Holy Cross Care Homes Limited

Bradeney House Nursing & Care Home

Inspection report

Worfield
Bridgnorth
Shropshire
WV15 5NT

Tel: 01746716686

Date of inspection visit:
05 July 2016

Date of publication:
05 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 5 July 2016 and was unannounced.

Bradeney House is registered to provide accommodation with nursing care for up to a maximum of 97 people. There were 95 people living at the home on the day of our inspection. People were cared for in five units over three floors. Some people were living with dementia.

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

The checks the provider had in place to monitor the quality and safety of the care were not always completed. Therefore they had not identified inaccuracies in care records or the inconsistencies in the quality of care across the home.

The provider did not ensure that all staff had the necessary communication skills to support people effectively. Staff had mixed views on the quality of training provided but felt they could approach their seniors for support when needed.

People did not receive adequate support to eat their meals in a dignified manner. There were charts in place to monitor what people ate and drank but these charts were not always accurately completed. This placed people's health and wellbeing at risk.

People were not always responded to appropriately or in a timely manner when they were distressed. People's privacy was not always protected.

People's preferences were not always known or respected. Although there was a range of activities on offer these were not always suited to people's needs or preferences. On one unit staff were working with a new approach on how best to support people living with dementia to positive effect.

There was a complaints process in place but this was not always followed. Concerns were not always dealt with to the satisfaction of the complainant. People were asked for their views on the services but recommendations for change were not consistently applied by all staff.

People were supported by staff who were able to recognise the different signs of abuse and knew who to report concerns to. Staff were aware of the risks associated with people's needs and how to minimise these risks. Staff demonstrated they would take appropriate action in the event of any accidents or incidents. The management analysed the information to identify any trends and action required to prevent reoccurrence.

People were supported to take their medicines as prescribed and accurate records were maintained. Staff received regular competency assessments to ensure the ongoing safe management of medicines. Staff monitored people's health and arranged medical appointments as required to maintain good health.

People were involved in decisions about their care and treatment. Where people were unable to make decisions for themselves these were made in their best interest by people who knew them well.

People and their relatives found staff and management friendly and caring. Staff promoted people's independence.

Staff found the management team approachable and supportive of them in their roles. Staff were asked their opinion on how the service could be improved and felt listened to.

You can see what action we told the provider to take and the end of the full report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff to meet people's needs. People were supported by staff who knew how to protect them from harm and abuse. Staff were aware of the risks associated with people's needs and how to minimise these. People received support to take their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not ensure that all staff had the necessary communication skills to support people effectively. Staff monitored people's health and arranged health care appointments as needed to maintain good health. Where people were unable to make certain decisions these were made in their best interest by people who knew them well.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always responded to appropriately or in a timely manner when they were distressed. . People did not receive adequate support to eat independently in a dignified manner.
People were involved in decisions about their care and found staff to be friendly and caring. Staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's preferences were not always known or acted upon. The provider had a clear complaints process but this was not always followed .The provider sought people's and staff's opinion on the quality of the service to drive improvements. The provider was trialling a new approach to dementia care with positive effect.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of effective leadership. The registered manager had not identified the inconsistencies in the quality of care provided. Checks in place to monitor the quality of the service had not always been completed and therefore shortfalls had not been identified. People found staff and management friendly and approachable. Staff felt supported and listened to.

Bradeney House Nursing & 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 5 July 2016 and was unannounced. The inspection was conducted by four inspectors, a specialist adviser and two experts 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.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We used this information to plan the inspection.

During the inspection we spoke with 14 people who used the service and seven relatives. We spoke with 23 staff which included the registered and deputy manager, nursing, care and support staff. We also spoke with a visiting health care professional. We viewed eight records which related to assessment of needs and risk. We also viewed other records which related to management of the service such as medicine records, accidents reports and recruitment records.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is specific way of observing care to help us understand the experience of people who were unable to talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at the home. "I feel safe alright. I would soon tell them if I wasn't". Another person said they always felt safe and secure. They knew they could report any issues to the staff and were confident they would address them. Two people told us they kept their valuables secure by storing them in the safe or in a lockable cupboard in their room.

Staff we spoke with had received training on how to protect people from abuse and discrimination. They were able to tell us about the different signs of abuse and who they could reports concerns of abuse or poor practice to. For example, one staff member said, "Any incident I felt was wrong would be reported to the manager straight away". Staff were confident that the registered manager would take appropriate action. They also knew that they could report their concerns to the local authority or the Care Quality Commission. The registered manager was aware of their responsibilities to report any concerns to the local authority. They said they always reported their concerns to the local authority safeguarding team and followed advice from them prior to conducting their own investigations. The registered manager had taken appropriate action and notified us of safeguarding concerns as they had occurred.

People were supported to move around the home safely. We saw one person was assisted by two staff with a hoist to transfer from their wheelchair to their armchair. We asked them how they felt during the transfer. They said, "It's very safe and comfortable – there is never any fear and I trust them [staff]. When I first came here we discussed the use of the hoist and that this would be the safest way to move around". Another person said, "I have difficulty moving and I need this [frame] to keep me safe". Staff told us they looked out for any changes in people's ability. For example, one person was assisted to walk by two members of staff. One of the staff members explained that the person was assessed as high risk of falls and was particularly unsteady on their feet that day. They had therefore asked another staff member to assist and had reported their concerns to the nurse. We saw that comprehensive risk assessments had been completed for each individual. These included risk of falls and risk to nutrition and skin integrity. However we found that there were some inaccuracies in some people's waterlow charts. Waterlow is a tool used to monitor people's skin integrity and allows staff to determine what intervention would be required to prevent skin breakdown. Where people were assessed as being at risk of skin breakdown staff were able to show us what they did to prevent this. If they had any concerns they would report these to the nurse. People also had pressure relieving equipment in place to reduce the risk of pressure sores developing. Where people were at risk of falls motion sensor alarms were in place to alert staff when people were attempting to mobilise unaided. We also saw that there were personal emergency evacuation plans in place for each person living at the home. These detailed the support people would need to evacuate from the home in the event of a fire or any other emergency.

People told us that, although staff were at times rushed they responded to their call bells in a prompt manner. One person said, "I don't have to wait long at all for my bell to be answered". Staff had different views on staffing levels. Some staff felt there were ample staff to meet people's care needs and spend one to one time with them. Two staff told us they would benefit from additional staff to allow them to spend more time talking with people. The registered manager told us and we saw that dependency assessments were

completed to determine staffing levels. We saw there were enough staff to meet people's needs. People were supported in a patient and unhurried way.

The registered manager told us that their recruitment process ensured that potential staff had two references and Disclosure and Barring Service (DBS) checks in place before they started work at the home. The DBS is a system which allows organisations to check potential staff are suitable to work with people who use their services. Staff we spoke with confirmed that these procedures were followed prior to them starting working. One staff member told us, "I was interviewed and after the offer I had to give two references and a DBS check". Although we found DBS checks were in place before staff started work we could not understand the information on all the staff records as it had not been recorded in English. We were therefore unable to establish whether staff were suitable to work with people. The registered manager told us that they had used a translator to determine staff suitability. They acknowledged that the translations should have been recorded on staff records.

Staff demonstrated they would take appropriate action in the event of an accident or incident. They would initially attend to the person and alert senior staff. They would subsequently complete the necessary forms and give these to the registered manager to review. The registered manager told us they would analyse the forms for any trends. If there was evidence of increased falls they would arrange a medical review or make a referral to the falls clinic. In the event of incidents of increased anxiety they would complete behaviour charts. They would share these charts with the mental health team who would advise on how best to support the person to reduce reoccurrence.

People's medicines were not always stored at the correct temperature. We found that two medicines which should have been stored in a fridge were stored in a cupboard where the temperature exceeded the manufacturer's guidance. This could alter the effectiveness of the medicine. We spoke with the clinical services manager who stated these medicines should have been stored in the fridge they agreed to rectify the situation. People told us staff supported them to take their medicines when they needed them. One person said, "I never have to wait for my medicines and if I ever have any pain they are always the first to offer [pain relief] and make sure I am comfortable. [Staff member's name] will always come back a little later just to make sure I am OK. I trust them to do what they say they will". Another person said, they always had their medicine on time and that the staff member remained with them until they had taken it. We saw people being offered assistance with their medicines. One person was gently made aware of the staff member's presence with light touch on their hand. When this person had orientated themselves the staff member asked them if they would like their medicines. This was provided in a safe way and the staff member stayed with them to ensure they were ok after taking the medicines. Only staff who had training to administer medicines safely did so. They told us regular checks were made to ensure that they were competent to support people safely. Records we looked at confirmed this.

Requires Improvement

Is the service effective?

Our findings

Although caring and attentive we found that some staff could not communicate clearly with people. One person said, "It's ok here and the staff are ok – well some of them are but you have to make yourself clear because they don't all understand you – I make them understand". They explained this was because some staff did not speak or understand English well. One relative we spoke with raised concern that not all staff were able to speak English with them or their family members. We saw that some staff struggled to make themselves understood as they had limited English vocabulary. This made it difficult when they supported people who were living with dementia as they had difficulty explaining things to them and in responding to their conversations.
We too had difficulty speaking with some of the staff as they were not able to answer some questions we asked about people's care and support needs. One staff member explained in order to enable some staff to understand the support people required, people were encouraged to use flash cards to tell staff what they wanted. We spoke with the registered manager about this. They told us that the staff in question were tactile and caring and not all communication needed to be verbal. They said these staff worked with staff whose first language was English. They also provided bilingual summaries of people's needs. In addition to this they also provided English lessons to staff whose first language was not English.

People had mixed views about the choice of and quality of meals. One person told us that meals were often cold when they reached them and had to be warmed up in the microwave. This was confirmed by a staff member. There was a microwave available on the unit which was used to reheat meals as required. The registered manager told us that staff had been instructed not to plate up food until people were ready to be served to prevent it going cold. When asked about the quality of the food one person said, "Yes I suppose it's good food – it seemed great at first but it is so repetitive. I have no complaints except the lack of variety. I have mentioned it but nothing changes". Other people we spoke with told us that they were offered a choice and were happy with the meals provided. One person said, "It's never a problem. You can have what you want when you are a little peckish". Another person said, "We had a choice for breakfast this morning. I had cereal but could have porridge – which is lovely here. You can also have bacon, sausages and toast if you want. Lunch is excellent". Staff told us people were able to choose what they wanted to eat and could ask for an alternative if they did not like what was on offer. Where people were unable to verbalise their views some staff told us they used pictures to help people to choose. However, we saw that not all staff used the pictures or other forms of communication to assist people to be involved in choices about what they would like to eat.

People's nutritional needs were routinely assessed and monitored. Where required there were speech and language therapy assessments in place to guide staff about people's dietary requirements. Staff were aware of people's dietary needs, such as who required thickeners in their drink and who required pureed meals. Staff told and showed us there were charts in place to monitor what people ate and drank however, we found that these were not always accurately completed. They explained if it was found that people had not drank or eaten then this was highlighted to staff during handover.

Staff told us they had access to a range of training relevant to their role. One staff member said, "They [management] encourage you to complete further training and will allow you time at work to do it". Staff had mixed views on the quality of training they received. Two staff felt that the training via DVD was not effective. One staff member said, "The training is all on DVD. We don't get the time to talk through it. If I didn't understand it there is no one to ask". However, another staff member told us they enjoyed watching the training DVDs and learnt from them. They said, "Sometimes we think we know what to do but the training shows me the right way". Staff were complimentary about the face to face training that they received. Two staff had found the fire training very beneficial as the trainer simulated the events of a fire with artificial smoke. They felt this training had given them the practical experience and confidence to support people to safety in the event of a fire. A nurse who had undertaken tissue viability training told us they had enjoyed and learnt from this training. They said. 'I can now diagnose if a wound will get better, I learned a lot". The registered and deputy manager told us they offered a range of training which included watching DVDs and practical training. They said the DVD training incorporated a test to see what staff had learned. If they felt that the staff member required further training this would be arranged. They also supplemented DVD training with role play where needed. The registered manager told us they had given a nurse the responsibility for monitoring and arranging training to meet staff development needs.

Staff told us they had regular one to one meetings with their seniors where they were able to discuss their development needs and get feedback on their practice. For example, one staff member told us they had asked for additional training to help move people safely. They were provided with a DVD and had practical training on the use of equipment from the deputy manager. Another staff member said, "I feel listened to, if there are any problems in between I can go to a senior". New staff we spoke with told us they completed a range of training such as manual handling and first aid prior to working with people. They also worked alongside experienced staff until they felt confident to support people on their own.

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. Staff we spoke with demonstrated a good understanding of the MCA and how to apply it to practice. They understood that if people were unable to make certain decisions for themselves, they needed to ensure that decisions they made on their behalf were in their best interest. We saw that best interest decisions had involved the person, their relatives and relevant professionals.

People's consent was not consistently sought before staff supported them. We observed that some staff assumed consent and proceeded to support people without asking or explaining what they wanted them to do. For example, staff placed tabards on people without any explanation of what they were doing or what they were for. However, we also some positive interaction where staff talked and reassured people as they supported them. Staff we spoke with told us they asked people's permission before supporting them and respected their right to decline support. If people declined support they would return later and were clear that they would not force anyone to accept support. They told us they encouraged and enabled people to be involved in decisions. Where people had difficulty communicating verbally they would use pictures, write things down, observe facial expressions or gestures.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. Where DoLS were in place we saw that the provider had a checklist in place which ensured risk

assessments were reviewed monthly and that the DoL remained appropriate. This process also ensured where DoLS applications had been submitted but not authorised people's safety was protected in the least restrictive manner.

People told us staff monitored their health and arranged medical intervention when required. One person said, "If it wasn't for the staff here I would be dead twice over. They saw that I was unwell and got the ambulance out to me on two occasions. If I ever need a doctor they will always ensure I see one without delay". This was confirmed by a staff member who told us that they recognised when people were not their usual self. For example, they noticed that one person was not responding to them as they normally did so they arranged a doctor's appointment. The doctor identified a build-up of earwax which was treated and the person was able to interact better. We spoke with a visiting health professional who told us that communication with staff had improved. They said referrals were now triaged by a nurse at the home to ensure they were appropriate and advice given was acted upon. We saw that do not attempt cardiopulmonary resuscitation (DNACPR) forms in place had been completed with consultation with the doctor the person and any family members. These followed current guidelines and were readily available in people's care records

Requires Improvement

Is the service caring?

Our findings

The quality of care provided to people differed across the home. While some people were positive about the care that was provided we found the delivery of care was not consistent. We saw that people were not always responded to appropriately or in a timely manner when they were distressed. We heard one person calling out loudly from their bedroom for in excess of 30 minutes. We approached a member of staff who provided support and reassurance to the person which calmed them down. The staff member explained that this person was living with dementia which caused them to call out. They told us and we saw in the person's care records that they responded positively to staff interaction during periods of distress. We were concerned that although this was known to staff they had not responded to the person's calls until we intervened. A relative felt that staff spent excessive time completing paperwork rather than interacting with people and settling them when they were anxious. At lunch time we saw that another person became distressed by the colour of the table cloth which was red with white spots. The person kept shouting about blood whilst wiping the table cloth with their hand. They were not offered alternative seating but encouraged to remain at the lunch table. We saw that they eventually calmed down with reassurance from staff but ate very little of their lunch.

People's meal time experience varied across the different areas of the home. We saw that not all people received the care and support they required to eat independently. Some people had adapted cutlery and crockery to aid their independence. Some people were supported to cut up their food and where required, received supported to eat in a dignified manner. However, on the Kensington unit we saw that people were struggling to cut up their food and no support was offered by the staff who were present. One person could not cut their sausage and had to pick it up whole with their fork and bite bits off. Napkins were not consistently offered or provided. As a consequence staff wiped the faces of two people with blue paper towels. On the Chatsworth Unit people were not offered napkins or tabards to protect their clothes. People who struggled with their cutlery resorted to eating with their fingers with much of their food falling down their front or on their laps. Some people had their plates removed whilst they were still eating off them. We also found that people were not always spoken about with due respect. For example, some staff referred to people as 'feeders'.

People we spoke with us told us they found staff to be caring and kind. One person said, "The carers here are lovely, first class. Moving here was my first choice and I have not regretted a single day. You can always have a bit of a chuckle with them [staff]". A relative we spoke with said, "They [staff] are genuine and caring". There were no restrictions on visiting times and relatives found staff welcoming. One relative told us they got on well with staff and said, "I just walk in at any time". A staff member told us how they enjoyed working with the people living at the home. They said, "I enjoy my job. I like being able to make sure they're happy and make them feel comfortable in this environment"

People told us they were given choice and involved in decisions about their care. One person said, "When getting up I am always offered a choice of what to wear". Another person said, "I can do as much or as little as I want there is no pressure and it is my choice". A visitor told us they were involved in decisions about their family member's care they said, "They [staff] ring me about any concerns. I feel they love my [Family

member]". Staff told us they involved people in decisions about their care by giving them choices in a way they understood. One staff member told us, "If people can't verbalise, we show them pictures of food or clothes". Another staff member said, "Everything is done to the way they want it". They went on to say, "All of these people have a choice. Just because they have dementia doesn't mean they don't know what they want".

People told us staff protected their dignity by supporting them with personal care in private. One person said, "They cover up my bits when I dress and shower. I think that the staff are very good and do respect me". A staff member told us they were mindful of people's dignity and where appropriate would stand outside the bathroom door until they called for assistance. They said they also placed do not disturb signs on people's bedroom doors when supporting them with personal care. Another staff member explained the steps they took to preserve people's dignity. They said, "We make sure their hair is brushed, clean and presentable". We saw that staff supported people discreetly with their personal care and ensured that their clothes were suitably arranged so that they were not exposed. People told us that staff promoted their independence by allowing them to do what they could for themselves and only provided support where needed. This was confirmed by staff who told us if they were supporting a person to wash they would give them the flannel to wash where they were able. They said, "They need to be able to know they can still do things".

Requires Improvement

Is the service responsive?

Our findings

People's preferences were not always known or respected. While some staff we spoke with demonstrated they knew people and their preferences well, other staff had limited knowledge of these or of people's past lives. A relative we spoke with told us their family member's preference was to be supported by female staff but they had been supported male staff. They had complained to the management but there had been further instances where their family member had been supported by two male staff. When we looked at the person's care plan we found it was recommended the person be supported by female staff to reduce their anxieties. This showed that people's known preferences were not always respected by staff. When we spoke with the registered and deputy manager they said they were not aware of concerns raised about gender, only that there had been a request for consistent support. They agreed to review the person's support needs and preferences.

The registered manager told us and showed us they had a clear process for dealing with complaints. However we found that this was not consistently followed. For example, one relative told us they had met with the previous manager about concerns they had about their family member's care. We saw in the person's records a meeting had taken place the previous month between the manager and the relatives. When we spoke with the registered manager and clinical services manager they were not aware of any such meeting or the nature of the concerns. The clinical services manager told us, "It would appear that the process was not followed in this instance". The registered manager told us they were unable to find a record of the complaint as the manager who had been dealing with it had left. They agreed to contact the family and arrange a further meeting. We found further examples of concerns that had been raised by people or their relatives which the registered manager was not aware of. We therefore could not establish what if any action had been taken to rectify these. The registered manager agreed to follow these up.

People had the opportunity to engage in a variety of activities but had mixed views on their suitability. One person told us, "We are involved in a number of activities and never get bored". However, another person said, "I do get very bored here – we do get asked if we want to do things but they are not the sort of things I want to do". We found that some staff had limited knowledge of people's past lives or interests. This meant they could not instigate effective communication in relation to their past and things that were important to them. In some areas of the home we saw that activities were not always suited to people's interests and abilities. Some people living with dementia struggled with the activities offered despite the support and encouragement provided by staff. For example, one person tried to put jigsaw pieces in their mouth until a staff member intervened. We asked the activities worker how decisions were made about the activities offered. They told us they used the internet and spoke with other activity workers both within the home and at other establishments. They showed us that there were different activity boxes available such as jigsaw puzzles and reminiscence boxes. They rotated and delivered the boxes around the different units for care staff to undertake with people. They said they also did other activities such as gardening, bingo and trips out. They said that staff on the Windsor unit were developing folders that determined people's interests, abilities and support needs. The registered manager told us they had two wheelchair accessible vehicles which they used to accommodate trips out, take people to appointments and which family could use to take their family members out in. We saw that some people had recently been on a trip to a dementia

awareness day at a local attraction.

On the Windsor Unit staff told us they were working on a new approach called the Pool Activity Level (PAL) which looked at how best to support people living with dementia. Staff completed a checklist which involved gathering information on people's background, interests and current abilities. They then used this information to create an individual action plan which gave preferred routines in areas such as eating, drinking and activities. They had used this approach to positive effect for one person who previously was reluctant to engage in activities but was now taking part. The staff explained that the new approach encompassed sensory stimulation such as using the smell of bubble bath to encourage people with bathing. Staff on this unit demonstrated that they knew people well and utilised this knowledge to engage in meaningful activities with them. For example, staff told us one person used to be a jockey and had a continued interest in horses. They enjoyed watching horse racing on television. Staff would also take this person to the back of the grounds where they could watch the horses in the neighbouring field. We saw that staff interacted well with people and responded appropriately to changes in need. Staff had created an environment that provoked memories and encouraged reminiscence. For example, people had memory boxes which were personalised with photographs of family, pets, gardening equipment etc. There was a memory tree in the corridor which people were encouraged to decorate with their memories. We also saw that there was a selection of memorabilia for people to engage with. A staff member told us that one person used to be a telephonist. They found that they could use the old fashioned telephone they had on the unit to engage them in conversation about their past. Another staff member was performing magic tricks with a person who liked to play cards.

The registered manager told us that they assessed people's needs before they came into the home to ensure they could meet their needs and expectations. This was confirmed by one of the people we spoke with who said, "Before coming here, they [staff] came out to see me and did my care plan with me and got to know me that way. When I moved in they [provider] encouraged me to personalise my room with my own pictures and furniture". Another person said staff had asked about their care and what was important to them". A nurse told us the initial assessments were developed further with the person and their family once they moved into the home. They said this allowed them to personalise the support provided and accommodate people's needs and wishes. A relative we spoke with told us they were kept informed of any changes such as progress made or any health matters. Staff told us they were made aware of any changes in people's needs during handover. They said they could also refer to people's care plans or speak to their seniors if they were unsure about people's needs. They in turn would report any concerns or changes to the nurse or their seniors. Staff told us and we saw that people's care plans were reviewed on a monthly basis or sooner if people's needs changed.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider had not displayed the most current inspection ratings on their website and they were not displayed at the home. The registered manager told us the ratings were displayed next to the visitor's book in reception, however when they checked they found that this had been put away on a shelf. Providers are required to conspicuously display ratings at the home and on their website, no later than 21 days after the report has been published on the CQC website.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was also the owner of the service. They had employed a manager to oversee the day to running of the service. However, the manager had left the day before our inspection. The provider had a range of checks in place to monitor the quality of the service however these were not consistently completed and therefore were ineffective. For example, we found that fluid balance and waterlow charts were not always accurately completed which left people at increased risk to their health and wellbeing. We spoke with the clinical services manager in relation to inaccurate recording of people's fluid intake who told us, "Staff should total the amounts but I realise this has not been happening". They went on to explain that quality audits had not been completed as regularly as they had anticipated. They told us this was because of recent changes to the management structure but they were making attempts to address this. They stated that had the quality checks been performed as required then these deficits would have been identified.

People's experience of care and support differed significantly across the home. These inconsistencies had not been identified by the registered manager. The registered manager told us they were not aware of the inconsistencies in staff practice or of all the complaints that had been raised and therefore corrective action had not been taken to address these. They also did not acknowledge the impact that some staff's lack of English language skills could have upon people, especially those living with dementia.

The registered manager told us their vision for the service was to be outstanding and to be the best home in the country. They wanted the people who lived at the home and their staff to be happy. They told us they had spent a lot of money and resources on the environment and wanted to reflect this in people's care. One staff member said, "I believe the values of the provider are to see the best in people and bring out their potential. By creating a happy and safe working environment staff feel happy and secure and therefore people benefit from a happy team." Another staff member said, "It's about doing the best we can for people".

People we spoke with told us they found the registered manager approachable. One person said, "I have spoken to the manager, and [registered manager's name] does listen usually". Relatives told us management were available to speak to them when needed. One relative said the provider was 'good and supporting' and that the clinical services manager was 'superb'. People and their relatives felt that the atmosphere at the home was friendly and caring. One person said, "It's very happy and friendly, I occasionally see the manager. I speak to them, and yes, I think that they listen to me".

Staff told us they saw the registered manager and other managers on a regular basis. They felt well supported by both the management team and other staff. One staff member told us that the managers helped out if they saw they were busy. They said, "Good teamwork, support each other". They went on to explain that this support was one of the reasons they still worked at the home. Another staff member told us, "Everyone will help everyone within the home". They explained that staff and managers helped each other and they felt supported. Staff told us there was always a manager on call to support them outside office hours. Staff told us they had regular team meetings, felt comfortable to speak out and felt listened to. For example, one staff member told us that staff had suggested that the Windsor unit needed refurbishing to create a better environment for people living with dementia. The registered manager had arranged for the work to be done.

People and their relatives told us they had opportunities to give their views on the service through meetings held at the home and through surveys. When asked about the meetings one person said, "Yes I have attended, but there was nothing of interest raised". Another person told us they would get their relatives to bring up any issues at the meetings. One relative said at the last meeting they discussed the accommodation, the care and food. We found that actions agreed were not always completed. For example, people had requested pictures of meals to be made available to help them make a decision about what they wanted to eat. We saw these had been introduced in some but not all areas of the home. Two other relatives were not aware of the meetings but said they would speak directly with the registered manager if they had any issues. The registered manager told us they employed an advocate to facilitate meetings for people and their relatives. Details of the meetings were advertised on a notice board in the home. The advocate was also available to support people to raise concerns or complaints about the services. The registered manager told us they used various methods to gain feedback from people, relatives and visiting professionals. They used the information gathered to drive improvements in the service. Results and actions from feedback were displayed in communal areas for people and relatives to look at.

The registered manager told us they were keen to build and maintain links with the local community. They said they had links with the local church whose representatives visited the home. People could attend the church if they preferred. They had visits from the local school and provided work placements for students. They also encouraged visits from local groups such as, the local choir and the British legion.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to conspicuously show the rating from their inspection both within the home and on the provider website.