# Rosewood Health Care Limited

# Barley Brook

## Inspection report

Elmfield Road
Wigan
Greater Manchester
WN1 2RG
Tel: 01942 497114

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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 |

## Overall summary

Barley Brook is a care home in Wigan and is owned by Rosewood Healthcare. The home is registered with the Care Quality Commission (CQC) to provide care for up to 28 people. The home provides care to those with residential care needs, although a large number of people live with dementia.

We last visited the home on the 07 and 09 of July 2014 during the testing phase of the new inspection methodology. The service was rated as 'Inadequate' during this inspection and we issued seven compliance actions with regards to care and welfare, safeguarding, medication, suitability of the premises, records, supporting workers effectively and monitoring the quality of service. We also issued a warning notice for regulation 10 with regards to monitoring the quality of service effectively.

At the time of our inspection, the manager was new in post and as such, was not yet registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

# Summary of findings

'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.

We found that the registered person had not protected people from the risks associated with monitoring the quality of service, medication and record keeping. These were breaches of regulations 10,13 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These relate to regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and governance.

At our last inspection we had concerns about how medication was handled in relation to hospital discharge and covert medication. During this inspection we had further concerns with regards to how people's medicines were handled. We found unsafe processes around the administration of medicines from the Bio dose system whereby medication could not easily be identified by staff. For example where specific administration instructions were required. This put people at risk of errors in selecting the wrong medication and also not receiving the medication in a safe manner.

We found improvements were required to handwritten medication records (MAR) to ensure staff were aware of any specific warnings relating to a certain medication so that administration was safe. We found one example where a person was put at risk with their medicines as the member of staff did not know this information.

We found examples of medication being given without due regard to any specific warnings. This put people at risk of the medication either not working in the best way or at risk of experiencing side effects. One person had run out of medication and not received a dose of the medicine as needed in the morning. This identified poor management and ordering of repeat medication, which put this person at risk with a delay in receiving the medicine. It was a particular concern that some people were given medicines late in the morning, as they were sleeping when staff first attempted to administer. However, no advice had been sought to ensure safe administration.

There was no consistent information available regarding PRN (when required) medication to support staff to administer medicines safely. Due to the lack of supporting information, it was unclear whether people received these medicines at the time they needed them. It was of particular concern for those people who could not clearly communicate their needs, as there was no evidence that their needs had been observed. The manager informed us that she was in the process of drawing up pain relief treatment plans which would help to address this concern.

At our last inspection we had concerns with regards to the safety of the premises and the fact that people had been able to access areas of the home which could place them at risk. We saw improvements in this area, as the home had introduced 'key pad' locks to areas of the home including the cellar, staircase and court yard at the rear of the building, which prevented potential trip hazards to people. One person had been able to leave the building due to a window only being secured with a chain as opposed to a window restrictor. During the inspection we found windows had now been fitted with suitable window restrictors, which prevented people leaving the building in a potentially unsafe manner. There were also specific risk assessments in place to cover these areas with daily, weekly and monthly checks in place.

At our last inspection we found appropriate Deprivation of Liberty Safeguards (DoLS) applications had not been submitted to the local authority when people had attempted to leave the building. The manager now kept a checklist in the office to show which people came under a DoLS and if an application had been made. In addition, people had specific DoLS care plans in place where necessary.

At our last inspection we had concerns about night time staffing levels and the fact that with no senior member of staff available, there was nobody to give medication to people such as pain relief. During the inspection we looked at staff rotas and saw senior care staff had been added to the night time rota and were supported by two care assistants. We were able to see these staff were on shift when we first arrived at the home in the morning.

We looked at how staff were recruited and looked at six staff personnel files. Overall, we found suitable checks were undertaken before staff began work, including ensuring two references were sought and DBS checks undertaken. However, we found one member of staff had only personal references on their file and none from

# Summary of findings

previous employers, despite having been employed elsewhere previously. We raised this with the manager who told us this member of staff had started working at the home before she had commenced the role as home manager, but would ensure appropriate checks were made in the future.

Staff supervision at the home was not consistent. Of the six files we looked at, only two had received supervision despite having worked at the home for several months. We raised this with the manager to see if the records were located elsewhere, however we were not shown them. Following our inspection, the manager sent us a supervision matrix which showed the majority of staff had received supervision in late February 2014 and would receive further ones every three months.

At our last inspection we felt the layout of the home was not suitable for those living with dementia. During this inspection we undertook a tour of the building to see what improvements had been made. Toilets, the lounge area, bathrooms, the dining room and ground floor were all clearly sign posted and supported by pictures, for people who may have difficulty with cognition. The sample of bedrooms we looked at had a large picture of the person living there and the number of their room was clearly displayed. The colour of people's doors was very similar to the colour of the walls, which could present difficulties for people in successfully finding their bedroom. We raised this with the manager who told us plans were in place to ensure doors clearly stood out from the rest of the home decoration and were easier for people to find.

At our last inspection we observed that there were a number of missed opportunities for interaction, between staff and people living at the home. During this inspection we saw that on occasions, this still presented an issue. We spent time observing care in the main lounge area of the home during the morning of the inspection. At this time, there were six people seated in the lounge area and on several occasions, staff walked straight through the lounge area from the kitchen area without acknowledging people or asking if there was anything they needed. We raised this issue with the manager who said she would re-iterate this to staff.

During our inspection we observed two people who struggled to communicate verbally, both with staff and other people living at the home. Their speech was unclear and it was difficult to understand what they were saying. We found there were no specific communication care plans in place to demonstrate what staff needed to look for to understand their requirements and what potential body language to look out for. We raised this with the manager who told us they would ensure these care plans were in place following our inspection.

At our previous inspection we identified concerns with the homes record keeping. Whilst looking at people's care plans we became aware that certain people needed to be weighed weekly, although records in care plans did not support that this had taken place. Additionally, we found three people required to be re-positioned at regular intervals and again, records did not support that this had taken place in line with the necessary timescales. We raised this with the manager who was confident these tasks had been completed by staff, but that accurate records had not been maintained.

At our previous inspection, we felt people's care plans could have been more person centred, capturing things of importance to them such as likes, dislikes and their life histories. In response to this, the manager told is they had introduced 'This is me' documents for each person living at the home. This detailed people's life story, photos of when they were younger, where they were born, hobbies/ interests and war time experiences.

We saw a system had been introduced called 'You said, we did'. This was a survey sent to staff, people who lived at the home and relatives asking how they would like things to be improved within the home. This asked questions about laundry services, food/menus and the general cleanliness of the home.

There were a range of audits undertaken at the home. These covered pressure sores, bed rails, medication, infection control and falls. Additionally, there were regular checks of window restrictors, fire exits, the courtyard door, building maintenances, step ladders and wheel chairs. Despite these audits being in place, there were no systems in place to check other important aspects of the service such as weekly/monthly weights, people being re-positioned and staff supervisions were being completed when they should. Additionally, the medication audits in place did not highlight the shortfalls we had identified.

# Summary of findings

## 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

Not all aspects of the service were safe. Medication was not handled safely, particularly in relation to use of the bio dose system, completing MAR sheets accurately, maintaining stocks of medication, people receiving their medicines late in the morning and PRN guidance for staff.

We looked at how staff were recruited and looked at six staff personnel files. Overall, we found suitable checks were undertaken before staff began work, including ensuring two references were sought and DBS checks undertaken. However, we found one member of staff had only personal references on their file and none from previous employers, despite having been employed elsewhere previously.

The people we spoke with and their relatives told us they felt safe living at the home and we were happy with the staff who cared for them.

**Is the service effective?**

Requires improvement

Not all aspects of the service were effective. Staff supervision at the home was not consistent. Of the six files we looked at, only two members of staff had received supervision despite having worked at the home for several months.

During this inspection we undertook a tour of the building to see how the environment had been adapted for those living with dementia. The colour of people's bedroom doors was similar to the colour of the walls, which could present difficulties for people in successfully finding their bedroom.

At our last inspection we found appropriate Deprivation of Liberty Safeguards(DoLS) applications had not been submitted to the local authority when people had attempted to leave the building. The manager now kept a checklist in the office to show who came under a DoLS and if an application had been made. In addition, people had specific DoLS care plans in place where necessary.

**Is the service caring?**

Requires improvement

Not all aspects of the service were caring. At our last inspection we observed that there were a number of missed opportunities for interaction with people living at the home. During this inspection we saw that on occasions, this still presented an issue. We spent time observing care in the main lounge area of the home during the morning of the inspection. At this time, there were six people seated in the lounge area and on several occasions, staff walked straight through the lounge area from the kitchen area without acknowledging people or asking if there was anything they needed.

The people we spoke with and their relatives were happy with the care they received at the home.

# Summary of findings

The staff members we spoke with were able to provide good examples of how they treated people with dignity and respect when providing care.

**Is the service responsive?**

**Requires improvement**

Not all aspects of the service were responsive. During our inspection we observed two people who struggled to communicate verbally, both with staff and other people living at the home. Their speech was unclear and it was difficult to understand what they were saying. We found there were no specific communication care plans in place to demonstrate what staff needed to look for to understand their requirements and what potential body language to look out for.

At our previous inspection we identified concerns with the homes record keeping. Whilst looking at people's care plans we became aware that certain people needed to be weighed weekly, although records in care plans did not support that this had taken place. Additionally, we found three people required to be re-positioned at regular intervals and again, records did not support that this had taken place in line with the necessary timescales.

We saw a system had been introduced called 'You said, we did'. This was a survey sent to staff, people who lived at the home and relatives asking how they would like things to be improved within the home. This asked questions about laundry services, food/menus and the general cleanliness of the home.

**Is the service well-led?**

**Requires improvement**

Not all aspects of the service were well-led. At the time of our inspection, the manager was new in post and as such, was not yet registered with the Care Quality Commission.

There were a range of audits undertaken at the home. These covered pressure sores, bed rails, medication, infection control and falls. Despite these audits being in place, there were no systems in place to check other important aspects of the service, such as weekly/monthly weights, people being re-positioned and staff supervisions being completed when they should. Additionally, our findings in relation to medication had not been identified.

Staff spoke positively about the leadership of the home and felt that improvements had been made since taking up the post.

# Barley Brook

**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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We carried out this unannounced inspection on 06 February 2015. The inspection team consisted of an adult social care inspector, a specialist pharmacist advisor 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.

At the time of the inspection there were 26 people who lived at the home. During the day we spoke with the registered manager, area manager, 10 people who lived at the home, seven relatives and five members of care staff. We also spoke with the cook, the cleaner and maintenance person. Of the 10 people we spoke with and due to many having a diagnosis of dementia, not everybody was able to fully communicate their views to us.

We spoke with people in communal areas and their personal rooms. Throughout the day we observed how staff cared for and supported people living at the home. We also observed the lunch time meal being served in the main dining room of the home.

Before the inspection we liaised with Wigan local authority to ask for their views about the home. We also looked at notifications sent by the provider as well any relevant safeguarding/whistleblowing incidents which had occurred. We also looked at the PIR (Provider Information Return), which had been sent to us in advance of our inspection.

Requires improvement

# Is the service safe?

## Our findings

The people we spoke with and their relatives told us they felt safe living at the home. One person said; "I do feel safe here. My room is very good and the staff are nice. I trust the staff here and they always respond when I need them". A visiting relative added; "I am visiting my husband's aunt and my husband and I usually take turns coming but also sometimes visit together. We have five years experience of this home and we have seen good times and bad times. She is safe and receiving good and regular meals so she is doing well and it shows".

We found that the registered person had not protected people against the risk of unsafe medication administration procedures. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medication was handled. At our last inspection we had concerns about how medication was handled in relation to hospital discharge and covert medication. During this inspection we had further concerns with regards to how people's medicines were handled. We found unsafe processes around the administration of medicines from the Bio dose system whereby medication could not easily be identified, in some cases medicines requiring specific administration instructions. This put people at risk of errors in selecting the wrong medication and also not receiving the medication in a safe manner.

We found improvements were required to handwritten medication administration records (MAR) to ensure staff were aware of any specific warnings relating to a certain medication so that administration was safe. We found one example where a person was put at risk with their medicines as the member of staff did not know this information. Additionally, One person

was observed chewing medicines when given by the a member of staff. When asked about this, the member of staff said that this person was new in the home but had always chewed the medicines since being there. This concern had not been acted upon and there was nothing mentioned in the daily records. One medicine was a slow release tablet and chewing this could alter its therapeutic effect. Another medicine was an iron tablets, which carries the warning not to chew as it can stain the teeth. The MAR chart was handwritten and there were no warnings listed. The warnings were clearly stated on the medicines label. This could place people at risk

We found examples of medication being given without due regard to any specific warnings. This put people at risk of the medication either not working in the best way or at risk of experiencing side effects. One person had run out of medication and not received a dose of the medicine as needed in the morning. This demonstrated poor management and ordering of repeat medication and put this person at risk with a delay in receiving the medicine. It was a particular concern that some people were given medicines late in the morning, as they were sleeping when staff first attempted to administer the medicine but no advice had been sought to ensure safe administration.

There was no consistent information available regarding PRN (as required) medication to support staff to administer medicines safely. Due to the lack of supporting information, it was unclear whether people received these medicines at the time they needed them. It is a particular concern for those people who could not clearly communicate their needs, as there was no evidence that their needs had been observed. The manager informed us that she was in the process of drawing up pain relief treatment plans which would help to address this concern.

We looked at the medication fridge and controlled drugs cupboard during the inspection. We found an antibiotic liquid which had been dispensed on 28 January stored on the medicines trolley and not in the fridge. This was being currently administered to one person and it was not clear how long this had been out of the fridge. Another person was prescribed some eye drops which needed to be stored in a fridge prior to use but could be stored at room temperature when in use. The eye drops had been opened but were still stored in the fridge. The fridge and room temperatures were monitored daily, but the fridge temperature had been over 8 degrees a few times in December 2014. The manager was not aware that the temperature had been out of range, as the staff had not informed her and no actions were taken or documented.

The home medicines were supplied in the Bio dose system. This was a pod system with all the medicines required at a particular time of day together. There was a medication profile supplied by the pharmacy which detailed descriptions of the medicines. We found that these

# Is the service safe?

descriptions were missing for a number of medicines which meant carers would not be able to identify that medicine if it was mixed in the pod. This would be a problem if people spat one medicine out for example, meaning the carer would not know what the medicine was and not be able record or easily obtain advice. Dispersible tablets were mixed in the morning pod and the carer had to separate these out in order to safely administer these medicines. One person was taking two dispersible medicines which had clear descriptions on the MAR chart so the carer could identify them. However, picking individual medicines out of the pods is not good practice and can be a risk if staff select the wrong medicine, or there are two tablets that look similar. These medicines should be separately packaged so that the carer can ensure the warning information relating to that medicine is followed for safe administration. The member of staff dispersed both tablets together in one glass of water. The care plan contained no advice to do this and again this is not good practice as the medicines could be altered in some way by being mixed together.

A senior carer working at the home told us the morning medicines round started at approximately 9am, after people had their breakfast. The senior said that they always made sure people had something to eat before they gave people any pain relief. We asked if there was anyone who needed medication before food and the member of staff told us there wasn't. One person was prescribed medicine which should be given 30-60mins before food but had eaten breakfast already when given this. The medicine was podded up in the morning pod mixed with other tablets and the member of staff did not identify that this was needed before food and administered it without any regard to the warnings.

A number of people slept in on the morning and were given their morning medication when they got up at approximately 11.35am. The member of staff said they worked the 8-8 shift and so were able to spread the remaining doses of medication out accordingly before handing over to the night staff. The senior told us other people were taking medication daily and so they did not have to consider the times of any subsequent doses. All the medication was signed for as if it had been given at breakfast and there was no mention of the actual time on the back of the MAR charts or in the daily record in the care plans. The member of staff had not obtained any advice in relation to the people who were given their medicines late.

We looked at how staff were recruited and looked at six staff personnel files. Overall, we found suitable checks were undertaken before staff began work, including ensuring two references were sought and DBS checks undertaken. However, we found one member of staff had only personal references on their file and none from previous employers, despite having been employed elsewhere previously. We raised this with the manager who told us this member of staff had started working at the home before she had commenced the role as home manager, but would ensure appropriate checks were made in the future.

People who lived at the home had specific risk assessments in place to help keep them safe. These covered areas such as falls, nutrition and pressure sores. Where people were identified as being at risk, there were guidelines in place for staff to follow to keep people safe. For example, one person required a soft diet as they were at risk of choking. Another person was required to have their walking aid near them at all times due to having poor mobility. This information was clearly recorded in people's care plans for staff to follow.

The staff we spoke with were clear as to how they would respond if they had concerns with regards to safeguarding. One member of staff said; "Initially I would speak with the home manager or area manager. I'm aware we can contact CQC as well". Another member of staff added; "I have never had to report to anything yet. However, I would speak with my manager first and get in touch with the central duty team at Wigan". Each member of staff we spoke with said they had completed training in safeguarding adults and this was confirmed by looking at the training matrix, which stated training had been undertaken as recently as January 2015.

At our last inspection we had concerns with regards to the safety of the premises and the fact that people had been able to access areas of the home which could place them at risk. We saw improvements in this area, as the home had introduced 'key pad' locks to areas of the home including the cellar, staircase and court yard at the rear of the building, which prevented potential trip hazards to people. One person had been able to leave the building due to a window only being secured with a chain as opposed to a window restrictor. During the inspection we found windows had now been fitted with suitable window restrictors,

Requires improvement

# Is the service safe?

which prevented people leaving the building in a potentially unsafe manner. There also specific risk assessments in place to cover these areas with daily, weekly and monthly checks in place.

At our last inspection we had concerns about night time staffing levels and the fact that with no senior member of staff was available, there was nobody to give medication to people such as pain relief. During the inspection we looked at staff rotas and saw senior care staff had been added to the night time rota and were supported by two care assistants. We arrived at the home at approximately 7.30am, where staff working on the day shift were beginning to arrive. The day shift was staffed by the registered manager, two senior carers and two care assistants. This was to provide care to 26 people. In addition, there was the cook, a laundry person and domestic member of staff. On the day of our inspection, through our observations we saw this proved sufficient in providing care to people. We saw people being given their medication, assisted to the toilet and dining room and assisted to eat their meals.

We asked staff for their views on the current staffing levels. One member of staff said; “Four members of staff during a day is definitely enough at the minute. We work well together”. Another member of staff said; “I always work during the day. There are always two seniors and two carers working. It is enough at the minute”. A visiting relative commented however; “We feel there are not really enough staff and those that are on duty are constantly distracted by the residents who move around a lot demanding attention. The result is that those who sit quietly are ignored.”

The staff we spoke with told us that on occasions, some people’s behaviour could be challenging. In order to support them with this, we saw each member had staff had completed relevant training in responding to behaviour that challenged in January 2015. One member of staff said; “Some people get upset and agitated and it can be difficult at times. I always aim to distract them from whatever it is that is bothering them to de-escalate the situation”.

Requires improvement

# Is the service effective?

## Our findings

At our last inspection we felt the layout of the home was not suitable for those living with dementia. During this inspection we undertook a tour of the building to see what improvements had been made. Toilets, the lounge area, bathrooms, the dining room and ground floor were all clearly sign posted and supported by pictures, for people who may have difficulty with cognition. The sample of bedrooms we looked at had a large picture of the person living there and the number of their room was clearly displayed. The colour of people's bedroom doors was very similar to the colour of the walls, which could present difficulties for people in successfully finding their bedroom. We raised this with the manager who told us that refurbishment plans were in place to ensure doors clearly stood out from the rest of the home decoration and were easier for people to find.

We looked at the arrangements in place to support staff with their work. Staff supervision presents managers and senior care staff with the opportunity to assess how the work of staff has progressed and if there is anything they could improve on. We found these were not undertaken on a regular basis. Of the six staff files we looked at, only two members of staff had received supervision despite having worked at the home for several months. Following our inspection, the manager sent us a supervision matrix which showed the majority of staff had received supervision in late February 2015 and would receive further ones every three months.

During the inspection we spoke with five members of care staff to ask them about the support they received and the training they had available to them. Each member of staff told us they undertook the company induction when they first began working at the home. One member of staff said; "This is my first job working in a care home and the induction gave me a very good start in my job". Another member of staff said; "I did the induction when I first started. It included all my mandatory training". A further member of staff said; "As I was new I was able to shadow more senior members of staff".

We looked at the training matrix to see what training staff had undertaken whilst working at the home. We also asked staff about the support available to them in their role. Staff had completed a range of courses including safeguarding, moving and handling, infection control, fire, food safety and food hygiene. The majority of this training had been completed as recently as January 2015. One member of staff said to us; "I'm very happy with the training on offer". Another member of staff said; "I'm working towards my NVQ 2. It's going really well so far".

We saw evidence that the home worked closely with other professionals. This included GP's, district nurses and chiropodists. Additionally, we saw people were appropriate referred to other external agencies such as Speech and Language Therapy (SALT) , falls team and dieticians when necessary.

We observed the lunchtime period at the home. This enabled us to see how people's nutrition and hydration needs were met. People who were able to eat and drink themselves ate first, whilst those who required assistance from staff, ate shortly afterwards. Where people did require assistance, this was provided to them by staff in an unhurried manner. We saw lunch was a relaxed and pleasant experience. There were 17 people at the tables who were supported by two members of staff. A third member of staff came in out of the room frequently to see if people needed anything. Lunch was the main meal of the day and there was a choice of chicken, potatoes, green beans, carrots and gravy. Sponge pudding and custard was available for dessert. We saw drinks were readily available to people in the form of tea, coffee and juice.

At our last inspection we found appropriate Deprivation of Liberty Safeguards (DoLS) applications had not been submitted to the local authority when people had attempted to leave the building. The manager now kept a checklist in the office to show who came under a DoLS and if an application had been made. In addition, people had specific DoLS care plans in place where necessary, with guidance for staff to follow.

The manager of the home displayed a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS are laws protecting people who are unable to make decisions for themselves. At the time of our inspection there were eight people under a DoLS and we saw documentation in people's care plans to show appropriate referrals had been made by the home manager to the local authority. The manager told us they had been advised by the council to send referrals through on an individual basis as opposed to

Requires improvement

# Is the service effective?

making applications for each individual. Despite this, we saw no evidence of any training in this area, which could have further enhanced staff knowledge. We raised this with the manager.

Requires improvement

# Is the service caring?

## Our findings

During our inspection we spoke with ten people who lived at the home and asked them for their views of the care provided, although not everybody was able to give us their opinions due to varying stages of dementia. Comments included; "I'm quite happy here. The care is pretty good" and "The staff are nice. They treat us well" and "No complaints whatsoever".

We spoke with seven visiting relatives. Their comments included; "I am very satisfied with the care my dad receives here. I always feel they are on top of things" and "I have no concerns as I think there are enough, well trained staff and the current manager is doing very well" and " X was in another home previously and they failed to handle her well. They tried to section her at one point but did not manage to do it. She does need careful help and handling and the staff are so good she is much better here. This place is not exactly state of the art but the staff and the care they give, are great".

At our last inspection we observed that there were a number of missed opportunities for interaction between staff and people living at the home. During this inspection we saw that on occasions, this still presented an issue. We spent time observing care in the main lounge area of the home during the morning of the inspection. At this time, there were six people seated in the lounge area and on several occasions, staff walked straight through the lounge area from the kitchen area without acknowledging people or asking if there was anything they needed. We raised this issue with the manager who said she would re-iterate this problem to staff.

The people we spoke with, who were able to, told us they were treated with privacy and dignity whilst living at the home. Staff spoken with were clear about how to ensure this happened whilst providing care. One member of staff said; "If people are ever incontinent I take them away from other people so they are not exposed in front of everybody else". Another member of staff said; "I always make sure people are covered when we use the hoist". A further member of staff added; "I'll ask people if they would like me to wait whilst they go to the toilet and give them a towel as soon as they come out of the shower so they are covered".

We observed staff were respectful towards people who lived at the home and acted in accordance with their wishes. For example, we observed people being escorted into the lounge area and asked where they would like to sit and spend their day. Another person told staff they would prefer to play their guitar rather than take part in the activity taking place. Again this decision was fully respected by the member of staff.

Staff spoken with were clear about how to offer people choice and promote independence. One member of staff said; "Some people can get lazy and not want to do things for themselves. I find its important to keep encouraging them and remind them that they can do things for themselves. When getting people ready in the morning I'll always let them try and put their clothes on before I help". Another member of staff said; "I think it's important to let people toilet themselves if they want to try themselves. That way they can have privacy as well".

Requires improvement

# Is the service responsive?

## Our findings

Each care plan we looked at contained an initial needs assessment which had been completed by the home manager. This enabled both the manager and staff at the home to gain an understanding of what peoples care requirements were. The assessments covered areas such as eating and drinking, mobility and equipment, personal care, history of falls, toileting and people's daily routines. Once this information had been gathered, it then enabled people's care plans to be created. We looked at six care plans during the inspection and saw the care plans provided an overview of what their care requirements were and how staff needed to support them. These were reviewed regularly and as recently as January 2015.

During our inspection we observed two people who struggled to communicate verbally, both with staff and other people living at the home. Their speech was unclear and it was difficult to understand what they were saying. We found there were no specific communication care plans in place to demonstrate what staff needed to look for to understand their requirements and what potential body language to look out for. We raised this with the manager who told us they would ensure these care plans were in place following our inspection.

At our previous inspection, we felt people's care plans could have been more person centred, capturing things of importance to them such as likes, dislikes and their life histories. In response to this, the manager told is they had introduced 'This is me' documents for each person living at the home. This detailed people's life story, photos of when they were younger, where they were born, hobbies/ interests and war time experiences.

We found that the registered person had not protected people against the risks associated with poor records keeping. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we identified concerns with the homes record keeping. Whilst looking at people's care plans we became aware that two people needed to be weighed weekly, although records in care plans did not support that this had taken place. Additionally, we found three people required to be re-positioned at regular intervals and again, records did not evidence that this had taken place in line with the necessary timescales. We raised this with the manager who was confident these tasks had been completed by staff, but that accurate records had not been maintained.

We saw a system had been introduced called 'You said, we did'. This was a survey sent to staff, people who lived at the home and relatives asking how they would like things to be improved within the home. This asked questions about laundry services, food/menus and the general cleanliness of the home. As a result of feedback from people who lived at the home and their relatives, additional cleaning hours had been provided at the home over the course of the week in order to improve the environment and general cleanliness of the building.

We looked at the activities provided at the home. There was an activity schedule in place which explained what was taking place at the home during the week. This included a social evening, sing along, ball games, baking ,quizzes and various activities of reminiscence. These included pot washing, folding items of clothing and a game called 'Tell me more'. This enabled people to relate to tasks they may have done in their previous home environment and try to recall things of importance to them in their lives. This was one of the scheduled activities for the day and we saw staff spending time sitting and chatting with people about these events. Additionally, staff provided people with books to read and one person played their guitar after requesting it from a member of staff.

There was a complaints procedure in place, although the manager told us no complaints had been made since our last inspection. There was a notice in the reception of the home which stated there was an 'open door' policy at the home and that any concerns could be reported to the manager. One relative said to us; "We would know how to complain and we did have a concern, which I would not call a complaint. It was about six weeks ago and I have to say that the manager listened to us and quickly put things right".

Meetings for residents and relatives were held at the home. This provided them with the opportunity to raise any concerns and influence any aspects of the care provided at the home. There was a notice displayed near the entrance of the home, informing people of the forthcoming meetings this year in February, June and October.

Requires improvement

# Is the service well-led?

## Our findings

At the time of our inspection, the manager was new in post and as such, was not yet registered with the Care Quality Commission. 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 staff we spoke with felt that the home was well-run and the manager did a good job. Comments included; "I've been impressed with the training recently. The manager runs the home well" and "The manager is good. Definitely the best person for the job" and "Things have definitely improved with the new manager" and "There is a better atmosphere since the manager has started" and "Things feel calm at the moment. The manager is approachable and you can go to her with anything".

We found that the registered person had not protected people against the risks associated with not monitoring the quality of service effectively. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a range of audits undertaken at the home. These covered pressure sores, bed rails, medication, infection control and falls. Additionally, there were regular checks of window restrictors, fire exits, the courtyard door, building maintenances, step ladders and wheel chairs. We noted that they displayed any actions that had been taken.

Despite these audits being in place, there were no systems in place to check other important aspects of the service such as weekly/monthly weights, people being re-positioned when necessary and staff supervisions. These were areas where we had found shortfalls during our inspection. Additionally, the medication audits in place did not highlight the shortfalls we had identified. This meant that the systems in place to assess, monitor and drive improvement in the quality and safety of the services provided were ineffective. An accurate record was not completed in respect of each person who used the service.

The staff we spoke with told us that team meetings took place regularly and that they could raise any issues which affected their work. One member of staff said; "They always take place of late. I couldn't attend once and I wrote things down which I wanted to raise. I was happy with the response I got". Another member of staff said; "It's a good opportunity to speak about things we can put right".

Staff told us they attended handover meetings at the end of every shift. This kept them informed of any developments or changes within the service. Staff told us their views were considered and responded to. One member of staff told us; "Handover is important. We get an overview of each person, what their mood is like and if there is any cause for concern".

At the end of our inspection we shared an overview of our findings with the manager and area manager who acknowledged some systems within the home could be improved. This indicated to us that they were open to feedback in order to improve the service provided to people who lived at the home.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>We found the arrangements in place at the service did not protect people against the risks associated with the unsafe administration of medication. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>We found the arrangements in place at the service did not protect people against the risks associated with poor record keeping and not monitoring the quality of service effectively. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.