Abbotsford Care Home Limited

Abbotsford Nursing Home - Manchester

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 August 2018 and was unannounced. At our last inspection in December 2017 we found multiple breaches of the regulations in relation to safe care and treatment, dignity and respect, consent, meeting nutritional and hydration needs, recruitment, safeguarding, person centred care, training, staffing and good governance. We rated the home inadequate and placed it in special measures.

At this inspection, we found that substantial improvements had been made and the provider was meeting the requirements of the majority of the regulations. However, we found an ongoing breach of regulations in relation to the safe management of medicines. We have made one recommendation, which is in relation to management of complaints.

Abbotsford Nursing Home – Manchester is a 'care home' that provides both residential and nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Abbotsford Nursing Home is located in a residential area in South Manchester. Local facilities and bus routes are within easy walking distance of the home and there are car parking facilities at the front of the property. The home accommodates up to 44 people in one adapted building. Accommodation is spread across four floors, with communal areas including a dining room, two lounges and activity room situated on the ground floor. At the time of our inspection there was a local authority suspension on placements at the home. This meant the home had reduced occupancy, and there were 26 people living there at the time of our inspection. The top-floor of the building was not being used for accommodation at the time of our site visit.

At the time of our site visit the manager was not registered with the CQC, and the service had been without a registered manager for over six months. However, the manager had recently re-submitted an application to register and their registration was completed during the course of this inspection.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were administered safely, and accurate records were kept. However, the treatment room was located on the top-floor of the home, away from where most people were administered their medicines. This meant that the medicines trollies were stored in the dining area during the day where the temperature the medicines were stored at was not monitored. It is important that medicines are kept at the temperature recommended by the manufacturer to ensure they remain effective.

We found that sharps containers, which are used for used needles for example, were kept on the medicines trollies in the dining areas when not being used. They were not kept securely, which would increase the risk of them being handled inappropriately and potentially causing injury. There was also an ongoing issue from our last inspection in relation to medicines administration records not being kept securely.

There were sufficient staff on duty to meet the needs of people living at the home. We saw people received the support they needed in a timely way throughout the inspection. The manager assessed staffing requirements using a dependency tool. Since our last inspection, the way staff were deployed had been changed to help ensure there was adequate staff support available during handovers and at night.

Staff assessed risks to people's health, safety and wellbeing. We saw risk assessments had in all but one instance been completed accurately. Staff took reasonable steps to help reduce the risk of people being harmed.

The provider was undertaking a continued programme of refurbishment. We found the home was clean, and the provider had received an overall green RAG (red, amber, green) rating during a recent external infection control audit. The provider had made some further adaptions to make the home more 'dementia friendly', although there was scope for further improvements in this area.

The chef was aware of, and met people's dietary needs and preferences. This included providing a choice of Chinese, Caribbean and Western dishes at meal-times. People told us they enjoyed the food on offer, and we observed that people received the assistance they needed to eat and drink.

Staff understood the basic principles of the Mental Capacity Act. We saw that decision specific capacity assessments and best-interest decisions had been undertaken as required. Staff had consulted with others involved in people's care, such as families when making best-interest decisions.

Since our last inspection, the provider had appointed a clinical supervisor. Their role was to carry out clinical supervision with the nursing staff and to assess their competence. We saw the manager also carried out competency spot-checks. We saw evidence that they had identified and challenged poor practice.

The home supported people from a range of cultural and religious background, including a proportion of people who were of Chinese origin. Reasonable steps had been taken to help ensure the service was meeting people's cultural and religious needs. One of the lounges at the home was decorated in a Chinese style, and the TV showed a Chinese language channel. There were visits from a range of religious groups.

Since our last inspection, the service had appointed a member of Cantonese speaking staff to act as an interpreter. The service was also actively looking to recruit further members of staff who could speak Cantonese. Other options to improve communication between staff and people living at the home who did not speak shared languages included the use of flash cards and translation apps.

People and relatives told us they found staff to be kind, caring and attentive. During the inspection, our observations supported these reports. We found staff interacted positively with people and communicated effectively and respectfully.

People had been involved in assessments and reviews of their care plans. Where it was of benefit to the individual, information in people's care plans had also been translated into Cantonese. Care plans provided details about people's preferences in relation to how they received care and support.

The activity co-ordinator had assessed people's likes, dislikes and interests to help provide them with personally meaningful and culturally appropriate activities. We saw a range of activities were provided, including one to one's where people accessed the local community, music afternoons, bingo and pamper sessions.

There had been one recorded formal complaint in the last year, which had been managed appropriately. We saw that key documents, including the complaints policy had been translated into Cantonese. Whilst most people felt able to raise any concerns they had, one person told us they had not reported their concern to the manager due to the language barrier. We have made a recommendation that the provider explores way to encourage and support people to make complaints.

There was an open an honest culture at the home. Staff told us the manager had discussed concerns raised during our last inspection with them, and what needed to be done to improve. Staff told us they would feel supported to report any incidents or mistakes and that they would be treated fairly. We also saw evidence from team meeting minutes that showed the manager encouraged open and honest discussions amongst the staff team.

The manager carried out a range of checks and audits to help them monitor and improve the safety and quality of the service. We found evidence that the checks had been effective in driving improvements in the service. For example, the manager had recognised a patter in accident/incident reports, which led to them changing the way staff were deployed, to help increase the available support in a certain area of the home.

The opinions of people using the service and relatives had been sought through the use of questionnaires, and direct conversations with the manager. The manager had sought to involve the input of people using the service and relatives to help drive improvements at the home.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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.

Medicines were kept in locked trollies in the dining area. The temperature they were stored at was not monitored. Sharps containers were kept insecurely in the dining area when not in use.

There were sufficient staff on duty to meet people's needs. We found one person did not have a call bell accessible to them, although they received regular welfare checks from staff.

Routine servicing, maintenance and checks of premises and equipment had been completed to help ensure their safety. However, we found materials inappropriately stored in one stairwell and the provider could not evidence all required checks in relation to the water system had been completed.

Is the service effective?

Good

The service was effective.

People were offered a choice of meal and received the support they needed to eat and drink. People told us they enjoyed the food on offer.

Staff had completed decision specific capacity assessments in relation to decisions about people's care and support. Families and others involved in people's care had been appropriately consulted about best-interest decisions.

The service supported people to access other health and social care services to meet their assessed needs. We saw the home worked with a range of other health professionals.

Is the service caring?

Good

The service was caring.

We received positive comments about staff from people living at the home and their relatives. Interactions we observed between staff and people living at the home were positive and respectful.

The home used a staff member as an interpreter to help ensure people who spoke Cantonese but not English could communicate their needs and wishes effectively.

Staff had taken reasonable steps to identify and meet the cultural and religious needs of people living at the home.

Is the service responsive?

Good

The service was responsive.

Care plans contained information about people's preferences, social histories, likes and dislikes. We saw evidence that people had been involved in their care planning and review.

People's preferences in relation to activities and occupation had been assessed. We saw a range of meaningful activities were provided.

People communication support needs were assessed. We found staff were aware of how to communicate effectively with people, including people who did not communicate verbally.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had not submitted a provider information return as we had requested. They told us they had not been aware of any request.

The manager's application to register with the CQC was completed during the course of the inspection. However, the home had been without a registered manager for over six months.

The service had made significant improvements since our last inspection. They had been supported in this process by two external consultants.

Abbotsford Nursing Home - Manchester

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 and 29 August 2018 and was unannounced. The inspection team consisted of two adult social care inspectors 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. The expert-by-experience had experience of supporting a person who used nursing home services. They were also fluent in Cantonese and so able to translate and speak with people living at the home who spoke Cantonese as a first language.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports, action plans and reports sent to us by the provider, and notifications of significant events such as deaths, safeguarding and serious injuries that the service is required to send to us. We reviewed any feedback we had received since our last inspection from people using the service or their friends/relatives.

We sought feedback from the local authority quality and contracts monitoring team and Manchester Healthwatch. The quality and contracts monitoring team fed-back that they had received positive feedback in relation to improvements made at the home.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the inspection we spoke with nine people who were living at the home and three relatives who were visiting at the time of our site visit. 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 spoke with eight staff members, which consisted of three care staff, the deputy manager, manager, nominated individual, activities co-ordinator and chef. We reviewed records relating to the care people were receiving, including seven care files, eight people's medication administration records (MARs) and daily records of care. We also looked at records relating to the running of a care home. This included records of training and supervision, four staff personnel files, records of maintenance and servicing and audits/quality checks.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2017 we found evidence of discriminatory practice and staf not responding to people's needs. We found there were not effective systems in place to prevent abuse and improper treatment, which was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

During our inspection we observed that staff treated people with dignity and respect, and responded to their needs promptly. Staff were aware of how to identify potential signs of abuse or neglect. They told us they were confident that any concerns they raised with the manager would be taken seriously. Staff were aware how they could escalate any concerns if they felt this was necessary, including by approaching the CQC or local authority safeguarding team.

The manager had sent the CQC notifications of alleged abuse that they had inform the local authority safeguarding team of. These notifications demonstrated that staff were identifying potential safeguarding concerns, and that the manager was escalating concerns appropriately. The manager kept a record of any safeguarding concerns raised, along with any actions they had taken to help ensure people were protected from harm.

At our last inspection we found the provider did not have adequate systems in place to assess and reduce risks to people's health, safety and wellbeing. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

Staff had recorded risk assessments in relation to hazards such as use of bed rails, falls, moving and handling and malnutrition. We saw risk assessments were reviewed monthly, and other than one exception, risk assessments had been completed accurately. In one case we found a person's falls risk assessment did not reflect that they had sustained a recent fall, which would have increased the indicated level of risk. However, we saw that staff had recorded the fall in another section of the care plan, and they had taken appropriate steps to help reduce the likelihood of a repeat incident.

Measures to reduce the risk of people experiencing harm were clearly identified in people's care plans and risk assessments. Our observations and records we reviewed supported that staff followed the risk reduction measures recorded in people's care plans to help keep them safe. For example, records showed people were supported to reposition as required when they were at risk of skin breakdown, and we saw equipment including pressure sensors, pressure relieving mattresses and bed rails were in place as needed.

Staff completed accident/incident forms following any unexpected events or people sustaining an injury. Staff recorded any immediate actions they had taken to assess people and keep them safe. This included carrying out clinical observations and contacting emergency services for example. We could see from the completed forms that staff had also considered whether any further actions were required to reduce future

risk. For example, staff had made referrals to other services such as a person's GP and the falls team. Two staff members we spoke with told us they had recently completed training courses in falls management, which they told us had increased their awareness of factors that could contribute to falls, and how to reduce them. One family member told us, "[Relative] has had some falls, and they were offered a room downstairs to enable increased monitoring [by staff]. [Relative] was happy to move."

Some people living at the home had behaviours that could challenge the service. Where this was the case, we saw their care plans identified how to reduce the likelihood of the person expressing these behaviours, any triggers, and how staff should support the person appropriately. Staff we spoke with were aware of the guidance as set out in people's support plans. They told us they felt confident that they had the skills to enable them to support people with behaviours that challenged in a safe and effective way.

At our last inspection we found that the premises and equipment were not always maintained in a way that meant they were safe for people living at the home. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, whilst we identified some minor issues, we found the provider was meeting the requirements of this regulation.

Prior to the inspection we received a concern that both of the two hoists the service owned, had been out of operation for a day. The provider confirmed this had been the case, and they had taken reasonable actions to get both hoists back in operation. At the time of our inspection, both hoists were working, and a competent person had examined them and determined them to be safe. No staff raised any concerns with us during our inspection in relation to there being adequate suitable equipment.

There were scheduled checks of equipment such as hoists, the passenger lift and bedrails to ensure they were in good working order. Required inspections of the electrical system and gas appliances had also been completed. Risk assessments had been carried out by competent persons in relation to fire and legionella. We saw the provider had acted upon recommendations made by the risk assessors. However, the home was in the process of appointing a new maintenance person, and evidence of some of the required steps to reduce the risk of legionella could not be located. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease that can be dangerous, particularly to more vulnerable people such as older adults.

People had assessments in place in relation to their ability to use a call-bell, and the frequency of checks by staff required to help ensure their safety when they were in their rooms. During the inspection we observed that one person being cared for in bed had a call bell that was not within their reach. However, we found staff came to their room frequently to provide support or check on their welfare. When we checked this person's room on subsequent occasions, we found the call-bell was accessible to them.

During our inspection we found that doors to the stairwells and other hazardous areas were secured. The manager had introduced daily checks to ensure that locking mechanisms and keypads were operating correctly. We noted that some old shelving and a mirror had been stored at the bottom of one of the stairwells, and raised this with the manager to take action to remove these items. People had personal emergency evacuation plans (PEEPs) in place, which we found were accurate and up to date. The provider had a business continuity plan in place that set out how staff should respond in emergency situations such as loss of utilities, fire, flooding or low staffing. Whilst the plan was relevant, it had not been reviewed since October 2015.

At our last inspection we found there were not sufficient numbers of suitably qualified staff deployed to meet people's needs. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. We found the provider was now meeting the requirements of this regulation.

The number of people living at the home had reduced since our last inspection. The top floor of the home was also not being used. The manager told us that staffing levels had been maintained despite this, which meant the dependency tool they used indicated the service was 'overstaffed'. We saw the manager reviewed the dependency tool every month. This helped guide them in relation to how many staff were needed to meet people's assessed needs.

At our last inspection we found there was no staff presence other than on the ground floor of the four-storey building during handovers. This meant some people did not receive timely support. The manager confirmed that they had revised the handover procedure, and that there was now staff present on every occupied floor during the day. During our inspection we observed there were sufficient numbers of staff to meet people's needs in a timely way. For example, we saw people received the support they required to eat and drink over meal times. When speaking with one person in their room they pressed their call-bell to request a drink. Staff responded promptly, and provided a drink within 10 minutes. People living at the home did not express any concerns in relation to staffing levels or the time they had to wait to receive support.

At our last inspection we found there were not robust procedures in place for ensuring staff employed were of suitable character. This was a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements had been made and the provider was now meeting the requirements of this regulation.

Since our last inspection, the manager had carried out audits of all staff personnel files to ensure there was evidence that suitably thorough procedures had been followed when recruiting those staff members. We saw these audits had identified issues such as gaps in employment history. The manager had taken reasonable steps to follow-up any information that was previously missing. This included asking staff for an explanation of any gaps in their recorded employment history, and contacting former employers for references.

We saw suitable procedures had been followed when recruiting new staff. This included obtaining a full employment history, health declaration, identification, a recent photo and a disclosure and barring service (DBS) checks. DBS checks provide information such as whether the applicant has any convictions or is barred from working with vulnerable persons. We saw these checks were in place prior to staff starting to work at the service. The manager completed regular checks to ensure that the qualified nursing staff had a current registration that did not place restrictions on their practice.

At our last inspection we observed that safe procedures were not always followed when staff administered medicines. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made. However, we identified some ongoing issues in relation to the safe management of medicines, and the provider remained in breach of this regulation.

Medicines were stored securely in lockable trollies. The treatment room was located on the top floor of the building away from where most people received their medicines in the ground floor communal areas. This meant the medicines trollies were stored in the lounge area, secured to the wall. Although the temperature of the treatment room was monitored, the temperature medicines were being stored at in the lounge was not. It is important that the temperature medicines are stored at is monitored, to ensure this in accordance with manufacturer's instructions. Some medicines may become less effective if they are stored at the wrong

temperature.

Sharps containers were kept with the medicines trollies, which also meant they were not stored safely when not in use. Controlled drugs were stored securely, and staff followed procedures to help ensure they were used safely. For example, two members of staff signed to confirm these medicines had been administered. Controlled drugs are medicines that are subject to additional legal controls in relation to their storage, administration and destruction, due to the risk of their misuse.

Staff recorded the administration of people's medicines on their medication administration records (MARs). As at our last inspection, we saw MARs were not kept securely. During the inspection we saw the MARs were kept on top of the medicines trollies in the communal dining area, which was not always supervised by staff. This would increase the risk that these important records could go missing.

MARs had an attached photo and relevant details such as how that person's medicines should be administered, contact details for the person's GP and a record of any allergies. We saw staff had completed these records without any omissions. We spot-checked a sample of people's medicines and found the quantities remaining reconciled with the MARs. The use of thickening agents in people's drinks and use of nutritional supplements were also recorded on MARs.

We saw that body maps were used to indicate to staff where they should apply any cream medicines. Staff had recorded the application of cream medicines on topical medication administration records. Some people using the service received medicines that came on patches that were applied to their skin. Many patch based medicines need to be applied to different sites on the body to reduce the risk of skin irritation. The nurse we spoke with was aware of this. However, there was no system, such as using body maps to monitor this.

Medicines, sharps and administration records were not always kept safely and securely. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found there were not effective systems in place to reduce the risk of the spread of infection. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was meeting the requirements of this regulation.

The inspection team observed that the environment was clean and free from malodours. We saw hand sanitiser and personal protective equipment (PPE) such as gloves and aprons were readily available. The laundry was set up to allow staff to keep clean and dirty washing separated and prevent cross contamination. The manager recorded regular checks in relation to the cleanliness of the environment and equipment, along with any required actions to address identified shortfalls. The home had received an infection control audit by the community infection control team in July 2018. This had rated the home as 'green' overall on the RAG (red, amber, green) rating scale. The provider told us they had already completed some of the required improvements identified by the audit, and other improvements were planned as part of an ongoing refurbishment plan.

Good

Is the service effective?

Our findings

At our last inspection in December 2017 we found evidence that staff did not receive adequate support, training, development and supervision to perform their duties effectively. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of this regulation.

Staff received an induction that prepared them to undertake the role they had been appointed to. This included being supported to complete the care certificate where they did not have previous experience working in care. The care certificate is an agreed set of standards that should be covered in the inductions of staff new to working in care. They help ensure staff have the required skills and knowledge to care for people safely and effectively. One member of staff told us, "I've had quite a lot of training such as moving and handling and diversity training. I felt my induction prepared me for the role. I had a long induction and the staff members who inducted me had been working here for a long time."

Staff told us they felt they received sufficient training to enable them to understand and meet people's needs. We saw they had completed a range of training relevant to their roles. This included training in health and safety, safeguarding, infection control, moving and handling, dementia and fire safety. Staff told us they were able to discuss their training needs with the manager who would look to meet any gaps in their learning.

People we spoke with felt staff were competent to provide the care and support they needed. One relative told us, "Yes they [staff] understand [family member's] needs. I would get a sense if that wasn't the case." The manager carried out competency checks of staff practice, and provided them with feedback that would help them develop and improve their approach. One of the nurses employed at the home was the home's clinical lead. Since our last inspection, the provider had also appointed a clinical supervisor who worked part-time at the home. As the manager was not a registered nurse, the clinical supervisor took responsibility for carrying out assessments of the nursing staff's clinical competence and providing clinical supervision. We saw nursing staff had last had their competencies checked by the clinical supervisor in March 2018.

Staff told us they received regular supervision. Records we reviewed showed that supervisions were scheduled to take place every three months, with an annual appraisal in addition. The manager told us there had been a gap in supervision shortly following our last inspection due to them prioritising other improvements that were needed in the service. However, we saw supervisions were taking place again, with most staff having received supervision within the previous three months.

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

homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection we found the service was not acting in accordance with the MCA. Consent to care and treatment was not always sought, the provider had not always submitted DoLS applications as required, and there was a lack of evidence that decisions about care had been made in people's best interests. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and that the provider was meeting the requirements of the regulation.

Staff understood the basic principles of the MCA, such as that any decisions they took on another person's behalf who lacked capacity should be in their best interests. We observed that staff communicated with people before providing care or support, and asked for people's consent where they were able to communicate this. We reviewed a staff competency check where the manager had recorded that they had challenged poor practice they had observed in relation to staff seeking consent, and they had noted that they had explained to the staff member why their practice did not meet expected standards.

The manager told us they had received support from a consultant around the use of capacity assessments and best interest decisions. We saw that capacity assessments were decision specific, and had been recorded in relation to decisions about use of equipment such as bedrails, administration of medicines and use of the person's photograph. Where the person was found to have capacity, they were asked to sign a consent form if they agreed to the planned care. If people had been found to lack capacity, we saw staff had consulted others involved in that person's care such as family members when making decisions in that person's best interests. Where people could not communicate in English, we saw it had been documented that a translator had been involved in the process of seeking people's views and assessing their capacity.

Staff had identified where people may be subject to restrictions that amounted to a deprivation of liberty. When this was the case, the manager had submitted DoLS applications to the supervisory body (local authority) as required. We saw they had systems in place for tracking the status and outcomes of any DoLS applications.

At our last inspection we found people's nutritional and hydration needs were not being met. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of the regulation.

People we spoke with told us they enjoyed the food and that they received a choice of meal. Comments included, "I like vegetables, and they are fine here", "The food is good" and after the mid-day meal, "I enjoyed it!". There was a menu on display in the dining area that was in both English and Cantonese. We saw the chef prepared a range of culturally relevant dishes. They told us they always prepared Chinese, Western, Caribbean, halal and vegetarian options. One relative told us a family member who was a chef of Chinese food had worked with the home's chef to teach them how to prepare several Chinese dishes to people's preferences. People's dietary requirements and preferences had been recorded, and the chef was aware how to prepare food to meet people's needs.

We observed the support staff provided at meal times on both days of our inspection. Whilst meal times were a positive experience for most people living at the home, we noted that there was a long wait of up to 20 minutes for some people to receive their food on the second day of our inspection.

People received the support they needed from staff to eat and drink. During our observation of the mid-day meal on the second day of our site visit, we noted that there was a delay of up to 20 minutes for some people to receive their meal after being seated. This did not appear to concern most people, although one person appeared to want to leave the dining area after having waited some time for their meal to arrive. Staff noticed this and arranged for their meal to be brought out sooner. This person was also resultant to eat their meal, and we saw staff offered them several alternatives. After eating a small amount, they chose to leave the dining area, and the manager prompted staff to offer them additional food and snacks later in the day. There were regular drinks rounds, and cold drinks were available for people to help themselves to in the communal areas. We saw people who choose to stay in their rooms were offered drinks regularly.

The manager monitored people's weights and malnutrition risk assessment scores though a monthly audit. Where people had experienced unplanned weight-loss, we saw appropriate actions such as referrals to the GP or a dietician had been completed. Any advice or actions taken by the home to help ensure people were not at risk of malnutrition were also recorded in the audit.

Staff assessed people's physical, social, psychological and emotional needs, and care plans had been developed to identify how staff would meet these needs. We saw care plans were in place in relation to aspects of care such as communication, activities, sleep, finances, personal hygiene, nutrition and mobility. Care plans provided sufficient detail to allow staff to understand what they needed to do to meet people's assessed needs.

People were supported to access other healthcare services to meet their assessed needs. Relatives we spoke with told us they were confident that staff ensured their family member's health care needs were met. One relative told us, "I feel assured that [family member's] health care needs are met by the home staff", and another said, "I am reassured that the manager will always contact me by phone if there are any concerns, for example if [family member] hasn't been eating well. So I do not have any concerns about the care."

There were 'ward rounds' twice weekly by a GP, and records showed input from other professionals such as podiatrists, speech and language therapists (SaLTs), district nurses, the continence team and dieticians. People's health care needs were recorded in their care plans, and we saw staff provided the support people needed to meet these needs. For example, we saw people with diabetes had diabetes care plans in place, and their blood sugar levels had been monitored as frequently as planned. Detailed and complete records had been kept in relation to nursing care provided such as wound care and other interventions.

We saw some adaptations had been made to make the environment more accessible to people living there. For example, there were pictorial signs on rooms such as the lounges and toilets. Since the last inspection, the provider had put people's names on their doors where they were happy for this to be done. They had also put up an 'orientation board' in the dining area, which included a clock and information about the day/date and weather in both English and Cantonese. This would help people, including those living with dementia to better orientate to time and place, which in some circumstances could help reduce people's anxiety. However, further improvements could be made in relation to making the environment more 'dementia friendly'. For example, there were no directional signs or use of photos or memory boxes that would help some people find their way around the home and to their rooms more easily.

The home had several communal areas, which were all located on the ground floor. This included a lounge that had been decorated in a Chinese style, which remained popular with people of Chinese origin. There was also an activity room, dining area and second communal lounge.

Good

Is the service caring?

Our findings

At our last inspection in December 2017 we found people were not always treated with dignity and respect. This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of the regulation.

The home supported people from a variety of cultural backgrounds and of different religions. A proportion of people living at the home were of Chinese origin and some of these people did not speak English. Since our last inspection, the home had appointed dedicated staff to act as interpreters to ensure people who only spoke Cantonese could communicate their needs and wishes to staff effectively. In addition, the manager encouraged staff to use 'flash cards' and they had recently started trailing the use of translation apps to facilitate communication between English speaking staff and people living at the home who did not have English as their first language.

People we spoke with told us there were always Cantonese speaking staff to hand if they needed assistance. The provider sought to employ Cantonese speaking staff, and at the time of our inspection there were Cantonese speaking staff on four out of seven nights per week. Staff told us they were able to understand the needs of non-English speaking people as they had got to know them well, and by making use of the flash cards if needed. The manager told us they were advertising to recruit a Cantonese speaking staff member to cover the remaining three nights per week.

During the inspection we saw staff frequently conversing with people living at the home in Cantonese and other languages that were shared by staff and people living at the home. Some of the care staff who had English as a first language had also learnt some key words in Cantonese to help them understand people and communicate with them effectively. One relative had commented in a survey returned to the provider that they had observed staff trying to speak with people living at the home in Cantonese despite not speaking the language fluently, which they commented was 'very considerate'.

The manager told us that any needs people had in relation to protected characteristics such as race, religion or sexual orientation would be identified though the assessment process. They told us the starting point for how the service met their needs would always be what that person wanted. For example, some people may identify with a certain religion, but not actively practice that religion or go to church. Some staff had received diversity training, and the manager told us this was now a training course they identified as mandatory. When asked what the home did well, one staff member told us, "The multiculturalism is really good. People do interact although there are some barriers due to language for example. The interpreter helps, and I've picked up words in Cantonese from them."

Staff told us the home was visited by faith groups, including a Chinese Christian group and Buddhist monks. The manager told us they accommodated the religious needs of both staff and people using the service by for example, providing a quiet area for them to pray during religious festivals. The manager told us the home had links with various local community groups who had been able to provide additional support to people

and help them maintain links with their communities. People's families had also been encouraged to put forward ideas and offer their help to ensure the service was meeting people's cultural needs. The activities co-ordinator talked about ideas they had to encourage people living at the home to further integrate and enjoy shared activities.

We received positive feedback from people living at the home in relation to the approach of staff members. Comments included, "Very nice staff", "I like it here. The care is good. Most of all, I like the people here" and "I like it here. Very nice staff. Staff are tops!". Relatives were also complimentary about the relationships their family members had with staff. One relative commented "I know my [family member] is happy as they smile at the staff." A second relative told us, "There is good care here. Staff are very good, very caring. This is invaluable, not something that money is guaranteed to buy."

Our observations of the way staff interacted with people living at the home were also positive. Staff supported people at a pace they were comfortable with, used appropriate touch and offered people reassurance as needed. For example, we saw staff communicated effectively with people and provided the support they needed to eat their meals. We observed two staff supporting a person with a hoist and staff talked to and reassured the person throughout the process.

We saw staff took time to spend talking with people or engaging them in short games of cards or dominoes for example. Staff were attentive to people's needs. For example, we observed staff get people cushions to help make sure they were comfortable. We observed one person started smiling and singing to a member of care staff when they came in the room, and another person responded, "All the better for seeing you" when a member of care staff asked how they were.

Staff understood the importance of respecting people's privacy and dignity. However, some improvements were required to ensure confidential information was kept securely. We saw people were able to move around the home freely. When people requested to be supported to go to their bedrooms we saw that staff respected these requests. Staff told us they would always knock before entering people's rooms and ensure doors and curtains were closed when providing support with personal care.

During our site visit we found a room on the top floor of the home was used to store old care records. There was a sign on the door instructing staff to keep the door locked. However, we found the door was not secured. There were no people living on the top floor of the home at the time of our inspection, and keypad locks controlled access to the top floor. However, there would be increased risk that these records would be accessed by unauthorised persons. We saw medication administration records (MARs) were also stored insecurely on-top of the medication trollies in the dining area. This would also increase the risk that these records could be viewed by unauthorised persons or be lost.

Staff told us they would encourage people's independence by supporting people to do what they could themselves, and by involving people in their care. One relative we spoke with told us staff encouraged their family member's independence by encouraging them to mobilise around the home.

Good

Is the service responsive?

Our findings

At our last inspection in December 2017, we found the service was not delivering person-centred care. There was a lack of evidence that people had been involved in planning or reviewing their care, and due to 'language barriers' staff were not always able to communicate with people effectively or understand their needs. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of the regulation.

Since our last inspection, the manager had introduced additional sections to the care plan that provided staff with details about people's interests, likes, dislikes and social histories. Care plans detailed information about people's preferences about how they received their care that would help enable staff to provide more person-centred care. We found that staff were aware of, and met people's preferences. For example, one person's care plan stated that they liked to sit in a certain place in the lounge and play dominoes whilst the TV was on. On several occasions during our visit we saw staff sit and play dominoes with this person, and they were supported to sit in their preferred chair in the lounge. Records of personal care showed people were supported with bathing as frequently as was indicated to be their preference in their care plans.

Staff reviewed care plans monthly, and there was evidence that people were involved in the planning and review of their care plans. Where it would assist the individual to understand and make choices about their care, we saw care plans had been translated in people's first language of Cantonese. As discussed in further detail in the caring section of this report, the provider had taken steps to help ensure people who did not speak English fluently were able to communicate their needs and wishes to staff. Although there were three nights per week when there were not Cantonese speaking staff on duty, the provider was attempting to recruit more Cantonese speaking staff, and had considered other ways to enable staff and people using the service to communicate.

We saw that people's communication support needs arising from any disability, impairment or sensory loss were assessed prior to their admission to the home. Staff had also considered and recorded whether there may be other barriers to effective communication, such as if some staff did not share the same first language as the person. Whilst we saw steps had been taken to meet people's communication support needs, the information recorded in the assessments could be strengthened if it stated what people's preferences were in relation to the format they received information in. For example, whether they preferred information to be presented verbally, written or pictorially.

We saw staff had translated information such as the complaints policy, menus, meeting minutes and care plans into Cantonese. A sign at the entrance to the home informed people that they could request any relevant documentation in alternative languages if they wished. Records indicated that staff had used the home's interpreter to help people who spoke Cantonese understand relevant information about their care and choices they could make. The manager told us that the interpreter would accompany people who spoke Cantonese on any external appointments if required to help ensure they were able to communicate with other health and social care professionals.

Where people were not able to communicate verbally, we saw that staff had completed 'communications passports'. These documents provided details about the behaviours, gestures and expressions that people used to communicate their needs, wishes and emotions, along with how staff should respond to this communication. Our observations showed that staff understood how to communicate with people as was detailed in their communication passports.

At our last inspection we found the activities co-ordinator had been required to provider cover for care staff. They told us that since our last inspection they had been dedicated to the role. This had allowed them to develop the activities on offer, and help them provide activities that were culturally relevant and person-centred. The activities co-ordinator had consulted with people living at the home about their interests and any current or previous hobbies, interests and occupation. They told us they used this information to provide activities and occupation that were meaningful to people. Records of activities confirmed that staff had considered and met people's preferences in relation to activities. Group activities included jazz, reggae and soul music afternoons, games, exercises, pamper mornings and bingo. Staff told us that they supported people to access the community and visit the shops or other local amenities when possible, although one person told us they would like to get out of the home on a more regular basis. One person told us, "[Activity co-ordinator] is a star" and confirmed that there were enough activity options to keep them occupied.

Staff visited and interacted with people who were cared for in bed regularly. This would help prevent them from becoming isolated. However, there was scope for staff to provide additional occupation based on people's interests to provide them with additional stimulation whilst being cared for in bed. For example, staff told us one person enjoyed listening to Chinese music whilst in their room. However, they did not have a stereo or other means to listen to music. Staff supported people to access communal areas where they could socialise with others living at the home when this was what they wanted. A toddler group visited the home every month, which staff and a family member we spoke with told us had been very popular with both people living at the home, and the visiting group.

We saw the home's complaints policy and procedure was displayed at the entrance to the home in both English and Cantonese. This contained details about how people should expect any complaints they raised to be handled and information about how people could escalate their complaint if they were not satisfied with the response they received. The home had recorded one formal complaint in the previous year, which the manager had looked into appropriately. One person we spoke with told us they had not raised a concern they had with the manager as they did not speak Cantonese. However, another relative we spoke with told us, "Neither of us [person/family member] speak English. Both [other relative] and the interpreter here translate for us. I was invited to meet and talk with the manager and staff last year. That was helpful."

We recommend the provider considers ways they can encourage and facilitate people to raise concerns when English is not their first language.

The home was not providing anyone with end of life care at the time of our inspection. However, we saw people's wishes in relation to end of life care had been considered and were recorded in their care plans. There was evidence that people's families or other people important to them had been involved in discussions when appropriate.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2017 the manager of the service had not registered with the CQC as is a condition of the home's registration with us. They had submitted an application to register during our inspection, but this was later withdrawn. At the time of our site visit, the service had not had a registered manager in post for over six months. The manager confirmed they had re-submitted their application to register. During the process of drafting this report, we assessed and accepted the managers application and registered them to manage the regulated activities at the home.

The registered manager was supported by a deputy manager/clinical lead, the clinical supervisor, a team of senior care staff and the nominated individual, who also had responsibilities for other homes owned by the company directors. Staff told us they had seen improvements being made at the home and had confidence in the manager, whom they told us was approachable. The manager told us that following our last inspection, the provider had sought the support of two consultants. The consultants had worked with the home and helped bring about the improvements we found at this inspection.

Relatives told us they had seen improvements, and they felt able to approach the manager and discuss any concerns or ideas for improvements. One relative told us, "I feel improvements have been made… The manager is busy all the time, which is a good sign, but I can always contact and speak to them if I've got any concerns. They gave me their mobile number to contact them if needed." During the inspection we observed that the manager provided support and advice to staff throughout the day, as well as frequently interacting and speaking with people living at the home. This meant that they were visible and accessible to anyone who might want to discuss issues or ideas with them.

At our last inspection in December 2017 we found systems and processes to monitor and improve the quality of the service were not effective, and accurate, complete records of care had not always been maintained. We found this to be a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements, and the service was meeting the requirements of this regulation.

The manager undertook a range of audits and checks to help them monitor the quality and safety of the service. This included audits of meal time experience, care records, weights, cleaning, first aid box contents, supervision, training, care plans and medicines. We saw that where the manager had identified any issues or shortfalls, that they had recorded actions to be taken and marked when these had been completed. The manager also provided feedback to staff in relation to the findings of their audits at team meetings where this would help staff understand and deliver the required improvements.

A comprehensive audit of accidents and incidents was undertaken that allowed the manager to identify and trends, such as common times of the day or locations in the home when accidents occurred. This had resulted in the manager taking action to allocate a member of night staff to be based on the first floor of the home during the night to provide additional supervision in this area. This showed the audits were effective and enabled the manager to take action to help keep people safe. An additional audit identified any

individuals who had sustained a higher frequency of accidents or falls, which helped the manager check that staff had taken appropriate actions to keep them safe, such as putting in place sensor mats or making referrals to the falls team or GP.

We found staff had in most instances, maintained accurate and complete records of the care they had provided to people. Where this had not been the case, the manager had identified this and reminded staff of their responsibilities. For example, the manager had identified when staff had not recorded the assistance they had provided to a person to reposition in bed. Staff were prompted to write at least three lines in daily records of care in an attempt to ensure they were sufficiently detail. However, some of these records lacked detail, and staff had written the records with large margins to ensure they covered three lines. However, we found staff had completed other records such as intake records and bathing records accurately, which complemented the overview provided in the daily record.

People using the service and others involved in their care, including relatives and health professionals had been given opportunity to provide feedback on the service. The manager had sent out questionnaires to seek people's opinions in April 2018, and told us they had gone through any suggestions or concerns raised in these with the individuals. The manager told us they had also sought the help of the relatives of people using the service following our last inspection to help identify ways in which they could improve the service and ensure they were meeting people's needs. Relatives we spoke with confirmed this.

There was an open and honest culture. Staff told us they felt confident that they would be supported and not treated unfairly if they made any genuine mistakes in their day to day work. We saw evidence of frank and honest discussions that had taken place within team meetings regarding any issues staff members had. This showed staff were comfortable to raise any concerns openly so that they could be addressed by the manager and staff team. Staff told us they had been made aware of the findings of our last inspection and said there had been a long staff team meeting following it to discuss the improvements that were needed.

Services such as care homes are required to display their CQC performance rating both at the home, and on any websites they maintain. We found the home's rating from their last inspection was displayed in the entrance lobby. The home did not have a website.

We requested the provider complete and send us a provider information return (PIR) in June 2018. The reminder for this information was sent to the nominated individual in June 2018. However, we received no response, and no PIR was submitted. The nominated individual told us they were not aware of having received a request for a PIR.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines, sharps and medication administration records were not being kept safely and securely. Regulation 12(1)