HC-One Limited

Victoria Park (Coventry)

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

Summary of findings

Overall summary

We carried out an inspection of Victoria Park on 28 July 2016. The inspection was unannounced.

Victoria Park provides accommodation with personal care for up to 32 people. There were 25 people living in the home at the time of our inspection. Some people were living with dementia.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager left in June 2016.

The service was last inspected on 4 February 2015 when we found a breach in regulation in relation to staffing arrangements. We asked the provider to take the necessary steps to ensure the required improvements were made. At this visit we found improvement had been made in this area. People told us they felt safe living at the home and there were enough staff on duty to meet their needs. Staffing arrangements had been reviewed and changes had been made to ensure there were enough suitable staff employed to meet people's needs.

At our last inspection we recommended the provider sought advice and guidance in relation to assessment of mental capacity and best interest decisions because where there was a doubt a person had capacity to make a decision an assessment of their capacity had not been completed. During this visit improvements had not been made. The provider was not compliant with their responsibilities in relation to the Mental Capacity Act (2005) and where people lacked capacity to make decisions, action was not being taken to ensure they were appropriately supported. This meant the rights of people who were unable to make important decisions were not protected.

Risks associated with people's care were not always identified, documented or managed well to ensure a consistent approach to the management of risks. Incident and accident forms were not always completed so analysis and action to reduce the recurrence of these could be taken.

People had some concerns about how they received their medicines. Medicines were not consistently managed or administered safely, which meant people did not always receive their medicines as prescribed. We could not be sure that the disposal of medicines was safe. We received mixed feedback from people and their relatives about the management of the home. The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. Both the provider and the temporary manager (known as a 'turnaround manager'), were committed to making on-going improvements to ensure people received care and support that met their needs and preferences. We refer to the turnaround manager as the manager in the body of this report.

Procedures were in place to protect people from harm. Staff had an understanding of what constituted

abuse, but some staff needed to refresh their knowledge by completing safeguarding training. The provider had taken measures to minimise the impact of unexpected events for example, fire.

New staff received an induction when they first started their employment at the service and training in health and social care to develop their skills further. However, we observed some staff did not always put their learning into practice.

Recruitment checks were carried out prior to staff starting work at the home to make sure they were suitable for employment.

People told us they enjoyed the food and told us they were able to have drinks and snacks throughout the day. We could not be sure people whose dietary and fluid intake required monitoring received enough to eat and drinks as records were not always completed correctly. People were referred to health professionals to ensure their health and well-being was maintained.

Overall, staff members demonstrated a caring approach. People and their families were positive about the care being provided by some staff. Staff supported people to make choices and some staff knew the people they cared for well.

People were encouraged to maintain relationships important to them. Staff respected people and treated them with dignity. Staff recognised the importance of promoting people's independence and people were satisfied with the social activities provided.

Care records required more information to ensure people received personalised care. Records were not always reviewed in-line with the provider's procedures and it was not clear if people were consistently involved in the planning and the review of their care.

People and their relatives had the opportunity to get together formally to feedback any issues or concerns. People, visitors and staff were encouraged to give their feedback about the quality of service within the home. People knew how to make a complaint if they wished to do so.

We found a number of breaches of the Health and social care Act 2008 (Regulated activities) Regulations 2014. 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 consistently safe.

People told us they felt safe and some procedures were in place to protect people from harm. However, some staff members needed to refresh their safeguarding knowledge by completing training. Staffing levels were sufficient to meet people's needs. Risks associated with people's care were not always identified, documented or managed well to ensure a consistent approach to the management of risks. Incident and accident forms were not always completed, so action could be taken to reduce their recurrence. Medicines were not consistently managed or administered safely. The provider's recruitment procedures minimised the risk to people's safety. The provider had taken measures to minimise the impact of unexpected events.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was not compliant with their responsibilities in relation to the Mental Capacity Act (2005) and where people lacked capacity to make decisions, actions was not being taken to ensure they were appropriately supported. Staff were supported to develop their knowledge and skills to meet people's needs, but some training was not always put into practice. New staff received an induction which supported them in meeting the individual needs of people. People were provided with a choice of food and drink and staff demonstrated some knowledge of people's nutritional needs. People were referred to healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives were positive about the permanent staff, but were dissatisfied with care provided by some temporary staff. Overall, people were supported by a staff team who were patient and treated people with kindness. People were encouraged to maintain relationships important to them. Staff respected people and treated them with dignity. Staff recognised

the importance of promoting people's independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not always responsive to people's needs. Some staff knew the people they cared for well. Staff supported people to make choices and people were satisfied with the social activities provided. Care plans required more information to ensure people received personalised care. Care plans were not always reviewed in-line with the provider's procedure and it was not clear if people were consistently involved in the planning and the review of their care. People and their relatives had the opportunity to formally feedback any issues or concerns and they knew how to make a complaint if they wished to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manger was not in post however a temporary manager was in post. We received mixed feedback from people and their relatives about how the home was run. Staff told us the temporary manager was approachable. The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. Audits and checks were completed, but these were not always effective to benefit the people who lived there. People, visitors and staff were encouraged to give feedback about the quality of service within the home.

Victoria Park (Coventry)

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 28 July 2016 and was unannounced. This inspection was undertaken to follow up previous concerns we had identified and to make sure the required improvements had been made.

The inspection was carried out by two inspectors and a pharmacy inspector.

We reviewed the information we held about the home. We looked at information received from agencies involved in people's care and spoke with the local authority commissioning team who told us they had last visited in July 2016. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They told us they had visited to discuss specific safeguarding concerns.

We analysed information such as statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We looked at four care records and other associated documentation such as people's risk assessments and medicine records. We looked at the complaints information, staff training records, accidents and incident records and quality monitoring information.

We spent time observing how staff interacted with people in the home. We also used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who were not able to talk with us. We also completed observations during the day, including mealtimes in the dining room and the lounges to see what people's experiences of the home were like.

We spoke with eight people who used the service, one person's relative, a visiting professional and nine staff members including the assistant operations director, the manager, a senior care worker, the activities co-ordinator and five care staff.

Requires Improvement

Is the service safe?

Our findings

During our last inspection at Victoria Park in February 2015 we identified there were not sufficient staff with the knowledge, experience, qualifications and skills to support people.

This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the visit the provider sent us an action plan outlining how they would make improvements to their staffing arrangements. They told us they would increase the number of staff on duty and review staff rotas to ensure staff with sufficient knowledge and skills were available to support people. They told us they would also employ an activities co-ordinator. All new staff would be assigned a mentor to support them with their probationary period and the training that staff completed would be reviewed. The registered manager would undertake more frequent supervision of staff practices and monthly meetings with staff would be held to ensure staff were aware of their responsibilities.

During this visit staff told us there were enough of them to keep people safe. Comments included, "There is enough staff, we can get everything done." And," It has been a lot better lately because there is an extra carer downstairs." We saw improvements had been made. On the day of our visit we saw there was enough staff on duty to provide the support that people needed. There were two senior care workers, four care assistants and an activities co-ordinator on duty. The assistant operations director explained that one of the senior care workers was in addition to the rota and this change had recently been implemented as the registered manager had left in June 2016. They said, "Staff told us there was not enough of them and we listened." They told us the provider had staffed the home to above the required levels to ensure people were kept safe and one of the provider's managers was supporting the home until a new registered manager was recruited.

During this visit we found risks associated with people's care were not always identified, documented or managed well. For example, we saw in one person's records they had been assessed by a health professional in May 2016 because they were at risk of choking. The assessment had identified they required their fluids to be thickened to reduce the risk however staff were not doing this. The person's risk assessment had last been reviewed on 2 July 2016 and stated staff were awaiting a thickener. No action had been taken to follow this up and this posed a risk to the person's health. Some staff did not know the fluids needed to be thickened. For example, a member of staff said, "[Person] doesn't need thickened drinks." Another said, "We give [Person] orange juice whilst we are waiting for the thickener to be delivered." We discussed this with a senior care worker who immediately contacted the person's GP and made arrangements for it to be delivered by the pharmacy.

A member of staff told us about another person. They said, "Sometimes food gets stuck in [Person's] throat." We looked at this person's care records and a risk assessment was not in place. We saw a referral to a health professional had been made, but the person had refused this support. It was not clear what other options to reduce this risk had been considered.

One person smoked cigarettes and we observed cigarette burns on their clothing. Staff told us about this, "[Person] puts their face up in the air whilst smoking. It (cigarette ash) drops on their dress." We saw staff supervised the person whilst they smoked, but this was not reflected in the person's care record or risk assessment. We could not see that additional safety measures had been implemented to keep the person safe from burns. We discussed these concerns with the manager and the assistant operations director. They told us they would review people's risk assessments immediately.

Accidents and incidents were reviewed by the provider's management team who took action to reduce the risk of them happening again. However, records showed not all accidents and incidents had been documented by staff. For example, on 10 July 2016 a person had tripped over another person's walking frame and on 19 July 2016 the same person had grabbed a staff member which had potential to cause them harm. Incident forms had not been completed in both these instances.

Prior to our visit, we had received information of concern in relation to how people's medicines were being administered. This related to people not always receiving their medicines, and other people being given the incorrect amounts. During our visit we found some concerns around administration, storage and disposal of medicines.

People voiced their concerns about how they received their medicines. One said, "They (staff) are supposed to ask me, I have said, don't keep slipping in the paracetamol. The agency staff do this, but I count them now first to see how many before taking the medicine." Another said, "I was a little annoyed last week. I had to wait 18 hours from 9pm Saturday to 3pm on Sunday for pain relief because of the agency staff. Normally my tablets are fine."

We observed two medicine rounds and saw medicines were not consistently managed or administered safely and staff did not always follow good practice. For example, one member of staff took medicines to people, provided them with a drink and watched them take their medicine before returning to sign the medicine administration record (MAR) to confirm they had taken it. However, another put medicines into a cup, signed the MAR chart and then took it to the person. This was repeated for three people. They told that this was 'usual practice' and that if the person didn't take the medicine they would alter the front of the chart to reflect this and annotate the back of the chart. We bought this to the attention of the assistant operations director as this was not good practice and using different systems posed a risk that medicine would not be given correctly.

We reviewed nine people's medicine records. Most medicines had been administered as prescribed. However, records showed one person had not received a medicine the day before our visit and this had not been identified. Also there had been one other missed dose since the medicine had last been checked. Not receiving the correct medicine posed a risk to the person's health. Additionally, the quantity of the medicines, held in stock for this person, did not correspond with the records recorded by the staff. Therefore the balances were not accurate and the medicine was unaccounted for.

Two people required injections administered by a district nurse. Records showed us one person had received these as prescribed. However, the other person had not. We saw a hospital discharge letter on their file dated January 2016 stating how it needed to be administered and that the home's staff were responsible for arranging this. The injections were not recorded on the person's MAR chart, staff had not checked whether the medication had been administered and they were not aware of the injections being in the refrigerator until we brought this to their attention. After we raised this, the senior care worker contacted the person's GP to make the necessary arrangements for the injections to be administered in the future.

Some people were prescribed 'as required' medicines. These are medicines that are prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. Protocols for medications informed staff when and why the medicine should be given and were in place for eight of the nine people's we looked at. However, one person was prescribed medicine as required to reduce their anxiety. There was no information to inform staff of when they needed to administer this medication.

We could not be sure that the disposal of medicines was safe. For example, we saw two bags of medicine on a shelf in the downstairs medication room. It was not clear what the medicine was, from the information written on the bags. We also found another bag containing medicine on the floor underneath a medicine trolley. The senior care worker explained they were ready to be returned to the pharmacy to be destroyed. In another medication room we saw an empty a carton of medication placed in a normal waste bin. We discussed this with the assistant operations director who told us they would take immediate action to make improvements.

Medicines that require additional controls because of their potential for abuse (Controlled drugs) were stored securely and were being checked correctly. For example, checks had been completed daily and double signatures were observed. However, further improvement was required because some entries had been altered, crossed out and were illegible.

Prescribed creams were stored in people's bedrooms however, these were accessible to people who lived with dementia, which posed a risk. Creams were applied by staff, but the plans to ensure these were applied as prescribed were not sufficient. For example, risk assessments had not been completed, not all creams had a chart, and those that did were not always applied regularly.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were clear and effective systems and processes of ordering and receiving medicines and we discussed the administration of medicines with the manager and the assistant operations director. They had already identified that the administration of medicines required improvement. The assistant operations director said, "We know what the problems are, we are in control of the situation, improvements are underway." Some staff had been disciplined by the provider for not following procedures correctly. They explained how they had already begun to liaise with people's GP's to commence medicine reviews to try and reduce the amount of medicine people were prescribed. Also, two staff members were now allocated to administer medications instead of one which shared responsibility and reduced the risk of further errors occurring. We were aware that the pharmacy who supplied medicines had visited two days before our visit to complete an audit and the provider's pharmacist had visited the day before to support and advise the home on how to make the required improvements.

People told us they felt safe. One said, "There is no problem about my safety here, everything is fine." Another told us, "I am not worried at all here, I think the home is safe. They let you know if there are any faults or anything."

The provider's recruitment procedures minimised the risk to people's safety. New staff members were subject to checks to ensure they were of good character and suitable to work at the home. Records confirmed these checks were in place before they started work. They included a Disclosure and Barring Service (DBS) check and written references. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.

The provider had taken measures to minimise the impact of unexpected events. Staff received training in the provider's emergency procedures. However, we saw some staff required their training to be updated in-line with the provider's policy. The fire procedure was on display in communal areas of the home which provided information for people and their visitors on what they should do in the event of a fire. Each person had a personal emergency evacuation plan which detailed their individual needs for support in an emergency. This should ensure people could be assisted to evacuate the building safely if required. A service contingency procedure was in place. Therefore, if there was disruption within the home due to an unexpected event people received continuity of care.

Procedures were in place to protect people from harm. For example, we saw the provider's safeguarding procedure was accessible to people, their visitors and staff so they could report if they felt unsafe. Records showed appropriate and timely referrals had been made to the local authority as required to ensure people were protected and potential abuse was correctly investigated. Staff described their understanding of safeguarding to us and comments indicated they understood their responsibilities to report concerns to keep people safe. Comments included, "Safeguarding could be neglect, not filling in food and fluid charts, not getting someone dressed," "Safeguarding means patient safety, correct use of equipment." And, "I would report it to the senior or manager or HC1 (provider)."

However, records showed that some staff needed to refresh their safeguarding knowledge by completing training in-line with the provider's policy and one member of staff told us they had not received any training but records confirmed they had. We raised this with the assistant operations director.

The provider's whistle blowing policy and contact telephone number was on display for staff (a whistle blower is a person who raises concerns about wrong doing in their workplace). Staff confirmed they were confident to raise concerns if they witnessed poor practice. One member of staff said, "If there is anything I cannot talk to the manager about, you can call the whistle blowing number for HC1".

Regular checks were carried out to ensure the building and the equipment were safe for people to use. For example, fire extinguishers were serviced annually and had last been checked in September 2015. A maintenance person worked at the home to undertake general repairs and complete the checks.

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 this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last visit we found the provider had not always sought advice and guidance in relation to assessment of mental capacity where there was a doubt that a person had capacity to make a decision. This posed a risk people may not have been supported correctly under the principles of MCA. At that time the registered manager assured us they would take appropriate action to address this.

During this visit we found improvements had not been made. Staff told us some people who lived at Victoria Park lacked capacity to make their own decisions but capacity assessments had not been completed. Therefore, the provider was not working within the principles of the MCA and the rights of people who were unable to make important decisions were not protected.

For example, records showed one person frequently refused assistance from staff to maintain their personal hygiene. In July 2016 their care record stated they had a 'cognitive impairment'. The person had sore skin and had also refused assistance from health professionals on several occasions to help them manage their health. It had not been documented or explored whether the person had the capacity to make this decision, understood the risks or whether a best interests meeting was required. This had an impact on the person's health and wellbeing.

At the time of this visit two authorised DoLS were in place because people's freedom of movement had been restricted in their best interest. However, we saw one person who did not have an authorisation was restricted by staff when they tried to leave. Staff told us they did this for the person's 'own safety' but a DoLS had not been considered. A professional who visited the person during our visit said, "[Person] needs more freedom, it's not working here." We discussed this with the assistant operations director who told us an application to the supervisory body would be completed straight away.

One person often refused to take their medicines and staff told us they did not have capacity to make this decision. The home's staff had contacted the person's GP in June 2016 who had advised one medicine could be put into water or juice to ensure the person took it. Records showed this medicine had been administered covertly. (Covert medication is the administration of any medicine in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the person is unknowingly taking their medication.) However, the person had not been involved in making this decision and a capacity assessment had not been completed. Therefore, we could not be sure if the person lacked capacity or if they were able to understand the risks to their health if they did not take their prescribed

medication. Administering medicine to a person who does have capacity is a breach of their human rights.

Despite training records confirming nearly all staff had completed training around mental capacity it was not effective. Some staff did not demonstrate an understanding of the key requirements of the MCA. For example, we asked a member of staff if a named person had capacity to make their own decisions. They said, "No, [Person] has no capacity, they can't make choices." However, at lunch time we saw the person chose where they wanted to sit in the dining room and chose a meal they would like to eat. Therefore, this person did have capacity in some areas. This same person had refused to sign to give consent to be photographed in June 2016. We saw their photograph was attached to their file. We bought this to the attention of the manager and assistant operations director as this further demonstrated staff did not understood the principles of the MCA.

This was a breach of Regulation 11 (Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us staff had the skills and knowledge to care for them effectively. Comments included, "I think the staff are very good." And "The staff seem trained; they come quickly when you call them."

During our last visit staff told us they didn't always have time to complete their training. The registered manager had acknowledged that some improvements in the delivery of training to staff was required. Records showed some improvements had been made. For example, 85.2% of staff had completed all of their training and had completed, or were working towards level two or three qualifications in health and social care. This meant staff should have the right skills and knowledge to provide effective care and support to people. The assistant operations director explained staff were being allocated time to complete any out of date training in the next few weeks.

Staff told us they had also completed training that supported them to understand and meet some people's specific needs. For example, records showed and staff confirmed they had received training in dementia and Parkinson's disease. Staff explained this training was useful and had increased their knowledge. They felt this had helped them to understand the conditions which had benefited the people who lived at the home. However, staff voiced their concerns about the quality of some of the training. One said, "Sometimes the training is useful when in a group, with Touch training (training completed on a computer) it can be too much to read it, it is not as effective." Another said, "It's all reading and answering questions, nothing face to face." We bought this to the attention of the manager and the assistant operations director.

Staff told us they had received an induction, to ensure they understood their roles and responsibilities when they started working at the home. One new member of staff said, "This is my induction week. I have been getting to know the residents. I had a walk around, did some training on-line. I have been doing the workbook for the Care Certificate. I've got to know most people upstairs and downstairs." (The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected).

Handover meetings took place at the beginning of each shift as the staff on duty changed to ensure people were cared for consistently and effectively. We saw this happened during our visit. The health and well-being of each person living in the home was discussed and changes were communicated. A 'flash meeting' also took place each day. During the meeting the heads of department within the home discussed issues and shared information about the service. A selection of 'handover records' were looked at. Changes in people's needs and appointments people had attended were documented and communicated to staff.

People told us they were satisfied with the food provided and they were given a choice of food and drinks that met their dietary needs. Comments included, "I like the food. It's very nice, especially the dinners." And, "I like the food, I've got no complaints." Snacks which included fresh fruit and drinks were available throughout the day.

Staff demonstrated some knowledge of people's nutritional needs. For example, they knew who needed encouragement to eat and who was diabetic. However, we identified that people did not always receive the support they required to consume their drinks. For example, thickener was not used when it was required.

At lunchtime, we observed the mealtime experience in the downstairs dining room was positive for people. A choice of drinks were available and there were two meal choices. We saw one person asked for a meal which was not on the menu and this was provided. People were asked verbally which meal they would prefer. Staff encouraged people to eat their meals and people were provided with adapted cutlery and plate guards to help them eat their meals independently.

Where people were at risk of dehydration or malnutrition this was identified through the risk assessment process. Some people needed their food and fluid intake monitored by staff using a chart system. We looked at a selection of these records and they had not been completed consistently to ensure people had received sufficient nutritional intake to maintain their health as accurate quantities had not being recorded. For example, fluids were not totalled and 'half,' or, 'quarter' of the food consumed was written but the original quantity was not recorded. We discussed this with a senior care worker who told us they would bring it to the attention of the manager.

People's records showed us how the home's staff worked in partnership and maintained links with health professionals. Where changes in people's health were identified they were referred to the relevant healthcare professionals including their GP. One person told us, "The district nurse comes in twice a day. They check my toes and heels. Staff sort it out if anyone needs to come in." Another said, "The doctor has come out and seen me twice." This meant people who lived at the home received health care to meet their needs.

Requires Improvement

Is the service caring?

Our findings

People and their relatives spoke positively about the permanent staff who worked at the home. Comments included, "I get on great with all the girls." "They are really kind and nice, very much so." And, "The regular girls work hard. I get on well with them, we have a joke together." A relative said, "The staff are brilliant."

However, several people were not satisfied with the temporary (agency) staff. One person explained in detail to us why they were unhappy. They said, "There are so many changes, you get a lot of agency staff. They don't know their job. One asked me where to put a bed pan, I was flabbergasted." And, "To get a shower is a problem. I can't get one a week." This did not demonstrate personalised care. We discussed this with the assistant operations director. They told us agency staff had had to be used temporarily as some staff had left the home and others had been dismissed. They explained the use of bank staff and regular agency workers were used to try and ensure consistency for people. However, the recent recruitment of new staff would decrease the number of agency staff that were used in the near future once recruitment checks had been completed.

During our last inspection we observed staff were busy, and interactions between people and the staff were limited. During this visit improvements had been made. We observed people were supported by a staff team who were patient and treated people with kindness. We spent time in the communal areas and the atmosphere was calm and relaxed. We saw staff had time to sit and chat with people. People confidently approached staff for assistance when they needed it. This showed us they trusted the staff.

All the staff we spoke with showed concern for people's wellbeing. This included staff who were not directly involved in providing care to people. For example, the administrator made two people a cup of tea and offered them biscuits during the afternoon. The people responded well to this and one said, "How lovely, she is so kind to me."

People were encouraged to maintain relationships important to them. People told us their visitors were welcome at any time. One person said, "My family love it here." We saw visitors stayed for long periods of time during the day to support their relations and provide company for them. We saw there was a payphone that people could use to make phone calls and a member of staff told us, "People are very welcome to use the cordless telephone if they want to make phone calls in private."

Staff treated people with dignity and respect. For example, they addressed people by their preferred names. We saw staff knocked people's bedroom doors and waited for permission before they entered. Staff were aware of people's right to privacy and provided support in a dignified way. A member of staff explained to us how they provided this support. They said, "With personal care, we shut the door, close the curtains, use two towels to cover people up. If someone goes to the toilet, we will close the door and ask them to press the button (call bell) when they are ready." However, on one occasion we saw a person sitting on the toilet with the door wide open. We alerted staff to this and they promptly closed the door. In this instance it did not provide the person with privacy or dignity. We bought this to the attention of the assistant operations director.

Staff recognised the importance of promoting people's independence. One said, "Everyone is different, people are all individuals." Our discussions with people indicated they chose how they wanted to spend their time. Comments included, "The care here is good, they help us if we need it, but leave me if I can do it." "They are easy going here, I've sat in the lounge half the night before watching TV." And, "They leave you to it, you're the boss." We noticed that clocks and calendars showed the correct date and time, which supported people to stay orientated in time and promote their independence.

We saw staff encouraged people to walk around the home throughout the day. For example, during the afternoon a hairdresser visited the home. A member of staff said to a person, "Come on lets walk together to get your hair done, you know you can do it." The person responded well to this. They laughed and said, "Come on then, let's do it." We saw bedrooms were individually decorated and people had their personal items on display. One person showed us their bedroom. They told us. "I have all my own furniture. My room is how I like it, it's homely, and it's like a battlefield! I like it."

Information about a local advocacy service was on display should people wish to use this service. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to help them to make a decision.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we found that the service was not consistently responsive to people's needs. During this visit we saw some improvements had been made, however temporary staff did not always know people well. Permanent members of staff we spoke with knew the people they cared for well and how to support them. Staff could tell us about some people's preferred routines and how they liked to spend their time. We saw staff were attentive for example, one person asked for a cushion to sit on because they were uncomfortable and this was quickly provided.

Despite this, discussions we had with some people and their relatives indicated that staff were not always responsive to their needs and this meant they did not always get the support they required. Comments included, "They (staff) are too busy," and, "You can't keep a routine (with agency staff)."

A permanent member of staff commented, "Agency staff don't want to do paperwork, they don't know about the residents." An agency staff member we spoke with was not able to explain people's basic needs to us. They told us they would ask a more experienced member of staff or read a person's care records if they were unsure of the help they needed.

We discussed this with the assistant operations director who said, "There have been unavoidable staff changes but, we feel more in control of things now." They explained some staff had left and others had been dismissed. New staff had recently been recruited and there was only one vacancy remaining. Until the new staff started work at the home agency staff were being used. To supplement the permanent staff team 'bank staff' were employed. These staff members provided cover for shortfalls in staffing and staff absences. A 'bank' employee was on duty during our visit and knew the risks associated with people's care. This meant people were supported by staff who knew them well.

Staff told us how they supported people to make choices and we spent time in communal areas and saw some staff members had a good understanding of the way people preferred to communicate. For example, we saw one care worker held discussions with people in Punjabi as their first language was not English. The care worker explained how speaking in Punjabi made it easier for the people to communicate their choices.

Prior to admission to the home, people were assessed to determine their level of independence and care needs. People's records reflected assessments had taken place. The turnaround manager explained this process was important as it made sure the home was the right place for the person to live and to ensure people's needs could be met. Historically, all assessments had been completed by the home's registered manager. In the future they explained to us how assessments would also be completed by senior care workers. They told us how they were going to support staff to develop their skills to do this. This meant that assessments could still take place if the registered manager was unavailable and the home would be more responsive as it would 'speed up' the admissions process for people.

We looked at four people's care plans which contained some detailed information about people and was presented in a personalised way. For example, people's likes and dislikes and life histories were

documented but it was not always clear how the person had contributed to the information. Adequate information was documented so staff could meet people's basic needs but more information was needed to be added to ensure people received personalised care in accordance with their preferred routines. For example, in one person's care plan it stated, 'Requires assistance with personal care,' and, 'Requires assistance to eat.' There was no further information available to assist staff to know how this person liked their assistance to be provided.

However, staff had good knowledge of the person's needs and described to us how they supported them. They said, [Person] prefers a shower and they wash their own hands and face, I always ask them what help they need." We discussed this with the assistant operations director. They were aware that care plans needed to be more detailed to provide 'personalised care.' They explained that making improvements to people's care plans was a priority and the turnaround manager would be supporting senior care workers to add more information in the next few weeks.

Care records were not always reviewed in-line with the provider's procedure. We were told by several staff members that people's care records were reviewed when they were, 'Resident of the day' and this was once a month. Records showed us this did not always happen and we saw information was not always accurate. A member of staff did not know who the resident of the day was despite this being communicated to staff at the handover meeting earlier in the day. The manager was aware that some people's records needed to be reviewed to ensure they reflected people's current needs and preferences. They said, "You are not telling me anything I don't already know." They explained reviewing people's records was a current priority and they would be making improvements in the near future.

Some meetings to review people's care took place, however we were unsure if these were regular. One person said, "There have been no reviews at the home. I have [family members] who would come." Another commented "I don't have meetings." It was not clear if people were consistently involved in the planning and the review of their care. However, for one person it was documented that their relative had attended a review meeting in March 2016.

People and their relatives had the opportunity to get together formally to feedback any issues or concerns every three months. Minutes from the last meeting were on display in a communal area alongside future meeting dates. We noticed meetings were planned to take place at weekends to provide flexibility to people. The home's administrator said this was to, "Try and improve attendance and gather more views as only two relatives had attended last time."

During our last visit we saw there were limited activities taking place for people to enjoy. We saw improvements had been made and overall, people were satisfied with the social activities provided. We saw a varied activities timetable on display. One person told us, "There is not a lot to do, it does not bother me, I play bingo and knit." Another said, "Activities are ok." On the day of our visit some people joined in with armchair aerobics whilst others chose to decorate biscuits. We saw one person was knitting a jumper and another chose to complete a crossword puzzle.

Since our last inspection an activities co-ordinator had been employed. They explained they offered individual and group activities to people. They said, "I go in quite a lot to people (in their bedrooms), I have a chat, see what they want to do each morning. We might listen to background music. I sometimes do hand and nail care." They further explained how activities that were supportive to people living with dementia were available. For example, one person enjoyed completing housework tasks and a member of staff explained how they had provided the person with a bowl of water and a cloth so they could 'clean.' They went on to say, "We have a book about Coventry, we look at old pictures together, it triggers conversations.

We also do 'let's get talking,' we talk about things like how people spent their first wage, their favourite colour."

People knew how to make a complaint and these had been recorded and responded to. One person told us, "I have no complaints," another said, "I am happy with everything." A system was in place to manage complaints and the complaints log confirmed one complaint had been received in 2016 which had been in relation to no toilet paper being available. The complaint had been responded to promptly and in accordance with the provider's policy. A variety of thank you cards had been received and comments included, 'Thank you so much for everything.' And, 'Thank you for being so kind and caring with mum.' This showed us that people were, overall, happy with the service provided.

Requires Improvement

Is the service well-led?

Our findings

Processes to identify risks related to the health, safety and welfare of people living in the home were not sufficient to ensure people were safe. For example, a risk assessment was not in place for one person who chose to smoke and we saw burns on their clothing. We were assured by the turn around manager that risk assessments would be implemented immediately. Following our visit a copy of the risk assessment was provided to us.

The manager told us quality audits and checks were completed to improve the quality and safety of services provided to people. We saw quality assurance systems were in place and checks had taken place. However, these checks were not always effective in identifying concerns. For example, monthly medicine audits had not identified a person had not received their prescribed injections for six months. Staff did not always follow good practice when administering medicines and medicine was not always disposed of safely.

Despite training records confirming nearly all staff had completed training, it was not always effective. Staff understood their responsibilities to protect people but records showed that some staff needed to refresh their safeguarding knowledge by completing training. Accidents and incidents were reviewed by the provider's management team who took action to reduce the risk of them happening again. However, it had not been identified that some accidents and incidents had not been documented by staff.

At our last visit we found the provider had not always sought advice and guidance in relation to assessment of mental capacity. During this visit we also found the provider was not working within the main principles of the Mental Capacity Act. Staff could not demonstrate an understanding of the key principles of this.

The arrangements to check the quality of people's care plans were not effective. A number of care plans were out of date and did not contain sufficient detail to support staff in delivering person centred care that was safe, appropriate and in accordance with people's preferences and wishes. Care plans were not always reviewed in-line with the provider's procedure and it was not always clear if people were consistently involved in the planning and the review of their care.

This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

There had been an inconsistency of leadership at the home. A registered manager was not in post and the home had had two registered managers within the last 12 months. A member of staff commented, "It would just be nice to have a permanent manager." Another said, "There has been no leadership so everyone is trying to take charge." They explained this had had a negative impact on staff morale. We discussed this with the assistant operations director. They said, "We are trying to recruit a new manager, we need a strong leader. So far we have interviewed three candidates and we are interviewing three more next week."

People told us about the management of the home. Overall, people were happy, but they were not satisfied with the agency care staff used. Comments included, "All I know with the managers is the last one went on

holiday, I learned she was not coming back. Then the deputy resigned. I don't think the manager got enough help. The head office is at fault a lot." "The staff are not happy; they think they are not looked after as they should be." And, "The head people are supposed to be sending someone to see what is going on."

One person's relative told us, When my [Family member] came here it was fantastic. Things went downhill; they have pulled it around in the last few days. The lack of staff created the problem, I am here every day. I knew things were getting worse, but today and yesterday it has been better."

Staff told us they enjoyed working at the home and the manager was approachable. One staff member said, "It has been quite stressful here, but it has been okay. I would be able to talk to staff if I had a problem. If you have a problem you can talk openly with the manager."

The provider's temporary management team consisted of a manager and senior care assistants until a new registered manager and a deputy manager were recruited. Support was provided to the managers by the provider's assistant operations director who visited the home weekly to provide on-going support, drive forward improvement and complete compliance audits. The manager told us they felt supported by the assistant operations director. They said, "She (assistant operation director) is there if I need her, we speak on the phone every day." They explained when they arrived staff morale was low and this could have impacted on the people living there. They said, "I am committed to making improvements to benefit the people and the staff."

Records showed that daily 'walk arounds' by managers took place. We observed the turnaround manager spent time in the dining room at lunchtime and visited people in their bedrooms. This approach ensured managers had an overview of how staff were providing care and support to people and gave them the opportunity to speak with people and staff.

We saw some good examples of team work and communication between the staff team and the manager during the visit. For example, we saw staff confidently approached the manager who provided them with support and advice. We looked at communication processes which included handover records, a staff newsletter and communication books. This showed that staff could pass on information and receive important messages from the management team.

Staff had team meetings which gave them the opportunity to meet with managers and contribute their views on the running of the home. They said, "Meetings happen," and, "Yes, we get together as a team." Records showed us team meetings took place each month and we looked at the minutes from the last meeting in July 2016.One to one supervision meetings were completed to ensure staff were given opportunities to talk about their role, raise any concerns they had or discuss their training and developmental needs. One staff member said, "One to one meetings happen" and they told us these were useful.

The assistant operation director said they were, "Proud of the committed and hardworking staff team, it had been a difficult period." The provider had a process of recognising individual staff member's commitment with 'Kindness in Care' awards. A nomination box was located in the foyer of the home and staff who received the award were presented with a certificate and gift vouchers. Their photograph was displayed on the noticeboard in the entrance hall. We saw staff had recently been nominated by some relatives for, 'Demonstrating care, compassion and love at a time of need and for going beyond the call of duty.' One member of staff said, "We can nominate whoever we want to, it's a good thing to be recognised for working hard."

The management team encouraged feedback from people, their relatives, visitors and staff. Annual quality questionnaire were sent out in June 2016 to gather people's views on the service and 12 people had responded. We looked at the completed questionnaires, 92% of respondents thought the ambiance within the home was 'good' and 75% thought the home was managed well. One person had commented, 'Staff and managers are always willing to answer questions.' However, 58% said staff were caring 'sometimes'. Completed questionnaires were analysed to assess if action was required to make improvements.

We saw there was a 'Have Your Say' tablet computer in the entrance hall where people could give instant feedback about the quality of care and share any concerns they had. However, this was not working on the day of our visit.

The manager told us which notifications they were required to send to us so we were able to monitor any changes or issues within the home. We had received the required notifications from them. They understood the importance of us receiving these promptly and of being able to monitor the information we had about the home.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not compliant with their responsibilities in relation to the Mental Capacity Act (2005) and where people lacked capacity to make decisions, action was not being taken to ensure they were appropriately supported. Care and treatment was not always provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not consistently managed or administered safely as prescribed and staff did not always follow good practice. We could not be sure that the disposal of medicines was safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Processes to manage risks were not sufficient. Quality assurance systems were not always effective. The arrangements in place to check the quality of people's care plans were not effective.