recommended that the service carry out additional annual checks or periodic checks with the Disclosure and Barring Service (DBS) in line with best practice to ensure long term employees remain suitable to care for vulnerable people.

There were no major concerns about staffing levels; staff working on the top floor told us they felt their team needed more staff. We observed care delivery at lunchtime on this floor and saw one person waited 25 minutes to be assisted to eat their meal.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We found that mental capacity assessments had been carried out and the provider had applied to the local authority for DoLS applications. However decisions made in people's best interests were not always made in line with the MCA principles. We have made a recommendation about this.

Staff received an induction into the company and were trained. The training plan was up to date with future training dates planned in advance. Formal staff supervisions and appraisals had taken place with the staff whose records we reviewed; however the records were not as detailed as they could have been.

Not everybody had a positive experience during mealtimes. The lack of a second hot trolley meant some people waited an excessive amount of time for their meal. People were supported by staff to maintain a well-balanced, healthy diet and the food looked appetising and nutritious.

People had been referred to external healthcare professionals to support their general health and social care needs.

We observed and heard staff offering people choices and they encouraged people to make decisions about daily life where appropriate. Staff treated people with respect and their privacy and dignity were maintained. Staff demonstrated kind and caring attitudes and treated people as individuals.

We saw people participated in a range of activities. Staff supported people to maintain links by welcoming family, friends and visitors into the home. The relatives we spoke with told us they knew how to complain and felt confident to do so if necessary. Complaints were briefly recorded; however investigatory notes and outcomes were not available for inspection. We were unable to ascertain whether complaints were managed well. 'Residents and Relatives' meetings were held but were poorly attended. The new manager had planned meetings for the year ahead and intended to encourage people to attend in order to gather their opinions and feedback on the service.

The provider carried out monthly quality assurance visits and had some oversight of the service. The provider audits had not been robust enough to identify that senior staff at the service were not satisfactorily completing daily, weekly and monthly checks on the safety and quality of the service.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to the management of medicines, safety of premises and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The storage and disposal arrangements of medicines did not follow best practice guidelines to ensure the safety and effectiveness of medicines and nutritional supplements.

The provider had failed to undertake urgent electrical work highlighted on the fixed electrical certificate, although the system was deemed to be safe.

Accidents and incidents were recorded but not thoroughly investigated to ensure appropriate actions were taken.

Staff recruitment was safe but routine checks on staff to ensure they remained suitable were not being carried out.

Emergency procedures were in place and people told us they felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

The manager and staff had an understanding of the Mental Capacity Act (2005) and capacity assessments were being carried out. Decisions made in people's best interests were not always in line with MCA principles.

The design and decoration of the home was not suitable to meet the needs of everybody who lived there.

Mealtimes were not a positive experience for all people. Some people waited an excessive amount of time for their meal. Food was of good quality, healthy and nutritious.

People were supported by trained and supervised staff and had good access to external services to support their general health and well-being.

Is the service caring?

Good

The service was caring.

Staff displayed kind, caring and compassionate attitudes.

People were treated with respect and had their dignity and privacy maintained.

The service provided advice, information and guidance relevant to the people living at the home.

Is the service responsive?

Good

The service was responsive.

Care plans and assessments were thorough and person-centred.

Care records showed the service had evaluated and reviewed care needs regularly with input from external professionals.

There was a weekly activities programme and we observed people participating in a variety of events.

There was a complaints policy in place and complaints had been briefly recorded, however investigations and outcomes to these complaints were not available for inspection. Relatives told us they knew how to complain if necessary.

Is the service well-led?

Requires Improvement

The service was not currently well-led.

The service did not have a registered manager. There was a new manager in post who had begun the process of registration with the Commission.

Systems in place to monitor the quality and safety of the service were not effective enough to identify the issues we raised during the inspection.

Surveys were used and meetings were held with people, relatives and staff to gather their opinion and feedback of the service.

The new manager encouraged a culture of openness and transparency. They demonstrated a commitment to improve the service.

Alexandra View Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 22 June 2016 and was unannounced. This means that neither the provider nor staff knew we would be visiting. The inspection was carried out by one adult social care inspector. We provided posters for the manager to display around the service during the inspection to encourage people and visitors to speak with us.

Prior to the inspection, we reviewed all of the information we held about Alexandra View including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their registration obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority to obtain feedback from their safeguarding adult's team and contracts monitoring team, about the service. We also asked external health and social care professionals about their experiences of the service. All of this information informed our planning of the inspection.

During our inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We were able to speak briefly with some people. We spoke with 11 members of staff including the manager, deputy manager, senior care workers, care workers, activities, domestic and catering staff, who were all on duty during the inspection. We also spoke with three relatives of people who used the service, who were visiting at the time and one relative provided feedback after the inspection.

The regional manager attended part of the inspection to support the manager as they were new in post. The

manager had only been employed by the provider for one week.

We spent time observing care and support at lunchtime and teatime in two dining rooms. We carried out an inspection of all three treatment rooms where the medicines were stored and we looked at the kitchen and food preparation areas. We also observed people engaging with activities.

We examined five people's care records in depth and we looked at other records of people's care, including food and fluid intake charts and medicine management.

We looked at six staff recruitment and training files, which included a mix of staff who carried out care and non-care related roles. Additionally, we reviewed a range of management records which related to the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

We checked how the service managed medicines during our inspection. We found that medicines were not being managed safely and properly in line with company policies and procedures or in line with current legislation and guidance. All three treatment rooms were extremely hot on the day of inspection. A thermometer read between 28°c and 30°c in each room. Staff told us and records showed that the temperature of the treatment rooms was not being monitored. Medicines and nutritional drinks supplements were stored in these rooms which (at these temperatures) was against the manufacturers recommendations. This meant the medicines or supplements may not have been as effective as they could be. Medicines which were being returned to the pharmacy for disposal were not stored in line with NICE guidance. Although the medicines were accounted for in a returns book, excessive amounts of medicines were kept in bin liners and overflowing unsealed containers. They were not in a locked cupboard within the treatment room. In one treatment room we observed approximately six open packets of prescription medicines on the work surface. We reported this to the manager immediately. In another treatment room the refrigerator was broken and the manager and provider were unaware of this. Staff were storing medicines which required refrigeration for people on a different floor within the home. This was not an ideal situation for the staff and administration of those medicines was time consuming. In general all three treatment rooms needed better organisation and more lockable space. In addition some flooring needed replaced as soon as possible.

A medicine audit was in place and the documentation for staff to use was thorough and comprehensive. It covered observing staff practice, medicine counts, ordering, storage and disposal, administration and recording. However the audits we reviewed had not been completed to a satisfactory standard and had not identified the issues we raised during the inspection. Additionally, staff had not had their competencies formally assessed. The manager told us they intended to commence regular competency assessments and would oversee the completion of audits.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12(2)(g) the proper and safe management of medicines.

Despite the storage and disposal arrangements we found other elements of medicine management were safe. Nurses were responsible for administering the medicines and senior care workers had completed advanced medicine training to be able to support with this task. We carried out a random check of the medicine stocks and found this to be correct. We reviewed medicine administration records and found these to be legible and up to date.

We reviewed the records kept which related to the safety of the premises. Checks which are legally required to be carried out by professional contractors such as gas, water and electricity had been undertaken. A certificate held within the service to evidence a five year electrical hardwire test was dated 2009. We asked the manager to find out from the provider's maintenance manager if a more recent test had been undertaken. Upon further investigation after the inspection, the maintenance manager provided a certificate dated December 2014. However, there were 18 items classed as "potentially dangerous" by the

electrician and "urgent remedial attention" was required. These items had had not been addressed at the time of inspection. We spoke with the provider's nominated individual and maintenance manager, who confirmed to us that the electrical systems at the home were deemed safe and the work listed on the certificate was now scheduled to be undertaken at the beginning of August 2016. This meant the provider did not have effective system in place to ensure required safety work was undertaken in a timely manner.

Portable electric appliance testing had been recently carried out. There were generic risk assessments in place for the building, housekeeping, catering and maintenance. Checks were carried out by on-site maintenance staff on all of these aspects of the service. We reviewed daily, weekly and monthly monitoring of safety on items such as fire doors, water temperature and equipment however the record books had not been audited by a manager or regional manager as directed within the books instructions of use. The premises were clean although in need of some cosmetic attention. A relative told us, "The fabric of the building could do with updating as it is in poor condition, the cleaning staff and maintenance staff do well to keep it going."

Accidents and incidents were recorded in an accident book; however we could not find any evidence which related to these being investigated. There were no thorough investigation notes, no witness statements and no evidence of follow up actions or referrals being made. For example, one accident we reviewed which related to a fall had a small 'investigation' section on the form completed which read, "Called paramedics… attended A&E." There was no comprehensive written evidence to show the circumstances of the accident, any mitigating factors, and the outcome of the A&E assessment or if a risk assessment had been reviewed and any actions such as referrals being made to external professionals if necessary. We discussed this with the manager and regional manager during the inspection and they told us the previous manager would have most likely recorded this information on the computer; however this was not available for the inspector to view. The manager assured us that they would complete thorough documentation and record any actions taken in the event of an accident or incident in the future.

The provider had drafted a business continuity plan which included emergency contacts, transport and alternative accommodation arrangements in the event of major disruption to the service such as a fire or loss of power. Personal emergency evacuation plans were also in place for each individual. These were plans which assessed each person's ability to evacuate the building in an emergency. A traffic light system was in place to highlight the priorities and information about handling equipment and staff support was documented. The evacuation register had been recently updated.

Staffing levels appeared appropriate to support people's personal care needs. We observed staff attended to people in an unhurried manner. We reviewed the staffing rotas for four weeks and saw there were consistently 12 staff scheduled to work through the day and eight staff scheduled to work overnight. During an observation at lunchtime in the dining room on the top floor, we saw people with complex high needs due to dementia related symptoms. One member of staff was present in the room with seven people, three of which needed assistance to eat their meal. After a short while another staff member came to assist but we observed one person waited over 25 minutes with their meal in front of them before being assisted to eat it. Staff who regularly worked on that floor told us they thought more staff was required. We reported this observation to the manager and asked them to reassess the staffing levels on that particular floor.

Staff recruitment was safe; we saw evidence of pre-employment vetting in staff files. An application and interview process had been followed, two references were obtained, identification was verified and enhanced checking with the Disclosure and Barring Service had been carried out. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are to be employed. We could not find evidence of these checks in two of

the six files we examined and these staff had been employed for 10 years and four years. We discussed this with the manager during the inspection. There was no audit of DBS checks in place to confirm if those checks had been made. Monthly checks were carried out with the Nursing and Midwifery Council to ensure the nurses were registered and remained fit to practice.

We recommend the provider has a system in place to regularly check long term staff suitability for working with vulnerable people.

People told us they felt safe at Alexandra View and the relatives we spoke with confirmed this. Comments included, "Dad is very safe here", "We trust these people [staff]" and "This is the best thing that has happened to her." Safeguarding procedures were in place and all of the staff we spoke with understood their responsibilities in relation to protecting people from harm or improper treatment. The service worked alongside the local authority and followed their guidance to determine the level of harm. For example low, significant or critical. We reviewed eight low level concerns which had been referred to the local authority, none of which had led to a formal investigation. The local authority did not share any concerns with us during the inspection planning.

Care records contained risk assessments and instructions for staff to support people safely and provided preventative measures to avoid repeat events. This meant the service had managed individual risks such as pressure damage and aggression to ensure people were protected and supported.

Requires Improvement

Is the service effective?

Our findings

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 it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA. Care records showed, and the manager confirmed there were people living at the home were subject to a DoLS. We reviewed the records regarding the application to the local authority and outcomes of these decisions. The provider had also notified the Care Quality Commission of these as they are legally required to do so. However, there was a lack of evidence to show that the principles around best interests decision-making were being followed. For example, the EU referendum vote was imminent and the manager was unaware that any arrangements had been made to support people to vote or to assess whether people had the capacity to understand this and make an informed decision. We saw evidence that a 'best interests' decision had been made for a person to receive their medicine covertly. This was in the form of a letter from a GP. However there was no evidence to suggest this decision had involved others such as the care home staff, relatives and social services. People who lack mental capacity may still have the ability to consent to some aspects of their care and treatment and therefore should be included in the best interests decision making process.

We recommend the provider ensures management and care staff fully understand and work within the principles of the MCA.

The design of the premises was not effective enough to meet the needs of all of the people who used the service. Although a lot of effort had been made in the 'Time to Think' unit and the middle floor, the top floor was in need of adaptation and decoration. People with complex needs due to dementia related illnesses mostly lived on the top floor and there was very little evidence of specific design in order to deliver best practice dementia care. We spoke to the manager about this because the middle floor was ideally decorated to suit this need; however the people living on the top floor had higher needs. The manager agreed that the top floor should have been redecorated first; however this decision had been made prior to her employment. We saw that the 'home development plan' did have the top floor design and decoration marked as the next priority and this was to start imminently.

We observed support being delivered over lunchtime and teatime on both days of the inspection on the middle and top floors. The system for serving people was not as well organised as it could have been. Staff told us that one hot trolley was broken so they needed to serve both floors with the same hot trolley. We saw meals were served to the people living on the top floor first and then the trolley was removed. This meant that these people did not have the opportunity for extra hot servings if they wanted any. It also meant (as we observed) one person sat for 25 minutes with their meal in front of them whilst waiting for assistance from

staff. In the dining room on the middle floor, we saw people seated in the dining room had waited 20 minutes before the hot trolley arrived. During this time, staff did not serve drinks or interact very much with people. We observed people looking bored and repeatedly asking where the food and drinks were. There was a kitchenette to the side of this dining room and hot drinks could have been served whilst people waited. People were eventually served drinks when the hot food arrived. We also noted on the second day of inspection that the menu board in this dining room still displayed the date and menu choices from the day before. This could have been confusing for people using the dining room.

Staff told us they used good quality ingredients to produce home cooked meals and snacks which we saw looked appetising and well balanced. Although the mealtime experience for people was not as positive as it could have been, the provision of food and drinks was good. We carried out an observation in the kitchen area and spoke with kitchen staff. Best practice guidelines were being followed. We saw separate preparation and storage areas for raw, cooked and dry foods. The refrigerators and freezers were clean and well stocked. The kitchen staff monitored the temperatures of equipment and also checked the temperature of food before serving. The staff we spoke with felt there were enough kitchen staff to provide a good catering service to people as long as there were no sickness absences and they had time to carry out deep cleaning tasks. Staff showed us a board on display in the kitchen which detailed the special dietary needs of people such as allergies, soft diets, likes and dislikes. They told us they received 'diet notification' sheets from the care staff which informed them of any changes to dietary needs. One care record showed the service had involved the speech and language therapy team when a person was at risk of malnutrition. The therapist had developed a soft diet plan and recommended pureed foods which the care and kitchen staff put in place and monitored.

People had a variety of choice from a planned menu but could also request an alternative if they wished. We read one meal pre-order form which stated, "Banana sandwiches, white bread." The staff told us they were happy to prepare anything they could if people did not want a meal from the menu. For example a kitchen assistant told us, "Yesterday I made cheese and crackers for someone who didn't want the meal and I made some cheesy chips and egg and chips for two others."

Staff had received and induction upon commencement of employment and were trained in key topics specific to their job role. One member of staff told us, "I am well trained, there is plenty available." We reviewed the training matrix for the service and saw that it was mostly up to date with some training taking place this quarter such as challenging behaviour and fire safety. We saw the fire safety training being carried out on the second day of inspection. More recently employed staff had set out to undertake the 'Care Certificate.' The care certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. A new member of staff confirmed they were working towards the Care Certificate. External training providers, the local authority and external professionals such as NHS staff had all provided training to the staff at the service. A member of staff said, "There's good opportunities to receive specialist training like in diabetes [awareness]."

Supervision and appraisals had been carried out. We reviewed six records held on the staff files we inspected. These records were pre-populated with key themes for discussion but contained no written notes of the discussions held with staff. One record was more in depth than the others but this was due to performance related issues. We discussed this with the manager who showed us they had implemented a matrix to plan the sessions and intended to hold them two-monthly. These were themed around different aspects of the service such as documentation, communication and care needs monitoring. Some of the staff we spoke with told us they had been given the opportunity to raise items at a private one to one supervision session and had been able to request specific training, but others told us they did not have confidence that

the previous supervisions would remain confidential so had not raised their issues in the past. We discussed this with the manager who agreed to ensure staff felt reassured with the supervision process in the future.

Staff told us they felt communication had improved since the new manager had arrived. Staff meetings had already taken place with care staff, nursing staff and a team meeting had been arranged with provider representatives present. Daily handover meetings took place twice per day led by nursing staff and a written record was taken. This was to ensure accurate information was communicated between the staff with regards to the needs of people. Care workers completed daily progress sheets twice per day. We reviewed these records and found them to lack detail. Some care staff had used comments such as, "slept well" or "settled day" as an entry in the records. These comments were described as 'not to be used' on the guidance information on the form. We discussed this with the manager who told us they would review and audit these notes in future in order to improve them.

People's care records included information on their general health needs. We reviewed records which were kept regarding professional visits and saw the service had responded to people's needs by involving other professionals such as a GP, a social worker, a dietician and a chiropodist to support a person's health and wellbeing.

Good

Is the service caring?

Our findings

The home had a homely and welcoming atmosphere. We saw staff approached people with a positive and caring attitude and they carried out their roles with kindness and compassion. The relatives we spoke with shared their positive experiences with us. We heard comments such as, "The staff are very supportive and take their caring roles very seriously", "They are absolutely brilliant", "They go above and beyond", "The staff are there for the people who don't have anyone else" and "I cannot praise the staff at Alexandra View enough. They do care."

We spoke with six members of staff about individual people's care needs and the staff were able to tell us about people's life histories, their preferences and their likes and dislikes. The staff clearly knew the people they supported well. Thank you cards were on display which read, "Thank you for the care and kindness, (person) was very happy and that's all down to you" and "Thank you for the excellent care and support. You made her last year's very happy, catering for her individual needs with genuine care and understanding."

All of the staff we spoke with displayed respect for people and told us how they maintained privacy and dignity. One staff member said, "We always maintain dignity and privacy, we let people be as independent as they can be and we only assist when needed. Confidentiality is important too." Another member of staff said, "We explain what we are doing, we respect their privacy and maintain their dignity." Staff used examples such as closing curtains and knocking on doors to demonstrate how they achieved this.

We did not find any evidence in the six staff files we reviewed that the provider had sourced 'privacy and dignity' or 'equality and diversity' training for the staff. However, during our discussions with staff, one long term member of staff told us they had undertaken equality and diversity training in the past. We also noted that 'privacy and dignity' or 'equality and diversity' were not featured on the managers training plan. We discussed this with the manager and regional operations manager who informed us that they felt these were very important topics and they would be added to the plan and provided to the staff in future. We observed staff treated people as individuals and saw they respected people's preferences such as choosing to eat their meals in the dining room or their bedrooms and staff considered people's differing needs when going about their duties, such as people's abilities to take medicines, mobilise and join in activities.

There was information and explanations displayed on noticeboards around the home about aspects of the service such as meetings, newsletters and activity programmes. We saw posters on display with photographs of named staff who were 'champions' in topics such as dignity, compassion in care and end of life services. Photos of the staff team were also on display. A dedicated notice board had been set up to highlight the staff's commitment to the 6C's. The 6C's are a set of values and behaviours drawn up by NHS England. They are Care, Compassion, Competence, Communication, Courage and Commitment. They are designed to help staff achieve a high level of care. People had been given a 'service users guide' upon admission and these booklets contained information about the service; what to expect, what services are offered and the local amenities. Other relevant information which would benefit people was also on display such as safeguarding contacts and leaflets on dementia, diabetes and advocacy.

We asked the senior staff whether any person using the service currently used advocacy services. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. We were told that people could access an advocate if they needed this support, and the manager was aware of one person who was visited by an external advocacy service. Some people had family who acted on their behalf formally with legal arrangements' in place such as relatives acting as a lasting power of attorney for finances and health matters. We saw this was evidenced in their care records. The manager was also aware of a small minority of people for whom the local authority had responsibility for under Court of Protection. The Court of Protection was created under the Mental Capacity Act 2005. It has authority over the property, financial affairs and personal welfare of people who lack the mental capacity to make their own decisions.

We saw the service had asked people to consider their end of life wishes and where appropriate these were documented in care records. We saw appropriate documentation regarding advanced care planning, emergency healthcare wishes and resuscitation preferences had been recorded in the records we reviewed.

Good

Is the service responsive?

Our findings

Care needs records were in the process of being transferred to a new style of paperwork. The care records we reviewed at random had all been updated recently. A summary of important information regarding the person was contained in a 'care passport'. This was to ensure relevant information was passed between professionals when a person was admitted or discharged between health and social care settings. A pre-admission assessment had been carried out and a 72 hour care plan was drafted. This ensured staff understood the person's basic care and support needs upon admission until the holistic care plan was created. The care plans were thorough and personalised. They contained sections entitled, 'What is important to me' and 'How best to support me'. Assessments had been carried out on all aspects of daily living including, mental capacity, mobility and nutritional needs. Each care plan had been evaluated and updated recently by a named nurse or key worker. Key workers have the responsibility of ensuring individual care records are up to date. Review meetings had also been carried out which were attended (at times) by external professionals and relative or friends to ensure those who mattered to people were involved in their care planning.

Individual people who were assessed as being 'at risk' in certain areas had additional risk assessment documentation drafted to assist the care staff to support and care for people properly. For example, one record highlighted a series of incidents which involved a person's behaviour which challenged the staff. The service had contacted the local challenging behaviour team and a member of that team had visited the home and held 'formulation' sessions with care staff to provide strategies to deal with incidents and helped staff to identify triggers to prevent the escalation of an incident.

There was a weekly activities programme advertised on the noticeboards around the home. During our inspection we observed the activities coordinator and care staff carried out activities with people. On the first day of inspection we saw the activities coordinator reading to a person during a one to one session. On the second day of inspection we observed a masquerade themed awards party took place with an entertainer singing to people. The staff had decorated the lounge with bunting and a red carpet. They had also made certificates and presented them to people for achievements. While the entertainer was singing, we saw staff asked people up to dance. People from throughout the home had been escorted by staff to attend the party. Relatives and friends had been invited and we saw there was a lot of enjoyment and laughter during this activity. This demonstrated the service encouraged people to maintain relationships with others who mattered to them.

The activities coordinator told us, "We treat people more like friends; they get a good service here." Other activities carried out during the week included, reminiscence sessions, arts and crafts, and pampering. Staff told us they were trying to build up individual memory boxes for each person with the help of relatives and friends. This meant staff could browse the box with people during one to one sessions to stimulate memories and conversation about their life. The activities coordinator also told us that they had a garden party planned for the following week. The aim of this was to get as many people as possible to access the outdoor space.

We reviewed the activities coordinators diary entries for the current week and found that four people and one relative had taken part in a reminiscence session with 1940's newspapers, two people had chosen 'story time' during a one to one session, one person had chosen 'games' in a one to one session, four people had taken part in some home baking, six people had taken part in a quiz and several people (mostly men) had enjoyed the latest England football game in the 'pub' room with shandies and snacks. This showed the service was providing activities and social events to meet individual interests and hobbies. We reviewed the entries made in individual care plans to show participation in the social activities.

There was a company complaints policy in place and we reviewed three concerns which had been raised in the last six months. We saw one issue had involved a member of staff and this had been discussed during a supervision session. Additional training had also been provided to refresh the staff member's customer care skills. Although the three complaints were briefly written on a 'complaints register' there was no evidence of an acknowledgement of receipt sent to the complainant, investigatory notes, witness statements or outcome letters to demonstrate an open and transparent approach to handling complaints. We were unable to gather whether these issues were resolved to the complainants' satisfaction. We were also unable to ascertain if an improvement had been made to the service. We discussed this with the manager and regional operations manager and they told us this information may have been recorded on the computer by the previous manager. The new manager assured us she would investigate any concerns or complaints appropriately in the future, ensure they are thoroughly recorded and available for inspection. She would also share the experience with staff in order to use the information as an opportunity to learn and improve the service.

Requires Improvement

Is the service well-led?

Our findings

The previous manager had been in post for over one year and had not registered with the Commission. The new manager had only been in post for one week and the regional operations manager had only been in post a few months at the time of inspection. A relative told us, "The fact that managers fail to stay very long is very unsettling both for carers and residents" and "The staff in my opinion have run the place very efficiently."

Auditing had been carried out on care records, catering and medicine management. Catering audits had scores between 97% and 99% with minor actions such as replacing the seal on a freezer. However, we did not see reference in these audits to the broken hot food trolley. Care plan audits had been completed in January and February 2016 but then had stopped. Medicine audits had been completed to date but were not to a satisfactory standard and had not identified the issues we raised at this inspection. Other record keeping was also poor such as investigations into accidents and incidents, the monitoring of staff suitability to work, supervision records, daily notes and outcomes to complaints.

Repairs to the defects highlighted in a hardwire electricity test had not been completed in a timely manner to ensure the provider met their obligations as a landlord and a repair of a broken hot food trolley had also not been addressed which had impacted on the effectiveness of the service people received.

Areas for improvement and development of the service could not be identified through these audits. We found that although the provider had basic oversight of the service through their own monthly audits, these audits had not been effective enough to identify the lack of governance carried out by the staff in the service. The senior staff had not maintained robust records to evidence that they fully monitored the quality and safety of the service on a daily, weekly or monthly basis. We discussed these audits with the manager and regional operations manager who assured us the service audits would be completed thoroughly in future and trends would be analysed by the manager in regards to all aspects of the service to improve it.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17(1)(2) good governance.

The provider carried out periodic quality assurance visits. We reviewed the last six monthly audits which were completed by an operations manager. These visits included a review of care files and staff files, identifying and managing performance issues, a health and safety audit, an infection control audit, a mealtime audit, observations around the home and speaking to people. Where issues had been identified, action was taken to rectify these such as purchasing new table clothes, replacing flooring, and ordering new chairs. The manager completed a monthly key performance indicator (KPI) report for the provider to ensure they had oversight of the service. This included hospital admissions, infections, weight loss and skin integrity.

The new manager started the process to become the registered manager of the service. Once accepted, this means she will accept legal responsibility for meeting the requirements of the Health and Social Care Act

2008 and associated regulations about how the service is run. The manager had experience of working in a supervisory role at a similar type of service.

The staff we spoke with told us they were happier at work with the appointment of a new manager. They said they had been supported very well by the deputy manager for a period of time but were glad a manager was now in post. They made comments such as, "She seems nice and approachable", "Good first impressions, you can go to her and she'll help you" and "(Manager) seems really nice – I feel I can approach her."

Prior to our inspection we checked whether statutory notifications were being submitted and we found that they were. The previous manager had sent several notifications to us about applications for DoLS and notifications of deaths which had occurred at the home.

The provider had produced guidance and information for people who lived in the home and for new people who may choose to move in. This included a 'Service User Guide' and the provider's 'Statement of Purpose". It was made available in a variety of formats for people. We reviewed these publications which were on display during the inspection. This ensured people had access to information and guidance which was important to them.

We observed the manager and staff talked with people and relatives during the inspection, which displayed an open culture. The manager promoted an 'open door' policy and encouraged staff, people and relatives to speak with her. We were told that a staff meeting had recently taken place and we reviewed the minutes of this meeting which included the manager's introduction, plans for managing the service in the future, new activities and maintaining good occupancy. We also reviewed a staff meeting held in June by the provider in the absence of a manager. Prior to those meetings, sporadic staff meetings had been held which included a night staff meeting in March, a 'qualified' (nurses and management) staff meeting in February and a kitchen staff meeting in January. The new manager told us she planned to hold monthly team meetings with the different departments in the future.

We also saw the manager had arranged an imminent relatives meeting to introduce herself and discuss the service being provided to people. We saw future dates planned for 'residents and relatives' meetings throughout the year. The relatives we spoke with said they were confident to approach the staff with any issue or problem they may have.

We reviewed minutes from the last four 'residents and relatives' meetings and saw they were not well attended. The meetings had a general agenda which covered decoration of the home, meals and activities. Comments from people were recorded such as, "People are happy with the décor programme", (Person) enjoys the food" and "(Person) said it's nice to have options like beans on toast or egg and chips." The new manager told us she hoped to attract more people to the meetings by opening up the agenda, discussing specific aspects of the service and future developments. This demonstrated that the manager valued the opinion of others and intended to involve them to ensure they were included and felt their opinion mattered.

The provider had recently issued quality monitoring surveys to people who used the service and their relatives or friends. The surveys were issued annually and the current responses where with head office to be analysed and have an action plan drafted. We reviewed the survey from 2015 which evidenced that where feedback had been given, action was taken to address this wherever possible. This survey included 'family opinion survey' which was overall positive and a 'professional's opinion survey' which was also positive. The service also held a supply of service review cards which they encouraged people and visitors to complete

and return to an external company who published the results on their website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of the premises within a timely manner as identified electrical work had not been undertaken and no monitoring had been undertaken to ensure the work was carried out. Medicines were not managed in line with safe practices. We found issues with storage and disposal of medicines. The temperature of the treatment rooms was too hot which meant medicines and supplements were not being stored in line with manufacturer's guidelines. Regulation 12(2)(d)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Provider oversight had not been robust enough to identify that staff at the service were not satisfactorily completing daily, weekly and monthly checks on the safety and quality of the service. Established systems were not being used effectively to ensure compliance. Records were not always accurate, complete, contemporaneous and available for inspection. Regulation (1)(2)(a)(b)(c)(d)(e)(f).