Scotia Health Care Limited

Scotia Heights

Inspection report

Scotia Road
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 7 and 9 February 2018.

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

Scotia Heights is registered to provide a service for up to 60 people who have a neurological disabilities, enduring mental health, brain injury, stroke and early onset dementia. On the days of our inspection there were 56 people living in the home. The home is situated on three floors and divided into six units of which were accessed by a passage lift.

At the previous inspection in March 2017, the service was rated 'Requires Improvement.' At this inspection we found that the provider had taken some action to improve the quality of service provided to people. However, there were still areas that required improvement. The overall rating for this service remains as 'Requires Improvement.'

The home has been without a registered manager since November 2017. 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. In the absence of a registered manager the home was being run by a peripatetic manager. In this report we refer to this person as the 'manager.'

The management of medicines needed to be improved to ensure people received their treatment as prescribed. People were at risk of not receiving consistent care and support due to the frequent use of agency staff who were unaware of their needs. However, we found that staff had been recruited safely. People may be discriminated against due to their disability and where their first language is not English. The provider's governance was ineffective to identify the shortfalls we found and to ensure people received a safe and effective service.

Staff had access to risk assessments to support their understanding about how to care for people safely. The hygiene standards within the home were satisfactory. Systems were in place to learn from near misses to ensure people's safety. People felt safe living in the home and staff were aware of their responsibility of safeguarding them from the risk of potential abuse.

People were cared for by skilled staff who were supported in their role by senior staff. The principles of the Mental Capacity Act were adopted in care practices to promote people's human rights. People were supported to eat and drink sufficient amounts and had access to a choice of meals. The involvement of other healthcare professionals assisted in maintaining people's physical and mental health.

People were cared for by staff who were kind and attentive to their needs. People's involvement in their care planning ensured they received care and support the way they liked. People's right to privacy and dignity was respected by staff and they were supported to maintain contact with people important to them.

People were supported by staff to pursue their interests. Complaints were listened to and acted on. People were given the opportunity to discuss their wishes regarding dying and end of life care.

People and staff were encouraged to be involved in the management of the home. People were complimentary about the new management team and were happy with the improvements made. The manager was supported in their role by the operations manager and the operations support manager. The managers had positive aspirations to drive improvements to ensure people received a good standard of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Practices did not always ensure that people received their medicines as directed by the prescriber. The frequent use of agency staff compromised the consistency of care people received. Systems and practices were in place to reduce the risk of cross infection. Lessons were learnt from near misses to improve safety in the home. People felt safe living in the home and staff knew how to protect them from the risk of potential harm.

Is the service effective?

Good

The service was effective.

People were cared for by skilled staff who were supported in their role. People's human rights were protected as staff adhered to the principles of the Mental Capacity Act. People's involvement in their assessment ensured they received the support they required. The environment and adaptations in place promoted people's independence. People were provided with a choice of meals and had access to drinks at all times. People were supported to obtain the necessary healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and attentive to their needs. People's involvement in their care planning ensured they received a service that met their preferences. People's right to privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People with a disability and where their first language was not English may face discrimination. People were supported by staff to pursue their interests. Complaints were listened to and acted

on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's governance was ineffective in identifying shortfalls that may compromise the quality of service provided to people. People were complimentary about the new management structure and were involved in running the home. Staff's views and opinions were encouraged. The provider worked with other agencies to ensure people's assessed needs were met. The managers had positive aspirations to drive improvements.

Scotia Heights

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 9 February 2018, and was unannounced. The inspection team comprised of two inspectors, a specialist advisor who was specialist in nursing care and an expert by experience.

As part of our inspection we spoke with the local authority about information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

At this inspection we spoke with 11 people who used the service, four visitors and 15 care staff which also included agency staff. We spoke with seven nurses this also included agency nurses. Discussions were also held with a clinical leads, the peripatetic manager, operations support manager and the operations manager. We looked at care records, medicines administration records, risk assessments and records relating to quality audits. We observed care practices and how staff interacting with people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection we found that the provider had not taken sufficient action and further improvements were required. This key question was rated 'Requires Improvement.'

At our previous inspection in March 2017, we found improvements were required to assist people who needed help with their breathing who had a tracheostomy. A tracheostomy is an artificial airway that is used to help people to breathe. At this inspection we found that staff had a better understanding of their responsibility in supporting people with their tracheostomy. One staff member explained the appropriate procedure to take in the event of an emergency. This staff member demonstrated a good understanding with regards to best practices to ensure people were safely supported with their tracheostomy. We also observed monitoring forms were in place to check tracheostomy and suction equipment. We saw these forms had been completed consistently to ensure the equipment were suitably for use. This showed that the provider had taken action to improve the care and support provided to people.

At our previous inspection we identified improvements were required to ensure the safe management of medicines. At this inspection we found the provider had not taken sufficient action to address this. We observed some medicines were required to be stored in a refrigerator as identified on the package. However, the temperatures of the refrigerators were inconsistent and we found that some medicines had not been stored at the correct temperature range as recommended by the pharmaceutical manufacturers. This meant the provider could not be sure these medicines were suitable for use. The operations manager said they were in the process of purchasing new refrigerators designed for the storage of medicines which would resolve this problem. They assured us medicines that had not been stored at the correct temperature would be disposed of and replaced with a new supply.

We found gaps on medicines administration records [MAR]. A MAR is a record of people's prescribed medicines. These should be signed by staff to show when medicines had been given to the individual. The nurse in charge was unable to confirm whether these people had received their treatment and the nurse responsible had failed to sign the MAR to confirm this. The people who had been prescribed these medicines did not have the mental capacity to tell us if they had received their medicines. Further discussions with the nurse confirmed they had completed an incident form for this to be investigated further. On a different unit we observed the MAR had not been signed to confirm the person had received their medicine. The nurse in charge of this unit confirmed they had administered this medicine but had failed to sign the MAR. We observed that the same nurse had completed three incident forms where another nurse had signed the MAR but medicines had not been given to the person. This meant people could not be assured they would receive their treatment as prescribed.

We observed medication plans were in place in relation to people's prescribed treatment. However, we found on one unit these had not been reviewed as some did not relate to information contained in the individual's support plan. We found that some records had not been reviewed since 2016. Up to date information is vital to ensure all staff have access to relevant information about people's prescribed

medicines.

People were supported by qualified nurses to take their prescribed medicines. One person told us, "My medicines are managed by the staff and that suits me, I get them on time and can have painkillers when needed." Another person told us they were fully aware of their treatment and were happy with staff managing their medicines. The manager informed us that competency assessments were routinely carried out. This was to ensure nurses had the up to date skills to assist people with their medicines safely and the nurses we spoke with confirmed the undertaking of these assessments. However, we found shortfalls with medicine practices.

A record showed the person required their medicines covertly. This is where people lack capacity to understand their health condition and the necessity to take their medicines. Medicines are disguised so people receive treatment as prescribed. Records showed a best interest meeting had been carried out and it had been agreed by the person's GP and the pharmacist that this method of administering their medicines was in their best interests. We observed that a nurse took their time to ensure this person took their prescribed medicines before leaving them.

At our previous inspection we identified shortfalls with regards to staffing arrangements. The previous registered manager informed us there were sufficient staffing levels provided to meet people's needs. However, they had not been deployed in areas where needed.

At this inspection people were at risk of not receiving consistency with the quality of care they received. This was because of the high level of agency staff used to bridge the gap of staff shortages. One person told us, "Staff are always available in the day to support you when needed. However, during the night time there isn't enough staff and you have to wait a long time for support. They continued to say, "I had to wait so long last night for assistance and I didn't get to the commode in time." Another person told us they did not receive the same quality of care during the night time as they did in the day. They said, "There are too many agency staff. They don't know me and ask me about the support I need to maintain my personal needs and what kind of hoist I need. However, I can't fault Scotia Height's staff." A relative said, "They rely very much on agency staff in the evening and night time. [Person] can get a bit upset when they are with people they don't recognise." A staff member said, "People come to work here thinking it is easy work but it isn't and then they leave." The continued to say, "This can be seen as a positive thing because you have to be 100% committed to work here." A nurse informed us about the frequent use of agency nurses. They said, "The use of agency nurses makes our job harder because we are continually auditing their work and performance."

The manager confirmed there were 462 hours per week vacant nurses posts and 33 care assistants' posts. They said they tried to use the same agency staff to provide some level of consistency. We spoke with an agency nurse who said, "They tend to block book me just for consistency." Further discussions with this nurse confirmed their knowledge of people's specific needs and how best to communicate with the individual. We observed that people knew this nurse and had a good rapport with them. A relative said, "They seem to be using the same agency staff now." The provider had implemented a project that would be managed by the operations support manager to develop a proactive recruitment plan and subsequently reduce the use of agency staff.

During our inspection we observed staff were nearby to support people when needed. The manager informed us that 12 people required one to one support to ensure their care and support needs were met safely. During the course of our inspection visit we saw these people were provided with this level of support.

People were cared for by staff who had been recruited safely. All the staff we spoke with confirmed safety checks were carried out before they started to work in the home. We looked at four staff files that provided evidenced of a Disclosure Barring Service [DBS] check. DBS assists the provider in making safe recruitment decisions. We observed that references were in place to ensure people were of suitable character. There was also evidence of checks to ensure overseas staff had the right to work in England. This meant people could be assured of the suitability of staff who cared for them.

We looked at how well people were protected from the risk of cross infection. We observed the cleanliness of the home were satisfactory. All the people we spoke with said the home was usually clean and tidy. A staff member said, "We have domestic staff who clean the home but we also clean as we go along." Staff confirmed they had access to essential personal protective equipment (PPE) such as disposable gloves and aprons and we observed these being used. Hand wash areas and hand sanitizers were located throughout the home to promote regular hand washing. The provider had a nominated infection, prevention and control [IPC] lead. This person was responsible for reviewing and monitoring hygiene standards throughout the home, through the process of observations and audits. The home had recently been awarded the maximum five stars with regards to their environmental health inspection. This demonstrated good hygiene practices with regards to food handling.

People told us they felt safe living in the home. One person said, "I feel safe here but sometimes I feel uneasy and shout but staff sit with me and calm me down. I am safe here, nobody can hurt me." Another person said, "I feel safe here because of the staff and the environment." Most staff we spoke with demonstrated a good understanding of their responsibility of protecting people from the risk of potential abuse. Staff confirmed if they had any concerns about poor care practices or potential abuse they would share this information with senior staff. They told us they were confident that this would be dealt with promptly to protect the individual. A staff member said discussions often took place with people who lived at the home about what to do if they felt unsafe. They said this was discussed on an individual basis and during meetings. The provider had maintained a record of safeguarding referrals to the local authority for further investigations. This process ensured that people were not placed at risk of further harm.

The provider had a whistleblowing policy which was supported by 'SeeHearSpeakUp.' Information relating to this was situated in each unit and other areas of the home. This provided information and contact details about what to do if the individual have any concerns.

We looked at how the provider managed risks to people. A staff member informed us about a person who was at high risk of falls. They told us, "[Person] is very active and they are at risk of falls, so a staff member always needs to be with them." We observed this person was supported as identified in their risk assessment to reduce the risk of harm to them. We saw that risk assessments were in place to support staff's understanding about safe practices and to inform them of essential aids and adaptations required to support and promote people's independence safely. For example, we observed people were equipped with specialised wheelchairs and walking aids. People also had access to assisted baths and showers. One person said, "I have just been reassessed for a wheelchair. I can't wait that means I will be able to go out more often." The risk assessments we looked at evidenced people's involvement and where they lacked capacity their family were encouraged to participate. We also saw where people lacked capacity to be involved in the assessment process; a best interest decision had been made on their behalf involving other relevant healthcare professionals.

Discussions with staff and the care records we looked at showed some people required support to manage their behaviours. Staff informed us that medication therapy was used as a last resort. One staff member told us they had received training about how to support people with their behaviours safely. Diversion

techniques were used; this is where a person is distracted away from what may cause them to be anxious and upset. The provider had a mental health specialist in post. They provided staff with support and advice about how to reduce people's agitation and so reduce the risk of inappropriate behaviours. With this support the operations manager said they had identified a decline in the use of physical restraint.

We looked at how the provider managed accidents and incidents. Staff told us about their responsibility of recording all accidents. The operations support manager informed us that accidents were monitored to identify any trends. Accidents and incidents were reviewed to find out if sufficient action had been taken to reduce the risk of a reoccurrence. This meant people could be confident that efforts would be made to protect them from further accidents.

We found that lessons were learned when things went wrong and action was taken to make improvements. For example, a clinical nurse manager informed us of a recent incident were a staff member had failed to fasten a person's lap belt whilst they were in their wheelchair. This placed the person at risk of injury. This incident had been recorded as a near miss. The provider had taken the appropriate action to notify the Commission of the incident. An investigation had been carried out and the importance of fastening the person's lap belt was addressed with staff during their supervision sessions to avoid this happening again.

Systems were in place to respond to external safety alerts. The provider had their own health and safety officer who was responsible for alerting staff about safety issues relating to equipment used in the home. Equipment would be taken out of use until deemed safe. We observed that a record of safety alerts were maintained and showed what action had been taken to ensure people's safety.

Good

Is the service effective?

Our findings

At our last inspection the provider was rated 'Good' in this key question. At this inspection we found that standards had been maintained and this key question was rated 'Good.'

Since our last inspection the provider had taken action to ensure staff received tracheostomy training. One staff member said, "This was face to face training and it was very good." To ensure skills learned were put into practice a nurse informed us they had been shadowed and supported by a clinical nurse manager who checked their practices at every stage. They informed us they had been observed carrying out three procedures irrespective of their experience before being allowed to do any tracheostomy work unsupervised. They also confirmed they would be undertaking a refresher tracheostomy training in the near future. Staff confirmed they had access to on going training that provided them with the skills to carry out their role effectively. A staff member told us about various equipment people required and confirmed they had received training about how to use them safely. The operations manager informed us that agency staff were also provided with training. We observed that the provider had a training matrix in place. This enabled them to monitor staff's training and to ensure refresher training was provided to ensure staff maintained their skills.

People confirmed the undertaking of assessments with regards to their care and support needs. We spoke with one person about their health condition who confirmed they were happy with the support they had received. They said they had all the necessary equipment to promote their independence. They told us the manager acknowledged their aspirations to live independently and was liaising with other agencies to enable this to happen.

We looked at how the provider supported new staff into their role. Staff confirmed they had received an induction. One staff member said, "I've had previous experience in care but my induction refreshed my memory with regards to good care practices." Another staff member who had recently been recruited said, "I had to go through induction, I did mental health, safeguarding, fire awareness and deprivation of liberty safeguards training." The manager said, "New staff work alongside an experienced staff member until they feel comfortable working by themselves." This demonstrated that new staff were adequately supported in their role.

Staff confirmed they received one to one [supervision] sessions. A staff member told us they found these sessions valuable. They said during this session they had raised concerns about care practices that caused a person to be anxious. They said the manager listened to them and addressed this to ensure the person's wellbeing." This showed that staff were supported to provide a safe and effective service.

We observed that the environment was suitable to meet people's needs. There was a passenger lift in place to enable people to access all parts of the home. Doorways were wide and accessible for wheelchair users. One person said, "I am fairly independent and have all the equipment I need." Another person said, "I have a lot of equipment to help me and I am being assessed for new wheelchair." The staff we spoke with said they had the relevant equipment to assist people to be as independent as possible. People were supported to

access out door areas in warmer months. We observed some people accessing the outdoors areas when they wanted to have cigarette. People confirmed there were quiet areas in the home where they can talk to their visitors in private.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The people we spoke with confirmed staff always obtained their consent before they assisted them. One person told us staff always respected their decision. For example, they told us that a speech and language therapist had advised them it would be more suitable to have soft foods. However, they wanted to continue to have normal meals and their choice was respected by staff. A staff member said, "We ensure that their meals are cut up small to reduce the risk of choking."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Discussions with the manager confirmed where they felt people did not have capacity to make a decision a mental capacity assessment would be carried out to determine their level of understanding. We saw evidence of these assessments. Where authorised DoLS were in place, the provider had systems to review these to ensure they were still appropriate. We also saw that best interest decisions had been made on behalf of people with regards to them receiving their prescribed treatment. Staff had a good understanding of MCA and the reasons why people had a DoLS in place. We found that the least restrictive measures were taken. For example, a staff member told us, "If [Person] wanted to go out I would take them out." We spoke with a person who did not require a DoLS who said, "There are no restrictions imposed on me I can come and go as I please." This demonstrated that the principles of the MCA and DoLS were used to ensure people's human rights were respected.

People were supported by staff to eat and drink sufficient amounts. One person told us the meals were brilliant and they could choose what they wanted. Another person told us they had a choice of meals and had access to drinks at all times. A different person said, "I can make a hot drink myself in the kitchen if I fancy one." We observed that drinks were made available throughout the day. The provider had introduced a drinks trolley during the day. People were offered a range of drinks such as smoothies and soft drinks.

We saw that people who required assistance with their meals this was carried out by staff in a dignified way. For example, a staff member sat beside a person whilst they encouraged them to eat their meal. One person told us, "I'm not a big eater but I can have something to eat at any time." We spoke with a visitor who said staff always informed them if their relative had not eaten or drank enough. They said this gave them the opportunity to encourage them to eat and drink whilst they were with them. A nurse informed us about a person who required their drinks to be thickened and their food to be pureed to reduce the risk of choking.

Menus were displayed throughout the home. A staff member told us if people did not like what was on the menu they were offered an alternative choice. We also saw evidence of this where people had been provided with meals that were not identified on the menu. This demonstrated that people's food preference was respected.

People were supported by staff to access relevant healthcare services. One person told us, "If I am unwell the staff will arrange a GP visit for me." Another person told us told us they had access to a specialist nurse to assist them with their health condition. A different person told us they had pressure sores and said they had access to a tissue viability nurse to assist them with their treatment. We spoke with a visitor who told us staff were prompt in calling out the GP for their relative and they also informed them of any health changes. The care records we looked at evidenced the involvement of other healthcare professionals to assist people with their physical and mental health needs.

Good

Is the service caring?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection we found that the provider had taken action to make improvements and this question was rated 'Good.'

One person said, "Since the change of the management and some staff, life is a lot better here." They told us, "The staff are lovely but there just isn't not enough of them." Another person said, "I need two staff to care for me and they are always very gentle. They know how to look after me. Staff often ask if I am happy with the care and I am." A staff member said, "We are their eyes and ears. We make people feel that this is their home. We chat with them and respect them." We spoke with another staff member who said, "It's really interesting working here and I feel the standard of care is good." We spoke with a senior care staff who informed us, "The staff are very committed and caring." A number of people were unable to tell us about their experience of using the service. However, were observed people were made comfortable and were well presented. One person was unable to speak English; a staff member told us they were familiar with the person's first language. We observed this staff member's approach was kind and caring and they took the time to make the person feel valued.

We observed people were cared for and supported by staff who were kind and friendly. For example, we saw that a person was unsettled and anxious. A staff member sat with them and reassured them. Staff were polite and respectful when they spoke with people and took the time with individuals who had limited understanding. One person who lived at the home said, "The staff treat me well." Another person said, "I've not seen any bad treatment to people. I would be happy for any of my family to receive care here." We spoke with a relative who said, "The staff couldn't do any better. Some people can be aggressive at times and the staff manage this well." Another person told us that staff were very caring and supportive to both them and their relative. We observed that staff were attentive to people's needs. For example, we heard a person tell a staff member they were in pain. The staff member shared this information with the nurse who immediately gave the person their medication to relieve their discomfort. We later spoke with this person who told us they were feeling a lot better and expressed they were well cared for by the staff.

Staff had a good understanding about people's specific needs. For example, one care record showed the person preferred to be cared for by female staff and we observed they were. They also liked to keep their hair short and we saw their hair was maintained in this style.

People were involved in planning their care. A number of people had difficulty with expressing their needs. Hence, care assessments were carried out with the individual by staff who were familiar with them and knew how to communicate with them. A staff member said, "It's important to have the same staff work on this unit, so they build a rapport with the individual and get to understand their method of communication." One person confirmed they were involved in planning their care and this had recently been reviewed. They said, "I am happy with the care provided." We observed one person used emoji [pictures] to express their needs and feelings. Staff were also aware of this person's needs through facial expressions and body language. Where it was deemed appropriate relatives were encouraged to be involved in the care planning process.

People's right to privacy and dignity was respected by staff. One person told us, "I can lock my bedroom if I want, keys are available but I don't lock it and nobody comes in, everything is safe." A staff member told us about a person who preferred to stay within the privacy of their bedroom and their choice was respected. Another staff member told us about a person who wished to have their dentures in at all times. The staff member said the person's wish was respected to preserve their dignity and we observed this. Staff were able to demonstrate care practices that ensured people's privacy. For example, to ensure personal care was carried out in a private area and not to discuss personal details about people with others. This showed that staff were aware of the importance of promoting people's right to privacy and dignity.

People's right to independence was respected by staff. For example, one person experienced difficulties eating their meals. However, they wanted to do this themselves and staff respected this. However, staff were nearby to assist the person if and when needed. Another person told us they were able to go out independently and staff accompanied them at times to assist them to access facilities in the community.

People were supported by staff to maintain contact with their family. One person told us, "I'm going out today with my relative, I go out every Wednesday with them." Another person told us their relative was in hospital and staff had made arrangements for them to visit them on a regular basis. They said, "The support was fantastic, they sorted out transport and carers for me." People confirmed they were able to have visitors at any times and there were areas in the home were they could talk to their visitors in private.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection we found that the provider had not taken sufficient action to make improvements and this key question was rated 'Require Improvements.'

People may not be protected from the risk of discrimination. For example, discussions with a staff member and the care records we looked at identified a person was unable to speak English. This person had been admitted to the home in 2016. However, no action had been taken to assist the person to communicate. The person's support plan showed if they were unable to express their needs or understand what was being said to them, this could lead to them getting agitated. Records continually identified concerns about the language barrier and the impact this had on the person. We shared this concern with the operations manager. They acknowledged the lack of support provided to this individual to assist them to communicate could be viewed as discrimination. They confirmed that since their appointment in December 2017, they were in the process of remedying this. They showed us pictorial cards that had recently been designed with the help of a staff member who spoke the same language as the person. These cards would help the person to express their needs. We found the provider had not explored the use of an advocate to support this person. The operations manager assured us that this would be looked at.

We observed another person experiencing difficulty talking with a staff member. We looked at their support plan which showed they had difficulty talking due to their health condition. There was a communication board in place to help them to communicate. However, we observed this was not used to assist the person and the person looked frustrated. Their support plan showed they would become agitated if staff did not understand them. We shared this information with the manager. They assured us action would be taken to remind staff to use the communication board to help the person express their needs.

We spoke with the operations manager about specific technology used in the home to support people with communication and to promote their independence. They confirmed there was very little assisted technology in place. They said they were looking at equipment available to help people to communicate. They also confirmed wheelchair assessments needed to be carried out to ensure people were provided with the appropriate equipment to support them to mobilise safely. This demonstrated that the provider had recognised the need to incorporate new technology to enhance people's life.

Discussions with one person who lived at the home raised concerns about them not being able to engage in conversation with people they lived with. This was due to other people's health condition. We shared this information with the manager who told us about 'community fit.' This is where they had identified some people had not been accommodated on the right unit. For example, where there was one female living amongst all male. The manager said this would be reviewed to ensure people lived on a unit where they could interact with others and staff had the specific skills to meet their needs.

The provider had employed five staff members to assist people to pursue their social interests and hobbies. However, we received mixed comments about social activities provided in the home. A number of people

we spoke with confirmed activities provided were boring. A staff member told us that activities were not always suitable for the individual and this needed to be reviewed and improved. We heard a staff member ask a person if they would like to spend some time in the sensory room. The person refused and said it was boring and they would prefer to chat with the inspectors. A sensory room is a special room designed to develop a person's sense, usually through special lighting, music, and objects. It can be used as a therapy for people who are unable to speak. We observed that staff supported one person to go out for a walk. When they later returned we observed them in the sensory room undertaking therapeutic exercises. One person told us they had access to various activities but preferred to chat with the staff. We spoke with a relative who told us, "Last week [Person] went to the cinema and today they are going out to play bingo."

People's choice about how they spent their past time was respected by staff. For example, a staff member told us about a person who disliked big groups and their relative confirmed this. During our inspection we observed this person sat in a small lounge watching the television. We asked them if they were happy and they nodded their head. They looked comfortable and settled within their surroundings.

We observed that each unit had a monthly planner of forthcoming activities. This included special themed events such as Chinese New Year, Mother's Day and religious events. For pastimes people had access to various indoor games. A staff member informed about a short break in Blackpool that people enjoyed. Discussions with staff identified their knowledge about people's past history and their interests. For example, one person used to be in the in the Welsh Fusiliers. A staff member had contacted the Welsh Fusiliers to arrange for someone to visit the person to talk about the military.

We observed that people were supported to engage in activities in their local community which they told us they enjoyed. A staff member told us about a person who lived at the home who often went swimming and for walks. The staff member said, "To provide some consistency [Person] always goes out with the same staff member." One person told us, "I was going to Gala Bingo today with staff but I don't feel up to it."

We spoke with people about their aspirations for the future. One person told us they had lived at the home for ten months. They confirmed a healthcare professional visited them to discuss their continuing health care needs. They said, "My goal is to live in my own bungalow adapted to my needs. I've discussed my goals with the manager but its early days. If I move I would like to stay within this provider because I'm happy with my care."

People and their relatives told us if they had any concerns they would feel comfortable to share this with the management team. People were confident their concerns would be listened to and resolved. One person informed us, "If I was unhappy I would tell the nurse on duty." A visitor told us they had raised concerns about a staff member's conduct and action was taken immediately to address this. They said, "I have not experienced any other concerns since." We looked at how the provider managed complaints. The manager informed us that all complaints were recorded and we saw evidence of this. Records also showed what action had been taken to address the concern. This meant people could be assured their concerns would be listened to and acted on.

Discussions with the operations support manager confirmed that no one in the home was receiving end of life care. However, they confirmed they were in the process of commissioning 'end of life care' training for the nurses. The operations manager said when a person required end of life care they would work closely with the person's GP, the palliative care team and any other relevant healthcare professionals. Working with these healthcare professionals would ensure the person had a pain free comfortable end of life. A clinical nurse manager told us about 'Preferred Priority of Care.' This is a tool used to obtain people's preferences and wishes about dying and death. This was usually carried out during the admission process. We looked

at a care record that identified the person's wishes regarding their end of life. This provided staff with information about who they wanted to be present during their end of life and who to contact when they died. One person said due to a recent bereavement they were going to have discussions with staff about their wishes with regards to their end life plan. They told us about the support provided to them during their relative's illness in hospital. They said, "The staff have put a shelf up opposite my bed, this is so I can put the container with my relatives ashes on. I will be able to see them before I go to sleep."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection the provider was rated 'Requires Improvement' in this key question. At this inspection we found that the provider had not taken sufficient action to make improvements and this key question was rated 'Require Improvement.' The provider continued to be in breach of regulation 17.

At our previous inspection we found the provider's governance was ineffective to assess, monitor or to drive improvements. At this inspection although some efforts had been made to improve the governance we continued to find shortfalls with the quality of service provided to people. For example, the management of people's prescribed medicines did not ensure people received their treatment as prescribed. People had raised concerns about the frequent use of agency staff and the inconsistency of care and support they received due to this. The governance did not protect a person with a disability or where another person's language was not English from discrimination which had an impact on the individual's behaviour.

This is a breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Discussions with the operations manager and the records we looked confirmed the governance looked at how systems and practices protected people from potential abuse. Systems were in place to review complaints and where necessary to take action to improve the service. Daily meetings had been introduced with head of departments. For example, unit managers, head of catering and the head of maintenance. This was to discuss areas of improvements and to ensure staff were aware of their roles and responsibility to ensure people receive a safe and effective service. The provider's governance had identified an increase in violence and aggression. The operations manager said they had identified this related to people who had recently moved into the home. They said they were in the process of reviewing how people were supported when they are admitted. The governance had identified shortfalls in relation to the management of medicines. The operations manager said observations would be carried out of nurses' practices and where necessary further training would be arranged for the individual. They also informed us that competency assessments would be carried out to review their practices. The governance also included the review of care notes. The operations manager said they identified that these records were not user friendly and would be reviewed. The operations manager said, "Anything we plan to do, we need to consider how this will benefit people in our care."

We spoke with the operations manager about the culture of the home. They said, "My aim is to move aware from task orientated methods and to focus on a person centred culture." They continued to say, "I want staff to really understand people's needs and to encourage community presence."

People were encouraged to be involved in the running of the home. Quality assurance surveys were routinely given to people to complete. This gave people the opportunity to tell the provider about their experiences of living in the home. Information gathered from these surveys were fed back to people during meetings. A service user council meeting was also carried out. Senior management would meet with a person who used the service who represented other people who lived at the home. This gave them the

opportunity to tell the provider about things that worked well and where improvements may be needed to enhance people's quality of life. One person informed about meetings carried out with people who lived in the home. They said, "There have been some changes made after these meetings. Decoration has started in the building and there's been an increased budget for social activities and to replace games and DVDs."

Systems were in place to enable staff to have say in the running of the home. Staff informed us that the new manager had reinstated regular meetings with them. Staff told us they were able to express their views during these meetings and the managers listened to them. Staff said during a recent meeting the manager had shared their vision of the organisation with them and discussed areas where improvements were needed and where progress had been made. A staff member said, "The management of the home is a lot better." The operations manager said, "I want to empower staff's involvement and involve them in future staff interviews."

A staff member told us they and other staff were allocated tasks to monitor the quality of service provided. For example, they told us they were responsible for checking charts to ensure people were repositioned in bed to reduce the risk of skin damage. They reviewed charts to ensure people were provided with enough drinks throughout the day. These checks promoted people's wellbeing. The manager informed us about a 'food' forum they had recently introduced. This enabled people to discuss and to provide an opinion with regards to the variety of meals and drinks on offer.

The clinical nurse manager said they were in the process of reviewing the work carried out by the 'activities team.' This was to ensure their approach was person centred to ensure people's specific interests were recognised.

People were supported by staff to maintain links with their local community. The home was situated next door to a leisure centre and people told us they often visited this centre. The operations manager informed us that a person who lived at the home had expressed a wish to attend the local youth centre. This was to talk with young people about their past and to encourage them not to pursue activities that may place them at serious risks of injury. They felt their experiences and the impact it had on their life would benefit young people who were tempted to go down this route. The provider worked alongside other agencies such as the local authority and healthcare professionals. This ensured people had access to specific service to ensure their needs were met.

Since our last inspection in March 2017, the management structure within the home had changed. The provider has not had a registered manager in post since November 2017. The home was being run by peripatetic manager until the appointment of a registered manager. The operations manager confirmed the provider was in the process of advertising the manager's post. The peripatetic manager was supported in their role by the operations support manager and the operations manager. People told us that the quality of the service had improved since the new management structure and wanted reassurance that improvements would continue. One person who lived at the home said, "I know the new manager, I can't fault them." Another person said, "Since the new management team I now feel settled and consider this as my home." They continued to say, "Things are going quite well at the moment. Things are a 100% better than last year." A relative said, "The manager stops and chats and asks how things are." A staff member said, "The manager comes in several times a day. I find them very approachable."

With the introduction of the new management structure an action plan was developed to review the current status of the home and to identify where improvements could be made. This included the review of staff's roles and responsibilities. To devise and implement a programme of leadership and management workshops for unit managers and also to introduce governance meetings to review the quality of service

provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance This is a breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's governance was ineffective to promote quality standards with the management of people's prescribed medicines. People with a disability and those who do not speak English were discriminated against and the frequent use of agency staff compromised the consistency of care provided.