Bondcare (London) Limited

Alexander Court Care Centre

Inspection report

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06 March 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place took place on 27 February 2018 and 06 March 2018. This was the first inspection since the home transferred to a new provider in July 2017. At our last inspection of the home on 8 June 2017, we found the provider at the time did not meet legal requirements to ensure the service was consistently safe, caring and well-led. We therefore attached conditions to the new provider's registration because of these concerns. The provider was required to submit information to us monthly to let us know what action they were taking to meet legal requirements and how they were ensuring these actions were being completed and monitored.

Alexander Court Care Centre is a 'care home'. 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.

Alexander Court Care Centre accommodates 82 people across five named separate units, each of which have separate adapted facilities. There are three units for people living with dementia and one unit for young people with physical disabilities. There is also a residential unit for older people. At the time of our inspection, 76 people were living in the home.

The home has a newly appointed registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left their position a few weeks before our inspection. The deputy manager was managing the service at the time of our inspection and completed their registration as manager shortly after our inspection.

Each unit in the home was managed by a registered nurse who was supported by the newly registered manager and a new deputy manager.

At our inspection, we found breaches of health and social care regulations. This was because people did not always receive safe care. They did not always receive their medicines as prescribed and when needed. Risks to people, such as diabetes and other conditions, were not always adequately assessed or identified to ensure they remained safe. This meant that the provider did not always assess, monitor and mitigate risks associated with the service to ensure people received safe care.

The provider's systems to support people who lacked capacity to make decisions for themselves were not effective. Staff received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). However, people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

The provider did not always ensure people had access to appropriate healthcare when needed because their appointments with health care professionals were not always followed up. This meant people's health needs were not being managed effectively to ensure they remained in the best of health and their wellbeing was maintained.

Most people told us they were treated with dignity and their choices were acted upon. However people were not always treated with respect. They were not always involved in their care planning. We have made a recommendation for the provider to look into establishing a more caring and sensitive environment.

People did not receive care and support to ensure their individual needs were met. Care plans were not person centred and did not contain sufficient information on people's backgrounds and preferences. Complete, accurate and contemporaneous records were not being kept for each person.

The registered manager was committed to developing the service, although significant improvements were required with quality assurance systems to ensure people received a safe, effective, caring and responsive service. Feedback was received from people and relatives in the form of questionnaires and surveys to help drive quality improvements.

The premises were clean and regularly maintained. The environment was suitable for people who had specific needs such as dementia.

Infection control procedures were followed to ensure the home remained safe from the spread of infections. Records of accidents and serious incidents showed that the provider learned from mistakes to prevent reoccurrence.

Staff received training on how to safeguard people from abuse. Staff were also aware of the whistleblowing policy. They were able to describe the actions they would take if they had any concerns about people's safety, both internally and externally.

The provider had safe recruitment procedures in place and carried out checks on new employees. Staff were supported with regular training, meetings and supervision. Staff performance was reviewed on a yearly basis and they were encouraged to develop their skills.

People were provided with a choice of meals on a daily basis. Staff had an awareness of equality and diversity and challenged any discrimination they encountered. People were encouraged to participate in activities and remain as independent as possible.

Staff were able to communicate with people in order to understand their needs. People and relatives were able to make complaints and have them investigated by the registered manager.

Staff felt supported by the management team. They were aware of their responsibilities when providing care.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we have asked the provider to take at the back of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Not all risks to people were assessed adequately to keep people safe and for staff to understand the risks.

People did not receive their medicines when they required them. Medicines were not always managed safely.

The provider had a safe recruitment procedure. There were enough staff to meet people's needs.

Staff were aware of the steps to take to report any allegations of abuse. They were aware of their responsibilities to report any concerns.

The provider was able to learn lessons from serious incidents to improve the safety of the service.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not have adequate knowledge and understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). People's consent to care and treatment was not recorded.

People's health needs were not monitored effectively to ensure they remained in the best of health.

Staff were supported with training and received regular supervision and guidance.

People were supported to eat a balanced diet and their nutritional needs were met.

Assessments of people's needs were carried out to identify the support they required.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with respect or sensitivity.

People and relatives were not able to express their views about their care and provide their consent.

Staff knew people well and provided care with dignity and kindness. People's confidentiality and privacy was respected.

People were supported to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans did not always contain personalised information about their preferences.

There was a formal complaints procedure and complaints were investigated by the registered manager. People and relatives were notified of the outcomes.

The provider ensured information was accessible to people in a way they could understand.

People were encouraged to participate in activities of their choice.

Staff supported people with end of life care sensitively and respectfully.

Is the service well-led?

Requires Improvement

The service was not well led. The registered manager was committed to making improvements to the service. Quality assurance audits took place regularly to ensure the service was safe and people's needs were being met. However, they had not identified the shortfalls we found in the service, which could put people at risk of harm.

Staff felt supported by the management team and were encouraged to provide their feedback.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

Alexander Court Care Centre

Detailed findings

Background to this inspection

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

This comprehensive inspection took place over two days on 27 February 2018 and 6 March 2018. The inspection was carried out by one inspector, a specialist nursing advisor and an expert by experience on the first day. 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 inspection was carried out by the inspector and a specialist pharmacy advisor on the second day. Both days of the inspection were unannounced.

Before the inspection, we reviewed the information we held about the service and provider. The provider had completed and sent us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We reviewed all the information we held on the service such as previous inspection reports and notifications. A notification is information about events that by law the registered persons should tell us about such as safeguarding alerts and serious incidents. We also obtained feedback from the local authority for their views on the service.

During our inspection we spoke with 12 people and with four relatives. We spoke with four nursing staff, four care staff, the registered manager, the deputy manager and a chef.

We looked at 20 care plans and other records relating to people's care, such as turn charts and medicine administration records. We also looked at accidents and incidents records, 10 staff files, training records, quality assurance audits, health and safety information and other records kept in the service.

Inadequate

Is the service safe?

Our findings

During our inspection, we found concerns with the way the home managed people's medicines. We saw that the availability of some people's medicines after they had been discharged from hospital or admitted to the home was insufficient. This put people at risk of harm.

Two people's medicines on one unit had not been supplied to the home following their discharge from hospital and they had gone without important medicines for more than seven days. One person's medicine, which was used to help treat people with schizophrenia or bipolar disorder, had run out a week earlier at the end of February 2018. The person had not been administered the medicine by the time of our second visit, six days later. The medicine had been prescribed to be administered to the person twice a day. Another person had not been given their medicine, which helped to lower cholesterol and prevent heart disease for seven days. We saw from Medicine Administration Records (MAR) that nursing staff had indicated that each medicine was unavailable. For both people, we noted that the home had repeatedly requested repeat prescriptions from each person's GP but was unsuccessful. The home's procedure for emergencies required staff to contact the pharmacy directly or an NHS number for further advice. Staff had failed to take further action or report the incident internally to alert the management team of the situation. This meant people were not provided with safe care and treatment because essential medicines were not being provided to them, to ensure their health care needs were being met. The registered manager took immediate action after our inspection to ensure the medicines were obtained without further delay.

We looked at how medicines in each unit were stored. We found the storage rooms to be tidy and well organised. Medicines were stored appropriately. The temperature of the room and refrigerators were monitored daily and recorded, as per the manufacturer's recommended guidelines. Controlled drugs, which are medicines that are at risk of being misused, were checked and were found to be managed safely.

Some people required their medicines, such as tablets, to be crushed or dissolved to make it easier for them to be taken. We found that a tablet crusher on the Rose unit was not being used safely because it contained residue from medicines that had not been cleaned away. This was a risk because the residue could contaminate other people's medicines that required crushing or medicines that the crusher was being stored next to. On the Blossom unit, two people required their medicines to be crushed but there was no tablet crusher available. Staff told us they used a spoon to crush the tablets instead. This is not recommended practice for medicine crushing. Suitable equipment was not being used for this task. This posed a safety risk to staff because it increased the chances of them being contaminated with tablet residue through improper crushing techniques.

All people had MAR charts in place, which contained the medicines they were prescribed and the time they needed to have them. They contained people's personal details to help identify them. MAR charts were signed by staff after each dose was administered. The storage, supply and disposal of any unused or expired medicines were carried out appropriately and safely. Medicines were labelled clearly and were stored in containers or blister packs for ease of use.

However, we found other concerns with medicines, including one person's medicine, which helped them with indigestion. A MAR chart was signed by staff showing it was administered but the medicine remained in the blister pack. Another person's medication had been removed from the blister pack but the MAR chart had not been signed by staff.

The provider had a protocol in place for medicines that were administered on an 'as required' basis (PRN), such as painkillers. We noted that some medicine records were not accurate in their descriptions on MAR charts and contained incorrect information. For example, one person's quantity of a medicine to help control seizures was written as 25 millilitres instead of 2.5 millilitres. Another person's topical medicine administration record (TAR), for medicines such as creams and gels, did not match what was actually being used. For example, two of their PRN medicines were not accurately transcribed on their TAR chart and another topical medicine was recorded instead. This meant medicines were not being managed and recorded safely to ensure people received the correct medicines in the correct amounts, when they required them. We brought these issues to the attention of the registered manager to investigate.

Risks to people's health were assessed prior to their admission to the home. People's care plans contained specific sections on their health care needs that included any risks. Records showed that risks to people were not always updated on a monthly basis or suitably reassessed when needed, to reflect their current needs. Risk management plans that were in place for each person were not being maintained consistently and did not provide sufficient information to help staff minimise risks. The plans covered risks such as falls, mobility handling, nutritional needs and any risks relating to the home environment. For example, one person living on the Daffodil unit was at risk of weight loss. Staff were required to 'control' the risk by "encouraging [person] with their food and fluid intake. [Person] is on fortified meals daily and has a fluid chart in place." There were no additional measures detailed to reduce the risk such as how often the person's food intake would be monitored, how often they would be weighed and whether the person would be seen by a dietician or other health professional. Another person on the Daffodil unit was assessed as having a food allergy and it was noted that they could experience anaphylactic shock. There was not a suitable risk assessment in place to help staff manage the risk of the person going into shock. There were no details or guidance of what actions they needed to take if it occurred.

Some people on the Bluebell unit required PEG (Percutaneous endoscopic gastrostomy) feeding, in which a tube is used for food and fluids to be passed into the person's stomach. One person had a risk assessment in place for this to identify any potential risks or complications of PEG feeding. However, we found that for another person who required a PEG feed, a risk assessment was not in place. Another person living on the Rose unit was diabetic but they did not have a sufficient risk assessment in place with details on how to mitigate any risks relating to this illness. Two other people that required insulin due to diabetes had records that contained information about the required levels of insulin for them. Hypoglycaemic and hyperglycaemic guidelines were in place for people who were diabetic, which provided guidance for staff on blood sugar levels when they are either too high or too low. However, one person did not have a current diabetic care plan in place with up to date information on when their insulin dosage was required. There were Blood Sugar Monitoring (BSM) record sheets in place for each person, which included sections for acceptable BSM targets and actions, although we found that these were incomplete. This meant it was difficult to gauge what the acceptable target was and what actions should be taken by staff if the person's blood sugar levels were not within the recommended range. This meant risks to people were not adequately assessed and put people at risk of unsafe care and treatment. Risks assessments were incomplete and did not adequately reflect their current needs.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection most people we spoke with told us they felt safe. One person said, "I am safe in the home." Another person told us, "Yes I feel safe here." A relative of a person in the home said, "It's a generally safe environment."

The provider had safeguarding policies and procedures in place for staff to refer to if they had any concerns about people's safety. Staff we spoke with demonstrated an understanding of how to recognise different types of abuse and what actions to take to prevent or report it. This helped to ensure people were safe. They had an understanding of their responsibilities and said they would report abuse if they were concerned about a person. They were also aware of the whistle blowing procedures. A whistle-blower is a person who raises a concern about the practice of an organisation to external organisations, such as the local authority, police or the CQC.

There were infection control procedures to ensure the environment was safe for people, staff and visitors. Staff we spoke with were knowledge about safe practices to ensure hygiene and cleanliness was maintained in the home. They told us they used PPE (personal protective equipment), hand gels and aprons when providing care and that they disposed of used items appropriately. We observed that the premises were clean and free from odour.

There was a procedure in place to review any accidents or incidents that occurred in the service. We noted from accident and incident reports, that the management team had ensured necessary actions were taken following incidents. This helped staff improve their understanding of how to respond to incidents. Lessons were learned from serious incidents or errors to help prevent reoccurrence.

The provider had systems to ensure only suitable staff were recruited to work with people who used the service. We looked at seven staff files which detailed their employment history, qualifications and previous experience. A number of pre-employment checks were undertaken before staff started working at the service. This included, obtaining references, checking if they had any criminal records and checking their identification and immigration status to see if they were allowed to work in the United Kingdom.

People and relatives had mixed views about the staffing levels in the home. There were approximately 20 people in each of the nursing care units. One relative told us, "I think they have a shortage of staff. My [family member] doesn't get taken to the lounge much because of this." Another person said, "It is a busy home and it is short of staff." Similar comments from other people and relatives included, "not enough staff" and "short of staff at weekends."

Each unit had a manager and a nurse's station and we saw that staff were available. When the service was short of staff, processes were in place for cover staff to be called. We saw there were four care staff and a nurse on duty in each unit in the morning and three care staff with a nurse in the afternoon. They were able to respond to the needs of people living in the units. We viewed staffing and nursing rotas for each unit, which were both planned for the following two weeks, in advance. They showed if additional staff were required on particular days over those two weeks. We saw that staff were available on each shift during our inspection, although we noted that the home had very quiet periods during the day when people were in their rooms and staff were busy with other work.

Staff and managers told us they did not have concerns about a lack of staff cover. The registered manager said that they used agency staff or bank staff, who had worked in the home previously, when needed and they were planning to recruit more permanent staff. They told us, "We currently have enough staff to cover all shifts when needed and according to our assessments of how many staff we need. We are recruiting about four more carers." Staff who worked for the provider on a permanent basis told us they knew people

well and covered sickness or leave to ensure people's needs were met.

The premises were maintained daily to keep it safe. We saw in the kitchen that refrigerator and freezer temperatures were kept at suitably safe settings. Equipment, such as hoists and wheelchairs were maintained and serviced as per the manufacturer's recommendations. We saw checks were carried out on fire safety equipment on a regular basis to make sure they were ready for use. People had individual evacuation plans in place in the event of a fire and practice drills took place regularly. Gas, water and electrical systems were serviced annually or when they were due.

Requires Improvement

Is the service effective?

Our findings

We found that the provider was not working within the principles of the Mental Capacity Act (2005). The 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. However, we found that conditions on authorisations to deprive a person of their liberty (DoLS) were not being met, when we enquired about the number of people that had bedrails in place around their beds, to keep them safe. The use of bedrails requires the person to provide their consent to their use because they could be a restrictive measure that deprived them of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Staff we spoke with did not have a full awareness of what DoLS meant in relation to the use of bedrails. They did not have a clear understanding that a clear process for assessment and agreement of their use should be in place. We looked at records of consent on four units where people had bedrails in place. We found that nearly 20 people across these units had not consented to their use, where they had capacity to do so. They were not subject to DoLS and there was no evidence that they had consented or that the principles of the MCA had been followed. This meant people were being restricted without the required authorisation and their legal and human rights were not being adhered to.

Staff told us they sought people's consent before providing care and support. We saw that where assessments of people's capacity or best interest assessments had been undertaken; for most of the people on each unit, these were only related to decisions over whether the person consented to their photograph being taken for 'identification purposes in case of injury.' They were not in relation to their care and treatment in the home which meant people, without capacity, had not provided their legal consent to care.

Staff had an understanding of the principles of the MCA and had received training on the MCA and DoLS. The registered manager had made applications for people in all units, where there were indications they may be deprived of their liberty for their own safety. A chart detailed all people that were assessed as needing a DoLS, including dates of when current DoLS were due to expire and when applications were submitted. This helped the registered manager keep track of them. However, further development was required in the home to ensure the full principles of the MCA were followed.

These concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us staff were helpful and provided them with the care that met their needs. One person told us, "Yes it is good here." Another person said, "Yes generally happy with the care." A relative told us, "It's ok but not very consistent. My [family member] is insulin dependent and they don't get the right sort of meals."

People's health care needs were checked daily. People's nutritional needs were recorded and monitored. If staff had any concerns about a person who was at risk of malnutrition, they sought advice from relevant health professionals, such as dieticians. People's food and fluid intake was recorded to show how much people ate and drank, so their nutrition and hydration could be monitored. People's weights were monitored and any risk of malnutrition or dehydration was assessed to make sure they maintained their health. Observations charts were in place and they were up to date, such as for people who required turning to avoid pressure sores, as well as fluid and diet charts. The staff used malnutrition universal screening tools (MUST), which identified people at risk of under nutrition. These helped staff monitor people's health and wellbeing and take action when necessary if their health or needs changed.

However, referrals were not always made to healthcare professionals if people became ill. We found that one person with diabetes had been discharged from hospital at the end of last year. Discharge information from the hospital stated they would benefit from a diabetic nurse visit. The referral to the nurse had been made by the GP, soon after they were discharged. The referral was not followed up and a visit had not taken place.

Another person had been admitted to hospital for treatment following a serious illness. On one occasion, they had missed a follow up hospital appointment and we saw a letter from the hospital to the home stating they had not been informed as to why they had not attended. They were discharged back to the care of their GP as a consequence of this. There was no information or details in the person's care plan with the reason they were unable to attend. This meant people's health needs were not being monitored effectively to ensure they received the best care. We brought these issues to the attention of the registered manager to look in to.

Staff were mostly knowledgeable of what the different needs of people were and received relevant training to help them meet their needs. We saw staff had completed mandatory training courses in areas such as health and safety, moving and handling, safeguarding adults, catheter care, medicine management, dignity in care and health and nutrition. They undertook regular online refresher training sessions to keep themselves updated with the latest guidance and practice. Some staff had achieved diplomas in Health and Social Care to become qualified in certain skills. Care Certificate standards were tailored into the training, which are nationally recognised learning standards and assessments for health and social care workers. This meant that staff were provided with relevant and up to date training.

Staff told us the training provided them with the necessary skills and knowledge they needed to carry out their role. One member of staff said, "The training helped me prepare and I got help when I needed it if I was not sure about anything. I had an induction. The managers are very helpful." New staff received a three day induction when they started working in the service. We saw records of staff inductions and competency assessments which staff acquired through training to ensure they were able to support people.

Staff felt supported by the registered manager and other members of the management team. Staff received regular supervision and we saw records of supervision meetings and annual appraisals between staff and their line managers. Staff were able to discuss topics in supervision meetings, such as any concerns they had, areas for further development and training needs. Improvement actions between line managers and staff were agreed for review at the next supervision meeting. This meant people were being supported by staff who had received guidance and support to carry out their roles.

Staff supported people to have sufficient amounts to eat and drink in order to maintain a balanced diet. Menus were available for each day and for the full week. We observed a lunchtime service during our inspection. In the dining rooms we saw people sitting together, whilst being served. Some people chose to

eat by themselves or in their rooms and their lunch was brought to them. One person requested a change to their initial choice of meal and staff provided them with their alternative choice, as they requested. Staff were observed being friendly, patient and attentive. However, we noted that one person waited a few minutes longer than other people before they were served their lunch. This led to other people waiting for the person to be served before they started eating and meant their food got cold. One person told us, "The food is adequate." Other comments from people about the meals included "good, tasty" and "very good." One person told us that if they did not like two of the menu options they could have an alternative meal prepared for them. We spoke with the chef who told us they were able to cater for people with specific dietary, cultural or religious requirements, such as soft or pureed food or meals that were suitable for people with diabetes. Drinks and snacks were available to people at other times when they requested them.

People's needs were assessed before they started to use the service. Information was obtained from other care professionals and relatives in order for staff to fully assess whether the home would be able to meet their needs. Pre-admission assessments of need contained details such as the person's mobility, nutrition, hydration, communication and personal care requirements. Changes to people's needs were communicated to staff at team meetings and handovers to enable them to respond to people's current needs. Staff shared important information with each other so that they were all aware of any issues and what actions needed to be taken.

The environment was suitable for people with complex care needs, such as dementia or physical disabilities. There was appropriate signage and adaptations around the premises, which was a large building with four levels. There were communal areas such as dining rooms, lounges for activities and a garden, which people could use to sit outside in suitable weather. People with mobility difficulties had enough space to get around. Adapted baths, showers and hoists were fitted in the home for people to use safely and according to their needs.

Requires Improvement

Is the service caring?

Our findings

Most people and relatives told us staff treated them with respect and that they were caring. One person said, "Yes the carers treat me like I'm their father." Another person told us, "Carers are nice. They're ok." Relatives were mostly satisfied with the level of care received by their family members. A relative told us, "Yes, my [family member] is looked after alright." However one relative told us, "The staff are not always considerate. They leave jugs of water and sweets for [family member] on the bedside table but they are not within their reach. They just get left." Another relative said, "The staff are failing to help us. They can be disrespectful of my [family member's] and our needs, although it is not intentional."

During our inspection, we observed how staff interacted with people throughout the day and we saw that they were mostly polite, friendly and gentle. Staff were mostly respectful when communicating with people, were supportive and told us they knew people and what their needs were. However, we did note that staff did not always ensure people were as comfortable as possible in their beds. One person's bed sheets were creased and had not been ironed, which could increase the likelihood of developing pressure ulcers. We spoke to a registered nurse and a member of care staff about this and said that it would be beneficial to the person for their sheets to be straightened. Staff told us that this would be carried out but we noted that it was not done immediately. We asked them again later in the day and they eventually straightened the person's sheets.

We also noted that people were not always spoken to in a manner that was appropriate. For example, one person entered one of the nurse's offices and appeared distressed. We saw staff assist and comfort them but also told them something that they thought the person wanted to hear, that was not in fact true, in order to encourage them to leave the office. We were concerned that the staff were using techniques that were not correct because they were raising the expectations of the person, only for them to likely be disappointed. This meant people were not being treated with respect and sensitivity with full consideration given to how this could impact them.

People and relatives told us they were involved as far as they were able to in decisions about their care and support needs. Relatives said they contributed to reviews of care plans for their family members. A relative told us, "Yes the home involves us and keeps us up to date." However, people's care plans had not evidenced their involvement, particularly in relation to how people's consent to care and treatment was obtained. This meant people were not being provided with sufficient information about how the provider proposed to care for them. Some people had bedrails in place but there was no information in their care plans to explain why this was necessary, what the risks were and evidence that the person had consented. The provider was not demonstrating how they helped a person understand the care they received and how they respected a person's wishes.

We recommend the provider seeks best practice guidance on establishing a caring and respectful environment that was sensitive to the needs of people.

Staff knocked on people's doors before entering their rooms and spoke to them politely, addressing them

by their first names. Staff had received training in equality and diversity. This helped them understand how to treat people as individuals, respected their human rights and ability to make decisions for themselves. They understood how to treat people equally regardless of their race, sexual orientation or religion and were respectful of people's cultures, beliefs and backgrounds. Any cultural and religious needs people had were identified and respected. For example, people were supported by staff to practice their religion.

A member of staff told us, "We have to be respectful of people's choices and make them feel at home and not feel neglected." Another staff member said, "We have a Dignity in Care standard here. I am a dignity champion and I use this everyday in my work to make sure people are treated with dignity and respect. I promote it all the time."

There was a calm and relaxed atmosphere in the home which helped to make it a comfortable place for people to live. We saw that people were appropriately dressed during the day and they were free to spend time in their rooms or in the communal areas. People could call for assistance by pressing a call bell attached to their beds. Staff were attentive and responded in a timely manner when checking to see what help a person required. Staff noticed when people were in discomfort and take action to provide care and support.

Relatives told us staff were friendly and welcoming. They told us they could visit the home at any time. One relative said, "The staff are amazing most of the time. They come as quickly as possible to help my [family member]."

Staff told us they ensured doors and curtains were shut when providing people with personal care to protect people's privacy. A 'do not disturb' sign was placed on the person's door while they were receiving personal care to ensure they were given privacy. Staff also respected people's confidentiality. People's personal information was kept securely in the nurse's offices. Staff treated personal information in confidence and adhered to the provider's data protection policies. This showed that the provider recognised the importance of people's personal details being protected. Staff said they were mindful of not sharing people's personal information. They adhered to the provider's data protection policies.

Staff also encouraged people to remain as independent as possible. One staff member said, "I make sure I let the person know what I am doing. I encourage and promote their independence." For example, people were encouraged to dress themselves and tend to their own personal care needs where they were able.

Requires Improvement

Is the service responsive?

Our findings

When a person started to use the service, a care plan was developed to meet their individual needs. People's care plans contained a brief 'social profile' on their personal history, details of significant people or relatives, their preferred reading material, any interests or activities and any significant events in their lives. For example one person's profile said that they, "Like to listen to music." There was also a 'snap shot' of the person's care needs that was broken down into categories such as emotional and psychological needs, mobility needs and requirements for personal hygiene and at night time.

The information within care plans was not very detailed or person centred to adequately reflect people's care needs. Care plans were not always reviewed and updated monthly as required. For example, when people's needs changed or were reviewed, a full re-assessment of the person's needs was not carried out so that they were up to date.

For example, some people's care plans were developed two years ago upon their admission but they had not been comprehensively reviewed and the person's needs were not reassessed fully during that period. One person's care plan dated was developed three years ago but there had not been a full annual review in any of the following years, to ensure that the person's current needs were evaluated and updated. This meant people were not being provided with care that was appropriate to their needs.

One person was identified as having diabetes but their care plan did not reflect this and it had not identified how the person would be supported with this illness. Another person required feeding via a PEG tube but their care plan had not identified how the person would be supported. This meant people were placed at risk of unsafe care because staff did not have relevant and important information about people's needs.

We saw that some people had a document called "Social Profile and My Life" in their care plan which contained a personalised portrait of them. For example, one person was able to discuss their childhood memories such as "Enjoying holidays in Italy from 1960s to 1990s and holidays with my wife and children." They also stated preference for activities such as "quizzes, card games, gardening" and were able to identify any cultural or religious requirements. However, not all people had this level of personalisation in their care plan which provided staff with information about their preferences, interests and histories. The registered manager told us they were working on obtaining these details for each person in order to make their care plans more person centred.

Some people also told us they were happy with the care staff and the management team. Most people and relatives told us the service was responsive to their needs. Comments from people included, "I had too much breakfast and was full. I needed a drink and they got me one instantly"; "I can raise concerns if needed" and "Nice bunch of carers." However, one relative described how their family member's room contained items left behind by the previous occupant. They said, "I asked management to remove the stuff. They did eventually. But the TV doesn't work and nothing has been done." One person said, "I know staff are busy so I don't always let them know when I need help." Another person told us, "I accommodate the staff rather than they accommodate me." This meant that the provider did not always address issues highlighted

by people and their relatives to ensure they received a responsive and person centred service.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had their own room with and had the required adaptations in place according to their needs. People's rooms were clean and had been personalised with their pictures and belongings.

There was an activity programme in place. People had the opportunity to take part in activities such as bingo, raffles, singing, coffee mornings, outside entertainment, animal therapy and celebrating cultural days such as St Patrick's Day. We spoke with an activity coordinator who told us they had arranged to renovate a small room into an afternoon tea area for people and relatives. We noted that it was popular and was well used during our inspection. We observed an afternoon activity session and saw the lounge was full with people playing bingo. People told us they helped other people mark their cards. The activity coordinator said, "We have some new ventures, like identifying a small number of people to establish links with a local nursery." This meant they were able to take part in activities with children. The coordinator told us it was going well and was very successful. One person said, "I love the activities. The coordinator is very nice and fun." A relative told us, "Good here. Lots of things going on. Coordinator is lovely, very enthusiastic and caring."

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure people that receive care have information made available to them that they can access and understand. Information people receive, will also tell them how to keep themselves safe and how to report any issues of concern.

Staff were not fully aware of the AIS but told us they communicated with people by using gestures or signs for those who were less able to communicate, so that they could understand each other. One staff member said, "I speak to the resident slowly so that they can hear me and understand me."

The provider had a complaints procedure in place for people and relatives to make formal complaints if they wished. An easy to read complaints procedure was available. There was a system in place for receiving and responding to complaints. We saw that the registered manager investigated all formal complaints that were received. They were acknowledged and responded to appropriately in detail, with explanations by the registered manager and any action they were taking. We saw that one complaint was currently in progress at the time of our inspection.

People's wishes for end of life care were respected. These were expressed in their care plans and staff ensured people were comfortable and any pain was managed sensitively and carefully. Support was received from health professionals, who provided advice to staff on managing people's end of life care. When required, advice and support was provided to people, relatives and staff on pain management for those on end of life care. Some people had DNACPR (Do Not Attempt Cardiac Pulmonary Resuscitation) forms where applicable, which meant that they confirmed they did not wish to be resuscitated should they fall into cardiopulmonary arrest.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we found that the provider was failing to ensure there was an effective system in place to assess, monitor and mitigate the risks to people's health and safety. When we registered the new provider after they had taken over the running of the home, we attached conditions to their registration to ensure breaches committed by the previous provider were rectified. However, there was still a lack of robust quality assurance, to ensure risks to people were assessed and monitored to improve the safety of the service. Complete records of each person were also not being maintained to ensure all their needs could be sufficiently met. The provider had failed to carry out steps to assess, monitor and improve the quality of care provided.

We also noted that some of the procedures and systems required updating from the previous provider to the new provider to ensure they were up to date for staff, people and relatives to view. For example, we noted that an old complaints procedure, with the previous provider's details, was still on display in one of the units. This meant people would not have access to the correct information on how to make a complaint.

There was a registered manager in place. They had been promoted from their previous role as deputy manager in January 2018 and they were supported by a new deputy manager, and an area manager. The new deputy manager was also promoted internally to fill the registered manager's previous post. The provider had taken over the running of the home in July 2017.

The provider's quality assurance system consisted of daily, weekly and monthly audits to ensure the home remained safe for people, was meeting health and safety requirements and improvements were made where necessary. There were monthly audits and inspections to ensure the premises and equipment was safe and that risks of infection were controlled. Daily 'flash meetings' were held between senior staff to discuss any significant activity across the whole home, such as hospital admissions or discharges, complaints and concerns. Audits to check the home was operating well at night also took place.

The provider had identified that further improvements were required in the home. For example, care plans for some people on the Blossom unit required additional information such as a person's life history and a mental capacity assessment. These were to be carried out by nursing staff by early February 2018. However, we saw that no action had been taken by this date and no information was recorded to explain why these actions were delayed. We addressed these issues with staff on duty and with the registered manager because we were concerned that information about people was not up to date. They told us that a named nurse and key worker policy was in place, where people were allocated a member of staff, who took responsibility for arranging their care needs and recording updates on their care plans and risk assessments. However, staff also told us it would be up to the nurse in charge of the unit on any given day to update the care plans and risk assessments. This meant there was not a clear line of responsibility in the service, particularly for when staff were busy caring for people on a day to day basis and did not have time to update people's records.

The provider had also identified that capacity assessments for people and records of their consent to care

was required. However, we were concerned that the provider had identified that such information was still missing for a large number of people across all units in the home. We asked the registered manager why so many people were affected. They told us, "We have had a lot of changes. The previous registered manager developed me and handed things over to me only a few days before I became manager. We have not been able to get ourselves up to date. We are in the process of change and there is a lot of work to do. I aim to improve our standards." This meant that the provider was not operating effective systems and processes to maintain complete, accurate and contemporaneous records for people and the decisions taken in relation to their care and treatment. For example, they were failing to ensure people had provided their consent and that this was obtained and recorded. This would ensure that people's legal and human rights were being adhered to.

People's health needs were also not being monitored effectively to ensure they received the best care because guidance from healthcare professionals or appointments were not always followed up by staff.

The home's audits had not picked up that two people did not have their essential and prescribed medicines available for almost one week. People were placed at risk of potential harm because medicines were not available when needed. We found that people's risk assessments and care plans were not sufficient in identifying people's needs and the risks associated with these needs. This meant the provider was not operating effective systems and processes to assess, monitor and mitigate the risks to the health, safety and welfare of people in the service.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives were generally complimentary of the home. One person said, "Yes it is a nice home." A relative told us, "The staff treat us with kindness." Staff told us they felt supported by the new registered manager and that they were pleased they had been appointed in the role. One staff member told us, "The manager is excellent very supportive. I am very confident in them. [Registered manager] is well liked and popular." Another staff member said, "[Registered manager] is very good. She is empowering and helps us to learn, challenge ourselves and use our initiative."

Staff told us they felt confident they had the skills to meet the day to day challenges of their work. The management team and staff shared learning and best practice, so they understood what was expected of them and what their responsibilities were. Meetings took place between the nursing staff and care staff and topics of discussion included recording, team working, medicines and staff rotas.

The home also held 'residents and relatives' meetings. The registered manager told us the meetings had not been well attended in the past. They were in the process of contacting families to encourage them to attend in order for them to express their views about the home, air any concerns and provide feedback. The registered manager said, "I aim to make the home better and make it comfortable and safe. Staff will be given support. I want to engage residents more socially and mentally like getting them involved in the community, such as with local schools." We saw that this was currently taking place and that activities in the home, for example, had improved. Relatives told us the activities had become more creative and imaginative. This showed that the registered manager was taking action to ensure people remained satisfied with the home and to make further improvements.

Annual questionnaire surveys were sent to people and other stakeholders such as relatives. We looked at the results from the most recent survey and noted comments were mainly positive. Comments from people and relatives included, "I think the home is good but short staffed at weekends" and "All I can say is the staff

are very much good. Very good." Compliments and thank you cards were also received by the service from people and relatives. One relative had written, "Thank you for looking after [family member]. For the care you gave and for being so kind and friendly." We contacted the local authority for their feedback on the home and they told us that the provider had made progress and was complying with actions that they had identified for further improvements.

The registered manager notified us of serious incidents that took place in the service, which providers registered with the CQC must do by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure care and treatment of people was appropriate to meet their needs and reflect their preferences in a person centred way. Regulation 9(1)(2)(3)a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not complying with regulations to obtain consent to care. Systems had failed to ensure people had provided their consent and that this was obtained and recorded. People's legal and human rights were not being adhered to. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of potential harm because the provider had failed to ensure people's medicines were available when needed. Risks assessments were incomplete or did not adequately reflect their current needs. The provider was not doing all that is practicable to mitigate risks.

Regulation 12(1)(2) a,b,c

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks relating to the health, safety and welfare of service users, were not mitigated against. Accurate, complete. Contemporaneous records for each service use, including decisions taken in relation to their care and treatment were not always maintained. Regulation 17(1)(2)a,b,c

The enforcement action we took:

We issued the provider a Warning Notice.