Bupa Care Homes (CFHCare) Limited

Old Gates Care Home

Inspection report

Livesey Branch Road
Feniscowles
Blackburn
Lancashire
BB2 5BU

Date of inspection visit:
12 December 2016
13 December 2016

Date of publication:
19 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 12 and 13 December 2016. The service had previously been inspected in January 2016 when we found it to be in breach of one of the regulations we reviewed; this was because the management of medicines needed to be improved.

This inspection was prompted in part by anonymous information we had received which alleged people who used the service were receiving poor care, particularly those on the unit for people living with dementia.

Old Gates Care Home provides accommodation in three units, for up to 90 people who need either nursing or personal care and support. These units are Cherry, Holly and Rowan. Care and support for people living with a dementia is provided in Rowan. There were a total of 79 people using the service on the days of our inspection.

Although the service had a registered manager in place at the time of this inspection they were absent from work. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. We were told the registered manager would not be returning to the service as they had gained a different position within the organisation. A new manager had been recruited to the service and was due to start in January 2017.

During this inspection we found five breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. These related to staffing arrangements in the home, a lack of regular supervision for staff, recruitment processes which were not sufficiently robust, a lack of effective systems to ensure the safe handling of medicines and quality assurance processes which did not drive forward improvements in the service. You can see what action we have told the provider to take at the back of the full version of the report.

Staffing levels had recently increased on Rowan unit following a number of safeguarding alerts raised with the local authority. However we found there was no robust system in place to determine what staffing levels were required and the skill mix needed on each unit to meet the needs of people who used the service.

Although most staff told us they enjoyed working in the home and felt they received good support from senior staff, we found staff were not provided with regular supervision which was a forum to discuss their learning and development needs.

The recruitment process in the service needed to be improved. Additional checks had not always been undertaken when staff had worked previously with vulnerable adults or children to ascertain why their employment in that service had ended. Records did not show that gaps in applicant's employment history

had been explored.

A number of audits had been completed by the provider and internally within the home. These audits had shown that improvements needed to be made to the way the service was run in order to ensure people who used the service always received high quality care. Our findings during the inspection showed necessary actions had not always been completed in a timely manner.

Improvements needed to be made to the way medicines were handled in the service. However, we did not find any evidence that people had not received their medicines as prescribed.

We saw that suitable arrangements were in place to help safeguard people from abuse. Guidance and training was provided for staff on identifying and responding to the signs and allegations of abuse. Staff were able to tell us of the correct action to take should they witness or suspect abuse.

People who used the service told us they felt safe in Old Gates and that staff were always kind and caring. The staff we spoke with had a good understanding of the care and support that people required. They told us, wherever possible, they would support people to maintain their independence.

Care records showed that risks to people's health and well-being had been identified, such as the risk of falls, pressure sores and poor nutrition. Where necessary we saw that people had charts in their rooms to confirm they had received the care they required to reduce the risk of pressure ulcers and poor nutrition. We saw that on Rowan unit these charts had not always been fully completed by care staff or signed by a senior member of staff; this meant we could not be certain people had always received the care they needed.

People were cared for in a safe and clean environment. Procedures were in place to prevent and control the spread of infection. Regular checks were made to help ensure the safety of the premises and the equipment used. Systems were in place to deal with any emergency that could affect the provision of care.

Staff received the induction and training they required to be able to deliver effective care. We saw that appropriate arrangements were in place to assess whether people were able to consent to their care and treatment. Where necessary applications had been made to the local authority to authorise any restrictions necessary to ensure people received the care they required.

Systems were in place to help ensure people's health and nutritional needs were met, although one person's relatives were concerned that a number of health appointments had been missed due to a lack of communication by staff. Records we reviewed showed referrals had been made to specialist services such as dieticians when any concerns were identified. People who used the service told us the quality of the food was good.

Although care records had been regularly reviewed and updated, there was limited evidence that people who used the service or, where appropriate their relatives, had been involved in formal review meetings. However, none of the relatives we spoke with had any major concerns about the care and treatment their family member received.

We saw that concerns had been raised in a number of different forums regarding the lack of meaningful and individualised activities in the service, particularly on Rowan unit. During the inspection we observed a number of activities taking place on Holly and Cherry units. However staff on Rowan were mainly focused on task related interventions with limited 1-1 attention given to people outside of these.

Systems were in place for receiving, investigating and responding to complaints. The provider kept a central record of all complaints in order that any themes and trends could be identified. The two most recent complaints in the service related to staffing levels and communication within the service. All the people we spoke with during the inspection told us they would be confident that any concerns they reported would be listened to and action taken by senior staff to resolve the matter.

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 always safe.

There was no robust system in place to ensure staffing levels were always sufficient to meet the needs of people living in the home.

The way medicines were managed in the service needed to be improved.

Recruitment processes needed to be improved to protect people from the risk of unsuitable staff.

People were cared for in a clean and safe environment.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff told us they received support from managers, there was a lack of formal recorded supervision to allow staff to discuss their training and development needs.

Staff understood the principles of the Mental Capacity Act (2005). Arrangements were in place to ensure people's rights were protected when they were unable to consent to their care and treatment in the service.

Systems were in place to help ensure people's health and nutritional needs were met, although one person had missed a number of important health appointments. People told us they enjoyed the food provided in the service and that it was of good quality.

Is the service caring?

Good

The service was caring.

People who lived in Old Gates told us staff were always kind, caring and respectful of their dignity and privacy. We saw that, wherever possible, staff supported people to maintain their independence.

Staff demonstrated a commitment to providing high quality, compassionate care. They had a good understanding of the care needs of people who used the service.

Systems were in place to protect people's confidential information.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care records were regularly reviewed and updated, there was limited evidence that people who used the service or, where appropriate, their relatives were offered the opportunity to participate in review meetings.

A programme of activities was in place throughout the home. However we saw little evidence that people living on Rowan unit were provided with the opportunity to engage with staff outside of task focused interventions.

Systems were in place for receiving, handling and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements needed to be made to the quality assurance processes in the service. The provider's own audits had identified a number of shortfalls in the running of the home.

Staff told us they generally enjoyed working in the service. Most staff considered the leadership in the service had recently improved with the appointment of new senior staff.

Old Gates Care Home

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 12 and 13 December 2016. The first day of the inspection was unannounced. We told the provider we would be returning on 13 December 2016 to continue to review the care people received in the service.

The inspection was prompted in part by information of concern we had received about the service; this information related to staffing levels, the lack of personal protective equipment (PPE) for staff to use and allegations of poor care; this inspection therefore included these areas of risk.

The inspection team consisted of two adult social care inspectors, a specialist advisor in the care of people with a dementia and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of residential and nursing care services.

Before the inspection we reviewed the information we held about the service including the last inspection report and notifications the provider had made to us. We also contacted the local safeguarding and quality assurance teams, the local clinical commissioning group and the local Healthwatch team to gather their views about the service.

During the inspection we spoke with seven people who used the service across all three units and 11 visitors. We also spoke with a total of 15 staff employed in the service. The staff we spoke with were the three unit managers, one registered nurse, six members of care staff including one who was employed by an agency, an activity organiser, a domestic, the chef, the maintenance person and the hotel services manager. In addition we spoke with the area trainer, a manager and clinical services manager from one of the provider's other services who were supporting the service in the absence of the registered manager, as well as the area manager and the quality manager who were present throughout the inspection.

We carried out observations in the public areas of the service. We also undertook a Short Observation Framework for Inspection [SOFI] on the unit for people living with a dementia. A SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care records for nine people who used the service and the records relating to the administration of medicines for a total of 25 people. In addition we looked at a range of records relating to how the service was managed; these included five staff personnel files, training records, quality assurance systems and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Due to their cognitive impairment none of the people living on Rowan unit were able to tell us if they felt safe. We were aware of a number of unwitnessed falls and incidents between service users which had been investigated by the local authority safeguarding team. The outcome of these investigations was that the provider was asked to increase staffing levels on Rowan unit, with a member of staff allocated to supervise the lounge area in order to ensure the safety of everyone living in the unit. However, on the first day of the inspection we observed that this arrangement was not always in place although staffing levels had been increased. The relatives we spoke with on Rowan unit told us they considered their family members were safe.

People living on Cherry and Holly units told us they felt safe in Old Gates. Comments people made to us included, "I feel safe here. Nobody bullies me", "I feel safe up to now" and "It is absolutely magnificent here. I feel very, very secure in the way I'm looked after and helped." Relatives we spoke with told us they had no concerns about the safety of their family members in either of these units. One relative commented, "I think [relative] is safe here. It has taken the pressure off us."

We received mixed feedback about staffing levels in the service. Two people who lived on Cherry Unit told us that while staffing levels in the daytime were good, they often had to wait for long periods for staff to respond to their requests for assistance at night. All the people we spoke with on Holly told us there were always sufficient numbers of staff available to provide the care required. None of the relatives we spoke with on Rowan unit expressed concerns about staffing levels.

Staff on Cherry unit told us there were enough staff available to allow them to spend time with people on an individual basis; this view was supported by our observations during the inspection. Staff on Holly unit told us that generally there were enough staff although mealtimes could sometimes be difficult due to the numbers of people who required support with eating. One staff member on Holly unit told us, "Lunch times can be very difficult. Sometimes it ends up with two staff trying to feed 15 people; this means it can take a couple of hours."

Staff on Rowan unit told us staffing levels had recently been increased on some shifts as a result of contact from the safeguarding team. Although there were dependency assessments in place to determine the level of need of people living on the unit, we did not see any evidence that these had been used to decide how many staff were required on each shift. Staff on Rowan unit also
told us they did not have time to spend with people to provide one to one attention and support outside of when they provided personal care; this was supported by our observations during the inspection when we saw that two people became agitated in their rooms but staff failed to attend to offer reassurance or support.

One member of staff on Rowan unit told us they considered an additional registered nurse was needed on the unit in order to meet the complex needs of people in a timely manner. We saw that they had reported these concerns to the registered manager several months previously but no action had been taken as a

result of this. When we raised these concerns with the area manager we were told an additional nurse could be provided on Rowan unit but it was not clear whether this would impact on the numbers of care staff deployed on the unit and if this would be the best use of resources to meet people's needs.

The lack of appropriate arrangements to ensure sufficient numbers of staff were deployed to meet the needs of people who used the service was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment processes in place. We reviewed the personnel files for five staff employed to work in the service. We noted that all of these files contained an application form, evidence to confirm each individual's identity and a criminal records check called a Disclosure and Barring service check (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. All of the personnel files we reviewed contained at least two references. However we noted that the provider had not undertaken the required additional checks with all previous employers where applicants had worked previously with vulnerable adults or children. In addition it was not clear that the gaps in one person's employment history had been fully explored during the interview process. This meant there was a risk people who used the service were not fully protected from the risk of unsuitable staff.

The lack of robust recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way medicines were managed in the service. At our last inspection we found that some areas of the medicines administration process needed further attention to ensure people always received their medicines as prescribed.

All medicines were administered by qualified nurses or by suitably trained care staff. Checks were completed to help ensure staff were competent to administer medicines safely. During the inspection we observed staff administering medicines to be kind, reassuring and patient to ensure people were supported to take the medicines they needed.

People we spoke with during the inspection confirmed they always received the medicines they required. One person told us, "The system works like clockwork. The staff make sure I take everything I need at the right time every day; I couldn't manage this without their help. The staff record everything properly so I know I'm getting what I need." Another person commented, "I can be forgetful but the staff here are so thorough in the way they check I have everything I need. They give me my medication at the right times and record it properly in my file. I find that a real comfort."

We reviewed the medication administration record (MAR) charts for a total of 25 people across the service. We found that all except one of these charts was fully completed. One person had not received a medicine they were prescribed on the morning of the second day of the inspection which was due to an oversight on the part of the member of staff concerned. When we brought this to the staff member's attention they ensured the medicine was administered.

During the inspection we were informed that a number of painkillers prescribed for one person had been found to be missing the previous week. It was not clear from our discussions with staff what action had been taken to report and investigate this incident. We discussed this with the senior managers on site who had been unaware of the incident but took immediate action to report the matter to the appropriate authorities.

We noted that the provider had completed a medication audit on Rowan unit in November 2016 due to concerns raised by the local safeguarding team about the management of medicines on the unit. We saw that this audit showed a compliance score of 31%. The audit showed a number of MAR charts did not contain photographs of individuals or a record of the allergies from which they suffered; this information is important to ensure people are not given medicines which are not prescribed for them or might be harmful. Although the timescales for actions to be completed was documented as 2 December 2016 we found that this information had still not been included on six people's records.

The lack of robust systems in place to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures were in place to guide staff about how to recognise when people might be at risk of abuse. Staff told us they had completed training in safeguarding adults and were able to tell us of the correct action to take if they witnessed or suspected abuse. A staff member told us, "I have a card in my purse with the number to call if we need to report things such as safeguarding. I would report anything to my unit manager or go further if they did not do anything." All the staff we spoke with were aware of the organisation's 'Speak Up' telephone line which they could use to report any concerns they had about the service. One staff member commented, "I am aware of the whistle blowing policy. I have used this policy in a previous job and would be prepared to use it here."

We reviewed the care records for nine people who used the service. We found that all records contained risk assessments that identified if individuals were at risk of harm from conditions such as pressure ulcers, poor nutrition and hydration, restricted mobility and the risk of falls. Where necessary we saw that people had charts in their rooms to confirm they had received the care they required to reduce the risk of pressure ulcers and poor nutrition. We saw that on Rowan unit these charts had not always been fully completed by care staff or signed by a senior member of staff; this meant we could not be certain people had always received the care they needed.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. Prior to the inspection we had received information that staff did not always have access to personal protective equipment (PPE). We therefore checked the stock of PPE and found there was sufficient available on all units for staff to use. Staff did confirm there had been some occasions on which a unit had run out of stock but told us they had been able to borrow supplies from one of the other units.

During the inspection we found most areas of the service were clean. Some of the bedrooms on Rowan unit were malodorous on the first day of the inspection but we noted this was improved on the second day. None of the people we spoke with during the inspection expressed any concerns regarding the cleanliness of the service.

We spoke with the hotel services manager who was the infection control lead for the service. They told us that they set high standards for all of the staff employed in the service in order to ensure people were protected from the risk of cross infection. They told us they visited all of the units on a daily basis and would always act immediately if they found staff were not following policies and procedures to protect people from the risk of cross infection. They told us they also provided regular training for staff on infection control.

Records we reviewed showed that the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This helped to ensure the safety and well-being of everybody living, working and visiting the home.

We saw a business continuity plan was in place for dealing with any emergencies that could arise. Inspection of records showed regular in-house fire safety checks had been carried out to ensure that the fire alarm, emergency lighting and fire extinguishers were in good working order. Personal evacuation plans (PEEPS) had been completed for all people who used the service; these records should help to ensure people receive the support they require in the event of an emergency. Staff had completed fire training and were involved in regular evacuation drills. This should help ensure they knew what action to take in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

We looked to see how staff were supported to develop their knowledge and skills. We spoke with the Area trainer who showed us the central training record held for all staff working at Old Gates. They told us they provided both the induction and refresher training for staff in the service.

Records we reviewed showed staff completed a five day induction when they started work at the service. This induction helped to ensure staff had an understanding of their role and how they should support people. The induction included training on topics such as safeguarding, moving and handling, food safety, fire safety, infection control, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), basic life support and health and safety. Comments staff made to us included, "I completed a booklet when I first started. The induction was good" and "The training I had was sufficient to be confident and competent."

We saw that there was a programme of refresher training in place. A central record was held by the area trainer to confirm what training staff had completed. We were told the area trainer was able to be very responsive to the needs of staff and ensure any required training was always delivered in a timely way. One staff member confirmed, "We get told when we need refresher training."

People who used the service told us staff appeared to be skilled and knowledgeable when providing care. One person commented, "I think they are well trained. I never feel embarrassed about the way they help me. They chat to me about they are doing and ask me how I want to be helped." Another person told us, "They know what they are doing and how to help me."

Although most staff told us they felt well supported, records we looked at showed there was a lack of evidence that staff had received regular supervision in line with the provider's supervision policy. We also found that some staff had only received supervision from their line manager if there had been an issue with their performance rather than the process being used to allow them the opportunity to discuss their learning and development needs.

The lack of regular supervision for staff was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). 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.

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 application 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.

We asked the provider about the number of people subject to DoLS in the service. We were told there were tracking sheets on each unit to show when DoLS applications had been submitted to the local authority and when these applications had been authorised. However, the information we found was not up to date and unit managers could not always tell us which people were subject to DoLS; this situation was rectified by the quality manager before the end of the inspection.

We saw there were appropriate arrangements in place to record people's capacity to make particular decisions. We saw meetings had taken place with family and professionals as necessary to ensure any decisions made about the care individuals received was in their best interests, including when it was considered necessary to administer medicines covertly (in food or drink without the person's knowledge) to help ensure their health needs were met.

All the staff we spoke with demonstrated a good understanding of the principles of the MCA and the need to support people to make their own decisions as much as possible. Staff on Rowan unit were able to tell us how they would gauge if people were in agreement with the care they wished to provide should they be unable to communicate verbally; this included observing people's non-verbal gestures and facial movements. People we spoke with on Cherry and Holly units confirmed they were offered choices about what they wanted to eat and drink, when they wanted to get up and go to bed, what they chose to wear and whether they wanted to take part in organised activities. One person commented, "The staff always ask what I want and listen to my needs."

We looked at the systems in place to ensure people's nutritional needs were met. All of the care records we reviewed contained a care plan which identified each person's needs and risks in relation to their nutritional intake. Where necessary staff had made referrals to specialist services including dieticians and speech and language therapists (SALT).

People who were able to express a view told us they enjoyed the food provided in the service and that it was of good quality. Comments people made to us included, "I really like fish. I can get a fish meal twice a week. I don't like to have too much food on my plate so I ask to have small portions", "I love my morning porridge. There is plenty of choice with the other meals too. There is always something I really like. I really enjoyed the pie and baked beans this lunchtime. If I don't feel like a meal I can order a sandwich filled with what I like" and "The food is great and there is plenty of it. I regularly have cheeseburger and chips; it is better than anything you can get outside the care home!"

We saw that drinks were made available to people both at mealtimes and throughout the day. We noted from the menus we reviewed that the lunchtime meal provided was a lighter option as the main meal was served in the evenings. The menu also offered a "Night Bite" option of dishes which staff could prepare in the small kitchenettes located on each unit when the main kitchen was closed.

We spoke with the chef at the service who told us they were aware of the likes, dislikes and any allergies people who used the service might have. They told us people were asked about their meal choices on a daily basis and that if they did not want what was on the menu alternatives were always available.

We found the kitchen was clean and well stocked. We saw that checks were carried out to ensure food was stored and prepared at the correct temperatures. The service had received a 5 rating from the national food hygiene rating scheme in January 2016 which meant they followed safe food storage and preparation

practices.

We asked staff how they kept up to date with people's changing needs to ensure they provided safe and effective care. All the staff told us they attended handover meetings at the start of each shift although we could not find a record of all the recent handovers which had taken place on Rowan unit. Staff told us that all important information was also recorded in the diary held on each unit so that staff could refer to this throughout their shifts.

People who used the service had access to healthcare services and received on-going healthcare support. Care records contained evidence of visits from district nurses, GPs, speech and language therapists, dieticians and mental health professionals. One relative we spoke with told us the only concern they had about the service was that their family member had missed a number of important health appointments. They told us they had attended a meeting with staff on the unit to discuss this but that the situation had unfortunately not improved following this. It is important that people are supported to attend external appointments so that any health needs can be investigated and addressed as necessary.

Good

Is the service caring?

Our findings

People who were able to express a view told us staff were kind, caring and respectful. Comments people made to us included, ""I think the staff nurse is wonderful. He checks my leg ulcers every three days. He is so gentle; there has been a big improvement with my legs", "They always close my door and pull my curtains when I have a wash in my room. Everything is respectfully done. They let me get on with what I want to do" and "Everyone is so nice and friendly. People talk to me all the time. We have a good laugh and a joke." A relative also commented, "The staff are so gentle with him. He is turned regularly and checked to see that he is comfortable."

During the inspection we observed warm and friendly interactions between staff and people who used the service, particularly on Holly and Cherry units. Where appropriate, we saw that staff knocked and waited for an answer before entering bathrooms, toilets and people's bedrooms; this was to ensure people had their privacy and dignity respected. Our conversations with staff demonstrated they had a good understanding of the needs of the people they cared for.

We observed there were several visitors to the service during the inspection. We noted that staff made all visitors welcome and took the time to chat with them. One relative told us, "The staff on Holly create a very peaceful and calm atmosphere. The general feeling is very restful and friendly. We are so pleased that our relative lives here. The staff know exactly how to make her comfortable. We could not find anywhere any better for the level of nursing support needed by our relative."

All the staff we spoke with told us they were committed to providing high quality care to people. One staff member commented, "I like caring for people; trying to do what you can to give them a happy life." Another staff member told us, "I would be happy for a relative to be looked after here."

Care records were organised into a number of sections including a pen picture ('My Day, My Life, My Portrait') of each individual, their likes/dislikes and their family and social history. This should help staff form meaningful and caring relationships with the people they supported. Care plans also included information for staff about how they should promote people's independence wherever possible.

Care records we reviewed also contained some information about the care and support people wished to receive at the end of their life. Some staff had completed training in end of life care to help ensure they were able to provide the best care possible at this important time.

We noted that Information was on display on all the units regarding the advocacy service people were able to contact should they want independent advice or support.

We noted that all care records were held securely; this helped to ensure that the confidentiality of people who used the service was maintained.

We saw that throughout the home there were cards on display expressing thanks and gratitude for the care

provided by staff. One card in particular stated, "Thank you all for looking after our relative for the past few years. A special thanks to [two staff members] for being so caring and Thank you to the young member of staff who helped my relative with her crosswords and all the other fantastic staff I do not know the names of. I offer you all my deep gratitude for the care and kindness shown to my relative. Your gentle caring ways were so comforting to all the family to witness especially as we live so far away. Our relative was safe and well looked after."

Requires Improvement

Is the service responsive?

Our findings

Arrangements were in place for the registered manager or a senior member of staff to assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. This process helped to ensure that people's individual needs could be met at the home.

People we spoke with on Holly and Cherry units told us they had been involved in formulating the original care plan when they moved into Old Gates. No one we spoke with during the inspection told us they had been involved in subsequent reviews although people who used the service told us they did have regular conversations with staff in which they discussed the care they received.

All the care records we reviewed contained care plans which had regularly reviewed and updated. We discussed the 'resident of the day' system for care plan reviews with one senior member of staff. They told us that this system helped to ensure that each person's care plan was reviewed on the same day each month but told us that this was usually completed without any discussion or involvement of the person, where possible, or their family members. They advised us that relative involvement was not sought, in line with good practice, even when they visited the unit on a very regular basis and could therefore be easily consulted. However, none of the relatives we spoke with expressed any concerns about the care their family member was receiving.

We looked at the activities available to promote the well-being of people living in the home. We noted the provider's own home audit completed on 30 November 2016 had identified that more meaningful activities needed to be offered, particularly on Rowan unit. We were told that a full time activity coordinator was currently being recruited to be based on this unit.

Information we saw on display in the home showed a number of activities were planned throughout each week. These included board games, chess, domino tournaments, arts and crafts, making Christmas cards, baking and movement to music. A number of external entertainers also visited the service including a petting zoo, singers and a magician.

People who were able to express a view were generally positive about the activities provided on Holly and Cherry units. Comments people made to us included, "I join in the activities and like to watch television. My favourite is bingo" and "I join in some of the activities mainly bingo and quizzes."

During the first day of the inspection we observed the activity coordinator spending individual time with several people living on Holly unit. We were told they had also supported people from different units to attend a bingo session that day. Children from a local primary school visited to deliver a carol concert on Cherry unit which all people who used the service and their family members were invited to attend. On the second day of the inspection several staff supported a number of people who used the service to visit a local

pub for a Christmas lunch.

Our observations on Rowan unit during both days of the inspection showed there was limited evidence of staff spending 1-1 time with people or providing organised group activities. Although items to stimulate the interest of people who used the service had been placed on walls in this unit, we did not see staff encouraging or supporting people to use these. Staff we spoke with on Rowan unit told us they considered there was not enough focus from the activity coordinators on spending time with people on the unit.

We discussed activities provided throughout the home with one of the activity coordinators. They told us they worked part time but always tried to share out their hours across each of the units to encourage all people who used the service to participate. They told us, "Everyone needs to be doing something." They told us they were aware of the plan for a full time activity coordinator to be deployed on Rowan unit and felt this would be beneficial for people who lived there.

We reviewed the systems for managing complaints received in the service. A copy of the complaints procedure was displayed in the reception area and was included in the service user guide. People who used the service and their relatives told us they would feel confident to approach staff on the units if they wished to make a complaint. Comments people made to us included, "I would go to the unit manager and I think she would listen to me. I am not afraid to voice my opinions" and "The new (unit) manager is all right. You can go to her if you need advice.
If I had a complaint I would go to her."

The area manager told us they would always sign off responses to complaints completed by the registered manager to ensure they met the standard the company required. All complaints were recorded and monitored centrally by the provider so that themes and trends could be analysed. We noted the two most recent complaints were from relatives. These referred to staffing levels and poor communication between staff and relatives resulting in a relative's expectations of the service not being met.

Requires Improvement

Is the service well-led?

Our findings

Although the service had a registered manager in place at the time of this inspection they were absent from work. We were told they would not be returning to the service as they had gained a different position within the organisation. A new manager had been recruited to the service and was due to start in January 2017.

During our inspection our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating.

Before our inspection, we checked the records we held about the service. We found that the service had notified CQC of accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were kept safe.

We were told that leadership within the home had been poor although this had improved recently with the appointment of a new clinical services manager and a new unit manager on Cherry. The manager who had been providing cover to the service in the absence of the registered manager told us they had identified that staff morale within the home was low due to staff not always having received the support they needed. They told us they were confident that the new manager would be able to improve the leadership in the home for the benefit of people who used the service and staff.

Staff we spoke with during the inspection were generally positive about how the service was being run. Comments they made to us included, "The new (unit) manager is supportive and she helps you out when you need it. It did not happen before", "The unit manager is supportive and available. We get the chance to have our say and bring up topics we want to" and "[Name of unit manager] has made a difference. She is a figurehead and will listen."

We saw that staff meetings had taken place on each of the units in July/August 2016. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice. From our review of the notes of these meetings we saw that staffing levels had been raised as a concern on both Holly and Cherry units. As there had not been any more recent meetings we were unable to see what feedback had been provided to staff about the issues they had raised.

The provider had a number of quality assurance systems in place which included a monthly home review, audits in relation to care plans, medication and accidents/incidents. The most recent audit of Rowan and Holly units had been completed on 30 November 2016 and resulted in a rating of 'Red' which meant significant improvements needed to be made. Although action plans had been completed for the audits we reviewed, we found timescales had not been adhered to in relation to the most recent medication audit on Rowan unit. There was also no clear plan articulated to us about how the required actions would be prioritised.

On the first day of the inspection we noted a 'First impressions' audit was completed by the maintenance person. The findings of this audit included a lack of evidence of positive interaction by some staff, some staff not using PPE and improvements needed to the way food was presented on some of the units. We discussed this audit with the maintenance person. They told us they considered identifying ways in which the service could be improved was an important part of their role. They advised us that they considered the environment on Rowan was not stimulating enough for people who lived on that unit. They were therefore making plans with the hotel services manager to improve the décor and furniture on the unit to improve the comfort and well-being of people who used the service.

We saw that some relative/resident meetings had taken place on each of the units since the last inspection although none of the relatives we spoke with were aware of these. When we looked at the minutes from the meeting in February 2016 on Rowan unit we noted that relatives had requested that more meaningful activities be provided; the fact that this was identified as a shortfall during this inspection meant the views of relatives had not been acted upon in a timely manner although we acknowledged the plan to recruit a full time activity organiser to be based on this unit.

The lack of robust quality assurance processes was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have robust systems in place to ensure the proper and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems in place did not drive forward improvements in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes in the service were not sufficiently robust to protect people who used the service from the risk of unsuitable staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of staff were always deployed to meet the needs of people who used the service. Staff had not been provided with regular supervision to help ensure they were able to deliver effective care.