Bupa Care Homes (CFHCare) Limited

Anglesea Heights Care Home

Inspection report

Anglesea Road
Ipswich
Suffolk
IP1 3NG

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 19 January 2017. This was to follow up the previous inspection completed on 1 and 2 June 2016. We had given an overall rating of requires improvement and found that it required improvement in every domain. We had found three breaches in regulation. These related to; medicines not being safely managed, a lack of sufficient suitably qualified nurses and a lack of responsiveness to emerging health conditions to ensure people's health needs were met in a timely way. We had placed positive conditions on the provider to ensure compliance with regulation. We had restricted admissions to the service. We had met with the provider to ensure they understood our concerns and to develop a plan for compliance. At this inspection we found steady progress overall, but with some concerns remaining about Gippeswyk House and medicines management.

Anglesea Heights is nursing home and they are registered to accommodate up to 120 people. They also have the regulated activities of treatment of disease, disorder or injury. On the day of our inspection visit there were 50 people resident. 18 people resided on Alexandra. This house is for people with high nursing needs and end of life care. 18 people resided on Christchurch. This is for people with some degree of nursing needs and some people living with dementia. There were 14 people on Gippeswyk. This house is for people living with dementia with lower nursing needs.
Bourne house remained empty.

The service requires a registered manager. We at CQC had received an application and are in the process of determining the outcome of registration of the applicant. 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.

People at this service were confident and happy with the service that they were provided with. Relatives told us that they had seen improvements and any concerns they raised had been addressed. People had care plans in place, but these were not as individualised as they could have been, along with known risks not being effectively and consistently mitigated. There were a variety of activities on offer for people to participate in, but these could have been developed further based upon the known likes and preferences of the people living at the service.

The number of staff had increased since our last visit. Recruitment was ongoing. We were given assurances that this would continue before the service was expanded into four houses again. Bourne House remained closed to admissions. CQC have given permission for planned incremental admissions to two houses, but that no admissions were in place for Gippeswyk. This was because we found a lack of stable management and oversight on this particular house. The thread of inconsistencies showed us that Gippeswyk was the weakest house with Alexandra and Christchurch providing an acceptable level of care and support to people. Despite having good staffing levels at lunchtime on Gippeswyk the mealtime was not well managed and staff understanding and implementation of their dementia training needed further monitoring and

development. Mealtimes had systems in place to provide people with the food they required and needed, but the lack of staff organisation and knowledge led to inconsistencies in the service provided.

At this inspection we found one on going breach in medicines management. There were issues found on each unit, but in particular with Gippeswyk where covert and crushed medicines were not as safely managed as should be. There were missed signatures and one person missed their medicines. In other units creams were not safely managed and records were not consistently accurately kept.

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 service did not consistently manage medicines well to ensure people were as safe as they could be.

Risks assessments were in place, but risks related to cross infection, pressure relieving equipment and impacted bowels could be further mitigated.

Staff had a good understanding of how to recognise and report any signs of abuse. People felt safe.

The provider maintained safety by making sure that there were enough staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was routinely sought, but staff did not understand processes that should be in place to make 'Best interest decisions'. Where people lacked capacity and their freedom of movement restricted, the correct processes were in place. The Deprivation of Liberty Safeguards (DoLS) was understood by the manager.

Staff understood how to provide appropriate support to meet people's health and nutritional needs. Mealtimes had improved but further development was needed on Gippeswyk to ensure it was a pleasing experience for everyone.

Staff received the training they required to provide them with the information they needed to carry out their roles and responsibilities. However, staff applying knowledge in practice in relation to dementia care training was not checked. No all staff received regular supervision.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring in the way that they provided care and support.

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

People were supported to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed before coming to the service and this formed the basis of care plans. Care plans were not always individualised.
Varied activities were on offer, but people were not consistently supported to follow a lifestyle of their choosing.

Active involvement in care planning was not thoroughly promoted or in place.

There was a complaints system in place and the manager responded to concerns and learnt from matters raised.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff told us the management were supportive and that developments and improvements had been seen. Staff were confident in the ability of the management.

The manager followed BUPA systems to monitor the quality of the service to take action to improve the standards when necessary.

People and their relatives were consulted on the quality of the service they received.

Anglesea Heights Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 January 2017 and was unannounced. The membership of the inspection team consisted of three inspectors from adult social care, a specialist adviser and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of experience was older people/ dementia care. Our advisor was a specialist in clinical governance and dementia.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

During our inspection we observed how the staff interacted with people who used the service and spoke with six people who used the service, seven people's relatives and 12 members of staff. We spoke with two health care professionals during the inspection.

We used 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 also looked at 12 people's care records and examined information relating to the management of the service such as health and safety records, medicines, staff recruitment files and training records, quality monitoring audits and information about complaints.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 1 and 2 June 2016 we had concerns around medicine safety and found a breach of Regulation 12. At this inspection we found that medicines were inconsistently managed. On Gippeswyk we found that three people had medicines given covertly, one of which had instruction to crush the medicine. However, we could not locate documentation in the care plan or medicines administration record (MAR) that showed that this was a 'Best Interest Decision' and was safe to give in this way. Therefore the nurses on this house (including agency nurses) would not have had this guidance to determine how they administered medicines. A pharmacist should have been consulted to decide if the medicine was suitable to be crushed as this may affect the absorption rate. Nurses did not also understand their responsibility in relation to covert medicines and capacity assessments needed under the Mental Capacity Act (MCA) a 'Best Interest Decision' was not available to authorise administration of medicines in this way.

Also on Gippeswyk we saw missed signatures on the MAR chart of one person on three occasions. The same person had missed one dose of their medicines. We found this because we audited the charts and stock. In Alexandra we found creams that were not clearly labelled with people's name, nor an opening and expiry date. A cream that was accessed by carers hands should be discarded after one month, as bacteria can grow from contamination from fingers. A pump dispenser can be used for up to three months, as hands are not coming into contact with the contents. This practice could not be followed due to no dates of opening being present or dates of prescribing being legible. On Christchurch we found some gaps in the administration recording of people's prescribed creams and lotions. People's medicines were not consistently managed safely. This is an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines, including controlled medicines, were stored safely and there was a system for the ordering, receipt and disposal of medicines. The provider had implemented daily audits which included a check of stock against the medication administration records (MAR). On Christchurch this system identified errors in a timely manner with evidence of action taken in response recorded. We saw that medicines that required additional checks were accurately recorded. The administration of the medicine and the balance remaining was checked by two appropriately trained staff. Each person's (MAR) contained a photographic record of them and there was detailed medicine and allergy information.

Staff told us they had received updated training in medicines management and also the use of specialist equipment. However, we found not all nurses had received up to date training in the use of syringe drivers to enable them to administer pain relief medicines to people at the end of their life.

On Christchurch we carried out an audit of stock for four people where we found that all stock tallied with MAR records. In Christchurch, where people were prescribed as and when required pain relief medicines and were unable to verbally communicate their needs, staff had recorded guidance which described for them potential indicators of pain. Where transdermal pain relief patches were prescribed there was good evidence of body maps in use which indicated where on the body the patch was placed. This provided staff with the information they needed to ensure the weekly application of this medicine was placed on alternate

sites of the body as prescribed to prevent harm to people.

In Alexandra the suction machine and syringe driver were checked on a daily basis. This was good practice to monitor and check equipment so that it is ready for immediate use.

Risks to people were inconsistently managed. Risks had been assessed including mobility, manual handling, and skin integrity. We found moving and handling equipment such as hoist slings inappropriate for the assessed needs of people. We found one sling in use for a number of people. Hoist slings had not been individually allocated for their personal use to avoid the risk of harm from inappropriate size of sling and cross infection. The management team had identified this as a risk and staff had been requested to submit a list of people requiring individually allocated slings. However, staff told us they had provided this information on three occasions but still not everyone had been provided with a sling appropriate to their requirements.

We observed staff supporting one person to and from their armchair to a wheelchair. Staff did not apply the brakes to the wheelchair and neither did they use the lap strap when transporting them to and from the bathroom. This put this person at risk of falling from the wheelchair.

On Alexandra we looked at the mattress settings for two people with a Transair pressure relieving mattress. One was set to normal, the other to maximum. However nothing was recorded in the care plan about this. This placed the persons at potential risk. The type of mattress being used and the correct setting for the person's weight should be recorded; this ensures that staff can check against the correct setting. Incorrect settings on air wave pressure relieving mattresses can lead to risk of skin breakdown and less effective pressure relief and comfort for the person. We found other control measures in place with guidance for staff as to the action needed to maintain their skin integrity. This included guidance for staff as to the regularity with which people would need to be repositioned.

Staff gave us conflicting information as to the current system for monitoring people at risk of impacted bowels. Some staff said they were required to write any bowel movements into daily records. However, we found that this was not always happening. We noted two people assessed as at risk of constipation and prescribed medicines for this purpose did not have their bowel movements monitored as required with gaps for one person of up to five days. This showed that known risks were not consistently mitigated.

People identified as being at risk of falls had equipment in place and those who were unable to use their call bells had sensor mats in place. Records showed the provider had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence. Where people had a high number of incidents of falling we saw the falls team had been involved, a falls assessment had been carried out, and falls risk assessments had been updated and observation charts had been put in place.

The staffing levels were maintained to meet the needs of the people at the service. This was achieved by the use of regular agency nurses and a focus on recruitment over previous months and ongoing. One staff member told us, "As a team we have been through a lot together, but it feels like we are on the right track now." A different staff told us, "The manager is supportive and things are much more stable. On this unit we are good for staff although we often have to go and help other units which leaves us short on occasions." And "We are more stable on this unit than others. We don't use much agency, only on nights." We found similar whilst on our inspection visit. On the day of the inspection the person in charge of Gippeswyk was a nurse who usually worked on Christchurch, she had only completed a couple of shifts on Gippeswyk prior to this and needed the support of the agency nurse to liaise with the GP as they knew people well because the agency person had worked consistently on Gippeswyk.

People told us that they experienced sufficient staff being available to meet their needs. One person said, "If you need anything in my room I have got a bell and only have to press it and they come quickly, the longest has been 15 minutes but that does not happen often." A relative when asked about staffing said, "Quite good, staff are very friendly and there seems enough staff, [named relative] is always clean and tidy and cannot fault much". A visiting health professional gave us their view and said, "Level of patient numbers to staff is workable now and if more residents came with complex needs it would be difficult."

Each care plan contained a dependency assessment document which was used as a guide to calculate staffing levels. This information was collated by the nurse in charge of each house and given to the manager to review on an on-going basis. The manager was able to show us how these dependency scores translated into staffing numbers on the rosters for each house. The manager informed us that the overall levels of staff sickness had been reduced and that coupled with the levels of recruitment completed had seen more stable staffing. On the day of our visit the service had 72 nursing hours still vacant and being covered by regular agency staff. The majority of nursing shifts on Gypeswyk were covered by agency. A unit manager had just been recruited into post for Gippeswyk with a contract of 30 hrs a week.

People told us that they felt safe. One person said, "Yes I feel safe, I was thinking about fire alarms the other day, but the staff told me the door will keep fire back for 30 minutes and I can go out of my door into the courtyard." A different person was able to explain. "It is very nice, it is the people who make it, staff are nice and caring and very helpful and any little problem you can talk to them and they will help solve it." The provider had systems in place and staff were trained in identifying acts of abuse and what steps to take to reduce the risk of people experiencing abuse. We followed up on one agreed procedure in place to keep a person safe. Staff were aware of the actions they needed to take to keep the person safe and staff were allocated appropriately. Staff had been provided with procedural guidance in reporting issues of concern such as whistleblowing and safeguarding policies and procedures to follow.

Staff we spoke with demonstrated a good understanding of how to recognise and report any signs of neglect and abuse. Staff were able to point out where contact information was held for staff to refer to if and when needed to report any concerns they might have to the local safeguarding authority.

We noted a need to improve the adaption, design and decoration of the service to enhance these houses and improve the environment to meet the needs of people living with dementia and promote their independence. Further work was needed with access to current research and good practice recommendations in providing a more enabling, dementia friendly environment. For example, improving the signage, changing the bland corridor walls and door colours and providing tactile objects for people to access. The environment was clean and fresh smelling. We met and saw domestic staff actively cleaning the environment.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 1 and 2 June 2016 we found a breach of Regulation 18 because there had not been a programme of increasing the clinical deficit skill of nurses. At this inspection we found that nurse's skills had improved.

One staff member said, "The staff are much more stable and know people well so can manage any behaviour." They went on to say that Gippeswyk would benefit from consistent nursing staff on the unit, but they felt that the newly appointed unit manager would help with this. A nurse said, "We have lots of training. There is so much of it! Anything that you want you can ask for." They gave an example that they had requested palliative care training and syringe driver training so that they could work across the site and that this had been arranged. They went onto say that their unit manager and the manager had supported them with their revalidation. A different nurse told us they had recently received update clinical training in maintaining skin integrity, end of life care and that further end of life care had been accessed via the local hospice to support and update other staff skills and knowledge.

We spent time talking with a visiting nurse practitioner. They told us they visited the unit weekly and had no concerns regarding the quality of the clinical leadership, oversight of people's complex needs and support provided for people. They were complimentary about the quality of care provided. We observed that a nurse spent time discussing an individual's care with the local hospice before the GP visited to make sure they were as up to date and as informed as they could be. This was effective practice and showed that the nurse liaised with other professionals to inform herself and other nurses at the service.

We were aware that BUPA were rolling out dementia care training for staff. Even the assistant chef said they had attended this training. But the impact of this specialist dementia training was difficult to see on Gippeswyk. Gippeswyk is a specialist house just for people living with dementia. Staff were kind and patient with people but verbal cues were often complex and open ended which made it difficult for people with a diagnosis of dementia to follow. Staff were not aware of how to offer meaningful choices to people in a manner they could comprehend.

There was a process for induction and training of newly employed staff. Staff recently employed told us their induction prepared them to work at the service with opportunities to work alongside more experienced staff and training opportunities which included recognising and safeguarding people from the risk of abuse, infection control and food safety awareness. One nurse told us that the level of induction was not adjusted to those who may already have a degree of knowledge and competency.

A nurse on Gippeswyk told us, "It is a very good team of staff. Without them I couldn't do my job." All the staff that we spoke with told us that they felt well supported by the unit manager and the general manager who had management oversight for the whole service. Annual appraisals of staff performance were in the process of being organised to commence shortly.

On Christchurch the unit manager had a system in place for monitoring the progress of supervisions and

performance reviews and determining when these were due. On Gippeswyk care workers told us that they had received up to date annual appraisals but did not have access to regular supervision sessions. They felt this was because there had been no unit manager or consistent senior nursing staff on Gippeswyk. Overall we concluded that training and support to staff had improved and with ongoing plans in place, along with review of the effectiveness of training given staff were more likely to meet people's needs than at previous inspection visits.

People were supported to maintain good health, but some issues were identified. People told us of their satisfaction with the healthcare on offer. One relative told us their experience, "The social worker picked up that there was no written protocol for high blood sugars. They were testing but not recording properly so the GP wrote a plan to go into [their relatives] notes. It is being implemented." Relatives told us that they were kept up to date with any changes in their relative's health care and informed of incidents affecting people's wellbeing. One relative told us, "They always keep you informed. I visit daily but in the meantime they would phone me if anything changed or they were concerned." A visiting health professional told us, "On the whole pretty good, I come twice a week. Staff know their patients well, no issues, they call us when it is appropriate. Workload now works well, I would have fears if they reopened with hospice/hospital or end of life discharges."

We did find some conflicting evidence on different units. On one unit a nurse had ordered a catheter of an increased size. We asked why the size had been increased, as there was no information concerning this in the care plan. The nurse on duty said she did not know why the size had changed. This placed the person at risk. Our specialist adviser found the person had been assessed as requiring a size 14 ch catheter, this was the normal size and it should not be changed unless a further assessment was carried out. The person drank fluids well and their urinary output was good. There was no indication of a need to change the size. The increase in size could lead to discomfort for the person.

On a different unit we reviewed the care of one person with a catheter. The care plan recorded that this should be changed six to eight weekly. There was a recording sheet with the adhesive labels from the catheters used on it. There was detailed information within the care plan to instruct staff as to the next date when re catheterisation should take place. Care plans provided staff with detailed guidance as to steps they should take to administer appropriate pain relief medicines prior to any re catheterisation. Specialist advice had been sourced from a urologist when required and the care plan updated according to recommendations made.

There was a lack of consistent oversight on Gippeswyk. On the day the nurse covering was from Christchurch and did not know people well. They required an agency worker to meet with the GP and write up care plans e.g. one person who had no family and had not accessed advocacy and needed nurses to have knowledge of their needs to inform the visiting GP. The agency nurse was not on the roster, but also stayed to order medication that was needed as a result of the GP's visit.

We saw from a review of care records that people had been referred to the GP who visited weekly and other healthcare professionals when required. A person at the service said, "I always get a visit from the doctor, chiropodist and hairdresser." Referrals had been made when needed to dieticians and speech and language therapists. People had received recent access to a visiting optician and regular opportunities to obtain the services of a chiropodist. A relative told us, "Some dentures went missing last August, so we got new ones."

Staff sought consent before they supported people with care tasks. Staff consistently told people what was happening and what they were doing whilst giving them care. We heard one member of staff ask, "Where would you like to sit today?" A different staff member was observed to say, "Here is your water and ring this if

you need me". The member of staff placed water and buzzer close by. They returned shortly with the person's glasses and asked permission before carefully placing them on their nose saying, "This will make it better to see."

However, we found that more complex decisions were not routinely understood by all staff in all the houses. Staff had received training in understanding their roles and responsibilities with regards to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). In Christchurch care records showed us that people who lacked mental capacity had a best interest assessment carried out so that any decisions made regarding their health and welfare where they lacked capacity had been made in their best interests. Some care plans in Gippeswyk showed that best interest decisions had been made in conjunction with family members but there was no indication that they had Lasting Power of Attorney (LPA) for health and welfare for the person. An example of this was the Flu vaccines. It had been given to people whose care plans stated that they lacked capacity, but there was no best interest decision or capacity assessment around administering the vaccine. Also on Gippeswyk one person had crushed medicines covertly given. Pharmacist, social workers and others were not routinely consulted and we found no evidence of written 'Best Interest decisions' in people's care plans. Staff did not understand LPA nor was this evidenced as part of the routine admissions assessment for transfer into the care plan. Given this service supported people living with dementia this should be an area known and used to ensure decisions are made involving the correct people and in a timely way.

In Alexandra we spoke to a person who told us that they were unhappy that their bedside had been removed and that they felt unsafe as though they may fall out of bed. They did not understand why or had agreed to have the bedside removed and wished for it back. We reviewed the care plan and found that they had full capacity to make decisions for themselves. They had previously had a bedside that had been regularly reviewed and inexplicably had been removed without consultation. Following discussions with the nurse on duty they agreed to look into this matter and then informed us that the bedside had been replaced. Whilst we understand that bedsides are not always a safe solution to keep people safe and alternatives should be considered, people can choose to make their own decisions and these can be deemed unwise, but the principles of the MCA are that people who have capacity can make unwise decisions that should be respected.

Applications for authorisation with regards to the deprivation of liberty safeguards for people where their freedom of movement may be restricted to keep them safe, such as those requiring constant supervision had been referred to the local safeguarding authority. One person had a DoLS in place but the authorisation had run out in November 2016. There was no recorded evidence of review in the care plan having been carried out. But when we spoke to the manager they had submitted this to the local authority for review and therefore had fulfilled their obligation to keep this person safe and acting within the legislation, but this information had yet to be transferred into the care plan.

Lunchtime was not consistently well managed across the houses. Gippeswyk had seven care staff, one nurse and a domestic supporting through lunchtime. However, people were not routinely offered visual choices of meals as seen in the other houses. This is a way that people living with dementia can be empowered to exercise choice when it comes to choosing food. Staff told us that they had supported people to choose what they wanted to eat for lunch from the menu the previous day. However, some people were not able to express themselves verbally and potentially would have found it difficult to make an informed choice without visual cues. One person observed at lunch time had difficulty expressing themselves and this was documented within their care plan. They repeatedly stood up and walked away from their meal. Staff encouraged them to sit back down on each occasion and asked if they would like something else to eat. However, they did not show them what the alternative was which may have prompted them to eat. We

reviewed the person's care plan which stated 'please cut up [named person] food into pieces she can pick up with her fingers as she's more comfortable with this.' The meal they had been given was chicken, cabbage and mash potato, and ice-cream for pudding. We observed them pick up the carrot batons from the plate and eat them but they ate nothing else. No finger food was ordered. The care plan showed this person was not losing weight, however there was a risk that this may occur if they continued to not receive appropriate foods. One member of staff was observed assisting a person who had significant cognitive impairment and limited verbal communication. Verbal prompts were very wordy and not direct. On Gippeswyk there were sufficient staff, but they were not organised or deployed effectively to support people living with dementia in a meaningful way.

We observed the midday meal on Alexandra and Christchurch. Where people required one to one support with eating their meal, staff provided this support appropriately. One person was able to tell us, "We have a menu to choose from and they try and get something you like, I have scampi twice a week with wedges. We all drink loads of water. The food is very good, I used to be a cook."

Care records showed us that people's weights were regularly monitored. Where people were consistently losing weight referrals had been made for specialist dietetic advice had been sought. Care plans reflected appropriate intervention such as cream shots given and high calorific drinks. However, where people had gained significant amounts of weight in a short period of time this had not been recognised as a risk to their health and welfare.

One person had been assessed as at risk of choking and a referral had been made to speech and language therapist specialists (SALT). Recommendations had been made to provide a soft, moist diet only so as to reduce the risk of choking but these had not been observed. For example, the check list provided by the SALT team of safe foods described the need to avoid rice. We observed this person was provided with their main meal which included rice. This person was placed at risk of choking or aspirating.

We observed four people in Christchurch were assisted with their lunches in bedrooms and all staff sat on stools/chair by the side of the bed. They had raised up the back of the bed so that they had good eye contact and the person was not at risk of choking. Staff were seen to be patient and encouraging.

We saw only two plate guards in use and no adaptive cutlery that could have improved independence. We observed that the soft food was attractive on plates. We spoke to the assistant chef in the kitchen. They were knowledgeable about the different types of food that they needed to produce to meet individual needs. We asked about finger foods for people living with dementia and were told, "Yes things like, chips, fruit, sausage rolls, and spring rolls but only offered if asked for them by the staff. Today sausage rolls are on for tea." They went on to tell us about the dementia training they had just completed. "It was quite helpful and I am now a bit more aware of how they are feeling and what impact my questions have on them. We have resident of the day. The chef or me goes and ask what they want special for tea and if they cannot say we suggest something savoury or something sweet – it works well." Our conclusions were that mealtimes had systems in place to provide people with the food they required and needed, but the lack of staff organisation and knowledge led to inconsistencies in the service provided.

Good

Is the service caring?

Our findings

Staff had developed kind and caring relationships with people. We saw and heard some warm interactions between staff and people. We observed interactions in all three houses in operation. We saw a friendly exchange between a person and a member of the cleaning staff. The cleaner had been chatting as they went about their duties and the interaction ended with "See you later," followed by smiles from both people. Relatives gave positive feedback as to the caring and respectful interactions they observed from staff. One relative told us, "I have no concerns. They are caring, always." Another said, "Carers are wonderful, food is wonderful and if anything happens to me I want to come here."

We observed some friendly and meaningful relationships, such as staff comforting people when distressed or speaking to people, positioned at eye level when communicating and supporting them with eating their meals. We heard conversations that orientated people to the rhythm of the day such as who was at breakfast and who was having their hair done today by the hairdresser.

Staff were observed to be respectful in their interactions with people, for example, when offering care, respecting people's wishes and refusals and when supporting them with their personal care. We observed the lunch time meal. We observed one person whereby they repeatedly rejected the meal provided and asked for a different meal. Staff patiently offered various choices. When meals suggested and requested by the person was provided and then rejected staff were patient, kind and courteous in their response.

People had varying degrees of involvement in their care planning process. One person said, "They let my daughter know of any problems, staff are 110% to me, they all know me and it is lovely here." One person was able to tell us, "They have a resident of the day and ask you questions and say is there anything you really like to eat." Care records confirmed this focus on the individual called 'resident of the day'. This was also referred to in the regular daily meeting as to who was nominated that particular day so everyone was aware, including care staff, catering and domestics. However, care records remained mainly task focused lacking detailed information as to how people would prefer to be supported through social stimulation linked to their level of dementia.

Interactions between staff and people who used the service were caring and appropriate to the situation. Many staff demonstrated an understanding of how to meet people's needs. They spoke about people respectfully and behaved with empathy towards people. Any personal care was provided in private to maintain the person's dignity. One person told us, "My favourite thing is a bath and I sit on the seat and they fill the bath with bubbles, I am not embarrassed, they stay with me and I have a soak, they always stay with me." When we spoke to staff about ensuring privacy and dignity was maintained at all times they gave consistent answers. One person told us, "Staff are very caring, very helpful and very considerate, they always knock on doors."

We were informed that people can have visitors any time they wished. A relative told us, "It's pretty good here, the staff are very caring, they make me welcome when I visit. I come regularly."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 1 and 2 June 2016 we had concerns and found a breach of Regulation 9. This related to a lack of responsiveness to emerging health conditions, recording and care planning that did not ensure people's needs were met in a timely way. At this inspection we found a degree of improvement with areas still to develop, but people were getting better care and treatment than previously seen.

People spoke positively about the personalised care they received. One relative was pleased at the progress their relative had been supported to achieve. They said. "She was hoisted but her mobility has improved and they have got her walking with a Zimmer frame. That is positive and I am delighted to see she can do it." They went on to say, "She likes the staff, the food, activities and says, 'I live here now'. Overall I have been impressed how the staff are."

One relative told us, "I was told that we would have a formal review of the care plan every month but none have happened, I think there should be one every six months." Our experience of care plans were that they were muddled with information stored in several places which meant that it was difficult to obtain a clear clinical overview of people. Care plans were not the cornerstone of peoples care, nor underpinned personalised care known by all staff. Care plans were in the main task focused. Given the number of agency staff employed, the front sheet to the care plan known as 'My day, My life, My portrait' provided agency staff and others with a helpful summary of a person's health, safety, care and support needs. There was limited information as to how personal care was to be provided and in accordance with people's wishes and preferences. For example, it was not always evident people had been consulted about their preferred wishes in relation to bathing, showering, for example when and how often. There was little information in relation to oral care. There was a lack of information as to a person's life history. This would be particularly important to reflect this information for people living with advanced dementia.

There was limited information available which would describe people's likes and dislikes, preferences and choices. There were no clear routines which would demonstrate people's involvement in planning for their night time needs. Further work was required to ensure that care plans reflected the current needs of people and reflected their choices and preferences as to how they chose to spend their days including provision to support people to maintain their hobbies and interests as much as they are able.

We observed that each of the houses were calm with staff generally attentive. The main entertainment for the day was based upon Gippeswyk house provided by an outside entertainer. People from the other houses could attend. We observed different interactions throughout the day with staff sat chatting, a person drawing with pencils and five people watching a black and white film. One person was supported into the community by one of the activities staff. Three activity staff were employed in total. We were told of events that had occurred such as a celebration for Valentines Day and Burns night.

In one house we saw a table in corridor that had dementia friendly items such as a dementia muff, woollen ball, many happy return cards for 1940's, wooden/wire dementia game, a dustpan with brush, broom and duster hanging up in corridor. This was appropriate and accessible to anyone who was passing.

On Christchurch there was a box of reminiscence items on a table. As the majority of people on Christchurch unit could not mobilise, other than one person, the others were not supported to access these items with quality interaction from staff to enjoy reminiscing. We found that there was no programme of regular trips out into the community. People told us there used to be regular trips to Felixstowe which had ceased within the last year. People's relative's and staff told us these were missed by people who used the service. The activities staff did on occasions take people out to the local area on a one to one basis. We concluded that whilst there were a number of activities and interesting events happening across the whole site these were not necessarily based upon peoples expressed preferences, nor wholly accessible to everyone.

The provider had a procedure in place to manage any concerns or complaints that were raised by people or their relatives. The organisation's complaints procedure was displayed openly throughout the service and we saw that complaints were recorded in line with these procedures. We spoke to one relative who told us they had complained about the standard of laundry care and lost items of clothing. They told us this had been responded to promptly by the manager and had been resolved to their satisfaction. We were able to see the records that related to this incident as the manager had kept records relating to concerns raised and responses given to these. We could also see though the complaints managed that the manager liaised with other professionals as appropriate to keep people safe.

Relatives said that they were encouraged to give feedback on the service and that they could do this through meetings at the service. One person told us, "We have been to the relatives meetings. There was one after your report and lots of staff came, social services, company people, we got a letter after the meeting but not minutes." The manager told us that they communicated with relatives and people at the service through a newsletter that was sent out. We saw a notice that advertised an upcoming resident/relative meeting that was planned for the coming weeks after our inspection. This meant that people were routinely listened to.

Requires Improvement

Is the service well-led?

Our findings

We met the manager who was available to us throughout the inspection visit. They were able to fluently talk about the service and each house at Anglesea Heights. They were able to tell us clearly the aims and objectives of each house and what type of needs could be catered for. They were aware of each person living at the service and could tell us whose needs had changed or escalated. This was because the manager led a meeting each day that was attended by representatives from each house (usually the nurse in charge), activities staff, catering and domestic staff. Each house and the changes and challenges for the day were discussed. Staffing numbers were checked upon as was the changing needs of people if there had been any incidents. A staff member said, "I attend the 11.30 meeting and find it useful." The meeting gave the management team a daily insight into how each house was managing and how the three houses could support one another if needed. On the day of our visit one staff member had been reassigned to a different house to enable better staffing ratios across the site. However, in spite of this regular communication we found the entry door on Gippeswyk swung to close but on checking found twice that it did not close and therefore was a potential concern that people may leave unsupervised. There was a sign on the door and we fed back to the manager that it needed immediate repair so that people remained safe.

Staff told us that the service had improved since our last inspection and that there was good visible leadership. One staff member told us, "The home is more stable and staff morale has improved. The manager is very supportive." Another said, "I like the new manager. They are visible on the units." Staff believed that more stability had returned to the service. One said, "It is more calmer throughout the site, residents are more relaxed. We have seen a big difference as residents settle better by not having so many residents. They calm easier and staff are trying hard to get back on track." This showed us that staff were committed to support the management in place.

Staff believed that they were involved with the service and could influence developments. One said, "There is now stronger management, you can approach them. Mostly they listen and they follow through most times. I do feel fully supported, not by just the management but by the girls who work here." Staff told us they had regular access to staff meetings and most had supervisions where they could air their views. They told us these meetings were informative and helpful at improving communication across the houses. There was only three staff meeting minutes available to review which had taken place in the last year. These contained feedback from CQC inspections. Updates regarding changes in policy and procedures related to staff leave, uniforms and training updates. Staff were reminded often in staff meetings and communication record books viewed to check people were sufficiently hydrated by offering regular access to drinks. This showed us that staff meetings were used effectively and were a vehicle to help the service improve.

Each house had a designated unit manager responsible for the day to day management of their house and a deputy manager. However, we noted that the unit manager had only six hours per week where they were not expected to be allocated to the rota to allow them time to accomplish staff supervisions, manage the staffing rota, update care plans and complete audits of their houses. Deputy unit managers did not have any supernumerary hours allocated to them even when the unit manager may be on leave. Unit managers were nurses who told us, and rotas confirmed, that they often lost their six hours non-clinical time to manage the

staffing rota taking action to cover vacant shifts arising from nursing staff shortages.

One unit manager told us they could not remember the last time they had any supernumerary hours. They confirmed that six hours were allocated each week but with the need to cover for vacant nurse shifts they did not get the hours as they should. We asked how this impacted on their ability to complete the delegated tasks. We were told they did not always have the time to supervise staff and have time to think about how to plan for improvement of the unit they were responsible for. This lack of management time would impact upon the service if not resolved before the service went back to full capacity. We were given assurances from management within BUPA that this would not be the case as recruitment was ongoing.

The manager was able to tell us about the improvements that they had made. This focussed around the recruitment of staff and in particular the recruitment of nurses. This coupled with managing sick time that had been reduced meant that people had an increase in the same staff supporting them than at our previous inspections. One staff member said, "Staffing is a lot better, we had better sickness over Christmas, staff seem better organised and they know what they are doing." People at the service had felt the impact of more regular staff. One person said, "It is a lovely place and staff very helpful."

The manager spoke about the quality assurance processes that were in place. Each house had been completing an audit of medicines on a monthly basis. The conclusion drawn from these were that for two houses there were thorough audits taking place that showed learning, but for Gippeswyk due to the lack of leadership this was more patchy. Where there had been medicine incidents we saw that there had been appropriate onward reporting with appropriate investigations in place. One was currently ongoing.

The manager said that they were well supported with regular visits from senior managers within BUPA. Senior managers visited the service both planned and unplanned and take time to evaluate the service on offer for themselves. These evaluations then produced a report that rated the service Red, Amber or Green. Anglesea Heights had been rated as Red and at the time of this inspection was currently at Amber based upon the services own inspections and rating systems.

The manager spoke of the differing levels and audits that had been completed using the BUPA tools provided. Infection prevention and control audits had been completed. We saw a corresponding action plan was in place with some actions already completed to improve the service. A health and safety audit had been completed with an action plan in place. The previous week a whole fire drill for the home had taken place. We were told that this had thrown up some issues that required to be addressed and the managers were actively working on solutions.

The manager told us about how they and BUPA monitored the impact of what they termed 'metrics'. These were statistics that were for incidents such as, pressure ulcers, mortality, medicine errors, GP reviews, bedrails in use, safeguarding made, infections and care plans reviewed. Issues with care plans had been highlighted in a recent audit and concurred with our findings in this report. The service had a 'Home Improvement plan' in place with actions identified to resolve matters. This was steadily being worked upon and resourced.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not consistently managed safely.